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DEPT. OF HEALTH AND HUMAN SERVICES

Division of Medicaid & Long-Term Care

Nebraska Medicaid Reform Annual Report for State Fiscal Year 2016-2017

December 1, 2017

Prepared in Accordance with Neb. Rev. Stat. § 68-908(4)

Message from the Director:

I am pleased to present the state fiscal year 2016-2017 Medicaid Annual Report.

As outlined in this report, the Division of Medicaid and Long-Term Care (MLTC) continues its commitment to increase efficiency, improve the delivery of services, and manage costs of the Medicaid program in Nebraska. This report offers a review of the ongoing work of the Division, highlighting the year's major initiatives, and describing the major projects for this fiscal year.

Our focus for this fiscal year is to continue improving the delivery of health care in Nebraska. The work of MLTC this year and next is to evaluate our programs and make changes to better support quality health care delivery in the state. Internally, we have worked to provide better fiscal and program information to the legislature and the public. Through initiatives like Heritage Health, long-term care redesign, and the MMIS modernization project, we are transforming Nebraska Medicaid to better meet the needs and challenges of the twenty-first century.

The Division looks forward to working with the legislature and our community partners in the year ahead as we undertake major initiatives to improve the provision of services to our clients. As we begin 2017, the Division is excited about the progress made and the work ahead. MLTC operates according to DHHS's mission, "Helping people live better lives," and we constantly strive to improve the quality of care provided to our state's most vulnerable residents.

Please contact me if you have any questions about this report.

Thomas "Rocky" Thompson, Interim Director
Division of Medicaid & Long-Term Care
Department of Health and Human Services

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I. EXECUTIVE SUMMARY

The Division of Medicaid and Long-Term Care (MLTC), part of the Nebraska Department of Health and Human Services (DHHS), is the administrator of the state's Medicaid program. With an appropriated budget of over two (2) billion dollars, MLTC provides health care to twelve percent (12%) of Nebraska's residents, including low-income children and their parents, the aged, and individuals with disabilities.

Every state outlines the eligibility, benefits, provider payments, and service delivery systems of its specific Medicaid program within guidelines set by the federal government. Although there are numerous federal requirements, eligibility, service delivery, and benefit packages can vary from state to state.

The greatest change implemented over the last fiscal year was the method of service delivery. Over the past twenty years, the method of delivery for Medicaid in the state has moved gradually from fee-for-service (FFS) to capitated managed care. Following an expansion of physical health managed care in 2012 and the coverage of behavioral health through capitated managed care in 2013, the state has integrated physical health, behavioral health, and pharmacy services through three statewide managed care organizations (MCOs) in a program called Heritage Health. Beginning on January 1, 2017, nearly all Medicaid clients were enrolled in managed care, including previously excluded populations. Most services are now delivered through managed care with the exception of long-term services and supports.

Medicaid is a significant payer of health services in Nebraska. Contracting with approximately 45,000 medical providers, MLTC has an important partnership with the medical community for the delivery of care. The Medicaid MCOs are required to maintain robust provider networks by federal law and their contracts. In state fiscal year 2017 (SFY17), over $2.1 billion was paid for services by Nebraska Medicaid.

MLTC takes seriously the trust the state's safety-net population and taxpayers place in it to provide quality health care in a cost-efficient manner. To achieve this goal, MLTC is undertaking many reforms to its information technology systems to transform how program data is gathered, service payment is made, and program eligibility (for clients and providers) is determined. Additional reforms are being made in modernizing processes and program regulations.

MLTC has made tremendous strides over the past fiscal year and looks forward to continuing its work in state fiscal year 2018.

II. MLTC STRUCTURE

MLTC includes Medicaid, Children's Health Insurance Program (CHIP), and the State Unit on Aging. Medicaid pays for health care services to eligible elderly, persons with disabilities, low-income pregnant women, children and their parents, covering more than one in every ten Nebraskans. The Division also administers non-institutional home and community-based waivers including the aged, adults and children with disabilities, and infants and toddlers with special needs.

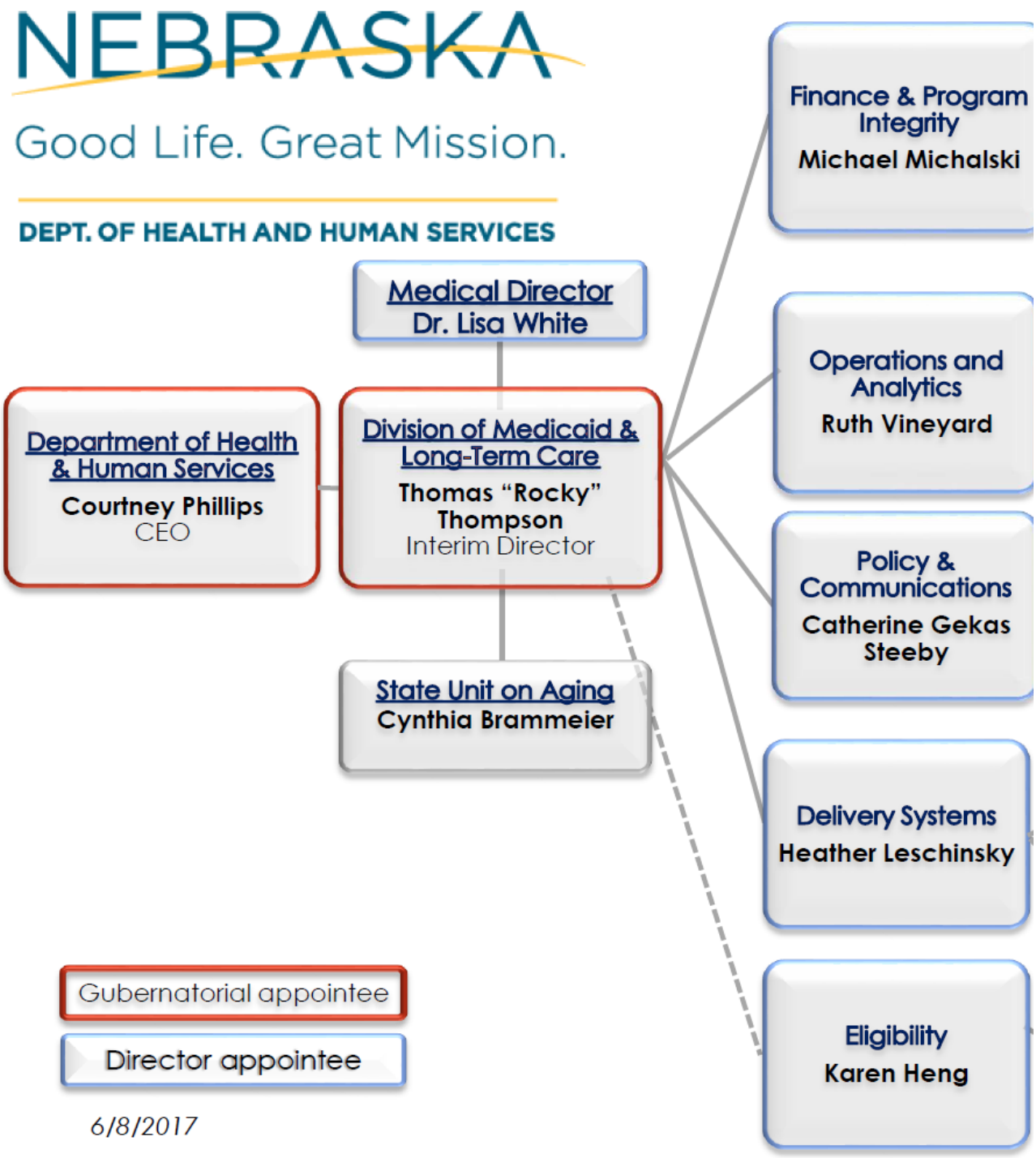
MLTC is divided into five sections with nearly six hundred full-time employees. During state fiscal year 2017, the Division continued a planned realignment to better manage the changing responsibilities as the State moved from payment of claims to contract administration. The Division is structured as follows:

- Delivery Systems: This section is responsible for oversight of the managed care program and its associated contracts (Heritage Health), home and community-based services, and benefit design.
- Operations and Analytics: This section has responsibility for business operations, technology initiatives to improve operational effectiveness, data analytics and supporting functions.
- Policy and Communications: This section is responsible for external communications, regulatory compliance, and oversight over the federal authorities under which the Medicaid program operates.
- Finance and Program Integrity: This section oversees the program integrity unit, provider enrollment, financial analysis and reimbursement, budget, and associated reporting.

The Division also includes the State Unit on Aging, which collaborates with public and private service providers to ensure a comprehensive and coordinated community-based services system that will assist individuals to live in a setting of their choice and continue to be contributing members of their community.

Beginning in SFY17, MLTC partnered with our sister Division of Children and Family Services (CFS) to implement a more streamlined organizational structure for eligibility field operations, overseen by the CFS Deputy Director of Field operations, who also reports to the Medicaid Director.

Chart 1: MLTC Leadership



III. ELIGIBILITY AND POPULATIONS SERVED

Nebraska Medicaid is a public health insurance program that provides coverage for low-income individuals. Originally enacted in 1965 under Title XIX of the Social Security Act, Medicaid is an entitlement program (a program that guarantees benefits to anyone who meets the qualifications) covering a low-income population that primarily includes seniors, children, and individuals with disabilities.

Nebraska Medicaid, in general, provides coverage for individuals in the following eligibility categories:

- Children,
- Aged, blind & disabled (ABD),
- Pregnant women, and
- Parent/caretaker relatives.

Eligibility factors vary by group and include income and resource guidelines. Medicaid enrollment and costs are closely related to the economy. Nebraska has had a fairly robust economy over the past several years, with both poverty rates and unemployment rates below the national average, as reflected in chart 2 and 3. This is reflected in total Nebraska Medicaid enrollment remaining fairly low (a little over twelve percent of the state's population) and the total Medicaid enrollment being fairly stable in Chart 4.

The major changes to enrollment as reflected in the chart show a modest growth in program enrollment during the Great Recession and the impact to two new eligibility groups. Effective July 19, 2012, Nebraska implemented a separate CHIP program that added prenatal and delivery services for the unborn children of pregnant women who are not Medicaid-eligible.

Chart 2: Nebraska Population by FPL Compared to the National Numbers

	Nebraska	United States	Percent of Nebraskans	Percent of Entire US
Under 100% FPL	184,700	41,077,500	10%	13%
100% to 199% FPL	298,700	54,621,300	16%	17%
100% to 399% FPL	627,300	94,275,300	33%	29%
Above 400% FPL	765,500	130,397,800	41%	41%

Chart 3: Average Unemployment Levels

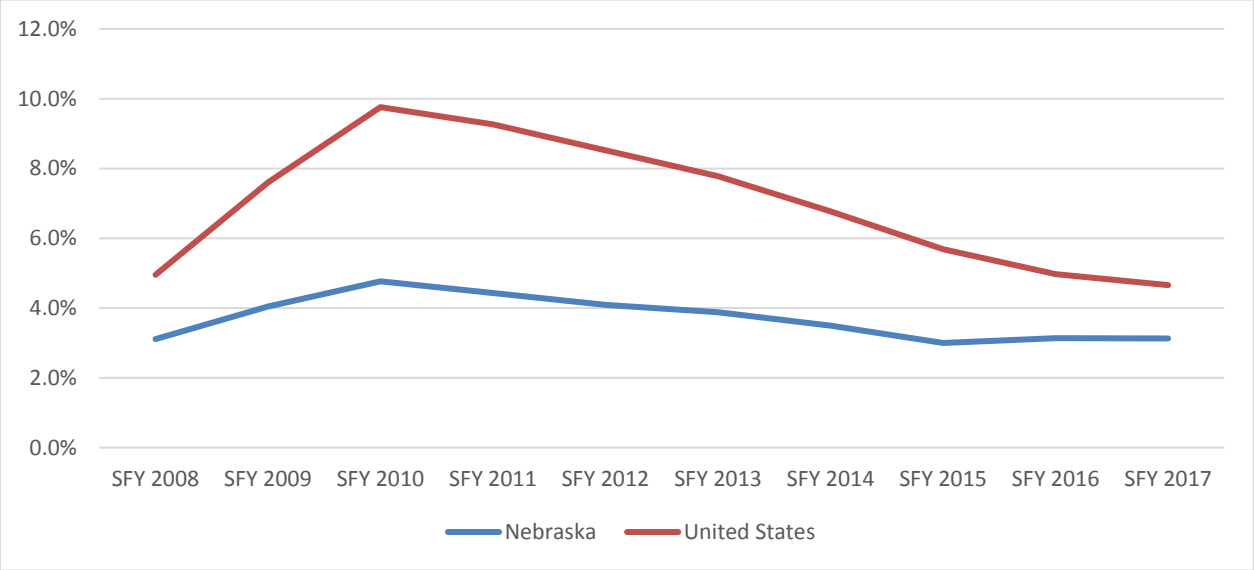
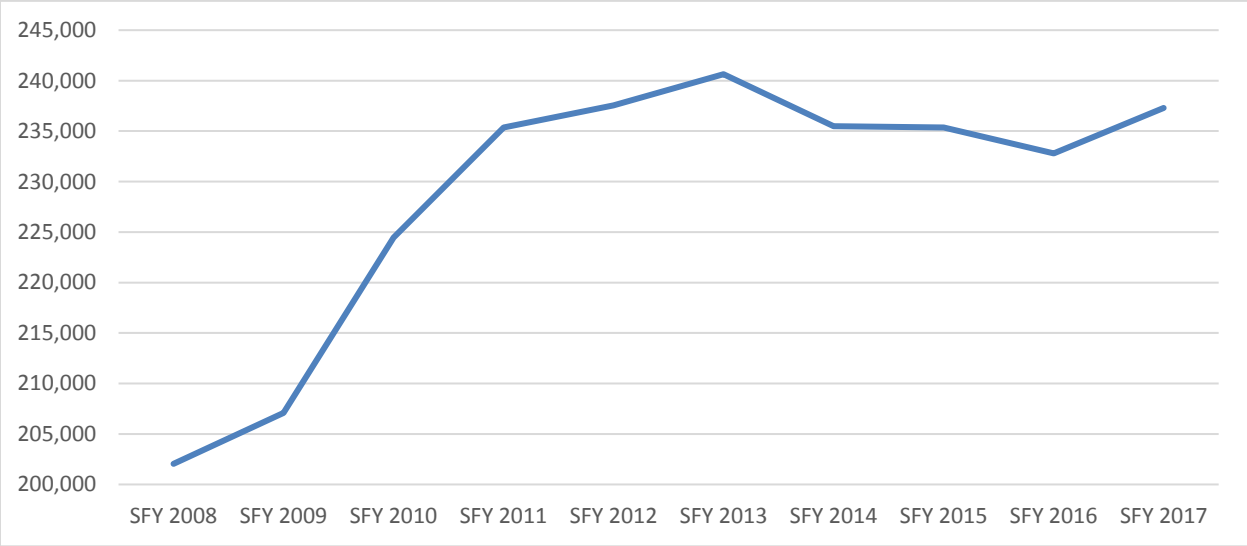


Chart 4: Average Monthly Medicaid Clients by SFY



The majority of Nebraska Medicaid clients (including CHIP children, pregnant women and parents/caretaker relatives) are subject to modified adjusted gross income (MAGI) budgeting methodology as required by the ACA. It uses federal income tax rules and tax filing status to determine an individual's eligibility for Medicaid. This change was to simplify eligibility for certain groups and align it with eligibility for the state insurance marketplaces. Other Medicaid eligibility groups in the state are still subject to other criteria, specifically groups that do not qualify subject solely to income. These are groups that qualify based primarily upon age or disability.

Chart 5 provides the 2017 federal poverty levels and Chart 6 explains several of the Medicaid programs. MAGI groups are in blue.

Chart 5: 2017 Poverty Guidelines

Household Size	50% FPL	100% FPL	138% FPL	200% FPL
1	$6,030	$12,060	$16,643	$24,120
2	$8,120	$16,240	$22,411	$32,480
3	$10,210	$20,420	$28,180	$40,840
4	$12,300	$24,600	$33,948	$49,200

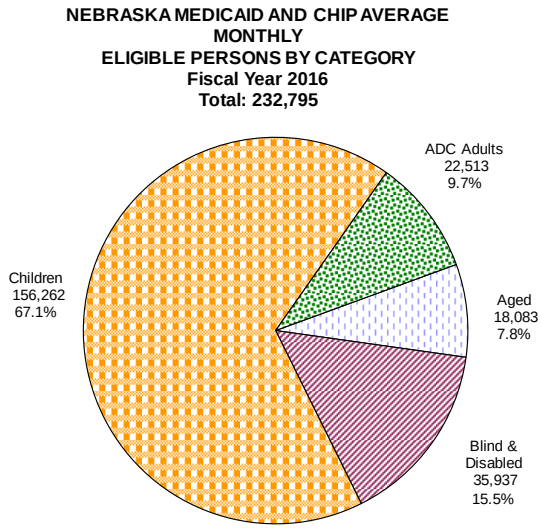
Chart 6: Nebraska Medicaid Coverage Groups and Income Eligibility Requirements

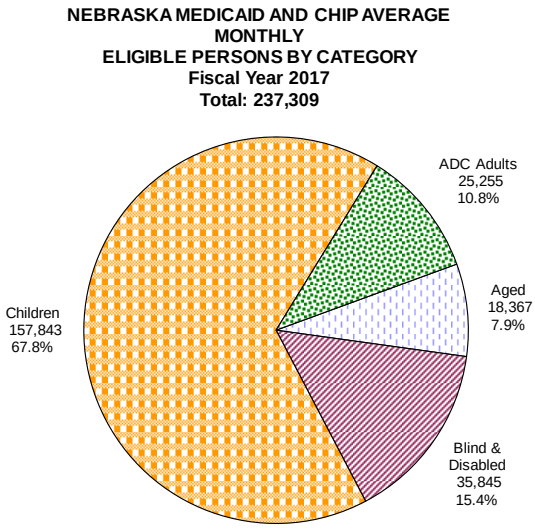
Program	Description	Income Limit
Subsidized Adoption and Guardianship Assistance (SAGA)	Individuals ages 19-21, if subsidized guardianship or adoption agreement was entered into after the individual turned 16	Twenty-three percent (23%) of the federal poverty level (FPL)
IMD	Individuals in an institution for mental disease ages 19-21.	Fifty-one percent (51%) of the FPL
Parent/Caretaker Relatives	Parents or caretaker relatives of a dependent child under the age of 19.	Fifty-eight percent (58%) of the FPL
Pregnant Women	An eligible pregnant woman remains Medicaid eligible through a sixty-day postpartum period. There is continuous eligibility for the newborn through his or her first birthday	194% of the FPL
Newborn to Age One	Children from birth to age one.	162% of the FPL
Children Ages One to Five	Children ages one to five.	145% of the FPL
Children Ages Six to Eighteen	Children ages six through the month of their 19th birthday.	133% of the FPL
CHIP	The Children's Health Insurance Program (CHIP) was created in 1997 under Title XXI of the Social Security Act. In Nebraska, CHIP is operated using the same delivery system, benefit package, and regulations as Medicaid. Eligible children must be uninsured.	213% of the FPL
599 CHIP	A separate CHIP which covers prenatal and delivery services for the unborn children of pregnant women who are not Medicaid eligibility.	197% of the FPL
Former Foster Care	An individual who is under twenty-six, was in foster care and receiving Medicaid at age eighteen or nineteen, and is not eligible for Medicaid under another program.	No income or resource guidelines, must meet general eligibility requirements (e.g. citizenship, residency, etc…)

Transitional Medical Assistance (TMA)	12 months of transitional coverage for Parent/caretaker relatives who are no longer Medicaid eligible due to earned income. In the second 6 months, if the income is above 100% FPL, the family can pay a premium and be Medicaid eligible.	The first six months are without regard to income. The second 6 months, 185% of the FPL
Aged, Blind, and Disabled	Individuals 65 or older or under 65, but are determined blind or disabled by SSA.	100% of the FPL with certain resource limits.
Medicare Buy-In	Specified low-income Medicare beneficiaries (SLMB) and qualified individuals for whom the state pays a Medicare Part B Premium	SLMB = 120% QI = 135% Of the FPL with certain resource limits.
Medically Needy	These are individuals who have a medical need and are over the income requirements for other Medicaid categories. This Medicaid category allows the individual to obligate their income above the standard on their own Medical bills and establish Medicaid eligibility	Income level is based on a standard of need. For a household size of 2 the income guideline is $392/month.
Medicaid Insurance for Workers with Disabilities	These are individuals with disabilities who are eligible for Medicaid but for their earnings. They are disabled and trying to work but need to keep their Medicaid coverage to enable them to work.	200% of the FPL Between 200% FPL and 250% they must pay a premium.
Katie Beckett	Children age 18 or younger with severe disabilities who live in their parent(s)'s household, but who otherwise would require hospitalization or institutionalization due to their high level of health care needs	Parent's income is waived under TEFRA.
Breast and Cervical Cancer	These are women screened for breast or cervical cancer by the Every Women Matters Program and found to need treatment.	Women are below 225% FPL using EWM criteria.
Emergency Medical Services for Aliens	Individuals who are ineligible due to citizenship or immigration status. Must have an emergency medical condition (including emergency labor and delivery)	Income and resource vary depending on the category of eligibility.
Subsidized Adoption	Children age 18 or younger for whom an adoption assistance agreement is in effect or foster care maintenance payments are made under Title IV-E of the Act. For non IV-E a medical review is required.	No income or resource guidelines.
Subsidized Guardianship	Children age 18 or younger for whom kinship guardianship assistance maintenance payments are made under Title IV-E of the Act.	No income or resource guidelines.

Chart 7, below, compares enrollment in different eligibility categories for SFYs 2016 and 2017. Total Medicaid and CHIP enrollment increased from 232,795 to 237,309. The majority of this increase is attributed to more Aid to Dependent Children Adults category.

Chart 7: Average Nebraska Monthly Enrollment for Medicaid and CHIP, SFY16 and SFY17





Charts 8 and 9 compares the cost differences of different eligibility categories. While the ABD category represents 23% of clients, they account for 68.9% of expenditures. Children account for 68% of clients but only 28.8% of expenditures. Expenditures per enrollee increased January 2017 when Nebraska Medicaid implemented Heritage Health as fee-for-service claims overlapped with managed care premium payments.

Chart 9 does not account for all Medicaid and CHIP expenditures, in part because some payments and refunds are not specific to a recipient or eligibility category. Examples of transactions not included are drug rebates, payments made outside the Medicaid Management Information System (MMIS), and premium payments paid on behalf of persons eligible for Medicare. Client demographic data is not available for these expenditures. This means some expenditures, particularly in the ABD categories, are understated.

Chart 8: Nebraska Medicaid Cost per Enrollee

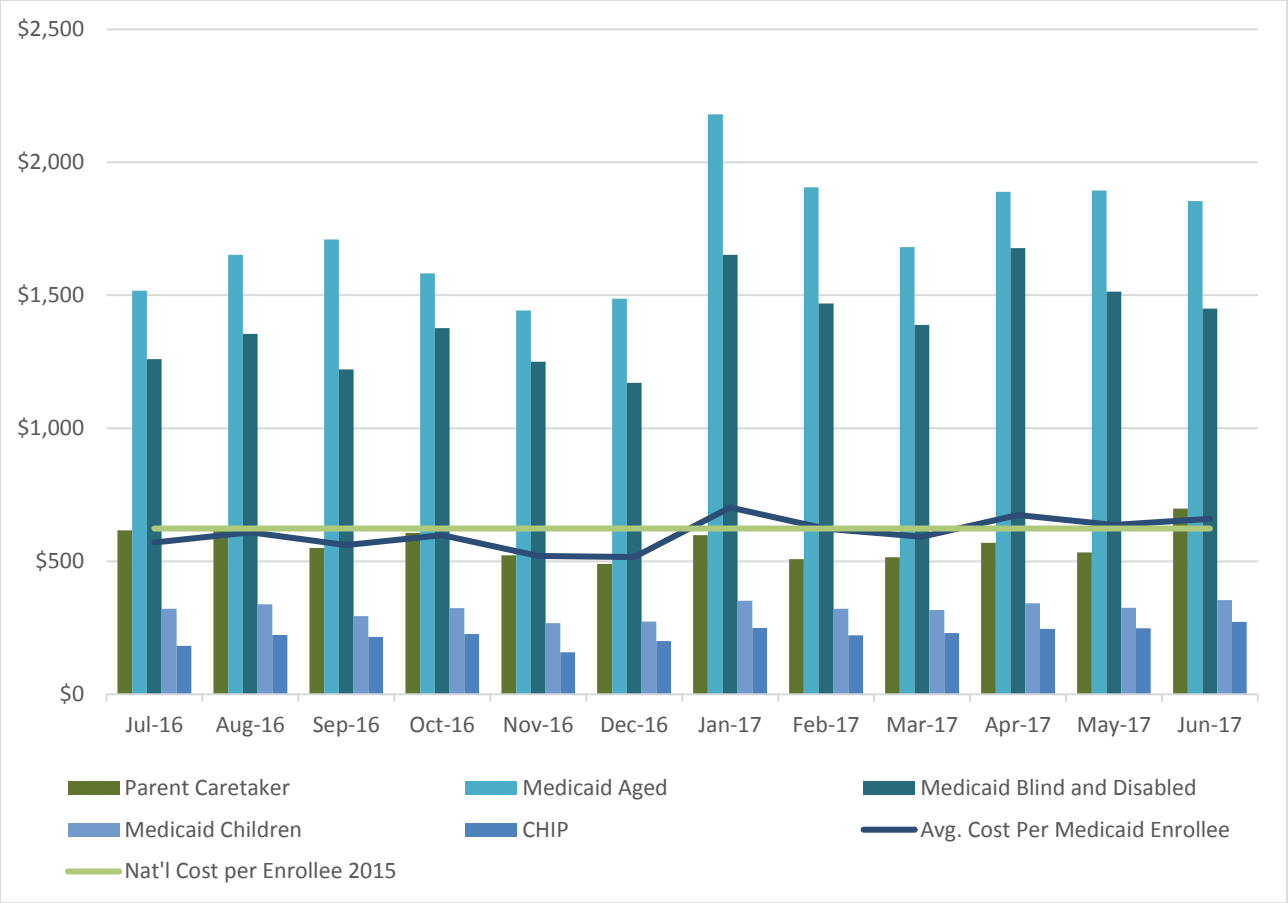
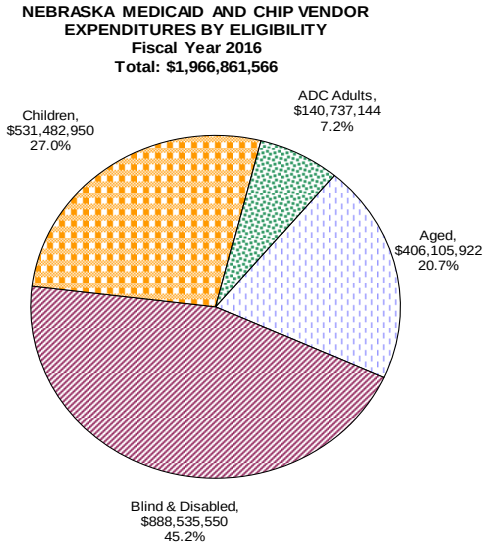
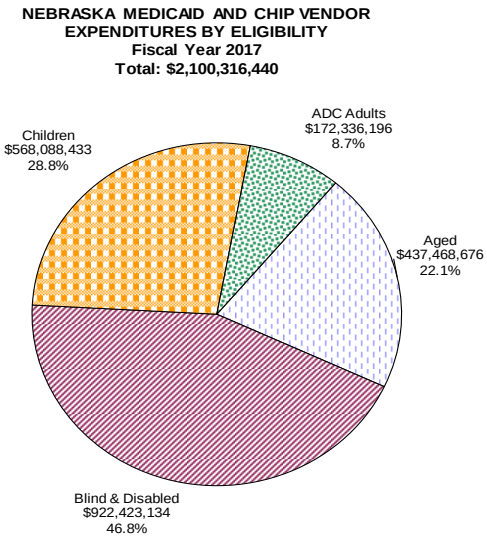


Chart 9: Nebraska Medicaid and CHIP Annual Cost by Eligibility Category





IV. BENEFIT PACKAGE

Federal Medicaid statutes mandate that states provide certain services and allow states the option of providing other services. The Nebraska Medical Assistance Act (68-901 to 68-975) and the Medicaid State Plan delineates the mandatory and optional services available to Medicaid and CHIP recipients in Nebraska. These mandatory and optional services are denoted in Chart 10.

Chart 10: Federal Medicaid Mandatory and Optional Services Covered in Nebraska
Neb. Rev. Stat. 68-911

Mandatory Services	Optional Services
Inpatient and outpatient hospital services	Prescribed drugs
Laboratory and x-ray services	Intermediate care facilities for the developmentally disabled (ICF/DD)
Nursing facility services	Home and community based services (HCBS)
Home health services	Dental services
Nursing services	Rehabilitation services
Clinic services	Personal care services
Physician services	Durable medical equipment
Medical and surgical services of a dentist	Medical transportation services
Nurse practitioner services	Vision-related services
Nurse midwife services	Speech therapy services
Pregnancy-related services	Physical therapy services
Medical supplies	Chiropractic services
Early and periodic screening and diagnostic treatment (EPSDT) for children	Occupational therapy services
	Optometric services
	Podiatric services
	Hospice services
	Mental health and substance use disorder services
	Hearing screening services for newborn and infant children
	School-based administrative services

Recent and Upcoming Benefit Package Changes

MLTC continuously evaluates its benefit packages to make changes based on new medical procedures and best practices. MLTC collaborates with the Heritage Health plans to identify any potential service gaps and policy implications.

Over this past fiscal year, several changes were announced, specifically concerning behavioral health services. Multisystemic therapy (MST) and functional family therapy (FFT) were added July 1, 2016. MST is a juvenile crime prevention program to enhance parental skills and provide intensive family therapy to at-risk teens which empowers youth to cope with family, peer,

school, and neighborhood problems they encounter in order to prevent recidivism. FFT is a program to help reduce out-of-home placements and prevent recidivism in juvenile offenders.

Peer support services were added to the behavioral health benefit package. The state plan amendment was submitted in November 2016 and implemented July 1, 2017. Peer Support services allow people with lived experience of mental health or chemical dependency issues to work with individuals and families who are involved in the behavioral health system.

Nutrition and lactation counseling was submitted March 2017 and implemented July 1, 2017. People whose nutritional status affects their medical condition will benefit from interventions designed to improve their dietary needs. Children experiencing difficulties breastfeeding are able to participate in lactation counseling services promoting growth and healthy development.

Input from statewide providers, Medicaid recipients, and other stakeholders is valued in assessing specific benefits, as is coordination with other divisions within DHHS to ensure successful implementation of new benefits.

V. SERVICE DELIVERY

Nebraska delivers Medicaid primarily through risk-based managed care. Managed care is a health care delivery system in which the state pays a monthly set amount per member each month as payment to the managed care organizations (MCOs) to pay health care providers for medical services. In a risk-based managed care delivery system, MCOs are responsible for the management and provision of specific covered services. This is an alternative to fee-for-service (FFS), in which a state Medicaid department pays each Medicaid provider for each service provided per state and federal law. Nationally, thirty-nine other states (including the District of Columbia) contract with risk-based MCOs to provide Medicaid services to their enrollees.

The Nebraska Medicaid managed care program, implemented in July 1995, initially provided physical health benefits to Medicaid members in three counties. In August 2010, the state added managed care to seven surrounding counties. On July 1, 2012, Nebraska's managed care program was expanded statewide for physical health services. On September 1, 2013, Nebraska shifted its behavioral health program to an at-risk managed care model. Within this managed care model, approximately eighty (80%) of Medicaid members received their physical health benefits through managed care and almost all Medicaid members received their behavioral health benefits through managed care.

Physical health services under this program were provided regionally by three MCOs, Aetna Better Health of Nebraska and UnitedHealthcare Community Plan, and Aetna Better Health of Nebraska and Arbor Health Plan. Behavioral health services were provided by a separate contractor, Magellan Health Solutions, statewide.

Managed care was implemented in Nebraska with the goal to improve the health and wellness of Medicaid members by increasing their access to comprehensive health services in a cost-

effective manner. With this goal in mind, Nebraska requires the MCOs to report certain performance measures. The incumbent managed care programs have shown positive outcomes for the health of Nebraska Medicaid enrollees.

In October 2015, the Department released a request for proposal (RFP) to select qualified MCOs to provide statewide integrated medical, behavioral health, and pharmacy services to almost all Medicaid members and the managed care program. In April 2016, the state awarded contracts to Nebraska Total Care (Centene), UnitedHealthcare Community Plan of Nebraska, and WellCare of Nebraska. The program, branded as Heritage Health (HH), began operations on January 1, 2017. Having one health plan responsible for a more complete range of services for a member encourages investment in more cost-effective services to better address the health care needs of the whole person.

Chart 11: Heritage Health Timeline

Heritage Health integrates health care for groups of enrollees who were previously excluded from participation in the State's physical health managed care program, but who received their behavioral health services through the State's behavioral health managed care contractor. These groups include individuals with Medicare as their primary insurance, individuals who are enrolled in one of DHHS's home and community-based waiver programs for individuals with physical disabilities or developmental disabilities, as well as individuals who live in long-term care institutional settings such as nursing homes or intermediate care facilities for people with developmental disabilities.

While these individuals now have their physical, behavioral, and pharmacy health services coordinated by their Heritage Health plan, the administration of their long-term supports and services (such as their institutional care or in-home care) remain administered through FFS.

Integrating behavioral health services with the physical health delivery system allows a person-centered approach that puts the member's needs in to focus for their health plan and gives the incentive for preventative health services that didn't exist in the previous models. The state aims to continue decreasing reliance on emergency and inpatient levels of care by providing clients with evidence-based care options that emphasize early intervention and community-based treatment. The integrated physical and behavioral health managed care program has the potential to achieve:

- Improved health outcomes
- Member choice
- Enhanced integration of services and quality of care
- Emphasis on person-centered care, including enhanced preventive and care management services and recovery oriented care
- Reduced rate of costly and avoidable care
- Improved financially sustainable system

In addition to providing coordination of physical health, behavioral health, and pharmacy HH has established quality oversight of its administrative and clinical programs. This includes local, regional, and state-wide committees with participants from the managed care organizations (MCO), providers, MLTC staff, and stakeholders. As well as work on performance improvement projects, and incentive based repayment of withholds to the MCO's.

With the implementation of Heritage Health less than two percent (2%) of the overall Medicaid population will remain in fee-for-service. MLTC estimates that over the course of a calendar year, approximately 2,500 unique individuals will become Medicaid-eligible within those remaining FFS population categories. Of those 2,500 eligible individuals, MLTC anticipates that approximately fifty percent (50%) are likely to be beneficiaries who have a share of cost obligation that must be met before that individual becomes Medicaid-eligible.

VI. PROVIDERS

MLTC works with Nebraska's medical providers to deliver health care to Medicaid clients. As discussed previously, the vast majority of Medicaid services are supplied through managed care organizations, or MCOs. The state makes capitation payments (premiums) to MCOs who coordinate provider networks and provider reimbursement. As noted, some programs are paid on a fee-for-service basis.

As of July 2017, there were 37,894 in-state Medicaid providers. Of those in-state providers, 14,509 are billing providers and 23,385 are group members. Out-of-state providers totaled 7,476 for Nebraska Medicaid. Of those out-of-state providers, 1,156 are billing providers and 6,320 are group members.

As part of the Affordable Care Act, Nebraska Medicaid was required to revalidate all providers by November of 2016. This revalidation effort closed the enrollments of office locations which were closed, providers no longer residing in Nebraska, deceased providers, and providers who no

longer wished to participate. The number of in-state and out-of-state providers decreased by almost half.

Provider details including the type of practice and number of in-state and out-of-state providers are noted in Chart 12.

Chart 12: Nebraska Medicaid Providers by Type, July 2017

Provider Type	Provider Type of Practice	In State	Out of State
Adult Substance Abuse Provider	Group Practice	37	1
Amb Surg Ctrs (ASC)		45	9
Anesthesiologist (ANES)	Group Practice	165	15
	Group Practice Member	872	394
	Individual or Solo Practice	21	10
Assertive Community Treatment (ACT) MRO Program	Group Practice	6	
Clinic (CLNC)	Group Practice	322	13
Community Support (CSW) MRO Program	Group Practice	51	
	Group Practice Member	611	
Day Rehabilitation (DAYR) MRO Program	Group Practice Member	21	
Day Treatment Provider (DAY)		16	
Dispensing Physician (MD)	Group Practice Member	5	
Doctor Of Dental Surgery - Dentist (DDS)	Group Practice	295	5
	Group Practice Member	720	69
	Individual or Solo Practice	392	22
Doctors Of Chiropractic Medicine (DC)	Group Practice	216	7
	Group Practice Member	162	33
	Individual or Solo Practice	214	9
Doctors Of Podiatric Medicine (DPM)	Group Practice	47	1
	Group Practice Member	74	17
	Individual or Solo Practice	33	4
Doctors of Osteopathy (DO)	Group Practice	2	
	Group Practice Member	488	298
	Individual or Solo Practice	7	13
Federally Qualified Health Center (FqHC)	Group Practice	43	1
Free Standing Birth Center		2	
Hearing Aid Dealer (HEAR)	Group Practice	45	1
	Group Practice Member	45	5
	Individual or Solo Practice	17	4
Home Health Agency (HHAG)		90	
Hospice (HSPC)		71	1
Hospitals (HOSP)	Children Facility (Hospital Only)	2	15

	Rehabilitation Facility (Hospital Only)	8	4
		168	232
Indian Health Hospital Clinic (IHSH)		1	
Laboratory (LAB) (Independent)		28	50
Licensed Dental Hygenist (LDH)	Group Practice	11	
	Group Practice Member	14	
	Individual or Solo Practice	12	
Licensed Drug & Alcohol Counselor (LDAC)	Group Practice Member	268	6
Licensed Independent Mental Health Practitioner (IMHP)	Group Practice	65	
	Group Practice Member	1,229	19
	Individual or Solo Practice	337	10
Licensed Medical Nutrition Therapist (LMNT)	Group Practice	6	1
	Group Practice Member	20	8
Licensed Mental Health Practitioner (LMHP)	Group Practice	3	
	Group Practice Member	1,175	74
	Individual or Solo Practice	38	
Licensed Practical Nurse (LPN)	Group Practice Member	3	
	Individual or Solo Practice	6	
Licensed Psychologist (PhD)	Group Practice	31	1
	Group Practice Member	552	71
	Individual or Solo Practice	97	2
Mental Health Home Health Care Provider (CT)	Group Practice Member	261	
	Individual or Solo Practice	1	
Mental Health Personal Care Aide (CTAI)	Group Practice Member	23	
Mental Health Professional/Masters Level Equivalent (MHP)	Group Practice Member	1,181	13
	Individual or Solo Practice	2	
Nurse Midwife (NW)	Group Practice Member	66	31
Nurse Practitioner (NP)	Group Practice	49	1
	Group Practice Member	1,713	651
	Individual or Solo Practice	56	20
Nursing Homes (NH)		1,193	15
Occupational Therapy Health Services (OTHS)	Group Practice	427	1
	Group Practice Member	912	35
	Individual or Solo Practice	1	
Optical Supplier (OPTC)		39	2
Optometrists (OD)	Group Practice	186	5
	Group Practice Member	252	37
	Individual or Solo Practice	74	4
Orthopedic Device Supplier (ORTH)		1	
Other Prepaid Health Plan (OPH)		3	
Pharmacist	Group Practice Member	2	
Pharmacy (PHCY)	Independent Pharmacy	180	89

	Large Chain Pharmacy	174	51
	Other Pharmacy	34	29
	Professional Pharmacy	9	2
	Small Chain Pharmacy	93	24
	Unit Dose, Indedpendent Pharmacy	6	1
	Unit Dose, Large Chain Pharmacy	2	1
Physician Assistant (PA)	Group Practice Member	1,319	532
Physicians (MD)	Group Practice	133	6
	Group Practice Member	7,457	3,937
	Individual or Solo Practice	187	189
Professional Clinic (PC)	Group Practice	2,558	151
Professional Resource Family Care (PRFC)	Group Practice	3	
Provisionally Licensed Drug & Alcohol Counselors (PDAC)	Group Practice Member	48	
Provisionally Licensed PHD-PPHD	Group Practice	1	
	Group Practice Member	109	
	Individual or Solo Practice	1	
Psychiatric Residential Treatment Facility (PRTF)		1	3
Qualified Health Maintenance Organization (QHMO)		6	
Registered Nurse (RN)	Group Practice	2	
	Group Practice Member	90	9
	Individual or Solo Practice	5	1
		3	
Registered Physical Therapist (RPT)	Group Practice	615	6
	Group Practice Member	1,487	66
	Individual or Solo Practice	16	
Rental And Retail Supplier (RTLR)		161	45
Nutrition services		2	
Adult day health care		12	
Emergency response system		37	5
Meals home delivered		67	1
Transportation		73	
Disability-related child care & respite care		141	3
Disability-related child care & respite care in home		312	5
Other developmental disability services		273	8
Community living supports in/out		391	7
Personal assistance service		1,100	9
Chore		1,700	14
Residential Rehabilitation (REST)	Group Practice	3	
		15	
Rural Health Clinic-Independent (IRHC)	Individual or Solo Practice	22	

Rural Health Clinic-Provider Based (PRHC)(Less Than 50 Beds)	Individual or Solo Practice	122	4
Rural Health Clinic-Provider Based (RHCP) (Over 50 Beds)	Individual or Solo Practice	8	
Specially Licensed Phd/Psychology Resident (SPHD)	Group Practice Member	11	
Speech Therapy Health Service	Group Practice	430	3
	Group Practice Member	2,195	15
	Individual or Solo Practice	16	2
Substance Abuse Treatment Center (SATC)	Group Practice	90	
Therapeutic Group Home (ThGH)		7	
Transportation		506	17
Treatment Crisis Intervention (TCI)		2	
Tribal 638 Clinic (T638)	Group Practice	8	1
Total		37,894	7,476

The Nebraska Medicaid program uses different methodologies to reimburse different Medicaid FFS services.

- Practitioner, laboratory, and radiology services are reimbursed according to a fee schedule.
- Prescription drugs are reimbursed according to a discounted product cost calculation plus a pharmacy dispensing fee.
- Inpatient hospital services are reimbursed based on a prospective system using either a diagnosis related group (DRG) or per diem rate.
- Critical access hospitals (CAH) are reimbursed a per diem based on a reasonable cost of providing the services.
- Federally qualified health centers (FQHCs) are reimbursed on the alternative payment methodology.
- Rural health clinics (RHCs) are reimbursed their cost or a prospective rate depending on whether they are independent or provider-based.
- Outpatient hospital reimbursement is based on a percentage of the submitted charges.
- Nursing facilities are reimbursed a daily rate based on facility cost and client level of care.
- Intermediate care facilities for persons with developmental disabilities (ICF/DDs) are reimbursed on a per diem rate based on a cost model.
- HCBSs, including assisted living costs, are reimbursed at reasonable fees as determined by Medicaid.

In order to control costs, many states cut provider rates during the Great Recession and its aftermath, as shown in Chart 13. However, as shown in Chart 14, Nebraska Medicaid providers have received rate increases every year since SFY 2012 through 2017. Primary care services increased nationally to Medicare rates in January 2013 as a result of the ACA. The federal

government funded the difference between Medicaid rates and Medicare rates. This national rate bump expired in December 2014. However, Nebraska elected to continue this rate increase.

Chart 13: Medicaid Provider Rate Changes

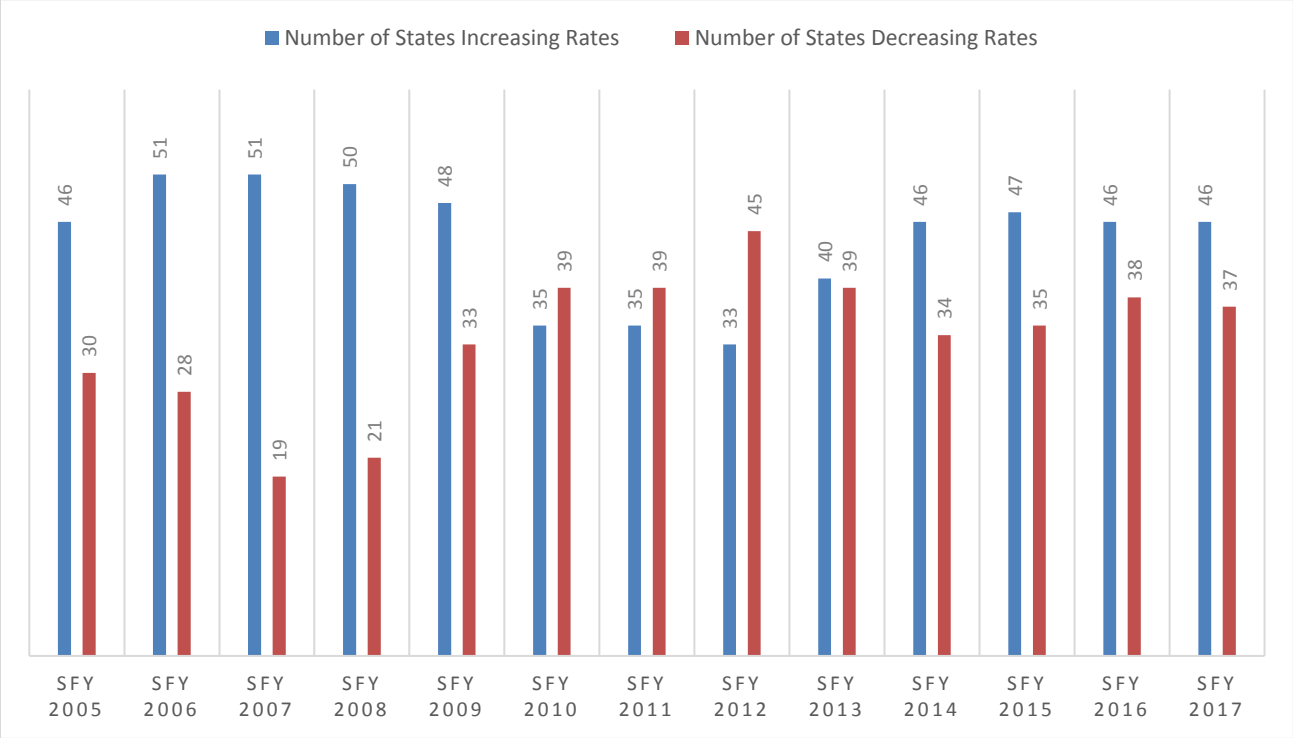


Chart 14: Nebraska Medicaid Rate Increases

SFY	Rate Increase
2012	Rates increased 1.54%
2013	Rates increased up to 2.25% to a maximum of 100% of Medicare rates as of January 1, 2013
2014	Rates increased up to 2.25% to a maximum of 100% of Medicare rates as of January 1, 2014
2015	Rates increased up to 2.25% to a maximum of 100% of Medicare rates for behavioral health, nursing facilities, assisted living, and ICF-DD providers. Other Medicaid services rates increased up to 2% to a maximum of 100% of Medicare rates.
2016	Rates increased up to 2.25% to a maximum of 100% of Medicare rates for behavioral health, nursing facilities, assisted living, and ICF-DD providers. Other Medicaid services rates increased up to 2% to a maximum of 100% of Medicare rates.
2017	Rates increased up to 2.25% to a maximum of 100% of Medicare rates for behavioral health, nursing facilities, assisted living, and ICF/DD providers. Other Medicaid services rates increased up to 2% to a maximum of 100% of Medicare rates.

The vast majority of services provided by Nebraska Medicaid are paid for by managed care and the MCOs are not bound by the state fee schedule. Each managed care organization must have an adequate provider network and may negotiate reimbursement rates with providers in its network. For SFY18, provider rates will hold steady with no change.

VII. VENDOR EXPENDITURES

Medicaid and CHIP are financed jointly by the federal government and state governments, with the federal government matching state spending at a rate known as the Federal Medical Assistance Percentage (FMAP), which varies from state to state. FMAP is based on each state's per capita income relative to the national average and is highest in the poorest states, varying from 50% to 73%. Nebraska's FMAP in federal fiscal year (FFY) 2017[1] was 51.85% for Medicaid and 89.30% for CHIP. Due to the ACA, the CHIP FMAP increased beginning in FFY 2016. Chart 15 shows the FMAP for both Medicaid and CHIP for FFY14 through 18.

Chart 15: Nebraska FMAP Rates

Medicaid	FMAP	CHIP	FMAP
FFY14	54.74%	FFY14	68.32%
FFY15	53.27%	FFY15	67.29%
FFY16	51.16%	FFY16	88.81%
FFY17	51.85%	FFY17	89.30%
FFY18	52.55%	FFY18	89.79%

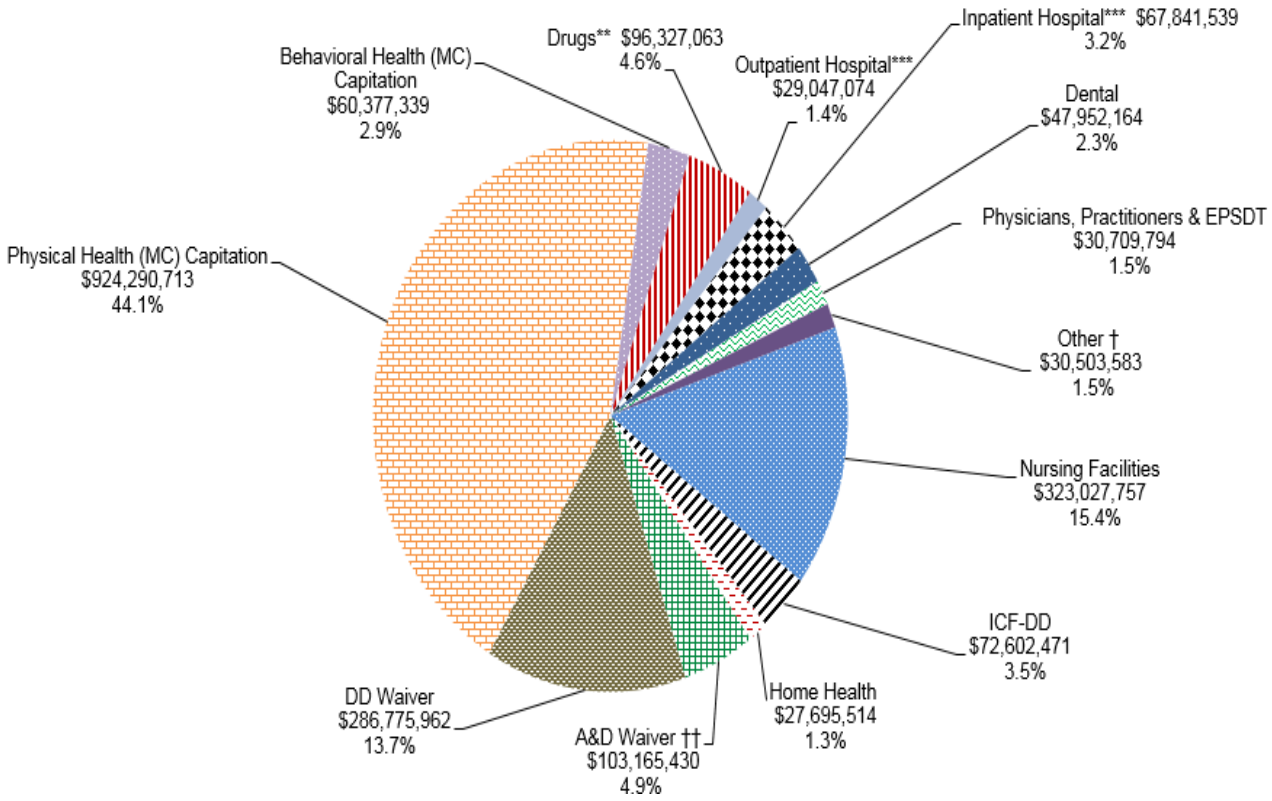
For SFY17, total vendor payments for Medicaid and CHIP expenditures were $2,100,316,440.

- The expenditures include payments to vendors only; no adjustments, refunds or certain payments for premiums or services paid outside of the Medicaid Payment System (MMIS) or NFOCUS.
- Of the $2.100 billion total:
    - $120.9 million in offsetting drug rebates is not reflected in the drug expenditures of $96.3 million.
    - DSH payments of $46.6 million are not reflected in inpatient or outpatient hospital expenditures.
    - Other includes
        - Speech/ Physical Therapy,
        - Medical/Optical Supplies,
        - Ambulance, and
        - Lab/Radiology.
    - A&D Waiver includes expenditures under the Traumatic Brain Injury waiver (FY16 = $694,746 & FY17 = $690,770)

[1] October 1, 2016 to September 30, 2017

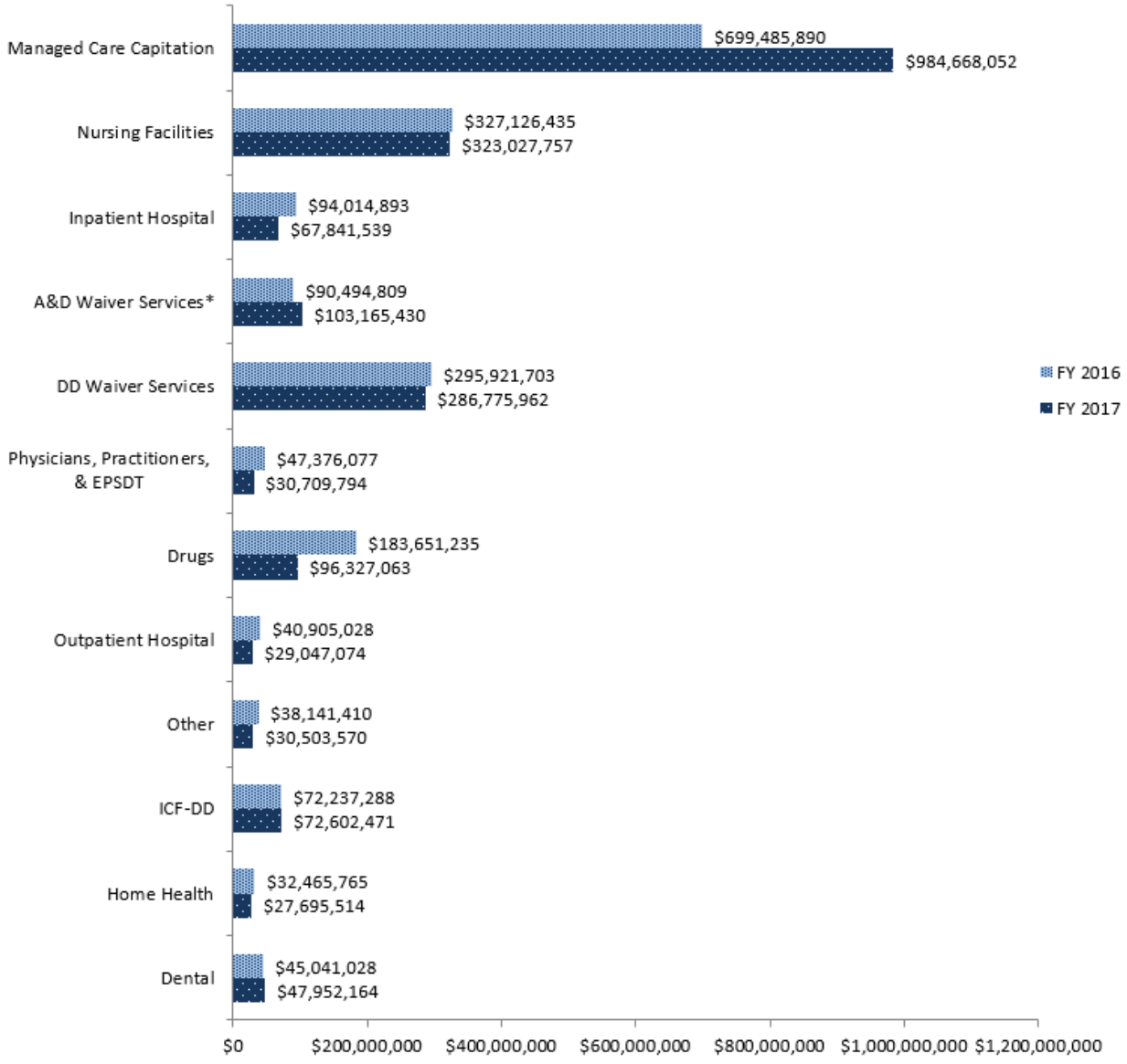
Chart 16 shows how the expenditures to vendors are distributed by vendor type.

Chart 16: SFY17 Medicaid and CHIP Expenditures by Service



As discussed above, a significant shift in the management and administration of Medicaid services has taken place over the past several years with the growth of managed care. This expenditure is expected to continue to increase with the implementation of Heritage Health and reductions in other vendor categories. Chart 17 shows vendor expenditures from SFY 2016 and 2017 side by side.

Chart 17: Medicaid and CHIP Expenditures SFY16 and SFY17



Not all Medicaid and CHIP expenditures are captured in Chart 16. Several other transactions are highlighted below.

- Drug rebates are reimbursements made by pharmaceutical companies to Medicaid and CHIP that reduce individual drug costs to a more competitive or similar price that is being offered to other large drug payers, such as insurance companies. In SFY 2017, Medicaid received a total of $120.9 million in drug rebates.
- Disproportionate share hospital (DSH) payments are additional payments to hospitals that serve a high number of Medicaid and uninsured patients. In SFY 2017, Medicaid paid $46,587,545 through the DSH program, a 3.6% increase compared to $44,980,223 paid in SFY 2016.
- Medicaid pays the Medicare Part B premium for clients that are dually eligible for Medicare and Medicaid. In SFY 2017, Medicaid paid $51,885,724 for Medicare premiums, an 11.8% increase from the $45,768,262 for Medicare premiums, paid in SFY 2016. CY 2016 monthly premium amounts were $121.80 and CY 2017 monthly premium amounts are estimated to be $129.96.
- Part D clawback payments are made to CMS to cover the State's share of prescription drugs for persons dually eligible for both Medicare and Medicaid. In SFY 2017, clawback payments totaled $62,138,338, an 11.8% increase from the $54,776,185 paid in SFY 2016. The clawback payment amount per person is based on a complex formula that takes into account the cost of drugs and the federal matching rate.

LONG-TERM CARE SERVICES

Long-term care (LTC) services support individuals with chronic or ongoing health needs related to age or disability. In SFY16 Medicaid expenditures for long-term care services totaled $813,326,713. These services are geared to multiple levels of client need ranging from limited assistance with activities of daily living to complex nursing interventions. Assistance can be offered in a variety of settings from care in an individual's home, to care in small group settings with community supports, to care in a nursing facility or intermediate care facility for persons with developmental disabilities. In general, home and community-based care is less expensive and offers greater independence for the consumer than facility-based care.

For these reasons, state and federal initiatives encourage the development of care options in the community as an alternative to institutional care. Efforts to encourage home and community-based alternatives to facility based-care are resulting in a gradual rebalancing of LTC expenditures.

The following charts (18 and 19) show the cost of Medicaid expenditures for LTC services, and the cost of LTC services delivered in institutions compared to the cost of care delivered in home and community settings for SFY17.

Chart 18: SFY17 Medicaid Expenditures for LTC Services

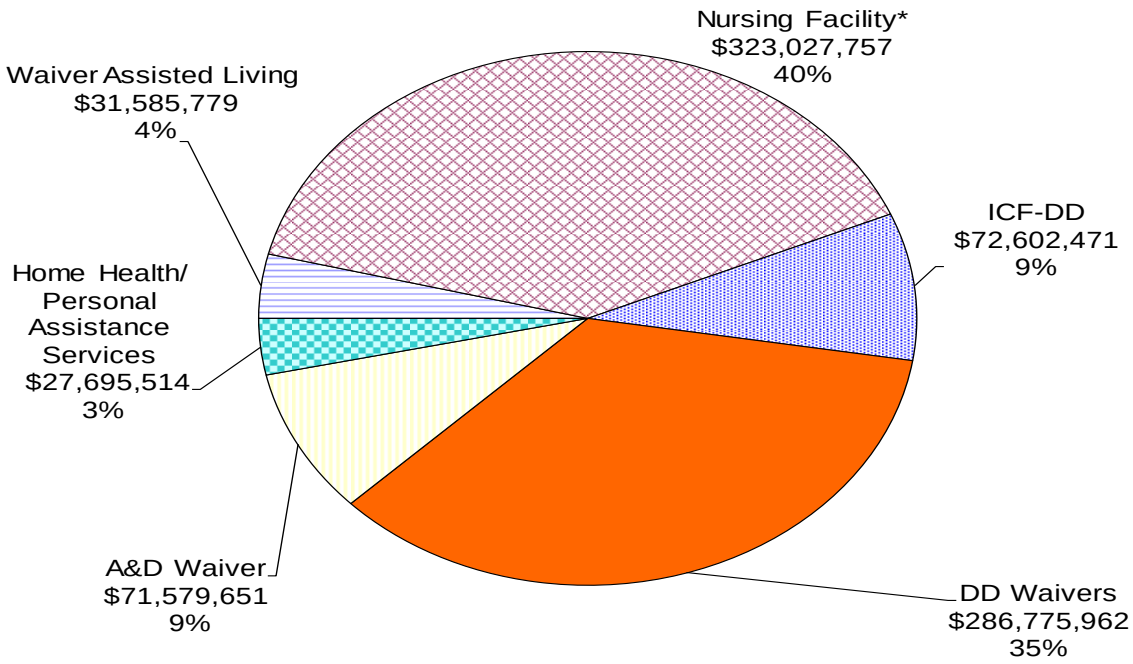
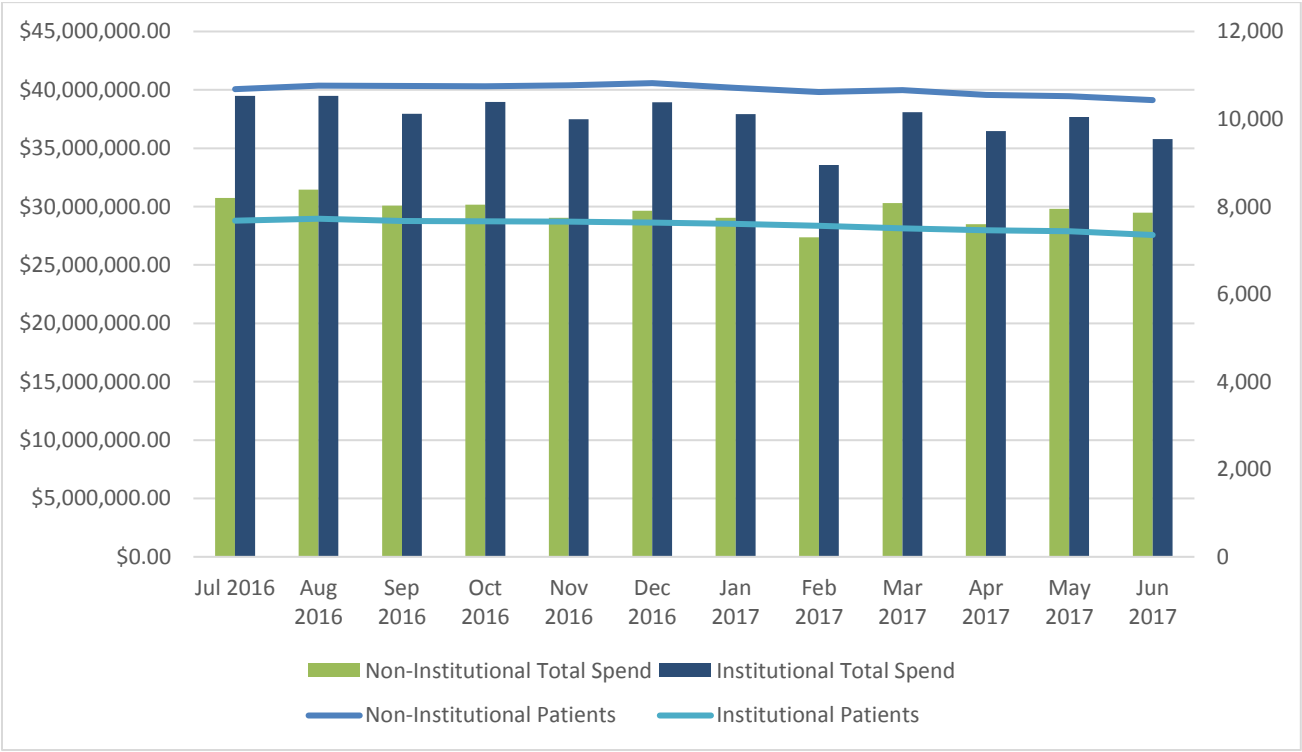


Chart 19: Nebraska LTC Expenditures by Living Arrangement



VIII. SFY16 HIGHLIGHTS AND ACCOMPLISHMENTS

Transformed-Medicaid Statistical Information System (T-MSIS)

The T-MSIS project, started in January 2013, is the expansion of federal reporting measures from the states' Medicaid programs. The new report is submitted to CMS monthly rather than quarterly as the program's predecessor, MSIS. The reported data has been expanded to include eligibility information, managed care information, and expanded detail regarding enrollees' received services.

As of August 2017, Nebraska has met the requirements for T-MSIS production readiness to report to CMS, involving multiple intensive and thorough testing phases. There will be ongoing data quality efforts in conjunction with CMS and their contractors to improve the completeness of T-MSIS reporting. Nebraska will participate in these efforts as it is invited by CMS.

Joint Independent Verification and Validation (IV&V)

Independent verification and validation (IV&V) is a process employed by a third party for evaluating the accuracy and quality of a project throughout the project duration. For major information technology system projects receiving enhanced federal 90% match, CMS requires states contract with an IV&V contractor to perform these services. A contract was awarded to First Data to provide IV&V services to monitor and evaluate the accuracy and quality of major information technology projects which receive the enhanced federal match rate of 90%.

Electronic Data Interchange (EDI) Platform Migration

The EDI project replaced software for the translation and transport of EDI HIPAA transactions related to and from the MMIS for various functions such as eligibility, claims status, referrals, claims, and remittances. This system, which currently front-ends the MMIS, ceased production by our current vendor on 12/03/15. The Department is replacing the expired EDI solution, using a phased migration strategy, to manage and maintain operations while simultaneously investing in its future state vision. The State of NE successfully implemented Phase I in May 2017. Phase II began in April 2017 and is expected to close out in June 2018.

Heritage Health

Heritage Health experienced a successful go-live on January 1, 2017 when 237,000 Medicaid enrollees were successfully enrolled in to the new health plans. On January 1, 2017, the state began hosting daily rapid response calls. There were rapid response calls for members and providers hosted on a reoccurring basis through the first several weeks of 2017 and again upon completion of the continuity of care period. The open forum included representatives from the health plans as well as Medicaid, all available on the line taking questions and discussing any ensures that members or providers may have been encountering. Heritage Health also included a number of Advisory Committees that met prior to implementation and continued meeting

through 2017. The Administrative Simplification meets bi-monthly, the Behavioral Health Integration meets monthly, and the Quality Improvement meets quarterly.

Dental Benefits Manager

On October 1, 2017 the fee-for-service (FFS) dental benefit transitioned to managed care with Managed Care of North America, Inc (MCNA) to administer this benefit. This change in the delivery dental services has resulted in increased member participation. Within the first two weeks of the program, 7,322 Nebraska members saw a Medicaid-enrolled dentist for an appointment. This increase was thanks in part to member dental cards, member outreach from the state and MCNA informing them of this change and an increase to the provider network. This preventative care is critical to the health and wellness of the Medicaid members.

Opioid Prescription Guidelines

During 2016, Medicaid worked collaboratively with its sister divisions to address opioid abuse in Nebraska. In 2017, Medicaid continued to address the opioid epidemic by removing barriers to medication assisted treatment. Beginning November 2017, Suboxone film became available without a prior authorization. These moves reflect an ongoing commitment by the entire Department to combat opioid abuse.

IX. LOOKING AHEAD

Data Management & Analytics (DMA)

The current MMIS has served the state well for over thirty-five years, but has become outdated as the Medicaid program has evolved. Providing an improved capability to manage the vast amounts of data received by the Medicaid agency continues to be a top priority for DHHS. Managing the data, producing accurate and timely reports, and utilizing analytics to make informed business decisions will continue to become more critical within the Medicaid program. An request for proposal (RFP) for the DMA procurement was released to the public in June 2016. Five (5) vendors responded with proposals that were assessed through the evaluation process. The resulting contract with Deloitte Consulting, LLP was approved by CMS and is currently being finalized. Procurement award protest resolution and extended contract negotiations resulted in revised project milestone target completion dates, as represented in the table below.

DMA Project Milestones	Target Completion
RFP released to public	Completed
Proposals Due	Completed
Publish intent to contract	Completed
Submit contract to CMS for approval	Completed
Finalize contract and start implementation	November 2017
Go-live	Late 2019 / Early 2020

Eligibility and Enrollment System (EES) Phase 2

The ACA requires significant changes to state Medicaid eligibility and enrollment (E&E) systems. Nebraska's current Medicaid eligibility system cannot meet the ACA requirements without significant modification and investment. As a result, Nebraska is implementing a new Medicaid E&E system. RFPs were issued for a new Medicaid eligibility solution and independent verification and validation (IV&V) activities associated with implementing a new Medicaid eligibility solution. The project to move Medicaid eligibility and enrollment to the new solution is called EES Phase 2.

A key EES component, the Master Client Index (MCI), will go-live in 2018 before the entire solution goes live as a way to mitigate risk. The updated go-live date for the entire solution is first quarter of 2019. The revision will ensure the state is able to fully test and successfully implement the new system, as well as comply with new federal requirements.

EES Project Milestones	Target Completion
Development and testing began	August 2017
Master Client Index (MCI) go-live	April 2018
Go-Live	February 2019

Eligibility and Enrollment System (EES) Phase 3

EES Phase 3 builds upon EES Phase 2 by modernizing Medicaid long-term care case management systems and eligibility/enrollment (E&E) systems for Economic Assistance (EA) programs, such as SNAP and TANF. EES Phase 3 will move EA E&E functions onto the new Medicaid eligibility platform developed in EES Phase 2. Integrating EA and Medicaid eligibility functions onto one platform creates operational efficiencies and a more seamless experience for clients enrolled in both Medicaid and EA programs. The case management system for Medicaid and State-only long-term care programs will be updated and integrated with the Medicaid E&E platform. This modernization and integration will improve operational efficiencies and provide better data to manage long-term care programs.

EES Phase 3 is in the early planning stages. DHHS anticipates one or more RFPs will be released in 2018 for hardware, software and professional services required to implement Phase 3. Once appropriate contracts are in place, DHHS expects Phase 3 to be a multi-year implementation. More precise timelines will be developed when scope is finalized and key partners have been procured.

Fiscal Agent/Electronic Visit Verification (FA/EVV)

A fiscal agent vendor facilitates the payment of service workers by managing tax withholding, unemployment compensation, wage settlements and fiscal accounting which are currently being performed by the State of Nebraska. Additionally, the Nebraska Long-Term Care redesign plan issued on August 9, 2017 included a specific high priority recommendation to create an independent fiscal agent to manage independent providers.

A component of this project also includes development of an EVV system to improve oversight and reduce manual intervention to process timesheets and payroll. The EVV is federally mandated through the 21st Century CURES Act with a compliance date of January 1, 2019 for personal assistance services (PAS). There are possible reduced rates of federal financial participation for failure to implement an EVV system.

MLTC has determined the fiscal agent and EVV services should be combined in a single request for proposals (RFP).

FA/EVV Project Milestones	Target Completion
Release RFP	January 2018
Vendor Begins Implementation	May 2018
EVV Go-live	January 2019

Claims Broker Services (CBS)

CBS project discovery and initial planning began in conjunction with UnitedHealthcare Community Plan of Nebraska in March 2017. The CBS was procured in conjunction with Heritage Health procurement and implementation. With the CBS the state is working to contract with an entity to pay the remaining fee-for-service (FFS) claims which are not paid under managed care. This is a purchase of services rather than purchasing a new MMIS system to pay the minimal FFS claims remaining. Concurrently, ongoing conversations with the Centers for Medicare and Medicaid Services (CMS) are occurring to secure the enhanced federal funding necessary. It is an innovative approach and MLTC is working with CMS to navigate federal funding and approval.

Several other projects and initiatives may impact the scope of CBS, such as FA/EVV and LTSS. The CBS project continues working in coordination with these and other MMIS replacement activities.

Long-Term Care (LTC) Redesign

As noted in last year's report work continues on the LTC redesign. MLTC continues to collaborate with our sister divisions, and LTC stakeholders to evaluate the current LTC landscape, identify key opportunities for improvement, and redesign the system to meet the future challenges and growing demand for LTSS.

In January 2016, DHHS released a concept paper launching the redesign project. In May 2016, DHHS contracted with Mercer to provide technical assistance for the redesign project and provide recommendations on system improvements. Mercer released a draft plan in March 2017, conducted a second state wide tour and released a final plan in August 2017. A number of key areas including updated and new IT systems as well as policies were noted as needing to be fully implemented before LTSS could be implemented in managed care. At this time a preliminary go live date for LTSS is in the year 2021.

Long-Term Care (LTC) Redesign Milestones	Target Completion
Concept paper released	January 2016
RFP release for consulting contract	March 2016
Contract award	May 2016
First phase of stakeholder outreach	September to October 2016
Preliminary redesign plan released	March 2017
Second phase of stakeholder outreach	March 2017
Release of final redesign plan	August 2017
Implementation of changes begin	2021

Regulations Rewrite

Nebraska Medicaid's regulations are, in many places, contradictory, not meeting the requirements of state and federal law, or simply outdated and do not meet current best practices. Nebraska Medicaid continues to review and rewrite all of its Medicaid regulations to remove obsolete provisions and make sure they comply with federal and state law. Under executive order 17-04 MLTC, along with all code agencies, held rulemaking efforts. During this time, MLTC continued to review all regulations with a focus to ensure they are essential and least restrictive. We expect this project to continue into SFY18.

Asset Verification Services (AVS)

Implementing an AVS for Medicaid-eligibility determination is a Federal mandate. Through the AVS, the Medicaid eligibility process will be enhanced with the capability to electronically locate and verify assets. Nebraska is working with other states on a multi-state procurement. Vermont has released an RFP to procure an AVS vendor in July 2017 which was awarded to PCG. Six other states have expressed interest in a multi-state procurement. MLTC will closely align EES and AVS implementation such that AVS goes live shortly after the EES. This strategy maximizes implementation resources and minimizes impact on Medicaid eligibility workers and clients.

X. CONCLUSION

MLTC continues to move forward and deliver better quality health care to Nebraska residents. As discussed in this report, MLTC takes its responsibilities seriously, which is why it continues to focus on improving the delivery of health care in the state. As MLTC provides health care services to over 230,000 of Nebraska's most vulnerable residents, the Division continuously seeks to improve processes and quality for Medicaid members, providers, and the state's taxpayers. Through initiatives like Heritage Health and long-term care redesign, procurements like the DMA and the DBM, and projects like the regulations rewrite, MLTC is getting in a better position to provide safety-net care and services in the twenty-first (21st) century.

Additionally, MLTC is committed to transparency and providing information to the legislature and the general public as the Division continues its transformation. The Division looks forward to continuing to work with the Governor, the Legislature and stakeholders to improve and sustain Medicaid for current and future generations.

XI. APPENDIX

Charts

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2. Nebraska Population by FPL Compared to the National Numbers
3. Average Unemployment Levels, in Nebraska and Nationally
4. Average Monthly Medicaid Clients by SFY
5. 2017 Poverty Guidelines
6. Nebraska Medicaid Coverage Groups and Income Eligibility Requirements
7. Average Nebraska Monthly Enrollment for Medicaid and CHIP, SFY16 and SFY17
8. Nebraska Medicaid Cost Per Enrollee
9. Nebraska Medicaid and CHIP Annual Cost by Eligibility Category
10. Benefit Package— Mandatory and Optional Groups
11. Heritage Health Timeline
12. Nebraska Medicaid Providers by Type
13. Medicaid Provider Rate Changes
14. Nebraska Medicaid Rate Increases
15. Nebraska FMAP Rates, FFY 2014 through 2019
16. Medicaid and CHIP Expenditures by Service
17. Medicaid and CHIP Expenditures SFY16 and SFY17
18. SFY17 Medicaid Expenditures for Long-Term Care Services
19. Nebraska LTC Services Expenditures by Living Arrangement