NEBRASKA

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DEPT. OF HEALTH AND HUMAN SERVICES

Division of Medicaid & Long-Term Care

Nebraska Medicaid Annual Report for State Fiscal Year 2019

December 2, 2019

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

Message from the Director

On behalf of the Nebraska Medicaid team, I am pleased to present the state fiscal year Medicaid Annual Report in accordance with Neb. Rev. Stat. § 68-908(4).

The Division thanks our partners in the Legislature and community, as well as the thousands of Medicaid providers across Nebraska, who share the Department of Health and Human Services' mission to "Help People Live Better Lives." The Division of Medicaid and Long-Term Care (MLTC) looks forward to continuing to improve the lives of the state's Medicaid beneficiaries.

If you have any questions about this report, please contact me by phone at 402-471-2135 or via email at Matthew.VanPatton@nebraska.gov.

Matthew A. Van Patton, DHA, Director
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I. EXECUTIVE SUMMARY

The Division of Medicaid & Long-Term Care (MLTC), a division of the Nebraska Department of Health and Human Services (DHHS), administers the state of Nebraska's Medicaid program. Each state outlines the eligibility, benefits, provider payments, and service delivery systems of its specific Medicaid program within guidelines set by the federal government.

Medicaid is a significant payer of health services in Nebraska. The Division's appropriated budget of more than $2 billion paid for services for approximately 12 percent of Nebraskans who were Medicaid beneficiaries in state fiscal year 2019 (SFY19). The program serves low-income children and their parents, the aged, and individuals with disabilities. Approximately 108,000 providers are enrolled with Nebraska Medicaid.

In November 2018, Nebraska voters passed Initiative 427, which called for the expansion of Medicaid eligibility to able-bodied adults age 19-64 earning up to 138 percent of the federal poverty level. On April 1, 2019, MLTC announced Heritage Health Adult (HHA) expansion, which builds on the Heritage Health managed care program. HHA will go live on October 1, 2020 and eventually serve approximately 90,000 eligible adults.

MLTC is a steward of stakeholders and taxpayers by facilitating quality health care in a cost-efficient manner. This requires MLTC to:

- update information technology systems for operational efficiency and effectiveness;
- modify how payments are made; and
- review how program eligibility (for beneficiaries and providers) is determined.

In SFY19, MLTC pursued a variety of projects with this end in mind, such as modernizing payment methodologies, carving in non-emergency ground transportation, and receiving approval for a federal waiver to treat substance use disorder more effectively.

MLTC has made tremendous strides over the past year and looks forward to continuing its work in SFY20.

II. MLTC ORGANIZATIONAL STRUCTURE

The Division of Medicaid & Long-Term Care includes Medicaid, the Children's Health Insurance Program (CHIP), and the State Unit on Aging (SUA). Medicaid serves low-income children and their parents, the aged, and individuals with disabilities, covering more than one in 10 Nebraskans. The Division also administers non-institutional home and community-based waiver programs for eligible individuals.

In calendar year 2019, MLTC reorganized its executive leadership structure. MLTC is now divided into seven sections with nearly 600 full-time employees, and also partners with the Eligibility section of the Division of Children and Family Services (CFS). The Division is structured as follows:

- **Business Performance and Analytics**: Business Performance and Analytics is responsible for oversight of the Heritage Health managed care program and the Division's technology initiatives to improve operational effectiveness, data analytics, and supporting functions.
- **Eligibility Operations**: Eligibility Operations is responsible for determining eligibility for Medicaid programs. Eligibility Operations also includes Economic Assistance programs, Child Support, and IV-E Foster Care Programs.
- **Experience Management and Provider Relations**: This section was created in 2019 and is tasked with defining and monitoring the experiences of Medicaid beneficiaries and providers. Nebraska is the first Medicaid program in the nation to have an executive function in this space.
- **Finance and Program Integrity**: Finance and Program Integrity oversees financial analysis and reimbursement, budget, associated reporting, the program integrity unit, and the provider enrollment team.
- **Medical Services**: Medical Services helps determines the services covered under Nebraska Medicaid and assures Medicaid-covered services adhere to a standard of care.
- **Policy and Regulations**: Policy and Regulations is responsible for external communications, regulatory compliance, and ensures compliance with the federal authorities under which the Medicaid program operates, including the Medicaid state plan.
- **Population Health**: This section was created in 2019 and is responsible for assessing health outcomes across the Medicaid population. Population Health includes health services, pharmacy, and home and community based services.
- **State Unit on Aging**: The State Unit on Aging is a business unit that collaborates with public and private service providers to promote a comprehensive and coordinated community-based services system to assist individuals with living in a setting of their choice and continuing to contribute to their community.

The organizational chart of the Division's leadership team is provided in Figure 1.

Figure 1. MLTC Organizational Chart - Leadership

III. ELIGIBILITY AND POPULATIONS SERVED

Originally enacted in 1965 under Title XIX of the Social Security Act, Medicaid is a public health program that provides coverage for low-income individuals. Nebraska Medicaid, in general, provided coverage for individuals in the following eligibility categories in SFY19:

- children;
- aged, blind, and disabled (ABD);
- pregnant women; and
- parent/caretaker relatives.

Eligibility factors, such as income and resource guidelines, vary by group. Medicaid enrollment and costs are closely related to the economy. With below-average poverty and unemployment rates, as reflected in Table 1 and Figure 2, Nebraska's total Medicaid enrollment has remained stable at about 12 percent of the state's total population for the last few years (see Figure 3).

The most noteworthy changes to enrollment (see Figure 3) are related to the Great Recession in the early 2010s, as well as a modest increase in enrollment since SFY16.

Table 1. Nebraska Population by FPL Compared to National Figures

	Nebraska	United States	Percent of Nebraskans	Percent of Entire US
Under 100% FPL	158,300	34,596,300	9%	11%
100% to 199% FPL	297,200	54,380,700	16%	17%
100% to 399% FPL	678,800	97,742,800	37%	31%
Above 400% FPL	724,900	130,302,700	39%	41%

Figure 2. Average Unemployment Levels

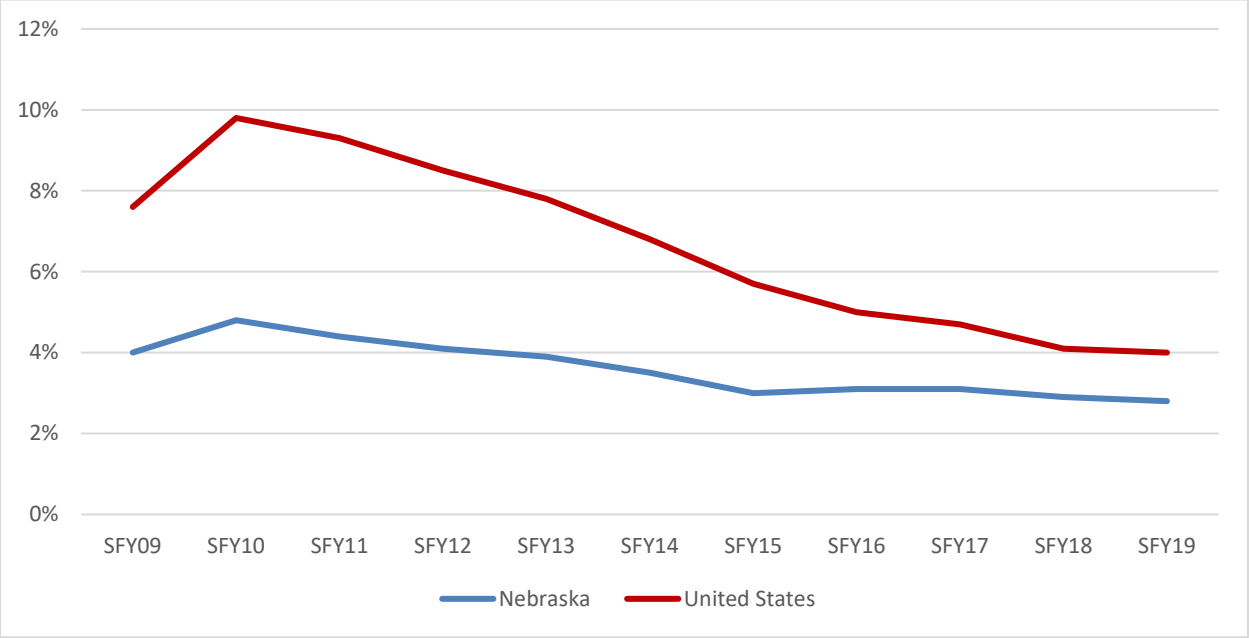
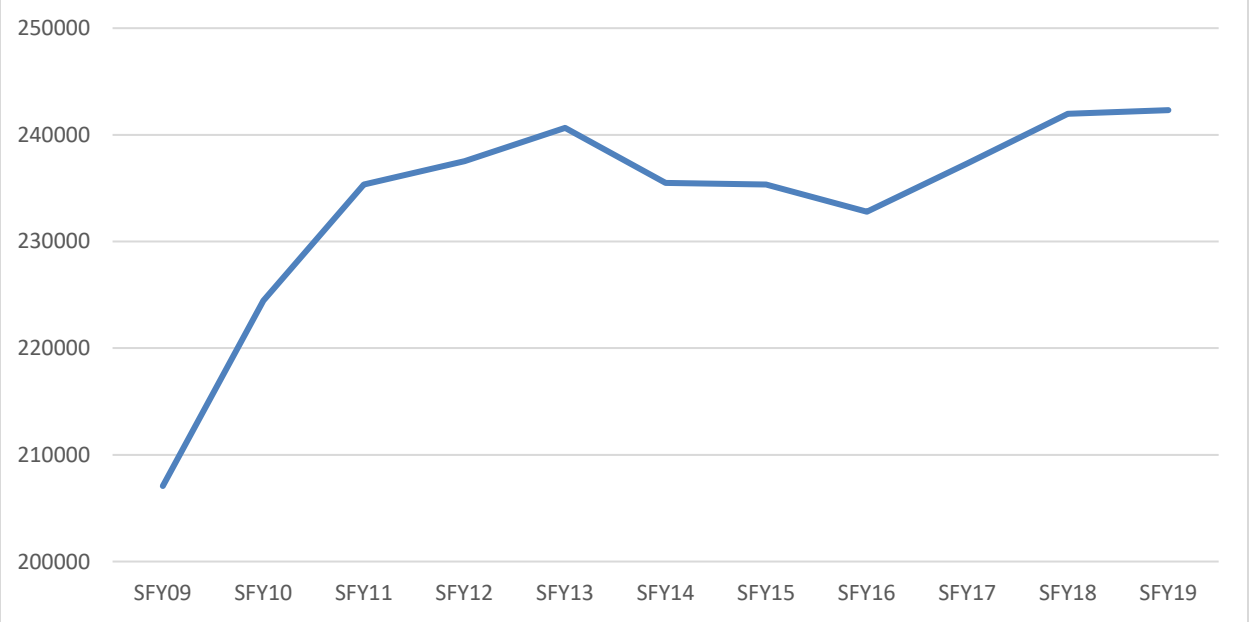


Figure 3. Average Monthly Nebraska Medicaid Clients by SFY



The majority of Nebraska Medicaid beneficiaries (including CHIP children, pregnant women, and parents/caretaker relatives) are subject to modified adjusted gross income (MAGI) budgeting methodology as required by the Affordable Care Act (ACA). It uses federal income tax rules and tax filing status to determine an individual's Medicaid eligibility. This change simplified eligibility for certain groups and aligned it with eligibility for state insurance marketplaces. Other

Medicaid eligibility groups in the state are still subject to other criteria, specifically groups who qualify for Medicaid based primarily on age or disability.

Table 2 provides the 2019 federal poverty levels in annual income, and Tables 3 and 4 explain several of the Medicaid programs. See Attachment 1 for more details on services available to each Medicaid program.

Table 2. 2019 Poverty Guidelines

Household Size	50% FPL	100% FPL	138% FPL	200% FPL
1	$6,245	$12,490	$17,236.20	$24,980
2	$8,455	$16,910	$23,335.80	$33,820
3	$10,665	$21,330	$29,435.40	$42,660
4	$12,875	$25,750	$35,535.00	$51,500

Table 3. Nebraska Medicaid MAGI Coverage Groups and Income Eligibility Requirements

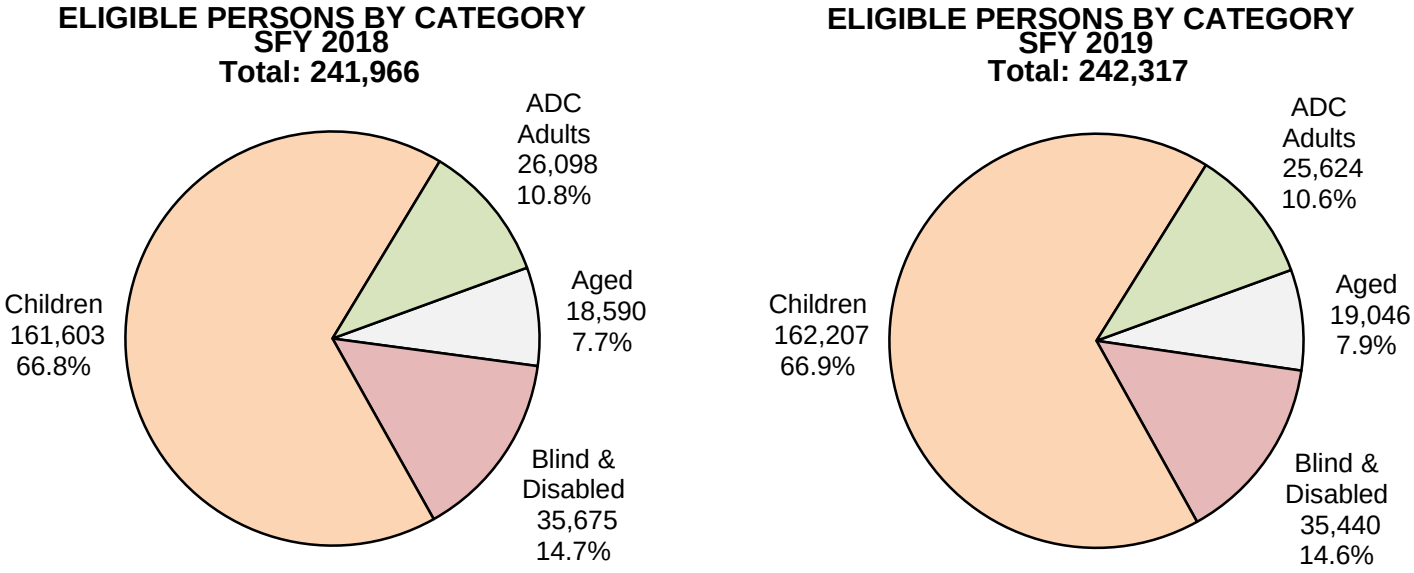
Program	Description	Income Limit
Subsidized Adoption and Guardianship Assistance (SAGA)	Individuals ages 19-21, if subsidized guardianship or adoption agreement was entered into after the individual turned 16.	Twenty-three percent (23%) of the federal poverty level (FPL)
IMD	Individuals in an institution 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 60-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 eligible.	197% of the FPL

Table 4. Nebraska Medicaid Non-MAGI Coverage Groups and Income Eligibility Requirements

Program	Description	Income Limit
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 with their parent(s), 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.

Figure 4 compares enrollment in different eligibility categories for SFYs 2018 and 2019. Total Medicaid and CHIP enrollment remained relatively stable with 241,966 in SFY18 and 242,316 in SFY19—a 0.15 percent increase. The aged population showed the largest change year over year, growing by 2.45 percent. There was a slight increase in children of 0.37 percent. The blind/disabled populations decreased by 0.66 percent, and adults decreased by 1.82 percent.

Figure 4. Average Nebraska Monthly Enrollment for Medicaid and CHIP, SFY18 and SFY19[1]



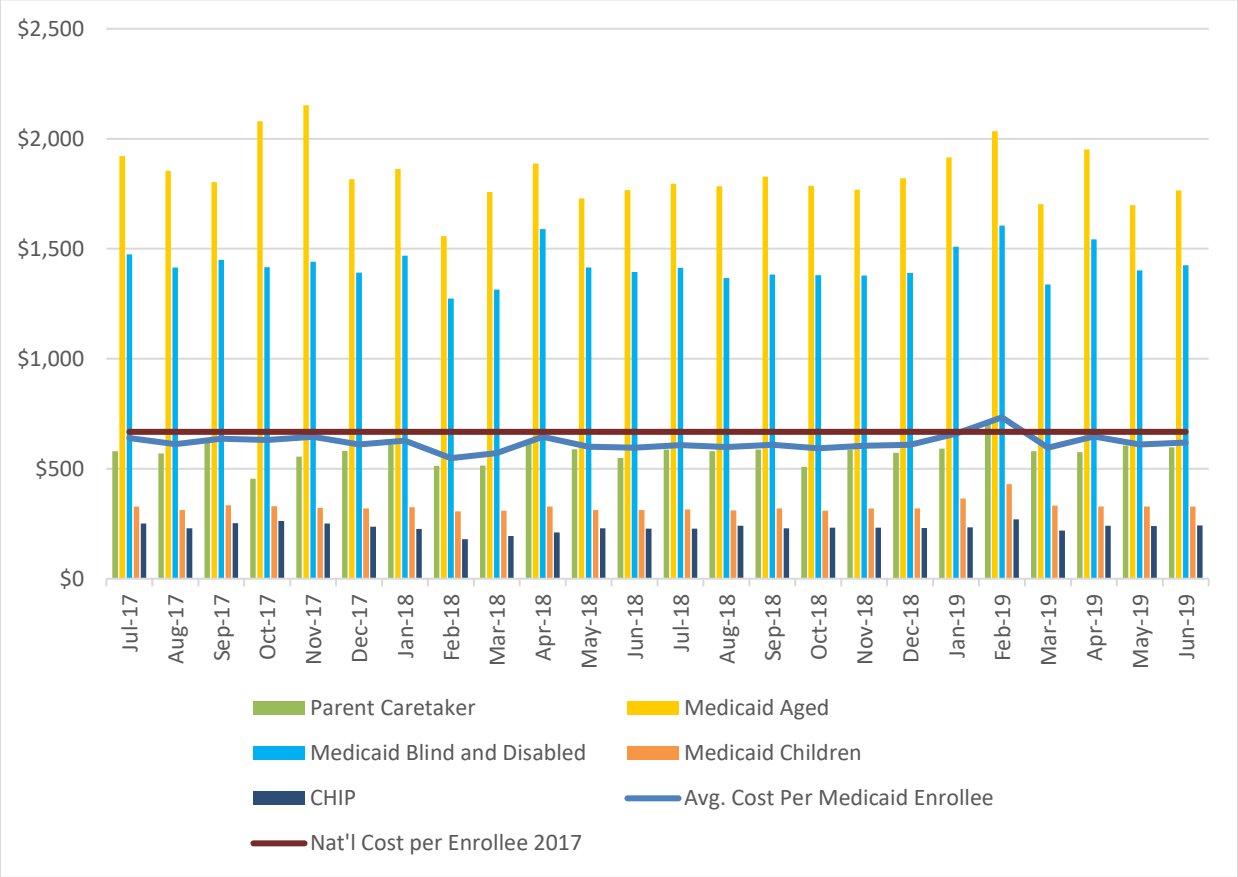
Figures 5 and 6 compare the cost of different eligibility categories. While the Aged and Blind & Disabled categories represent 22.6 percent of beneficiaries, they account for 64.9 percent of expenditures. In contrast, children account for 66.9 percent of beneficiaries, but only 27 percent of expenditures. As noted in Figure 5, the average cost per Medicaid enrollee briefly increased at the launch of Heritage Health in January 2017, as fee-for-service claims still overlapped with managed care premium payments. Since, the average monthly cost per enrollee has remained at or below the national average in most months.

Of note, Figure 6 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

[1] ADC: Adults with Dependent Children

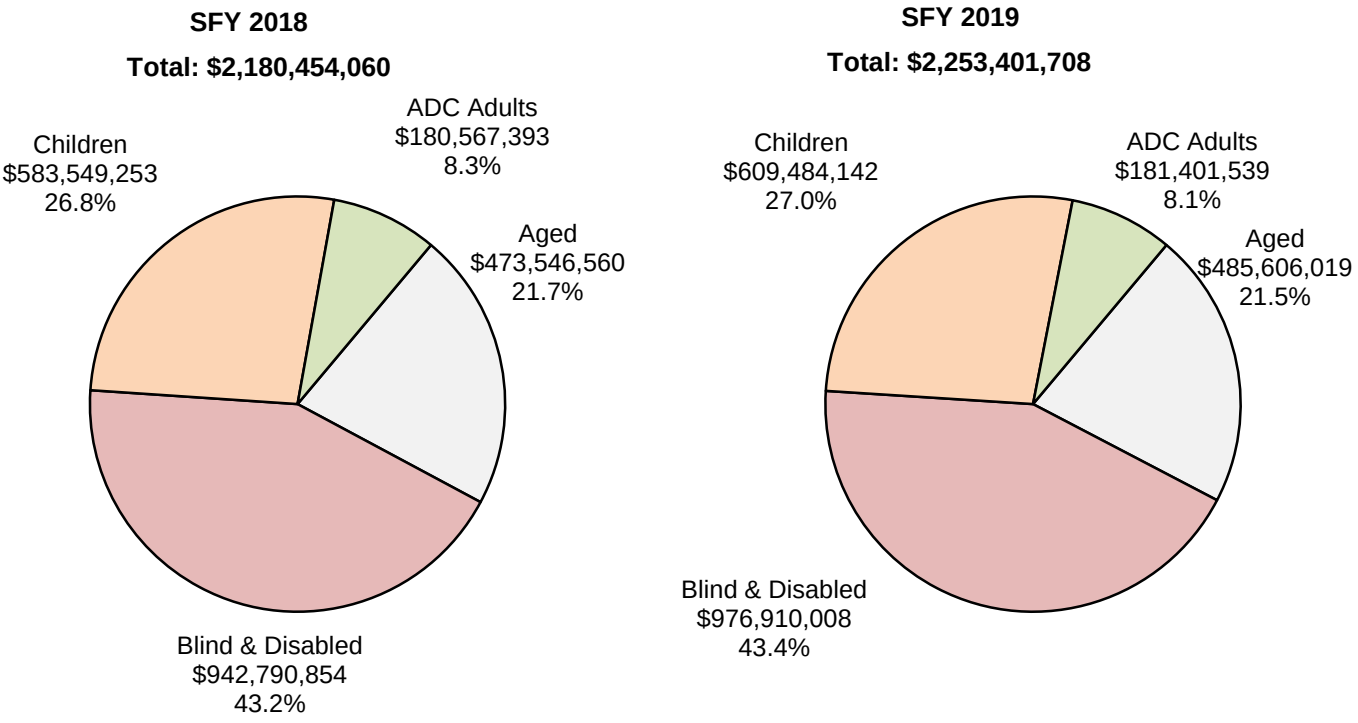
Information System (MMIS)[2], and premium payments paid on behalf of persons eligible for Medicare. Beneficiary demographic data is not available for these expenditures. This means some expenditures, particularly in the Aged and Blind & Disabled categories, are understated.

Figure 5. Nebraska Medicaid Cost per Enrollee



[2] These payments include Aged and Disabled Waiver Providers (paid in N-Focus), sub-award agencies (On-Base), and assistive technology partnership contractors (Nebraska Information System).

Figure 6. Nebraska Medicaid and CHIP Annual Cost by Eligibility Category



IV. BENEFIT PACKAGE

Federal Medicaid statutes mandate that states provide certain services, while also allowing states the option to provide other services. The Nebraska Medical Assistance Act (68-901 to 68-975) and the Medicaid State Plan delineate the mandatory and optional services available to Medicaid and CHIP recipients in Nebraska. These mandatory and optional services are noted in Table 5.

Table 5. Federal Medicaid Mandatory and Optional Services Covered in Nebraska

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 benefits package 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.

Substance Use Disorder Treatment

Recent federal Medicaid regulations had the potential to limit MLTC's ability to allow residential substance use disorder (SUD) services in Institutes for Mental Disease (IMDs) for Medicaid-enrolled adults ages 21-64. These regulations prevent managed care entities, such as those in Nebraska's Heritage Health program, from paying for stays in IMDs longer than 14 days, which may be necessary for certain individuals receiving SUD treatment.

In November 2018, MLTC submitted a Section 1115 demonstration waiver application to the federal government to continue Nebraska Medicaid's policy of allowing SUD residential services in IMDs for Medicaid-enrolled adults ages 21-64. This application was approved in June 2019 with an effective date of July 1, 2019. Unless renewed, this waiver will expire on June 30, 2024.

Non-emergency Medical Transportation (NEMT)

Beginning in late 2018, MLTC began publicly sharing its intent to place NEMT into the Heritage Health program. Placing NEMT into Heritage Health aligns with many of MLTC's long-term goals and strategies, such as maximizing the value of the managed care system and enhancing care coordination and management.

NEMT was placed into Heritage Health effective July 1, 2019. Each of the three Heritage Health plans have separate vendors who provide the NEMT benefit to members. Those vendors are:

- Nebraska Total Care, Medical Transportation Management
- UnitedHealthcare Community Plan, National MedTrans
- WellCare, IntelliRide

Heritage Health members who need NEMT now contact their health plan. Including NEMT in the Heritage Health benefit package is one measure MLTC is taking to prepare for the needs of the adult expansion population.

Basic and Prime benefits

A key component of Heritage Health Adult expansion will be its innovative two-tier benefit structure. MLTC will seek to waive certain default parts of federal law with a section 1115 demonstration waiver. Everyone who meets eligibility criteria, such as age, income, and residency, will receive at least Basic benefits. Basic benefits include all benefits covered by Nebraska Medicaid, with the exception of dental, vision, and over-the-counter medications. Prime benefits add these three services.

Members of the adult expansion group will have the ability to earn Prime benefits – the full array of benefits outlined in the State Plan – by meeting certain wellness, personal responsibility, and community engagement activities. This two-tier structure incentivizes individuals to take charge of their own health and wellness.

V. SERVICE DELIVERY

Nebraska delivers Medicaid and CHIP primarily through Heritage Health, a capitated managed care program. The managed care entities (MCEs) are responsible for the management and provision of specific Medicaid-covered services and use population health and care management strategies to manage their beneficiary population in a quality and cost-conscious manner. Nationally, 39 other states (including the District of Columbia) contract similarly with MCEs to provide Medicaid services.

Heritage Health combines physical health, behavioral health, and pharmacy benefits into a comprehensive plan available to Nebraska Medicaid beneficiaries. In SFY19, there were three MCEs available for beneficiaries: Nebraska Total Care; UnitedHealthcare Community Plan; and WellCare of Nebraska.

An integrated managed care program has the potential to achieve:

- improved health outcomes;
- enhanced member satisfaction;
- enhanced coordination of care and quality of care;
- reduced rate of costly and avoidable care; and
- improved fiscal accountability.

When a Medicaid beneficiary enrolls in Heritage Health, MLTC's enrollment broker, Automated Health Systems, assigns them to one of the available plans. New members can select a different plan within 90 days of joining Heritage Health. In addition, the annual open enrollment period is available to all members from November 1 – December 15 and all members may choose a different plan.

Heritage Health focuses on improving the health and wellness of Medicaid members by increasing their access to comprehensive health services in a cost-effective manner. Managed care oversight is a top priority with monthly performance reports from the MCEs. These performance metrics include:

- member engagement;
- provider engagement;
- network adequacy;
- claims adjudication;
- care management;
- quality of care;
- utilization management; and
- financials.

MLTC also uses a Quality Performance Program (QPP) that allows the MCEs to earn a withhold payment for enhanced quality in specific areas. In SFY19, all clinical quality QPP measures were met but one by a single MCE.

Nebraskans enrolled in home and community based waiver programs, as well as those living in long-term care institutional settings such as nursing homes or intermediate care facilities, still have certain services provided via fee-for-service (FFS). 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 or in-home care) remain administered through FFS.

VI. PROVIDERS

MCEs leverage provider and value-based contracts with medical providers to deliver health care to Medicaid beneficiaries. MLTC makes capitation payments to MCEs.

At the end of SFY19, there were 104,918 in-state Medicaid providers. Of those in-state providers, 10,200 are billing providers and 94,718 are group members[3]. Out-of-state providers totaled 3,222 for Nebraska Medicaid. Of those out-of-state providers, 1,922 are billing providers and 1,300 are group members.

Provider details including the type of practice and number of in-state and out-of-state providers are noted in Table 6.

Table 6. Nebraska Medicaid Providers by Type, July 2019

Provider Type	Provider Type Prac	In-State	Out-of-State
Doctors of Medicine (MD)	Group Practice	217	175
	Group Practice Member	31,028	
	Individual or Solo Practice	161	214
Doctors of Osteopathy (DO)	Group Practice	4	4
	Group Practice Member	2,333	
	Individual or Solo Practice	8	13
Doctors Of Chiropractic Medicine (DC)	Group Practice	258	24
	Group Practice Member	522	
	Individual or Solo Practice	180	8
Optometrists (OD)	Group Practice	240	19
	Group Practice Member	991	
	Individual or Solo Practice	65	4
Doctors Of Podiatric Medicine (DPM)	Group Practice	57	11
	Group Practice Member	212	
	Individual or Solo Practice	28	3

[3] Group members are providers who render medical services. Billing providers are entities that bill Medicaid or a health plan for a service rendered. A solo practitioner could be counted as both. Likewise, multiple providers could be grouped as a single billing provider.

Provider Type	Provider Type Prac	In-State	Out-of-State
Ambulatory Surgical Centers (ASC)		46	10
Hospitals (HOSP)		175	523
	Rehabilitation Facility (Hospital Only)	9	5
	Children Facility (Hospital Only)	3	26
Nursing Homes (NH)		1,368	16
Clinic (CLNC) (Hospital Based Clinic, Licensed Mental Health Centers)	Group Practice	319	146
Professional Clinic (PC)	Group Practice	2,803	703
Home Health Agency (HHAG)		101	3
Anesthesiologist (ANES)	Group Practice	164	74
	Group Practice Member	3,223	
	Individual or Solo Practice	20	29
Laboratory (LAB) (Independent)		35	269
Federally Qualified Health Center (FqHC)	Group Practice	44	12
Rural Health Clinic-Provider Based (PRHC)(Less Than 50 Beds)	Individual or Solo Practice	124	25
Rural Health Clinic-Independent (IRHC)	Individual or Solo Practice	19	15
Dispensing Physician (MD)	Group Practice Member	41	
Physician Assistant (PA)	Group Practice Member	6,994	
Rural Health Clinic-Provider Based (RHCP) (Over 50 Beds)	Individual or Solo Practice	8	
Indian Health Hospital Clinic (IHSH)			5
Tribal 638 Clinic (T638)	Group Practice	12	
Nurse Midwife (NW)	Group Practice Member	301	
Nurse Practitioner (NP)	Group Practice	77	7
	Group Practice Member	10,671	
	Individual or Solo Practice	72	23
Registered Nurse (RN)	Group Practice	8	
	Group Practice Member	443	
	Individual or Solo Practice	15	
Licensed Practical Nurse (LPN)	Group Practice Member	70	
	Individual or Solo Practice	6	
Registered Physical Therapist (RPT)	Group Practice	625	24
	Group Practice Member	5,850	
	Individual or Solo Practice	13	1
Personal Care Aide (PCA)	Group Practice Member	1,169	
Mental Health Personal Care Aide (CTAI)	Group Practice Member	530	
Mental Health Home Health Care Provider (CT)	Group Practice Member	459	
	Individual or Solo Practice	1	

Provider Type	Provider Type Prac	In-State	Out-of-State
Licensed Mental Health Practitioner (LMHP)	Group Practice	1	
	Group Practice Member	2,762	
	Individual or Solo Practice	2	
Mental Health Professional/Masters Level Equivalent (MHP)	Group Practice Member	3,651	
	Individual or Solo Practice	1	
Licensed Independent Mental Health Practitioner (IMHP)	Group Practice	117	4
	Group Practice Member	3,775	
	Individual or Solo Practice	348	14
Doctor Of Dental Surgery - Dentist (DDS)	Group Practice	302	36
	Group Practice Member	2,006	
	Individual or Solo Practice	358	18
Assertive Community Treatment (ACT) MRO Program		9	
Licensed Dental Hygienist (LDH)	Group Practice	78	10
	Group Practice Member	82	
	Individual or Solo Practice	12	
Community Support (CSW) MRO Program	Group Practice	49	1
	Group Practice Member	1,199	
Day Rehabilitation (DAYR) MRO Program		15	
	Group Practice Member	12	
Residential Rehabilitation (REST)		20	1
Substance Abuse Treatment Center (SATC)	Group Practice	95	1
Adult Substance Abuse Provider	Group Practice	42	13
Pharmacist	Group Practice Member	29	
Pharmacy (PHCY)	Professional Pharmacy	10	3
	Independent Pharmacy	113	178
	Small Chain Pharmacy	93	27
	Large Chain Pharmacy	173	53
	Other Pharmacy	34	31
	Unit Dose, Large Chain Pharmacy	2	2
	Unit Dose, Independent Pharmacy	6	5
Provisionally Licensed PHD-PPHD	Group Practice Member	250	
Provisionally Licensed Drug & Alcohol Counselors (PDAC)	Group Practice Member	263	
Hospice (HSPC)		63	6
Hearing Aid Dealer (HEAR)	Group Practice	46	6
	Group Practice Member	195	
	Individual or Solo Practice	15	2

Provider Type	Provider Type Prac	In-State	Out-of-State
Transportation		561	81
Rental And Retail Supplier (RTLR)		168	178
Licensed Medical Nutrition Therapist (LMNT)	Group Practice	7	1
	Group Practice Member	104	
	Individual or Solo Practice	3	
Specially Licensed Phd/Psychology Resident (SPHD)	Group Practice Member	23	
Orthopedic Device Supplier (ORTH)		1	14
Optical Supplier (OPTC)		39	2
Licensed Psychologist (PhD)	Group Practice	46	2
	Group Practice Member	1,365	
	Individual or Solo Practice	93	2
Speech Therapy Health Service	Group Practice	433	13
	Group Practice Member	4,640	
	Individual or Solo Practice	19	1
Occupational Therapy Health Services (OTHS)	Group Practice	446	12
	Group Practice Member	2,518	
	Individual or Solo Practice	2	
Qualified Health Maintenance Organization (QHMO)		6	2
Other Prepaid Health Plan (OPH)		4	
Day Treatment Provider (DAY)		20	
Licensed Drug & Alcohol Counselor (LDAC)	Group Practice Member	473	
Treatment Crisis Intervention (TCI)		3	1
Therapeutic Group Home (ThGH)		4	
Professional Resource Family Care (PRFC)	Group Practice	3	2
Psychiatric Residential Treatment Facility (PRTF)		1	10
Free Standing Birth Center		2	
NFOCUS Providers		5,584	99

The Nebraska Medicaid program uses different methodologies to reimburse for Medicaid services via FFS:

- 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 on a per diem based on a reasonable cost of providing the services;
- federally qualified health centers (FQHCs) are reimbursed via the alternative payment methodology;
- rural health clinics (RHCs) are reimbursed their cost or on 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 beneficiary 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; and
- Dental services are reimbursed by the dental PAHP, a managed care entity for Medicaid managed care members and via fee-for-service for fee-for-service Medicaid clients.

Figure 7. Nebraska Medicaid Rate Changes

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.
2018	No rate changes were implemented
2019	No rate changes were implemented

No provider rate changes occurred in SFY19. The vast majority of services provided by Nebraska Medicaid are paid for by MCEs, which are not bound by state fee schedules. Each MCE must have an adequate provider network and may negotiate reimbursement rates with providers in its network.

VII. VENDOR EXPENDITURES

Medicaid and CHIP are financed jointly by the federal and state governments, with the federal government matching state spending at a rate known as the Federal Medical Assistance Percentage (FMAP). FMAP is based on each state's per capita income relative to the national average and is highest in poorer states, varying from 50 percent to 77 percent. Nebraska's FMAP in federal fiscal year (FFY) 2019[4] was 52.58 percent for Medicaid and 89.81 percent for CHIP. Due to the ACA, the CHIP FMAP increased beginning in FFY16. Table 7 shows the FMAP for both Medicaid and CHIP for FFY14 through FFY20.

Table 7. Nebraska FMAP Rates

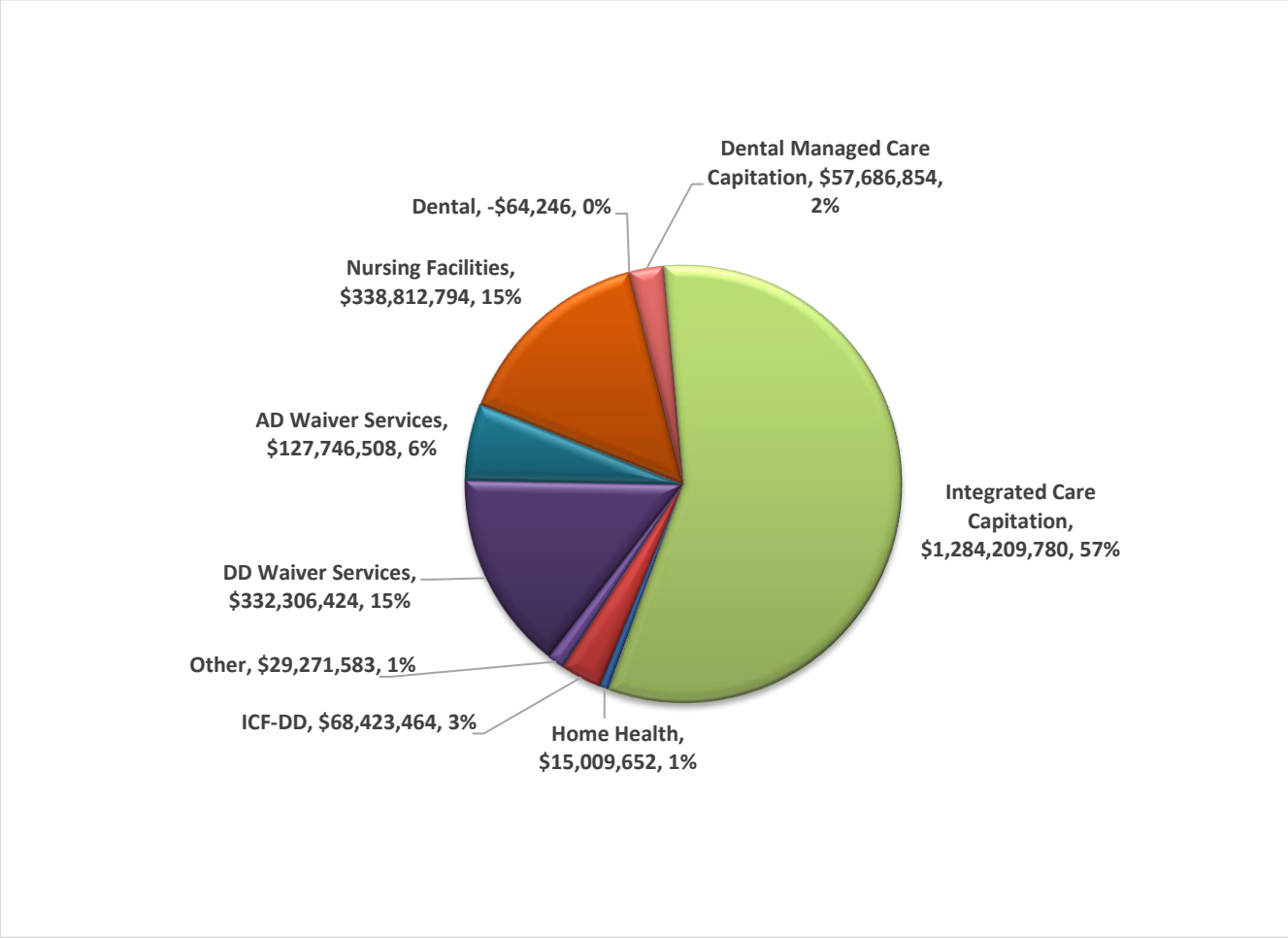
Federal Fiscal Year	Medicaid FMAP	CHIP FMAP
FFY14	54.74%	68.32%
FFY15	53.27%	67.29%
FFY16	51.16%	88.81%
FFY17	51.85%	89.30%
FFY18	52.55%	89.79%
FFY19	52.58%	89.81%
FFY20	54.72%	79.80%

Total SFY19 vendor payments for Medicaid and CHIP expenditures were $2,253,402,812. This total includes drugs, inpatient and outpatient hospital, physicians, practitioners, and early and periodic screening, diagnostic and treatment. A&D Waiver includes $558,243 of expenditures under the Traumatic Brain Injury Waiver. 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.

[4] October 1, 2018 to September 30, 2019

Figure 8 shows how the expenditures to vendors are distributed by service type.

Figure 8. SFY19 Medicaid and CHIP Expenditures by Service



Not all Medicaid and CHIP expenditures are captured in Figure 8. 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 offered to other large drug payers, such as insurance companies. In SFY19, Medicaid received a total of $172.8 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 SFY19, Medicaid paid $32.8 million through the DSH program, a 25.6 percent decrease compared to $44.1 million paid in SFY18;
- Medicaid pays the Medicare Part B premium for beneficiaries that are dually eligible for Medicare and Medicaid. In SFY19, Medicaid paid $60,831,613 for Medicare premiums, a 12.21% increase from the $54,211,723 for Medicare premiums paid in SFY18. Monthly premiums were $134.00 for calendar year 2018 and $135.50 for calendar year 2019; and

- 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 SFY19, clawback payments totaled $67,143,631, a 1.17 percent increase from the $66,367,837 paid in SFY18. 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.

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. As noted in Figure 8, a majority of MLTC's expenditures come in the form of capitation payments for managed care. Figures 9 and 10 note the relative cost of services covered via capitation payments.

Figure 9. Percentage of Capitated Health Spend by Service Category

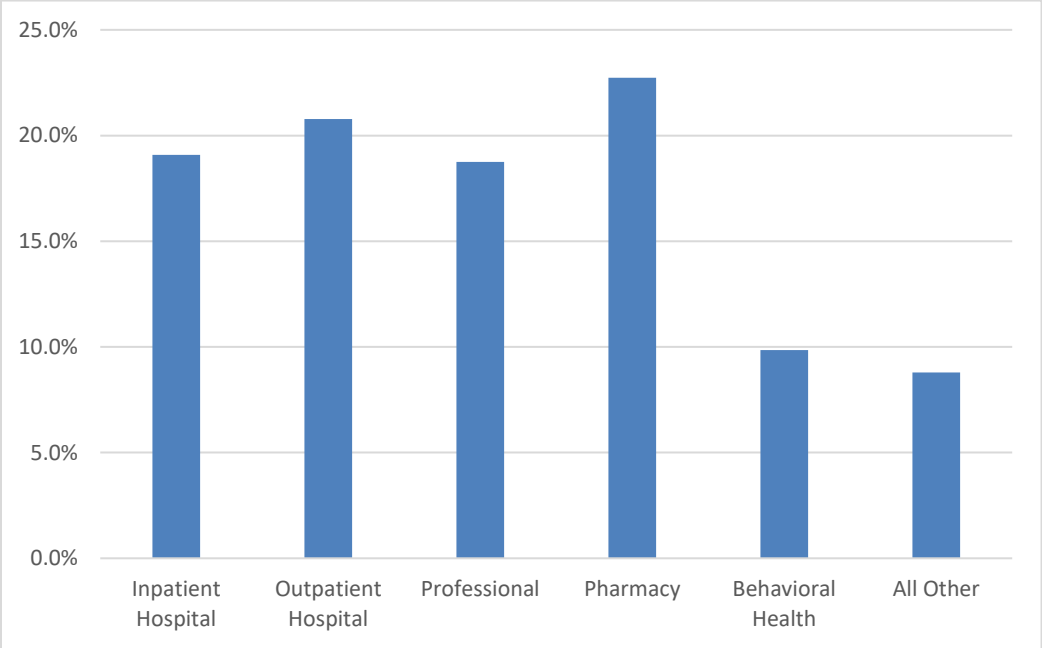
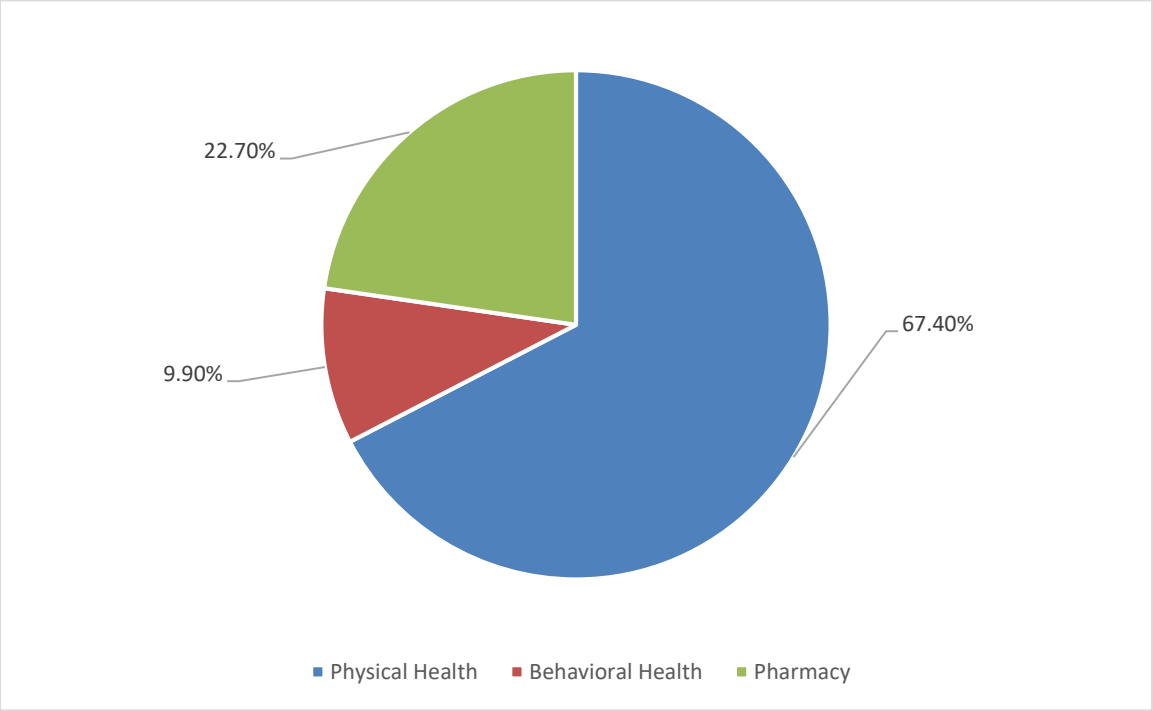


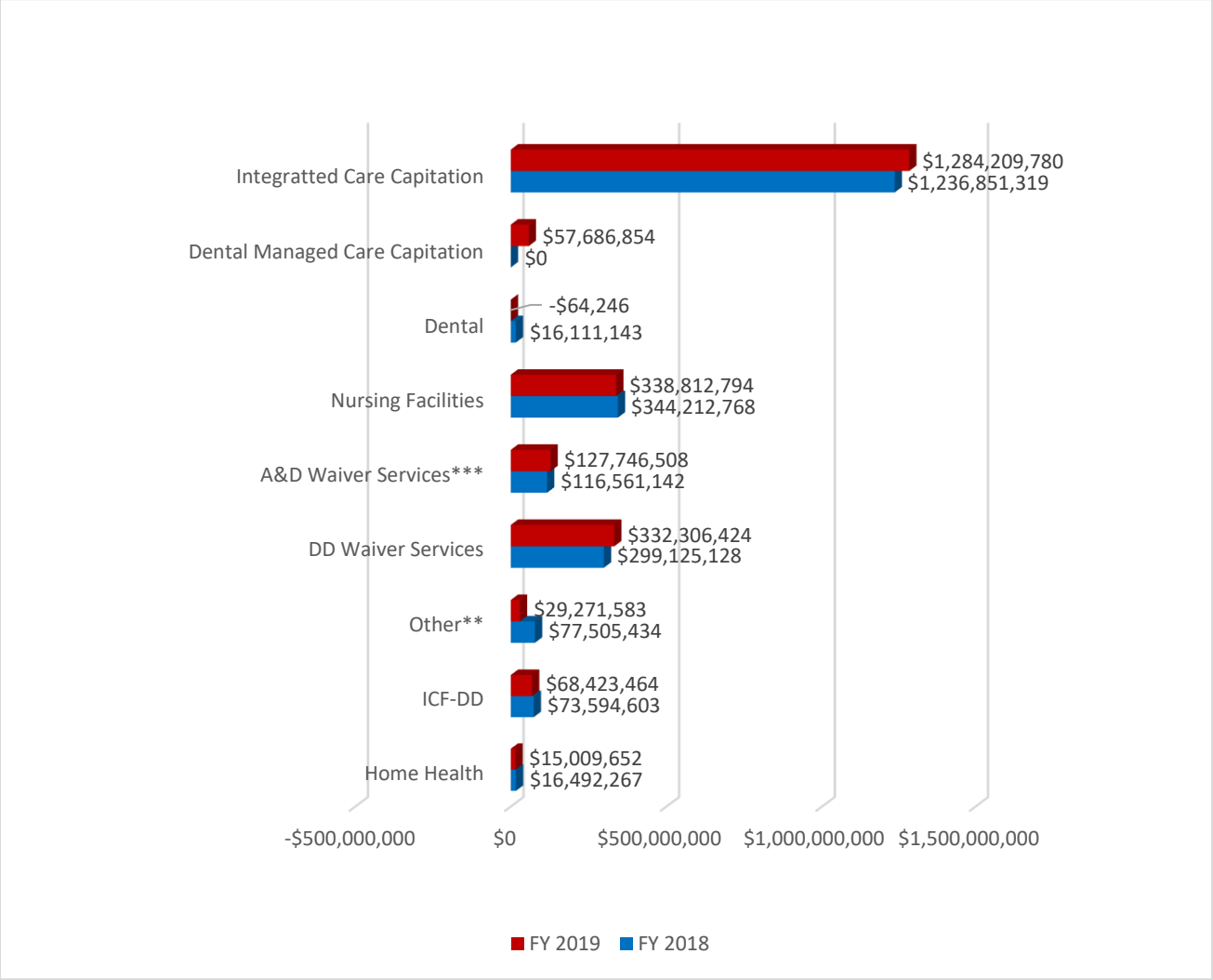
Figure 10. Heritage Health Medical Services by Relative Cost[5]



[5] There are additional behavioral health services that are provided alongside physical health services which are counted in the physical health total.

Figure 11, below, compares vendor expenditures from SFY18 and SFY19.

Figure 11. Medicaid and CHIP Expenditures SFY18 and SFY19[6]



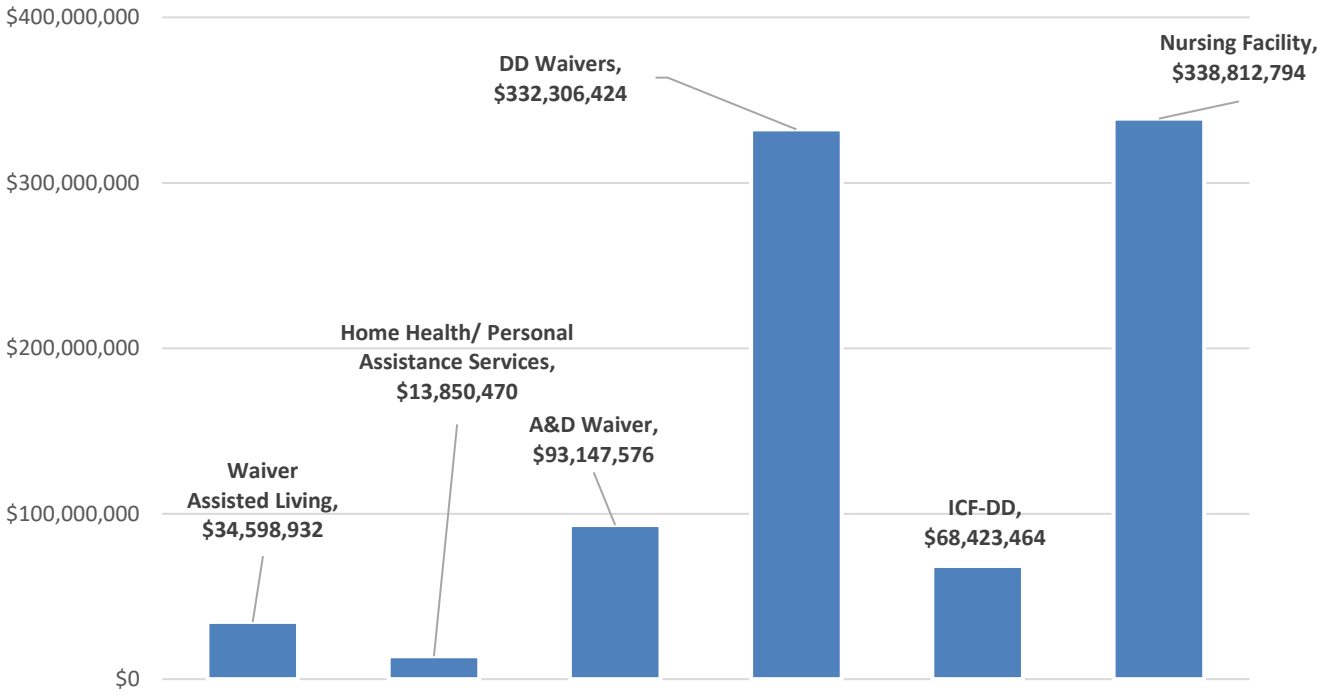
LONG-TERM CARE SERVICES

Long-term care (LTC) services support individuals with chronic or ongoing health needs related to age or disability. In SFY19, Medicaid expenditures for LTC services totaled $881,139,659. These services are tailored to multiple levels of beneficiary needs ranging from limited assistance with activities of daily living to complex nursing interventions. Assistance can be offered in a variety of settings, from an individual's home to small group settings with community supports or nursing facilities. In general, home and community-based care is less expensive and offers greater independence for the consumer than facility-based care.

[6] Dental services were carved into Dental Managed Care Capitation effective October 1, 2017, during SFY18

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 care are resulting in a gradual rebalancing of LTC expenditures. The following Figures show the cost of Medicaid expenditures for LTC services, and the cost of LTC services delivered in facilities compared to the cost of care delivered in home and community settings for SFY19.

Figure 12. SFY19 Medicaid Expenditures for LTC Services

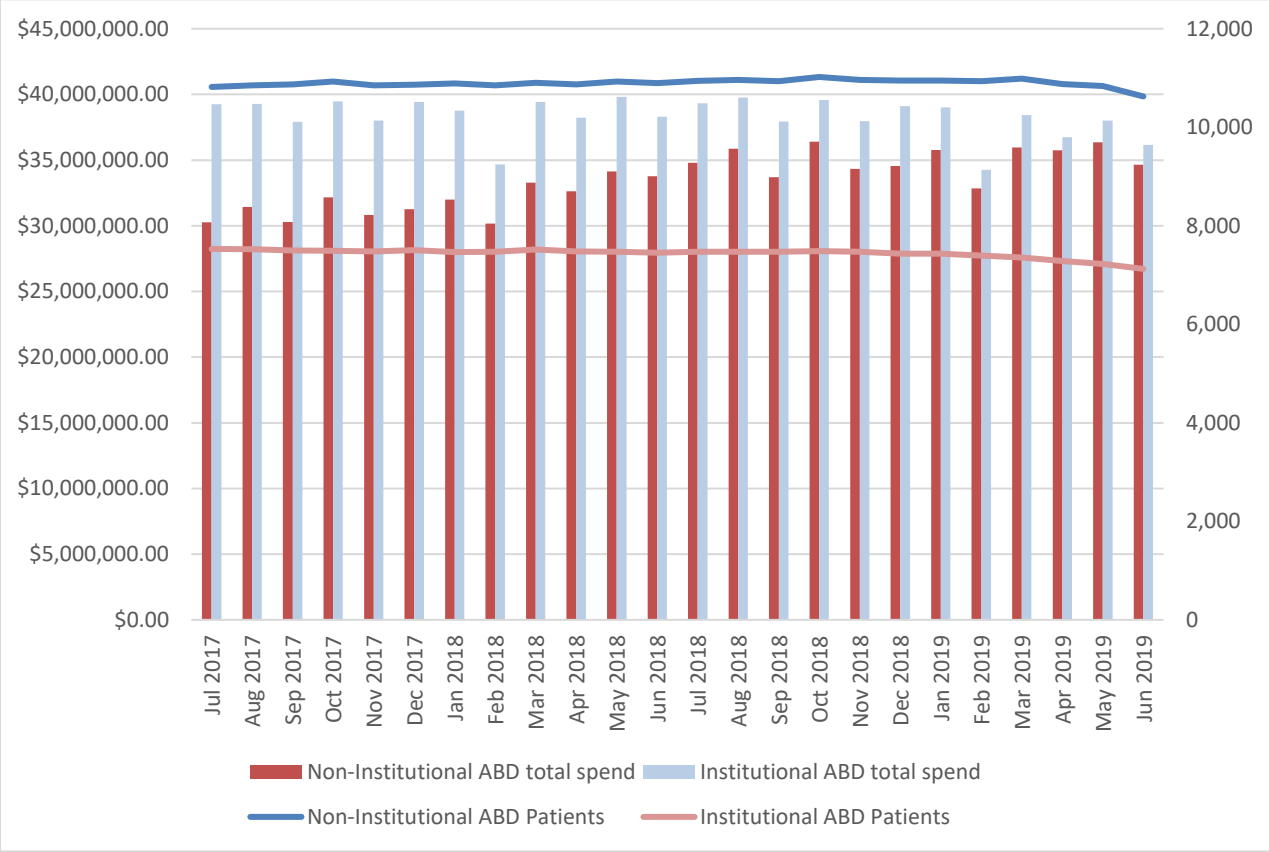


Definitions of each expenditure categories are below.

Category	Definition
Nursing Facility	Payment made to nursing facility services for aged and disabled Medicaid eligible beneficiaries.
ICF-DD	Payment made to intermediate care facility services for intellectually and developmentally disabled Medicaid eligible beneficiaries.
DD Waivers	Payment made for an array of home and community based services for intellectually and developmentally disabled Medicaid eligible beneficiaries; Medicaid offers two waivers for this population.
Home Health/Personal Assistance Services	Payment made for community-based care covered under the Medicaid State Plan to support Medicaid eligible beneficiaries living independently in their own home.
A&D Waiver	Payment made for an array of home and community-based services for aged and disabled Medicaid eligible beneficiaries to support living independently in their own home.

Category	Definition
Waiver Assisted Living	Payment made for the Assisted Living service within the Aged and Disabled waiver, this payment allows beneficiaries to continue living in the community rather than in a nursing facility. This includes services provided through the TBI waiver.

Figure 13. Nebraska LTC Expenditures by Living Arrangement



VIII. MEDICAID EXPANSION

In November 2018, Nebraska voters passed Initiative 427, which requires DHHS to extend Medicaid eligibility to adults ages 19-64 who earn up to 138 percent of the federal poverty level. The initiative required the Department to submit to the federal government a state plan amendment by April 1, 2019. DHHS met this deadline, and submitted state plan amendments and a concept paper outlining MLTC's vision for Medicaid expansion.

The Medicaid expansion product in Nebraska will be called Heritage Health Adult (HHA) expansion. HHA will be an innovative new program, designed to serve the needs of the estimated 90,000 newly Medicaid-eligible individuals living in Nebraska starting October 1, 2020. Heritage Health Adult will build on MLTC's existing managed care system and more fully capitalize on the value of Medicaid's relationships with the health plans.

HHA will utilize a two-tier benefit structure in order to provide health care services to the adult expansion group. Members of the adult expansion group will, in most cases, begin with Basic benefits. They can earn additional, Prime benefits by completing certain wellness, personal responsibility, and community engagement activities. All members of the adult expansion group will be eligible for at least Basic benefits regardless of whether they choose to earn Prime benefits, as long as they meet underlying Medicaid eligibility criteria, such as age, income, and residency.

More information about Nebraska's Medicaid expansion is available on the DHHS website.

To allow Nebraska the flexibility to implement Medicaid expansion in a way that is right for Nebraska, MLTC will be applying for a Section 1115 Demonstration Waiver from the federal government. The waiver application will be submitted in December 2019.

Through SFY19, MLTC took steps to implement expansion, including technology system builds, staff recruitment, and discussions with the federal government. HHA will launch on October 1, 2020.

IX. SFY19 HIGHLIGHTS AND ACCOMPLISHMENTS

Heritage Health Begins Year 3

Heritage Health, Nebraska's integrated Medicaid managed care program, moved into the third year of operations fully focused on improving the beneficiary and provider experience, improving the health of the population and reducing the per capita cost of healthcare. Heritage Health incorporated both the Nebraska Refugee Population and the State Disability Program's beneficiaries this year as well.

With an emphasis on the provider experience, all three Heritage Health MCEs maintain a global issue log on their webpages to ensure transparency with any claims, reprocessing projects, recoupment projects, or changes to system configurations. The Heritage Health provider advisory committees and subcommittees were consolidated in SFY19 to form the Heritage Health Stakeholder Forum, offering a comprehensive platform for providers, health plan representatives, and employees from sister divisions of DHHS to meet with MLTC to discuss process improvement opportunities and solve any concerns that arise between meetings.

Non-Emergency Medical Transportation

Non-emergency medical transportation (NEMT) is a service by which Medicaid will pay for transportation to and from regular health appointments when the Medicaid members has no other transportation available. Previously, NEMT was provided fee-for-service through MLTC.

NEMT was added to the Heritage Health benefit package effective July 1, 2019. No changes were made to the criteria for receiving this service. NEMT being included in the Heritage Health benefit package allows for enhanced care coordination and case management through the MCEs.

Organizational Restructuring in MLTC

When it was created in the 1960s, Medicaid's original function was to pay claims. This fee-for-service model is largely being phased out across the country, including in Nebraska. With the Heritage Health program soon entering its fourth year, MLTC is no longer primarily a payer of claims. Instead, the organization's main function is monitoring services and ensuring better and more cost-effective health care.

In mid-2019, MLTC began reorganizing its internal structure to more closely align with its primary business function. To lead this effort, MLTC created three new deputy-level positions: Business Performance and Analytics, Population Health, and Experience Management and Provider Relations. While the first two of these reorganized existing teams within Medicaid, Experience Management and Provider Relations was newly created to enhance Medicaid's relationship with members and providers, while actively crafting the experiences of those involved in the Medicaid program.

New MLTC Public Website

In March 2019, DHHS debuted a new public website, which improved on the Department's former website in a number of areas. The new website is simpler to read and easier to navigate, and it can be easily used on smartphones and tablets.

MLTC's portion of the Department's new website is organized by audience, with sections designed for Medicaid members, providers, and the State Unit on Aging. There is also a section for general audiences, with important information on the Medicaid program like Heritage Health and Medicaid's rules and regulations.

X. LOOKING AHEAD

Heritage Health Adult Expansion

A substantial portion of the work needed to launch Medicaid expansion will occur in SFY20. MLTC will be submitting an application to CMS for a Section 1115 Demonstration Waiver for approval. This wavier will allow the State to include the innovations built into Heritage Health Adult expansion discussed in section VIII of this report. MLTC is planning to submit this application in December with approval from the federal government anticipated in April 2020. Among the other tasks that will take place in SFY20, there will be technology development, staffing, regulatory changes, provider outreach, and more.

Data Management and Analytics (DMA) Solution

DHHS is currently replacing its data warehouse and decision support system with an updated data warehouse and business intelligence technology platform. MLTC contracted with Deloitte Consulting LLP to implement their Health Interactive Analytics solution. The project began in February 2018 and is scheduled for launch in April 2020. More information on this project is available in MLTC's MMIS Replacement Planning Report, which is submitted to the Legislature quarterly.

Electronic Visit Verification (EVV)

The Electronic Visit Verification (EVV) solution is required for Nebraska to become compliant with the federal 21st Century CURES Act, passed in December 2016. EVV is federally mandated for implementation prior to January 1, 2020, for personal assistance services and prior to January 1, 2023, for home health services. MLTC submitted and anticipates approval of a Good Faith Exemption request to allow implementation for personal assistance services in 2020.

Development of an EVV system will improve oversight, ensure authorized services are delivered as planned, and reduce manual activities needed to process paper timesheets and claims payment. The project's focus for the past year has been the preparation and release of a Request for Proposal (RFP) for the state-wide EVV solution, which was released on August 9, 2019. The State has also focused on the completion of all activities required for enhanced federal matching funds.

MLTC plans the EVV rollout will begin in October 2020.

Nursing Home Payment Methodology Changes

As mentioned in last year's report, Nebraska Medicaid continually evaluates its payment methodologies for value and effectiveness. In the upcoming state fiscal year, MLTC will be focusing on modernizing its payment methodology for nursing homes.

Whereas the majority of Medicaid benefits are covered through a per-member, per-month payment to the Heritage Health managed care plans, Medicaid continues to pay nursing homes directly for services provided to Medicaid members. Currently, Medicaid reimburses nursing homes a percentage of cost, meaning payments to facilities can vary, even for residents who are receiving the same services. This unintentionally disincentivizes nursing homes that provide quality care at lower costs.

In SFY20, MLTC is working with providers and stakeholders on reform to create more equity in payment rates across providers. Additionally, nursing homes can win additional payments for being recognized by CMS with a 3, 4, or 5 star quality rating. This new payment methodology will promote equity and reward nursing homes for providing quality care.

Substance Use Disorder Demonstration

Recent federal Medicaid regulations added new limits to the Division of Medicaid and Long-Term Care's ability to allow residential substance use disorder (SUD) services in Institutions for Mental Disease (IMDs) for Medicaid-enrolled adults ages 21-64. This had the potential to disrupt treatment for some of Nebraska Medicaid's most vulnerable members as they may be forced to seek treatment in less appropriate and more costly settings.

To remedy this situation, Nebraska applied for a Section 1115 Demonstration Waiver to allow the State to continue covering SUD services in IMDs. CMS approved this waiver in June 2019.

Looking ahead to 2020, Nebraska Medicaid will cover two new services to fulfill the objectives of the SUD waiver: methadone and medically monitored withdrawal management. MLTC anticipates that these services will be available beginning in 2020 and be covered through the Heritage Health managed care plans.

XI. CONCLUSION

MLTC takes seriously its ongoing commitment to delivering quality health care to Nebraskans in need, both for those currently enrolled in Medicaid and those for whom expanded Medicaid is being built. To meet this commitment to all of Medicaid's stakeholders, including beneficiaries, providers, and taxpayers, MLTC continues to focus on improving all aspects of its operations. Through initiatives like Heritage Health Adult expansion and the modernization of nursing home payments, procurements like the DMA solution, and integrating services and partnerships, MLTC is positioning itself to be able to continue to provide quality services in the years to come.

Additionally, MLTC is committed to transparency and providing information to the Legislature and the general public as it continues to improve its operations. MLTC looks forward to continuing to work with the Governor, the Legislature, and stakeholders to improve and sustain Medicaid.

HERITAGE HEALTH
ADULT PROGRAM

Current Eligibility Groups Services Comparison Mandatory (NRS 68-911(1))

Eligibility Category	Newborn to Age 1	Children Ages 1-5	Children Ages 6-18	CHIP	599 CHIP (Pregnancy related & prenatal care only)	Former Foster Care	Former Ward	Subsidized Adoption	Subsidized Guardianship	Extended Subsidized Guardianship or Adoption	Katie Beckett	Children in an Institution for Mental Disease	Parent/Caretaker Relative	Pregnant Women	Transitional Medical Assistance	Aged, Blind, or Disabled	Aged, Blind, & Disabled Qualified Medicare Beneficiary	Medicare Savings Program Qualified Medicare Beneficiaries (Payment of Medicare part B premium only)	SLMB (Payment of Medicare part B premium only)	QI-1 (Payment of Medicare part B & D premiums)	Medicaid Insurance for Workers with Disabilities	Medically Needy	Breast & Cervical Cancer (Breast or cervical cancer treatment only)	Emergency Medical Services for Aliens	Presumptive Eligibility for Pregnant Women (Ambulatory prenatal care only)	Hospital Based Presumptive Eligibility	Hospital Based Presumptive Eligibility for Pregnant Women (Ambulatory prenatal care only)
Inpatient Hospital	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x				x	x	x	x		x	
Outpatient Hospital	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x				x	x	x	x	x	x	x
Laboratory	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x				x	x	x	x	x	x	x
X-Ray	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x				x	x	x	x	x	x	x
Home Health	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x				x	x	x	x	x	x	x
Nursing	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x				x	x	x	x	x	x	x
Clinic	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x				x	x	x	x	x	x	x
Physician	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x				x	x	x	x	x	x	x
Medical and Surgical services of a Dentist	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x				x	x	x	x	x	x	x
Nurse Practitioner	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x				x	x	x	x	x	x	x
Nurse Midwife	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x				x	x	x	x	x	x	x
Pregnancy-related	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x				x	x		x		x	
Medical Supplies	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x				x	x	x	x	x	x	x
Mental Health and Substance Abuse	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x				x	x	x		x	x	x
Early and Periodic Screening and Diagnosis and Treatment (EPSDT)	x	x	x	x		x	x	x	x	x	x	x														x	

HERITAGE HEALTH ADULT PROGRAM

Heritage Health Adult Program

Services Comparison - Optional Services (NRS 68-911(2)(3)(4))

Eligibility Category	Newborn to Age 1	Children Ages 1-5	Children Ages 6-18	CHIP	599 CHIP (Pregnancy related & prenatal care only)	Former Foster Care	Former Ward	Subsidized Adoption	Subsidized Guardianship	Extended Subsidized Guardianship or Adoption	Katie Beckett	Children in an Institution for Mental Disease	Parent/Caretaker Relative	Pregnant Women	Transitional Medical Assistance	Aged, Blind, or Disabled	Aged, Blind, & Disabled Qualified Medicare Beneficiary	Medicare Savings Program Qualified Medicare Beneficiaries[1]	SLMB (Payment of Medicare part B premium only)	QI-1 (Payment of Medicare part B & D premiums)	Medicaid Insurance for Workers with Disabilities	Medically Needy	Breast & Cervical Cancer (Breast or cervical cancer treatment only)	Emergency Medical Services for Aliens	Presumptive Eligibility for Pregnant Women[2]	Hospital Based Presumptive Eligibility	Hospital Based Presumptive Eligibility for Pregnant Women[3]
Prescribed Drugs	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x				x	x	x	x	x	x	x
Intermediate Care Facilities for persons with Developmental Disabilities (ICF/DD)	Must meet level of care	Must meet level of care	Must meet level of care	Must meet level of care		Must meet level of care	Must meet level of care	Must meet level of care	Must meet level of care	Must meet level of care	Must meet level of care	Must meet level of care	Must meet level of care	Must meet level of care	Must meet level of care	Must meet level of care	Must meet level of care				Must meet level of care	Must meet level of care	Must meet level of care				
Home and Community Based Services waivers	Must meet level of care	Must meet level of care	Must meet level of care	Must meet level of care		Must meet level of care	Must meet level of care			Must meet level of care		Must meet level of care	Must meet level of care		Must meet level of care	Must meet level of care	Must meet level of care				Must meet level of care	Must meet level of care	Must meet level of care				
Dental	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x				x	x			x		x
Rehabilitation	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x				x	x	x		x		x
Personal Care	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x				x	x	x		x		x
Durable Medical Equipment	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x				x	x	x	x	x	x	x
Medical Transportation	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x				x	x	x		x		x
Vision Related	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x				x	x	x		x		x
Speech Therapy	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x				x	x	x		x		x
Physican Therapy	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x				x	x	x		x		x
Chiropractic	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x				x	x	x		x		x
Optometric	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x				x	x	x		x		x
Pediatric	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x				x	x	x		x		x
Hospice	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x				x	x	x				
Mental Health and Substance Abuse	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x				x	x	x		x		x
Hearing Screening services for newborn and infant children	x																										
Community based secure residential and sub-actue behavioral health services	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x				x	x	x				
Services provided as a part of Individualized Education program	x	x	x	x				x	x	x	x	x															
Services provided as a part of Individualized Family Service Plan	x	x	x	x				x	x	x	x	x															

[1] (Payment of Medicare part B premium only)

[2] (Ambulatory prenatal care only)

[3] (Ambulatory prenatal care only)