NEBRASKA MEDICAID ANNUAL REPORT

STATE FISCAL YEAR 2020

December 1, 2020

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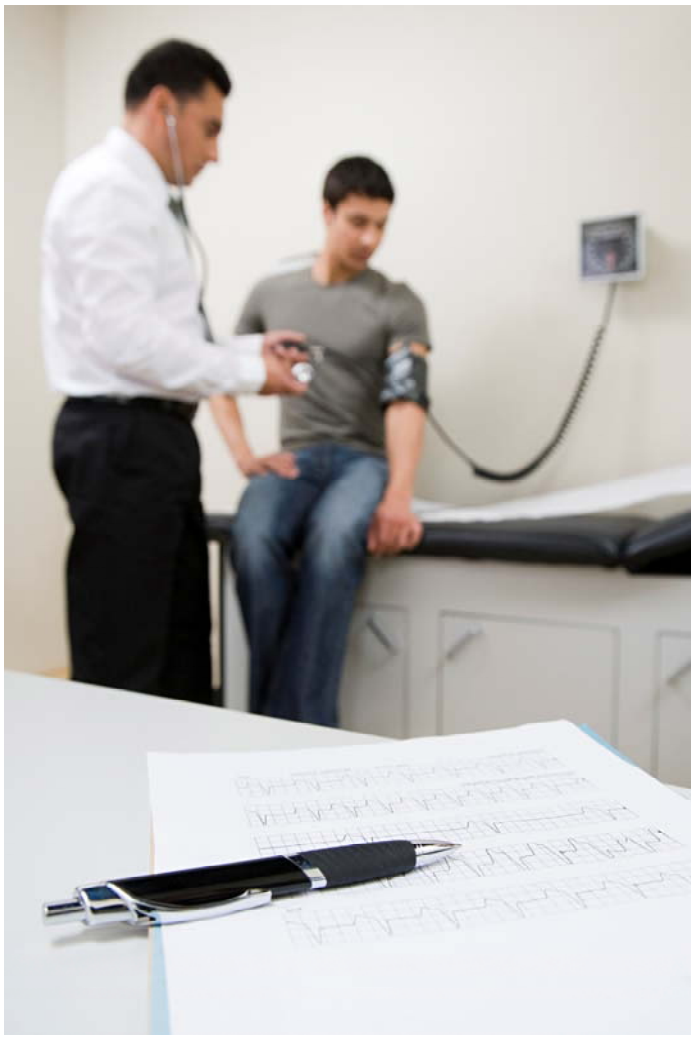


This report is prepared by the Nebraska Department of Health and Human Services, Division of Medicaid & Long-Term Care in accordance with Neb. Rev. Stat. § 68-908(4).

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 Nebraska Legislature and in communities across the state, 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 the Department at (402) 471-5046 or via email at Jeremy.Brunssen@Nebraska.gov.

Kevin Bagley, Director
Division of Medicaid & Long-Term Care
Department of Health and Human Services

1. EXECUTIVE SUMMARY

The Division of Medicaid & Long-Term Care (MLTC), a division of the Nebraska Department of Health and Human Services (DHHS), administers 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 2020 (SFY20). The program serves low-income children and adults, the aged, and individuals with disabilities. Approximately 106,000 providers are enrolled with Nebraska Medicaid.

Throughout SFY20, Nebraska Medicaid prepared for the launch of Heritage Health Adult (HHA), Nebraska's Medicaid expansion program. These preparations included finalizing regulations, hiring staff, developing technology systems, and educating the public on this new program. Adults who are eligible for coverage through HHA are between the ages of 19 and 64 and earn up to 138 percent of the federal poverty level. HHA launched on October 1, 2020.

Medicaid also continues to play an important role in Nebraska's response to the COVID-19 pandemic. Through the end of SFY20 and beyond, Medicaid and its managed care partners promoted telehealth and telephonic methods of delivering health care services to beneficiaries to ensure Medicaid beneficiaries received needed services safely.

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

- Information technology systems and business process models;
- Health services array and delivery models;
- Provider policies and payment methodologies; and
- Beneficiary program eligibility and processes.

In SFY20, MLTC acted on a variety of projects with this end in mind, such as modernizing payment methodologies, finalizing Medicaid expansion implementation readiness, and adapting policies to support stakeholders through the COVID-19 pandemic.

MLTC has executed with purpose to achieve the strategic goals established, all while adapting to meet the challenges imposed by the public health emergency over the past year. The division looks forward to building off the successes in SFY20 and continuing our meaningful work in SFY21.

2. 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 adults, the aged, and individuals with disabilities, covering more than one in 10 Nebraskans.

In SFY20, MLTC leadership experienced a transition with certain members of the leadership team moving on to new opportunities. DHHS is actively recruiting for these vacancies. A new Medicaid director is joining DHHS at the end of November 2020.

MLTC has over 600 full-time employees, and partners with the Eligibility section of the Division of Children and Family Services (CFS) for Eligibility Operations. 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.
- **Finance and Program Integrity**: Finance and Program Integrity oversees financial analysis and reimbursement, budget, associated reporting, the program integrity unit, and the provider screening and enrollment team.
- **Medical Services**: Medical Services helps determine 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 ensuring compliance with the state and federal authorities under which the Medicaid program operates, including the Medicaid state plan and monitoring legislation.
- **Population Health**: This section is responsible for assessing health outcomes across the Medicaid population. Population Health includes health services, pharmacy, as well as home and community-based services.
- **Privacy and Compliance:** This section was created in 2020 and is primarily responsible with aligning policies, procedures, guidance documents, and other internal and public-facing information; as well as ensuring the Nebraska Medicaid program complies with relevant state and federal law.
- **State Unit on Aging**: The State Unit on Aging 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 on the next page.

MLTC Organizational Chart - Leadership

3. 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 SFY20:

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

Coverage for lower-income adults through Heritage Health Adult began in early SFY21.

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 (see Table 1, below, and Appendix 1), Nebraska's total Medicaid enrollment has remained stable at about 12 percent of the state's total population for the last few years (see Appendix 2).

One noteworthy change to enrollment (see Appendix 2) is related to the economic impact of the COVID-19 pandemic, though the pandemic's effects did not take place until the final third of SFY20.

Table 1. Nebraska Poverty Level Compared to National Figures, 2019

	Nebraska	United States	Percent of Nebraskans	Percent of Entire US
Under 100% FPL	199,202	33,804,600	10.3%	12.3%
100% to 199% FPL	313,308	53,168,400	16.2%	16.6%
100% to 399% FPL	651,758	110,603,400	33.7%	29.6%
Above 400% FPL	769,732	130,623,600	39.8%	41.5%

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

Table 2 provides the 2020 federal poverty levels in annual income, and Tables 3 and 4 explain several of the Medicaid programs.

Table 2. 2020 Poverty Guidelines (Annual Income)

Household Size	50% FPL	100% FPL	138% FPL	200% FPL
1	$6,380	$12,760	$17,608.80	$25,520
2	$8,620	$17,240	$23,791.20	$34,480
3	$10,860	$21,720	$29,973.60	$43,440
4	$13,100	$26,200	$36,156.00	$52,400

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 that covers prenatal and delivery services for the unborn children of pregnant women who are not Medicaid eligible.	197% of the FPL
Heritage Health Adult	Adults between the ages of 19 and 64 who meet income, residency, and citizenship requirements who are not otherwise eligible for another Medicaid category.	138% 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.

Program	Description	Income Limit
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.

Appendix 3 compares enrollment in different eligibility categories for SFYs 2019 and 2020. Total Medicaid and CHIP enrollment remained relatively stable with 242,317 in SFY19 and 243,003 in SFY20—a 0.28 percent increase. The children category showed the largest change year over year in terms of total individuals eligible, growing by 0.6 percent. The Aged, Blind, and Disabled categories saw slight increases: 1.2 percent for Aged, and 0.19 percent for Blind & Disabled. Adults with Dependent Children and other adults saw an enrollment decrease of 1.8 percent.

Appendices 4 and 5 compare the cost of different eligibility categories. While the Aged and Blind & Disabled categories represent 22.5 percent of beneficiaries, they account for 55.1 percent of expenditures. In contrast, children account for 64.3 percent of beneficiaries, but only 24 percent of expenditures. As noted in Figure 5, the average monthly cost per enrollee has remained at or below the national average in most months.

Of note, Appendix 5 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)[1], 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.

[1] 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).

4. 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 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
Mental Health and Substance Abuse Services	Occupational therapy services
Early and periodic screening and diagnostic treatment (EPSDT) for children	Optometric services
	Podiatric services
	Hospice services
	Mental health and substance use disorder services
	Hearing screening services for newborn and infant children
	School-based administrative expenses

Recent Benefit Package Changes

MLTC continuously evaluates its benefits package to make changes based on new medical procedures and best practices. MLTC's evaluation of covered benefits includes not only types of health care services, but the best ways to deliver these services as well. MLTC collaborates with sister divisions, providers, beneficiaries, managed care partners, and other stakeholders to identify any potential service gaps and policy implications.

Substance Use Disorder Treatment

Nebraska Medicaid administers a section 1115 demonstration waiver for adults with substance use disorders. This waiver allows Medicaid to cover residential substance use treatment for adults ages 21-64 in facilities with more than 16 beds. Without this waiver authority, Medicaid is not able to pay for residential stays in these facilities longer than 15 days.

The demonstration waiver was approved for 5 years on July 1, 2019. For the first year of the demonstration program, Medicaid has focused on adding two additional covered services. Those services are Opioid Treatment Program and Medically-monitored Inpatient Withdrawal Management. Medicaid has submitted state plan amendments to add coverage for these services, which CMS approved in November 2020. Coverage of these services through the Medicaid State Plan is required under the 1115 SUD waiver program.

COVID-19 Testing and Telehealth Options

As a significant payer of health care services in Nebraska, MLTC continues to play an important role in the state's response to the COVID-19 pandemic. MLTC began covering testing for COVID-19 with any service dates on or after February 4, 2020.

Another important part of MLTC's response to the COVID-19 pandemic was educating providers in the use of telehealth to deliver services. Providers were encouraged to use telehealth methods of delivering health care services when appropriate to limit close personal contact. While telehealth services were covered prior to the pandemic, MLTC ramped up provider education and communication and introduced additional flexibilities for providers to provide some services for patients via telephone in certain circumstances. The telephonic flexibilities will remain in place so long as the public health emergency declaration is in place, which will last at least until January 2021. Telehealth services will continue to be covered after the pandemic.

Prime benefits for Additional Adult Beneficiaries

Nebraska's Medicaid expansion program, Heritage Health Adult, launched on October 1, 2020. In original plans, MLTC hoped to be able to begin the program with its section 1115 demonstration waiver in place. However, due to the federal government's priority of responding to the COVID-19 pandemic, Nebraska's 1115 waiver was not approved until October 20, 2020.

The 1115 waiver will provide an opportunity for additional people covered through Heritage Health Adult to qualify for dental services, vision services, and over-the-counter drugs (prescribed by a physician) by choosing to engage in wellness, personal responsibility, and community engagement activities. Nebraskans who choose to participate in the demonstration will be able to begin completing these activities starting April 1, 2021.

5. SERVICE DELIVERY

Nebraska covers Medicaid and CHIP services primarily through Heritage Health, a capitated managed care program, designed to integrate medical, behavioral, and pharmacy needs. 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 cover Medicaid services via a managed care delivery system.

Heritage Health combines physical health, behavioral health, and pharmacy benefits into a comprehensive plan available to Nebraska Medicaid beneficiaries. In SFY20, 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 back a portion of their capitation revenue, withheld by MLTC, if targets are achieved for enhanced quality in specific areas. In calendar year 2019, all of the managed care health plans met at least 8 of the 14 clinical quality QPP measures.

Medicaid beneficiaries 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. While physical and behavioral health, as well as pharmacy services are delivered through the Heritage Health managed care organizations, the management and

reimbursement of all Medicaid long-term services and supports remain fee-for-service in Nebraska Medicaid.

6. PROVIDERS

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

At the end of SFY20, there were 23,702 in-state Medicaid providers. Of those in-state providers, 16,212 are billing providers and 7,490 are group members[2]. Out-of-state providers totaled 82,491 for Nebraska Medicaid. Of those out-of-state providers, 3,370 are billing providers and 79,121 are group members.

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

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 either on prospective system using Enhanced Ambulatory Patient Groups (EAPGs) or on a percentage of the submitted charges;
- Nursing facilities are reimbursed a daily rate based on facility cost, beneficiary level of care, and quality 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.

[2] 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.

Unlike the previous two years, Medicaid rates increased in 2020 as specified in the table below. 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.

Table 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
2020	Rates for Medicaid services increased by 2.0% Rates for Behavioral Health services received an additional 2.0% increase. Nursing Facilities received a specified appropriation increase of $21.25 Million for increasing rates and utilization changes.

7. VENDOR EXPENDITURES

The federal and state governments finance Medicaid and CHIP jointly, 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) 2020[3] was 54.72 percent for Medicaid and 79.8 percent for CHIP. Table 8 shows the FMAP for both Medicaid and CHIP for FFY15 through FFY21.

Table 8. Nebraska FMAP Rates

Federal Fiscal Year	Medicaid FMAP	CHIP FMAP
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%
FFY21	56.47%	69.53%

Total SFY20 vendor payments for Medicaid and CHIP expenditures were $2,300,246,557. This total includes drugs, inpatient and outpatient hospital, physicians, practitioners, and early and periodic screening, diagnostic and treatment. A&D Waiver includes $721,483 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.

Appendix 7 shows how the expenditures to vendors are distributed by service type.

[3] October 1, 2019 to September 30, 2020

Not all Medicaid and CHIP expenditures are captured in Appendix 7. 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 SFY20, Medicaid received a total of $136.7 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 SFY20, Medicaid paid $27.4 million through the DSH program, a 16.4 percent decrease compared to $32.8 million paid in SFY19;
- Medicaid pays the Medicare Part B premium for beneficiaries that are dually eligible for Medicare and Medicaid. In SFY20, Medicaid paid $56,539,620 for Medicare premiums, a 7 percent decrease from the $60,831,613 for Medicare premiums paid in SFY19. Monthly premiums were $135.50 for calendar year 2019 and $144.60 for calendar year 2020; and
- Medicare Part D Phased-Down state contributions ("clawback"), are required monthly payments to CMS for each person dually eligible for Medicare and Medicaid. This is funded entirely by state general funds, as it is meant to cover part of the savings to the Medicaid program for prescription drug costs of dual eligibles which Medicare pays under Part D. In SFY20, clawback payments totaled $67,739,255, a 0.8 percent increase from the $67,143,631 paid in SFY19. 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 last decade with the growth of managed care. As noted in Appendix 7, a majority of MLTC's expenditures come in the form of capitation payments for managed care. Appendices 8 and 9 note the relative cost of services covered via capitated managed care.

Appendix 10 compares vendor expenditures from SFY19 and SFY20.

LONG-TERM CARE SERVICES

Long-term care (LTC) services support individuals with chronic or ongoing health needs related to age or disability. In SFY20, Medicaid expenditures for LTC services totaled $936,705,894. 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.

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.

Appendices 11 and 12 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 SFY20.

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.
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.

8. MEDICAID EXPANSION

Through SFY20, MLTC prepared for the launch of Medicaid expansion in Nebraska. Heritage Health Adult (HHA), Nebraska's Medicaid expansion program, provides Medicaid coverage for adults ages 19 to 64 with incomes up to 138 percent of the federal poverty level. This is an annual income of approximately $17,000 for a single person or $36,000 for a household of four.

HHA covers two benefits packages. At the launch of the program, most individuals will be eligible for basic benefits, which includes physical health, behavioral health, and prescription drug coverage. Certain people will eligible for prime benefits, which include all basic benefits, plus dental, vision, and over-the-counter drug coverage. Those who will be eligible for prime benefits will be covered through HHA and are ages 19-20, pregnant, or medically frail.

Work on expansion through SFY20 focused on regulatory, staffing, and technology preparations. Additional staff were hired to process Medicaid applications and technology system upgrades were made to ensure eligibility determinations were made accurately and timely.

In October and November 2019, MLTC held public hearings to gather feedback on the state's application for a section 1115 demonstration waiver. This waiver application was submitted to the federal government on December 12, 2019, and was approved on October 20, 2020. This waiver seeks to improve health outcomes for individuals with HHA coverage and allow them to qualify for additional benefits in the process. The demonstration waiver is scheduled to begin on April 1, 2021.

Through summer 2020, MLTC focused on educating the public about HHA, including details like who is eligible for coverage, how to apply, what benefits are covered, and more. Education included direct engagement via webinars and similar forums, media campaigns including TV, radio, billboards, and social media. Informational materials like FAQ booklets and flyers were also made available digitally and in print.

Coverage through HHA began on October 1, 2020. Nebraskans were able to apply for coverage beginning August 1, 2020, and those interested in coverage can now apply at any point throughout the year. As of November 1, there were already 16,187 Nebraskans eligible for coverage.

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

9. HIGHLIGHTS AND ACCOMPLISHMENTS

Heritage Health Adult – Medically Frail

MLTC completed the majority of the work to prepare for the launch of Heritage Health Adult (HHA) during SFY20. As noted in Section 8, these preparations included many different facets, from hiring additional staff to updating state regulations. In many instances, these preparations involved creating entirely new processes, such as the Medically Frail review process.

DHHS can determine people eligible for HHA with certain health needs or life circumstances as Medically Frail, which qualifies them to receive prime benefits. This designation is new to Medicaid and specific to HHA, so a new process was needed. Medically Frail is a designation for people eligible for HHA who have particular health needs or social determinants of health that may be barriers to improving their health. Medicaid's Health Services team successfully built and implemented a new process to take in and review client information to determine whether the client is Medically Frail. This new process is coordinated with DHHS's Eligibility Operations to efficiently ensure individuals with particular health needs receive the full array of benefits for which they are eligible.

Nursing Home Payment Re-design

During SFY20, MLTC worked closely with stakeholders from the long-term care community to finalize the details of a new payment methodology for Nursing Facility per diem payments. Key components of the new payment methodology include the introduction of quality into the payment paradigm. Nebraska now pays Nursing Facility providers an enhanced rate for better quality outcomes, as well as changes to the methodology that begin to more closely narrow the rate variance between providers, which are based on cost reports received by nursing facilities.

Beginning July 1, 2020, MLTC implemented the new payment methodology for nursing facilities. MLTC worked with stakeholders to gain concurrence on the new methodology, update regulations to allow for this change to occur, and gain approval of the Medicaid State Plan to secure federal financial participation under the new payment model. MLTC would like to thank stakeholders across the state for their feedback while this new payment methodology was developed.

COVID-19 Response

As noted, responding to the COVID-19 pandemic continues to be a top priority for MLTC. Though this is an ongoing effort, MLTC has taken noteworthy steps to this point. As highlighted in Section 4, MLTC has provided additional flexibilities to health care providers to be able to provide services via telehealth or telephonically to avoid close personal contact when possible. These flexibilities apply to both standard Medicaid services as well as certain services administered through the state's Medicaid waivers. Medicaid is also keeping cases open while the federal government's public health emergency declaration is in place, which is currently declared to last at least until January 2021.

In addition to some of these more direct steps MLTC has taken, MLTC has also made an effort to relay useful information to providers and other community members when it can, including notifying providers of opportunities to apply for relief funds from the federal government. MLTC thanks

Nebraska's health care providers for everything they have done to help the state respond to the COVID-19 pandemic.

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 launched on November 2, 2020. More information on this project is available in MLTC's MMIS Replacement Planning Report, which is submitted to the Legislature quarterly.

10. LOOKING AHEAD

Heritage Health Adult – Phase 2

From the beginning stages of planning Heritage Health Adult (HHA), a section 1115 demonstration waiver was an important part Nebraska's program design. The federal government must first approve these waivers before they go into effect. With the federal government's response to the COVID-19 pandemic taking priority, Nebraska's 1115 waiver was unable to be approved until later than MLTC originally anticipated.

In October 2020, Nebraska launched benefits coverage through HHA and also received federal approval of its 1115 waiver. Phase 2 of Heritage Health Adult will center on implementing the state's approved 1115 waiver. This waiver will seek to improve health outcomes for individuals with HHA coverage and allow them to qualify for additional benefits in the process. The demonstration waiver is scheduled to begin on April 1, 2021.

Heritage Health Plan Rebranding

Some Nebraskans with Medicaid coverage will have a new name on their managed care plan card beginning January 1, 2021. WellCare of Nebraska will be rebranded to Healthy Blue following Anthem's acquisition of WellCare of Nebraska in January 2020. This acquisition was made following Centene's purchase of WellCare corporate. Nebraska's contract with the health plan's do not allow for one parent company to operate more than one managed care plan that partners with Nebraska's Medicaid program (Centene also operates Nebraska Total Care). Thus the divestiture of the Wellcare of Nebraska Plan to Anthem was necessary as Centene acquired Wellcare at a corporate level.

The change to Healthy Blue will not affect the covered benefits or options for health care providers available to people WellCare currently covers. WellCare is currently contacting all of their 80,000+ members to let them know about this name change and any other details their members should know about this change. Similarly, Wellcare is working with providers to ensure a smooth transition. MLTC expects a seamless transition as it has been performing operational readiness and system testing with Anthem as it prepares for the transition in January 2021.

Electronic Visit Verification (EVV)

Electronic Visit Verification (EVV) is required for Nebraska to become compliant with the federal 21st Century CURES Act, passed in December 2016. The use of EVV is federally mandated for personal assistance services (PAS) and home health services.

Through a competitive bid process, DHHS awarded the contract to implement EVV to Tellus, LLC. Tellus has assisted Nebraska with building the EVV platform that will be available to Medicaid-enrolled PAS providers. Providers who are already using EVV systems may be able to continue using their EVV system if it complies with criteria found in the CURES Act.

DHHS began hosting stakeholder meetings to prepare effected providers in May 2020. The EVV system is expected to launch December 13, 2020. For more information, visit the DHHS website.

Policy Review Project

In September 2020, MLTC began a new project to gather and review all of its internal policies and procedures to ensure they are all written accurately and consistently. In the process of reviewing these policies and procedures, MLTC will make updates as needed if items as written include outdated language or formats. The final objective of this project is to produce a publicly available guide that includes all of MLTC's policies together in a single publication so Nebraskans can easily reference it should they have questions about how Nebraska Medicaid operates. MLTC anticipates this will be a multi-year project and currently estimates this project's first phase will be completed in 2023.

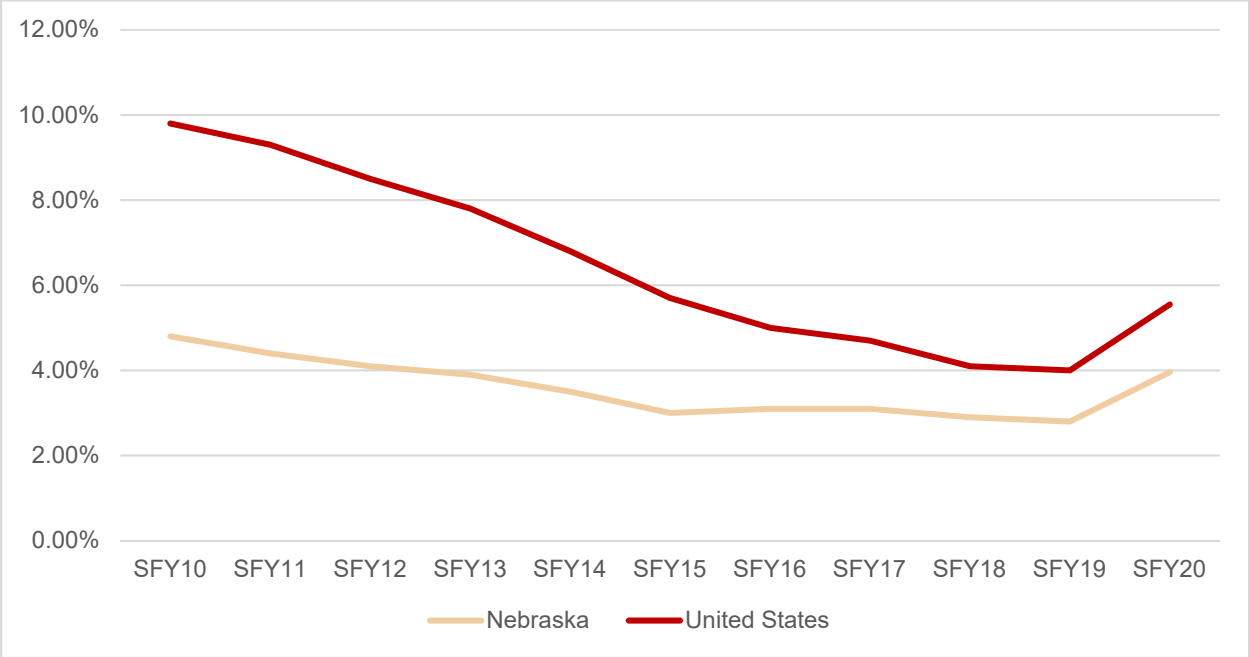
11. CONCLUSION

MLTC takes seriously its role in supporting the delivery of quality health care to Nebraskans in need, particularly in the face of the ongoing COVID-19 public health emergency. 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. The launch of Heritage Health Adult, implementation of the 1115 waiver, implementation of needed payment reform for providers, and responsiveness to the public health emergency are all examples of purposeful efforts to align the division's actions with these priorities. Other initiatives like the implementation of the DMA and EVV platforms will ensure MLTC is positioning itself to be able to continue to evaluate and improve on the services, the delivery system, and processes in the years to come.

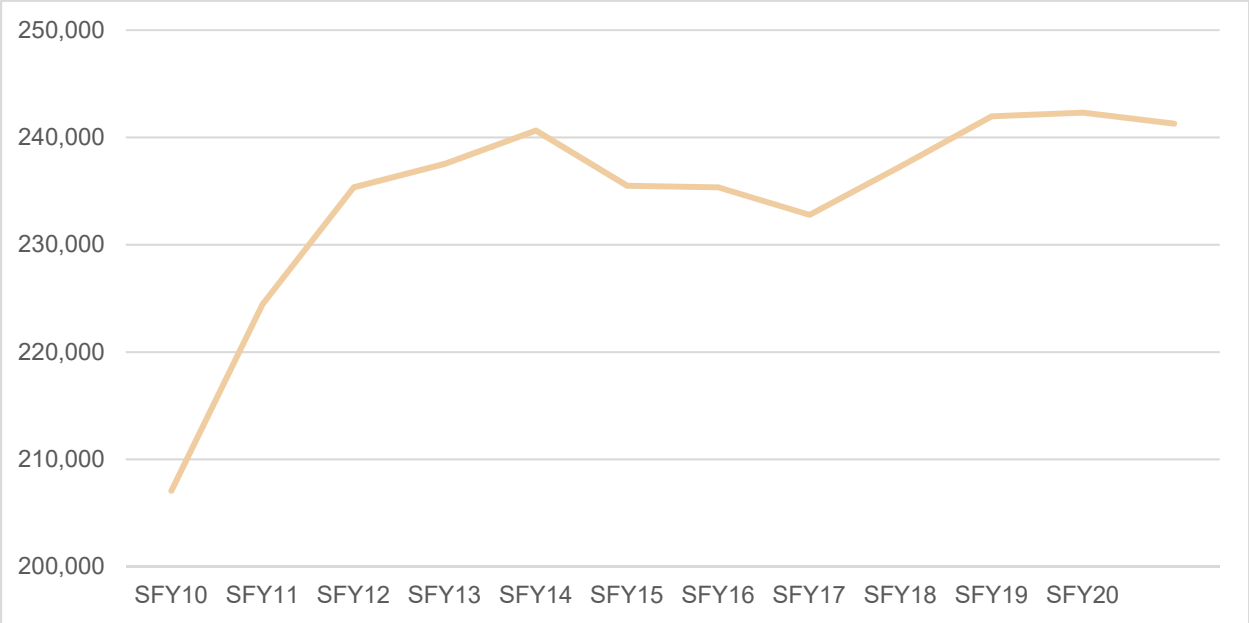
Additionally, MLTC is committed to transparency and providing information to the Legislature and the general public as it continues to improve its operations. MLTC looks forward to continuing to work with the Governor's Administration, the Legislature, and stakeholders to improve and sustain Medicaid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

APPENDIX

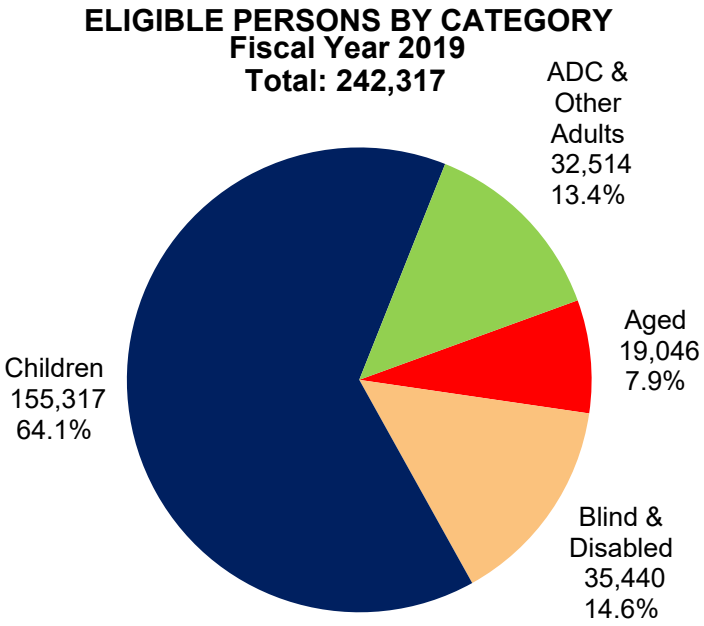
Appendix 1. Average Unemployment Levels

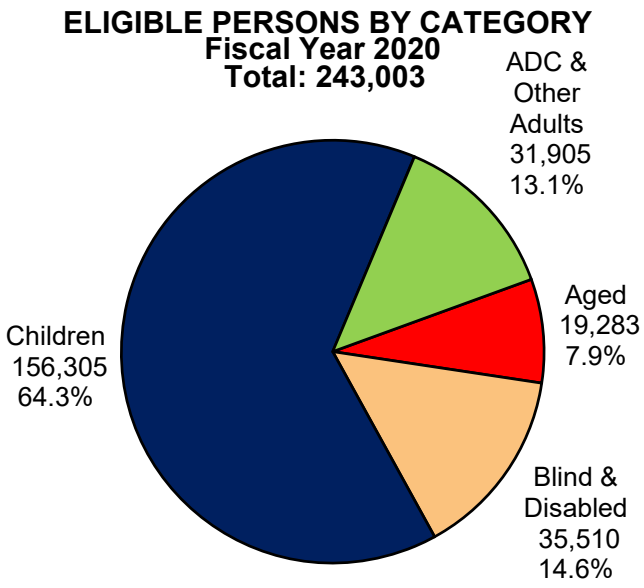


Appendix 2. Average Monthly Nebraska Medicaid Clients by SFY



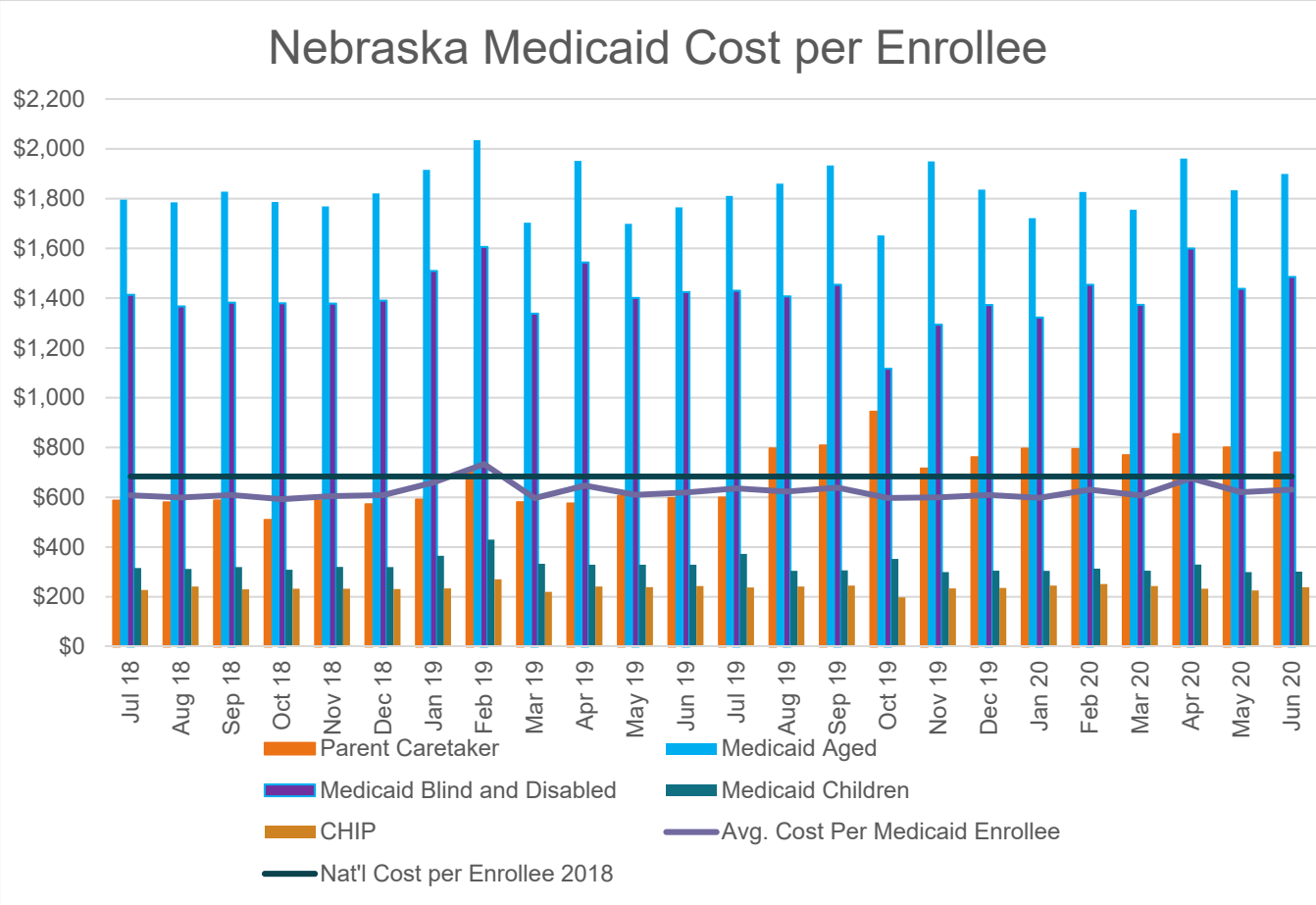
Appendix 3. Average Nebraska Monthly Enrollment for Medicaid and CHIP, SFY19 and SFY20[4]



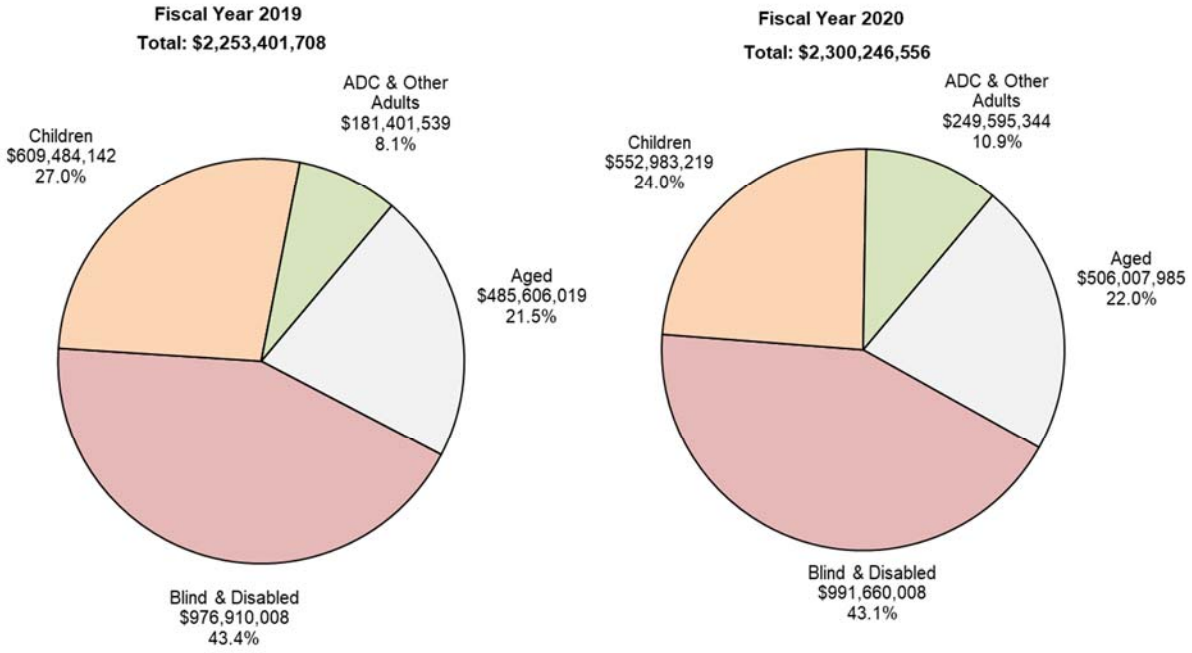


[4] ADC: Adults with Dependent Children

Appendix 4. Nebraska Medicaid Cost per Enrollee



Appendix 5. Nebraska Medicaid and CHIP Annual Cost by Eligibility Category

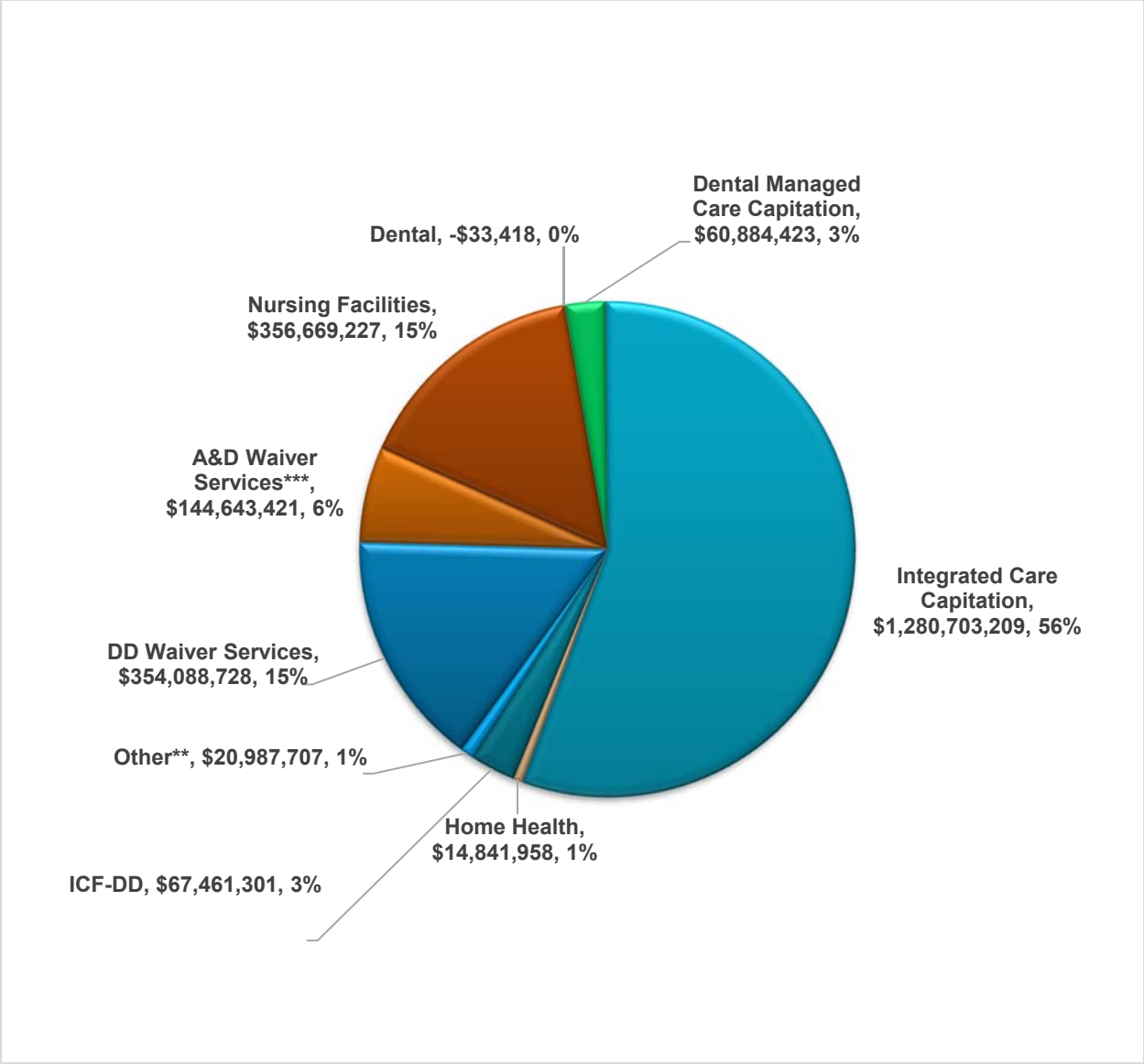


Appendix 6. Nebraska Medicaid Providers by Type, July 2020

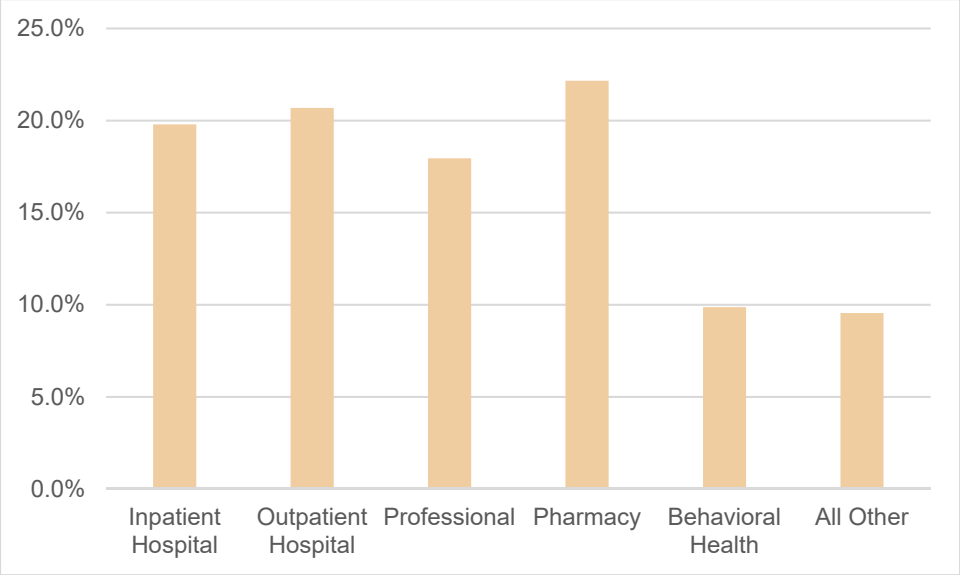
Provider Type Description	Nebraska	Out of State
Ambulatory Surgical Centers	52	9
Hospitals	191	617
Nursing Facilities	205	11
Assisted Living Facilities	247	
ICF/DDs	12	10
Hospice (in Nursing Facility)	726	
Home Health Agency	85	3
Laboratory	33	319
Federally Qualified Health Center	62	16
Rural Health Clinic-Provider Based (Less Than 50 Beds)	121	30
Rural Health Clinic-Independent	17	15
Rural Health Clinic-Provider Based (Over 50 Beds)	6	
Indian Health Hospital Clinic		5
Tribal 638 Clinic	11	
Assertive Community Treatment - MRO Program	4	
Day Rehabilitation - MRO Program	14	
Residential Rehabilitation	17	1
Pharmacy	584	148
Hospice	44	6
Transportation	565	93
Rental and Retail Supplier	169	205
Orthopedic Device Supplier	2	14
Optical Supplier	41	3
Qualified Health Maintenance Organization	6	2
Other Prepaid Health Plan	4	3
Day Treatment Provider	17	0
Treatment Crisis Intervention	3	1
Therapeutic Treatment Home	5	1
Psychiatric Residential Treatment Facility	2	19
Freestanding Birth Centers	2	
NFOCUS Provider	5829	115

Provider Type Description	Groups		Group Members		Solo Providers	
	In state	Out of State	In state	Out of State	In state	Out of State
Physicians	254	223	1792	32711	170	214
Doctors of Osteopathy	4	4	133	2634	13	13
Doctors of Chiropractic Medicine	279	24	88	466	161	8
Optometrists	242	19	132	961	61	2
Doctors of Podiatric Medicine	58	12	16	211	24	2
Clinic	320	157				
Professional Clinic	2863	771				
Anesthesiologist	167	75	147	2683	19	29
Dispensing Physician			3	40		
Physician Assistant			288	7230		
Nurse Midwife			16	394		
Nurse Practitioner	87	8	450	12046	71	22
Registered Nurse	9		27	440	19	
Licensed Practical Nurse			1	89	1	
Registered Physical Therapist	367	26	321	4566	12	
Personal Care Aide - Schools			2086			
Mental Health Personal Care Aide			12	335		
Mental Health Home Health Care Provider			74	435	1	
Licensed Mental Health Practitioner			417	1433		
Mental Health Professional/Masters Level Equivalent			358	1937		
Licensed Independent Mental Health Practitioner	168	7	318	3051	357	10
Doctor of Dental Surgery - Dentist	285	38	187	1549	340	12
Licensed Dental Hygienist	10		2	83	5	
Community Support - MRO Program	40		85	574		
Day Rehabilitation - MRO Program			10			
Substance Abuse Treatment Center	92	2				
Adult Substance Abuse	38	14				
Pharmacist			27			
Provisionally Licensed PHD			35	129		
Provisionally Licensed Drug & Alcohol Counselors			17	181		
Hearing Aid Dealer	45	5	17	152	13	
Licensed Medical Nutrition Therapist	10	1	15	141		
Specially Licensed PHD/Psychology Resident			2	14		
Licensed Psychologist	46	2	160	1117	94	2
Speech Therapy Health Service	169	10	107	1866	16	
Occupational Therapy Health Services	201	11	110	1390	2	
Licensed Drug & Alcohol Counselor			37	263		
Professional Resource Family Care	3	1				

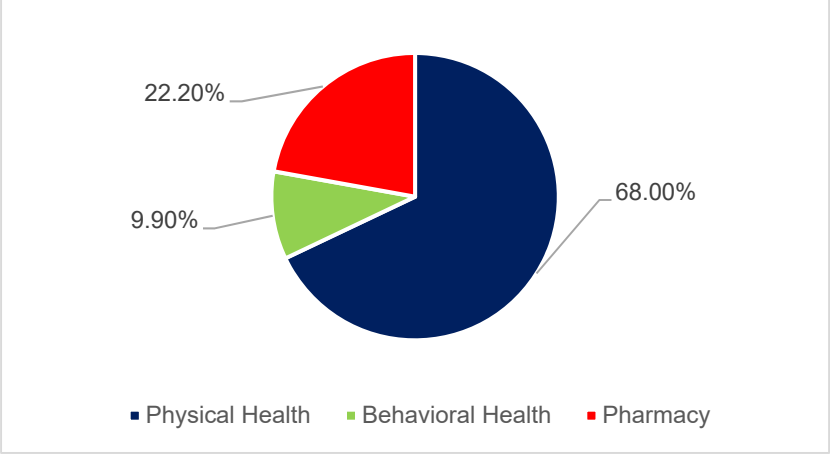
Appendix 7. SFY20 Medicaid and CHIP Expenditure by Service



Appendix 8. Percentage of Capitated Health Spend by Service Category

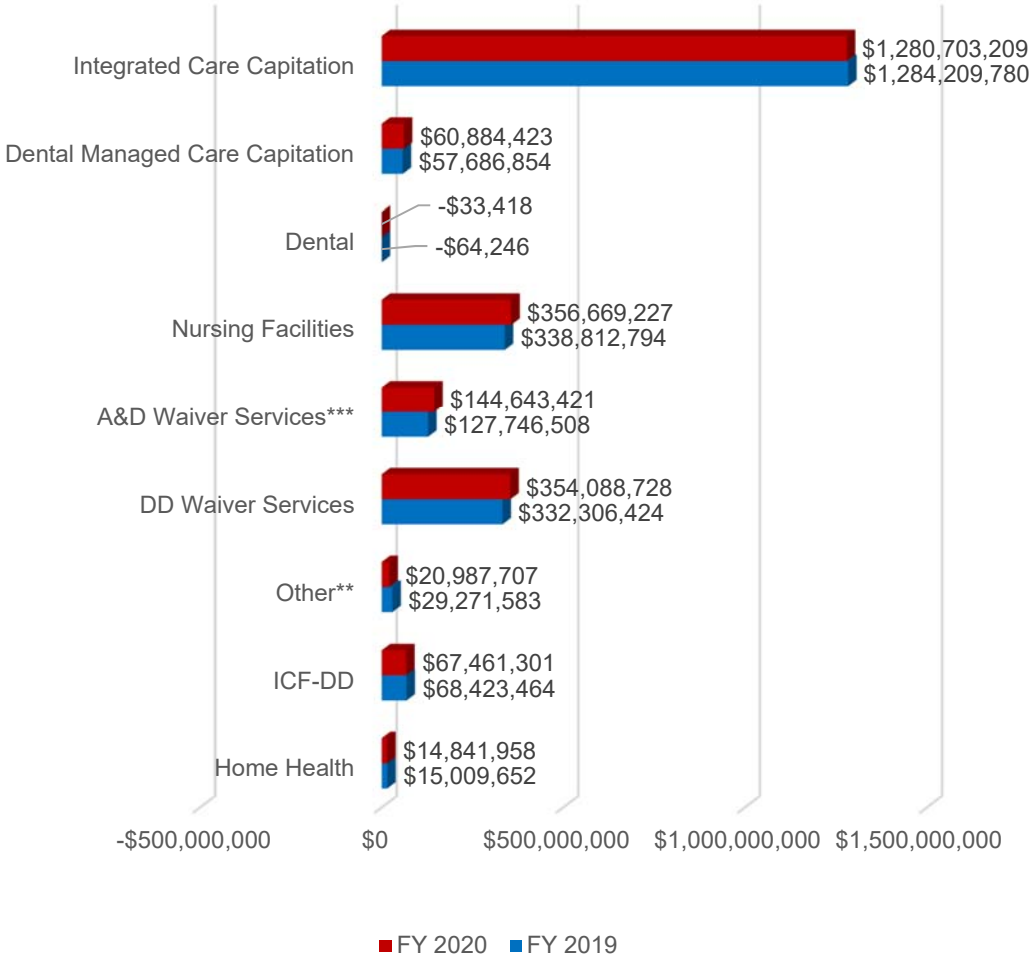


Appendix 9. Heritage Health Medical Services by Relative Cost[5]



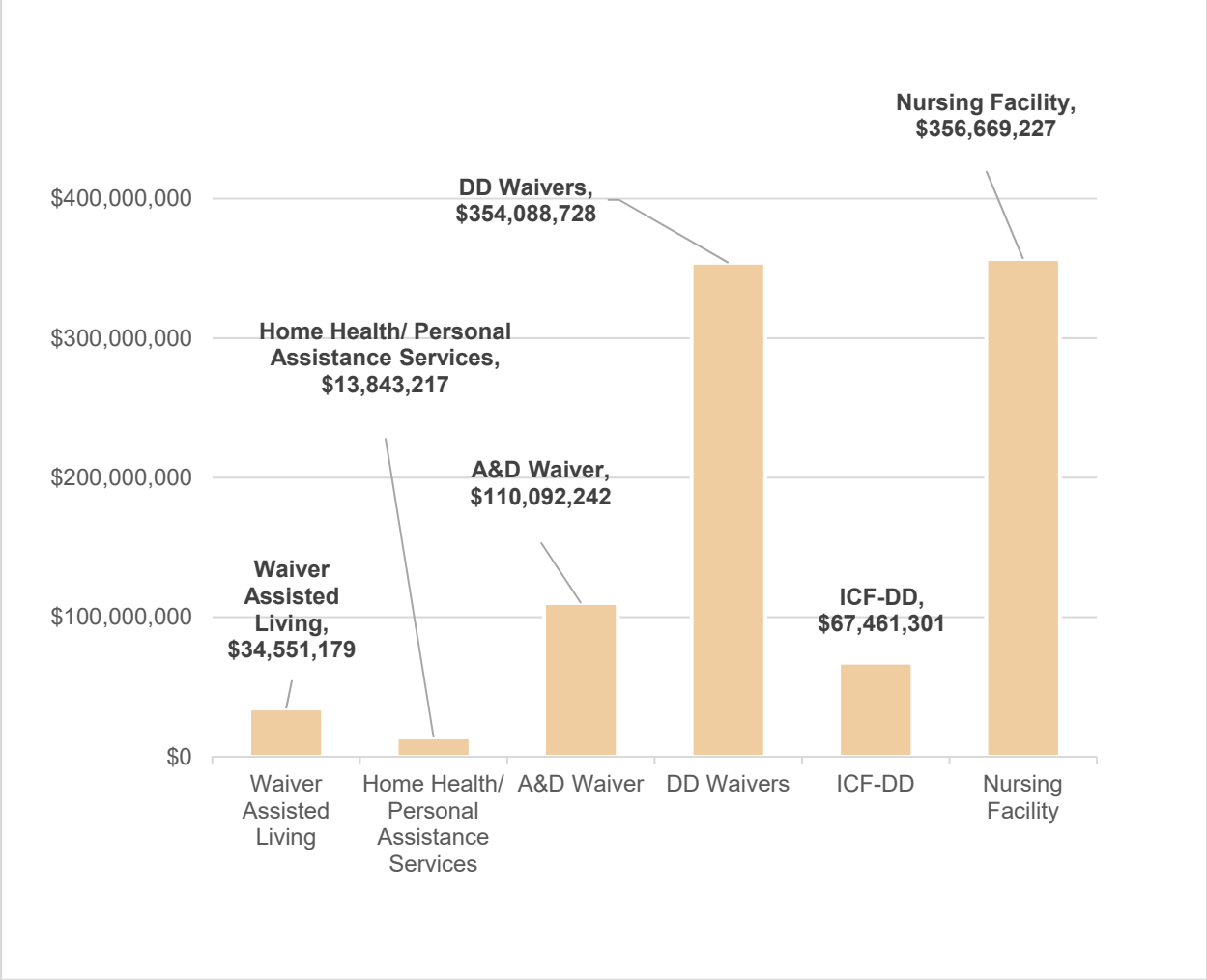
[5] There are additional behavioral health services that are provided alongside physical health services which are counted in the physical health total.

Appendix 10. Medicaid and CHIP Expenditures SFY19 and SFY20[6]



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

Appendix 11. SFY20 Medicaid Expenditures for LTC Services



Appendix 12. Nebraska LTC Expenditures by Living Arrangement