Nebraska Medicaid

Annual Report

State Fiscal Year 2021

December 1, 2021

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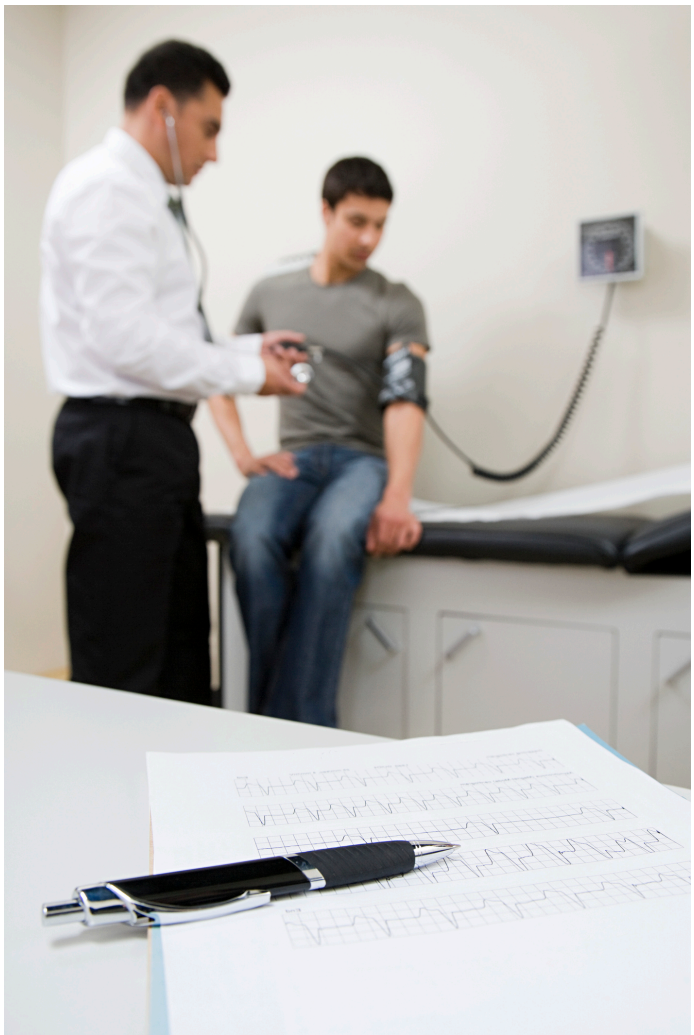


This report is prepared by the Nebraska Department of Health and Human Services, Division of Medicaid & Long-Term Care in accordance with Neb. Rev. Stat. § 68-908(4).

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) 471-4535 or via email at Kevin.Bagley@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 approximately $3 billion paid for services for approximately 15 percent of Nebraskans, who were Medicaid beneficiaries in state fiscal year 2021 (SFY21). The program serves low-income children and adults, the aged, and individuals with disabilities. Approximately 92,000 providers are enrolled with Nebraska Medicaid.

MLTC successfully navigated the challenges of 2020, supporting health care providers through the COVID-19 pandemic while also launching the Heritage Health Adult (HHA) expansion program. In the year since the HHA program launched on October 1, 2020, more than 55,000 Nebraskans who were not previously Medicaid-eligible have signed up for coverage. Both the federal COVID-19 public health emergency and the HHA program launch have notably affected program enrollment and expenditures, which are detailed in this report.

Over the last two years, the MLTC team has proven itself capable of adapting to changing dynamics that affect the program in particular and healthcare overall. When DHHS announced it was no longer seeking to implement the HHA demonstration program, the Medicaid team was able to execute changes to the expansion program that went into effect the next calendar quarter. Similarly, MLTC has been able to implement quickly the rapidly changing guidance from our federal partners surrounding the administration and payment of COVID-19 vaccines.

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 SFY21, MLTC acted on a variety of projects with this end in mind, such as adding new services to treat substance use disorder, implementing eligibility changes for Medicaid beneficiaries with disabilities, and pivoting from the HHA demonstration program on short notice.

Looking forward, MLTC is preparing a new initiative to plot out its strategic plan for the next several years. The division thanks its many stakeholders and is eager to show how MLTC can serve the community even better in the years to come.

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.

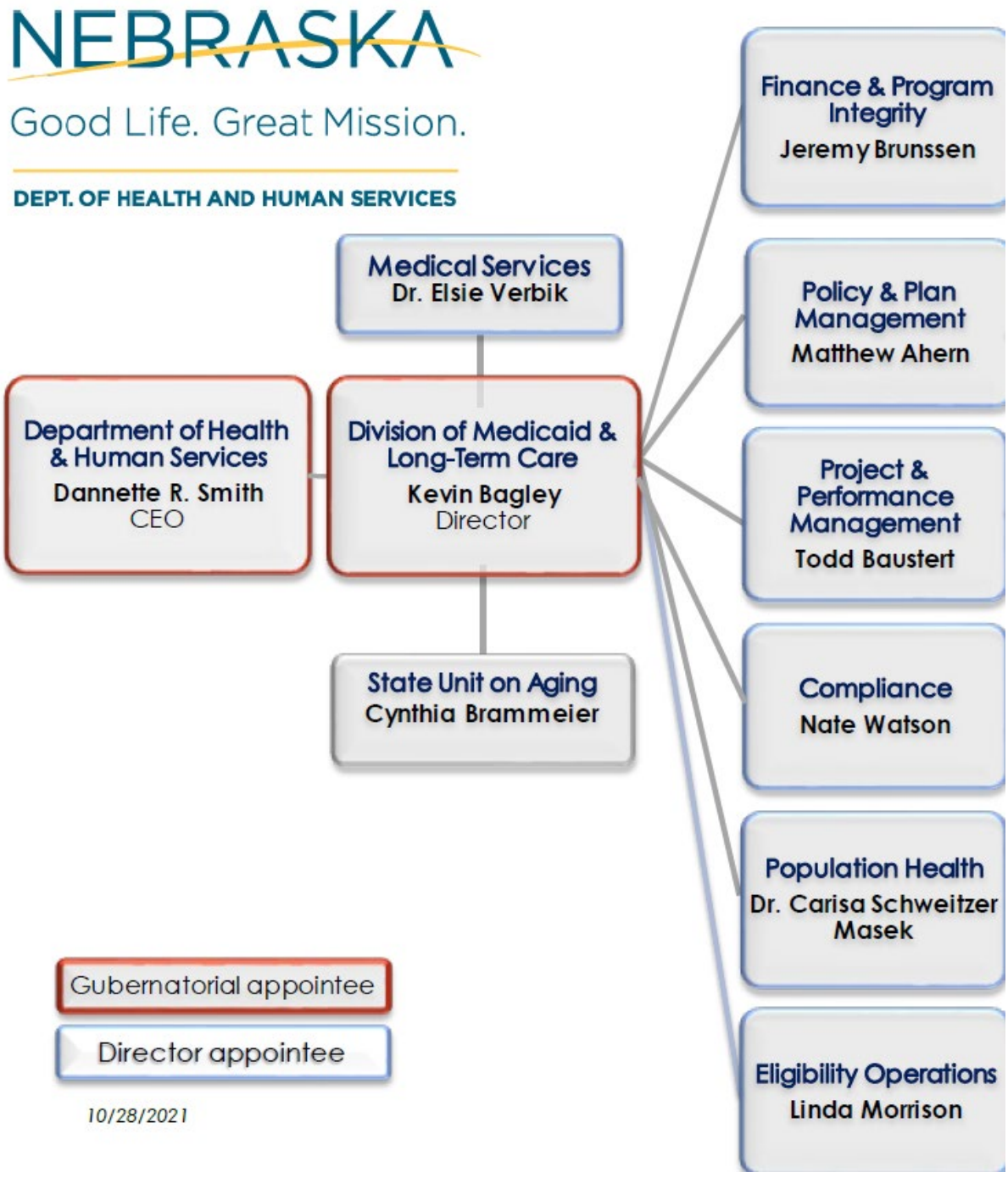
In 2021, Medicaid undertook a strategic realignment of its organizational structure to better position the program for the future, filling two open deputy director positions in the process. As a part of this re-alignment, Medicaid created the new Policy & Plan Management and Project & Performance Management sections, which will see previously existing Medicaid teams working more closely together to better serve Nebraskans. This new structure will lead to better operational efficiency and allow the division to accomplish its future goals more successfully.

MLTC has over 600 full-time employees, and partners with the Division of Children and Family Services (CFS) for Eligibility Operations. The Division is structured as follows:

- **Policy and Plan Management**: Policy and Plan Management is responsible for oversight of the Heritage Health managed care program, 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.
- **Eligibility Operations**: Eligibility Operations is responsible for determining eligibility for Medicaid programs.
- **Finance and Program Integrity**: Finance and Program Integrity is responsible for financial operations of the division to include planning, budgeting, reporting and analysis. Additionally, the unit is responsible for provider rates and reimbursement policies as well as fee-for-services (FFS) claims processing. This section is also responsible for Medicaid provider fraud, waste, and abuse monitoring in the program integrity unit as well as provider screening and enrollment activities for the Medicaid program.
- **Project and Performance Management:** Project and Performance Management drives the implementation of Medicaid's strategic initiatives through the management of MLTC's data and analytics capabilities, IT initiatives, and planning activities.
- **Medical Services, Behavioral Health and Pharmacy**: Medical Services helps determine the services covered under Nebraska Medicaid and assures Medicaid-covered services adhere to a standard of care.
- **Population Health**: Population Health is responsible for assessing health outcomes across the Medicaid population. Population Health includes medical and behavioral health services, pharmacy, long-term care services, as well as home and community-based services.
- **Privacy and Compliance:** Privacy and Compliance 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. Medicaid's communications team is also part of this unit.
- **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 below:

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 SFY21:

- Children;
- Aged, blind, and disabled (ABD);
- Pregnant people;
- Parent/caretaker relatives; and
- Adults age 19-64.

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 remained stable at about 12 percent of the state's total population for several years prior to SFY21. However, average enrollment climbed this year with Medicaid expansion launching, as well as Medicaid cases remaining open while the federal public health emergency declaration related to COVID-19 remains in place (see Appendix 2).

Table 1. Nebraska Poverty Level Compared to National Figures, 2020

	Nebraska	United States	Percent of Nebraskans	Percent of Entire US
Under 100% FPL	160,800	37,643,600	8.3%	11.6%
100% to 199% FPL	358,100	52,323,000	18.6%	16.1%
200% to 399% FPL	537,300	92,042,400	27.9%	28.3%
Above 400% FPL	871,700	143,628,700	45.2%	44.1%

The majority of Nebraska Medicaid beneficiaries (including CHIP children, pregnant people, 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 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 2021 federal poverty levels in annual income, and Tables 3 and 4 explain several of the Medicaid programs within Nebraska.

Table 2. 2021 Poverty Guidelines (Annual Income)

Household Size	50% FPL	100% FPL	138% FPL	200% FPL
1	$6,440	$12,880	$17,774.40	$25,760
2	$8,710	$17,420	$24,039.60	$34,840
3	$10,980	$21,960	$30,304.80	$43,920
4	$13,250	$26,500	$36,570.00	$53,000

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)
Institution for Mental Diseases (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 individuals 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 2020 and 2021. Total Medicaid and CHIP enrollment increased from 243,003 in SFY20 to 304,656 in SFY21—a 25.37 percent increase. The main reasons for this increase is the launch of the Heritage Health Adult expansion program as well as Medicaid cases staying open while the COVID-19 public health emergency remains in effect. Through the public health emergency, Medicaid has not disenrolled members unless they request to be disenrolled, move out of state, or die.

The adult category showed the largest change year over year in terms of total number of eligible individuals, growing by 140.2 percent. The Aged, Blind, and Disabled categories saw slight increases: 3.4 percent for Aged, and 3.6 percent for Blind & Disabled. Children's enrollment increased by 9.6 percent.

Appendices 4 and 5 compare the cost of different eligibility categories. While the Aged and the Blind & Disabled categories represent 18.6 percent of beneficiaries, they account for 56.6 percent of expenditures. In contrast, children account for 56.2 percent of beneficiaries, but only 22.2 percent of expenditures. Further cost-per-enrollee details are included in Appendix 4.

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 Services

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 federal government approved this waiver in SFY20.

As part of this demonstration program, Medicaid added two new services to the package of benefits available to beneficiaries: Opioid Treatment Program and Medically-monitored Inpatient Withdrawal treatment. Providers were able to begin providing these services to Medicaid beneficiaries in June 2021, though retroactive enrollment to provide these services was available back to January 2020. Because these services are provided for under the Medicaid State Plan, they will continue to be available with or without the demonstration waiver in place.

COVID-19 Vaccines

As COVID vaccines became more widely available in early 2021, MLTC shared guidance as soon as possible on who was eligible for vaccines and how they could be administered. Through 2021, MLTC issued a series of provider bulletins as guidance on this topic evolved. MLTC issued the first provider bulletin on COVID vaccines on January 7, 2021.

COVID vaccines are available at no cost to Medicaid beneficiaries who are interested in receiving a vaccine; all three managed care health plans cover the vaccine cost. Of note, MLTC also supports Medicaid beneficiaries who may be unable to leave the home and will pay providers an extra add-on fee to administer the vaccine in the home. Looking forward to late 2021 and 2022, MLTC is monitoring new guidance on booster doses of the vaccine.

Single Benefit Tier for Adult Beneficiaries

Nebraska's Medicaid expansion program, Heritage Health Adult, launched on October 1, 2020. In original plans, MLTC hoped to launch a section 1115 demonstration waiver alongside the expansion program. This demonstration waiver would have provided an opportunity for 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.

However, due to a change in federal guidance, Nebraska decided to no longer pursue this demonstration program, with DHHS announcing this decision on June 1, 2021. Following this decision, MLTC decided to provide for a single, full set of benefits to all expansion beneficiaries–including dental services, vision services, and over-the-counter drugs–effective October 1, 2021. MLTC successfully implemented this change on time, and now all expansion beneficiaries have access to the full set of health care benefits.

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, 40 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 SFY21, there were three MCEs available for beneficiaries: Nebraska Total Care, UnitedHealthcare Community Plan, and Healthy Blue Nebraska[2]. Dental services are managed separately by the dental prepaid ambulatory health plan, MCNA.

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.

[2] Healthy Blue Nebraska began providing services to Nebraska Medicaid beneficiaries on January 1, 2021.

MLTC also uses a Quality Performance Program (QPP) that allows the MCEs to earn back a portion of their revenue, which the Department requires to be held back, upon successful achievement of Department-established administrative and clinical metrics.

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

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

In October 2021, there were 69,306 in-state Medicaid providers. Of those in-state providers, 7,165 are billing providers and 62,141 are group members[3]. Out-of-state providers totaled 22,607 for Nebraska Medicaid. Of those out-of-state providers, 1,766 are billing providers and 20,841 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 directly or on a prospective rate depending on whether they are independent or provider-based;
- Outpatient hospital reimbursement is based either on a 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 appropriations and relative 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

[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.

- Dental services are reimbursed by the dental pre-paid ambulatory health plan (PAHP), a managed care entity for Medicaid managed care members and via fee-for-service for fee-for-service Medicaid clients.

Medicaid rates saw an across-the-board increase of 2 percent in 2021 as specified in the table below. On top of this increase, MLTC increased behavioral health rates by an additional 2 percent. Nursing facilities were also appropriated an additional $14.45 million for rate increases and account for changes in service utilization.

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
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.
2021	Rates for Medicaid services increased by 2.0% Rates for Behavioral Health services received an additional 2.0% increase. Nursing Facilities also received a specified appropriation increase of $14.45 million for increasing rates and utilization changes.

7. VENDOR EXPENDITURES

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, currently varying from 56.2 percent to 84.5 percent. Nebraska's FMAP in federal fiscal year (FFY) 2021[4] was 56.47 percent for Medicaid and 69.53 percent for CHIP. Table 8 shows the FMAP for both Medicaid and CHIP for FFY16 through FFY22.

Table 8. Nebraska FMAP Rates

Federal Fiscal Year	Medicaid FMAP	CHIP FMAP
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%
FFY22	57.80%	70.46%

Total SFY21 vendor payments for Medicaid and CHIP expenditures were $2,937,218,415. This total includes drugs, inpatient and outpatient hospital, physicians, practitioners, and early and periodic screening, diagnostic, and treatment. A&D Waiver includes $635,370 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.

[4] October 1, 2020 to September 30, 2021

Not all Medicaid and CHIP expenditures are detailed in Appendix 7. Several other transactions are highlighted below:

- Drug rebates are reimbursements 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 SFY21, Medicaid received a total of $167.8 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 SFY21, Medicaid paid $42.5 million through the DSH program, a 55.1 percent increase compared to $27.4 million paid in SFY20;
- Medicaid pays the Medicare Part B premium for beneficiaries that are dually eligible for Medicare and Medicaid. In SFY21, Medicaid paid $61,954,969 for Medicare premiums, a 9.6 percent increase from the $56,539,620 for Medicare premiums paid in SFY20. Monthly premiums were $144.60 for calendar year 2020 and $148.50 for calendar year 2021; 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 that Medicare pays for dually eligible individuals enrolled in Part D. In SFY21, clawback payments totaled $56,871,451, a 16 percent decrease from the $67,739,255 paid in SFY20. 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.

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 SFY20 and SFY21.

LONG-TERM CARE SERVICES

Long-term care (LTC) services support individuals with chronic or ongoing health needs related to age or disability. In SFY21, Medicaid expenditures for LTC services totaled $1,028,433,007. 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.

Appendix 11 shows the cost of 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.
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. HIGHLIGHTS AND ACCOMPLISHMENTS

Heritage Health Adult – Single Benefit Category

Due to a change in federal guidance, MLTC pivoted from planning to implement the Heritage Health Adult Demonstration program to a single benefit category for all Medicaid beneficiaries with Heritage Health Adult coverage. With this change, everyone enrolled in Heritage Health Adult automatically qualified for full state plan benefits effective October 1, 2021, meaning everyone with Heritage Health Adult coverage will receive dental, vision, and over-the-counter medication benefits as part of their Medicaid coverage.

MLTC staff accomplished a variety of tasks during spring and summer 2021 to implement this program change, including technological, regulatory, and contractual changes. Communications staff prepared informational materials and correspondence to beneficiaries and met directly with stakeholders to discuss these changes to the program. Following the benefit change that occurred on October 1, 2021, MLTC staff will continue to improve its technology system to manage benefits more efficiently in the future.

Medicaid Insurance for Workers with Disabilities

The Medicaid Insurance for Workers with Disabilities (MIWD) program allows individuals with disabilities who are employed to qualify for and receive Medicaid coverage even if their income is above the levels necessary for Medicaid eligibility. In 2020, the Nebraska Legislature passed a new law that made a number of changes to MIWD, including the creation of two new eligibility groups, modifying standards for eligibility, and lowering premium caps. These changes went into effect on October 1, 2021, and allow more individuals to qualify for and maintain Medicaid benefits through the MIWD program.

DHHS hosted multiple presentations throughout 2021 about these program changes and created a new webpage that has more information. Below is a link to this webpage:

https://dhhs.ne.gov/Pages/MIWD.aspx

Informational materials available on this page detail the MIWD program changes, including a one-pager, FAQ, premium calculation chart, and a recorded presentation.

Homeless Outreach Promotional Items

Medicaid and Long-Term Care initiated an outreach project designed to connect heath care with members of the community who are homeless or have unstable addresses. Our goal with this project is to reach current Medicaid beneficiaries and future community members who may receive Medicaid benefits, and provide resources to help make sure their benefits continue no matter what life brings.

For this outreach project, MLTC staff assembled items for distribution, including:

- Drawstring bags;
- A laminated one-pager detailing how to update contact information;
- A info card detailing how to update contact information, and Economic Assistance information;
- Water bottle;
- Pen, hand sanitizer, and face mask.

These items were given to DHHS teammates and stakeholders throughout the state to be distributed to the community. They are designed to help communicate the importance of having up-to-date contact information to ensure Medicaid benefits continue, as well as how to contact DHHS with questions about Medicaid benefits.

Substance Use Disorder Demonstration

Through a Section 1115 Demonstration Waiver, MLTC has enhanced its ability to cover substance use disorder (SUD) services. Specifically, this waiver will allow MLTC to continue covering SUD residential services in institutions for mental diseases for Medicaid-enrolled adults ages 21-64. Nebraska created this program to address the growing need for SUD services and improve the continuum of care for Medicaid beneficiaries.

With this demonstration program in place, Medicaid has added additional health care services to support the program's goals: Opioid Treatment Program (OTP) and Medically Monitored Inpatient Withdrawal Management (MMIW). Opioid Treatment Programs provide access to medication-assisted treatment, counseling, and other behavioral therapies for treatment of opioid use disorder. MMIW provides medical services for managing detoxification and substance use disorder treatment. Both OTP and MMIW will be able to be covered even if the demonstration program ends, which is currently slated to run through June 2024.

9. LOOKING AHEAD

Behavioral Health and Substance Use Disorder Regulatory Update

Access to behavioral health and substance use disorder treatment and services is important to help improve health outcomes and help people live better lives. As research and practice in these fields continues to evolve, the state has added services to ensure Nebraska Medicaid recipients have access to cost-effective treatment. MLTC has developed State Plan Amendments along with changes to regulations and statutes to implement these services. Over time, these changes create complexity for providers and duplicate regulatory language. For example, the DHHS Division of Behavioral Health also provides reimbursement for mental health and substance use disorder treatment, with service definitions that are not necessarily the same as Medicaid's definition.

To address providers' need for simple, consistent direction, Medicaid has initiated a Behavioral Health and Substance Use Disorder Regulatory update project. The scope of the project is a comprehensive review of existing Medicaid behavioral health and substance use disorder services to identify and recommend changes to align service delivery and reimbursement across state and federal authority. The project will focus on ensuring access to care, decreasing complexity for providers, removing duplicate regulatory language, and developing a step-by-step guide for implementing new services to ensure consistency.

Tribal Health Outreach Efforts

Nebraska Medicaid has created a series of new webpages with information specifically for Native American beneficiaries and tribal providers. These pages have information to help navigate the various federal laws and treaties that uniquely effect these beneficiaries and providers. Additionally, these pages have information on public meetings that Medicaid hosts with representatives of the Ponca, Santee Sioux, Omaha, and Winnebago Tribes. These pages provide resources and information to assist Medicaid's Native American stakeholders. Looking ahead, the Medicaid program is seeking feedback to help add additional relevant content.

Throughout the federal COVID-19 public health emergency, Medicaid has been meeting regularly with tribal representatives and health care providers to communicate critical information related to the administration and payment of vaccination and testing. These meetings are also a place where tribal providers can receive clarification and assistance on day-to-day problems, such as issues in billing for services. These meetings are a key way that Nebraska Medicaid communicates with tribal stakeholders and will continue to be important going forward.

Medical Care Advisory Committee

In late 2021, Nebraska Medicaid re-launched the Medical Care Advisory Committee (MCAC). This committee is made up of Medicaid beneficiaries, their advocates, and health care providers. The purpose of this committee is to provide these stakeholders with an opportunity to interact directly with the Medicaid program and share their valuable perspectives. This committee will be tasked with making

policy recommendations, analyzing and recommending program changes, and sharing stakeholder opinions and needs in regard to the Medicaid program.

When the committee is fully formed, it will consist of 17 voting members- 9 beneficiaries or advocates and 8 providers- as well as 4 non-voting members from DHHS. Medicaid is still working toward filling out the voting membership of the committee. Medicaid hopes that the committee, once fully formed, becomes a dynamic and active group that offers new perspectives on Medicaid services that the program has not considered in the past.

Medicaid would encourage interested members to apply to serve on the committee. More details are available on the DHHS website.

Focusing on External Relationships

Medicaid is a single part of the state's broad health care system, so forming strong relationships with our stakeholders is essential to ensuring Nebraskans receive high quality health care. The MCAC is part of a broader strategy over the next several years to focus on the program's stakeholders and cultivate more trusting and transparent relationships with them.

Medicaid began planning for this important initiative in fall 2021. The initial stages of this project include taking stock of the program's stakeholders who come from a wide variety of backgrounds and considering all the different ways the program communicates and interacts with these stakeholders. With this information, Medicaid will create a current picture of our external relationships, and from this, a roadmap of how to enhance these relationships.

Public Health Emergency Unwind

The federal government's COVID-19 public health emergency (PHE) declaration has affected MLTC's operations in a variety of ways. As mentioned earlier in this report, one of the main ways Medicaid responded to the PHE was by continuing Medicaid coverage for members who may have otherwise become ineligible. MLTC receives enhanced federal financial participation for keeping these individuals' Medicaid coverage active.

The PHE is currently set to expire in mid-January 2022, though the date is subject to change. Because the exact end date of the PHE is unknown, MLTC has been taking steps to prepare for the end of the PHE and its associated program flexibilities that have been in place. One of the largest tasks that will be associated with the PHE expiration will be the re-determinations of Medicaid eligibility for cases that have been kept open because of the PHE. MLTC has been preparing estimates for staffing needs and other considerations associated with the end of the PHE so that the division will be prepared once the PHE declaration is officially over.

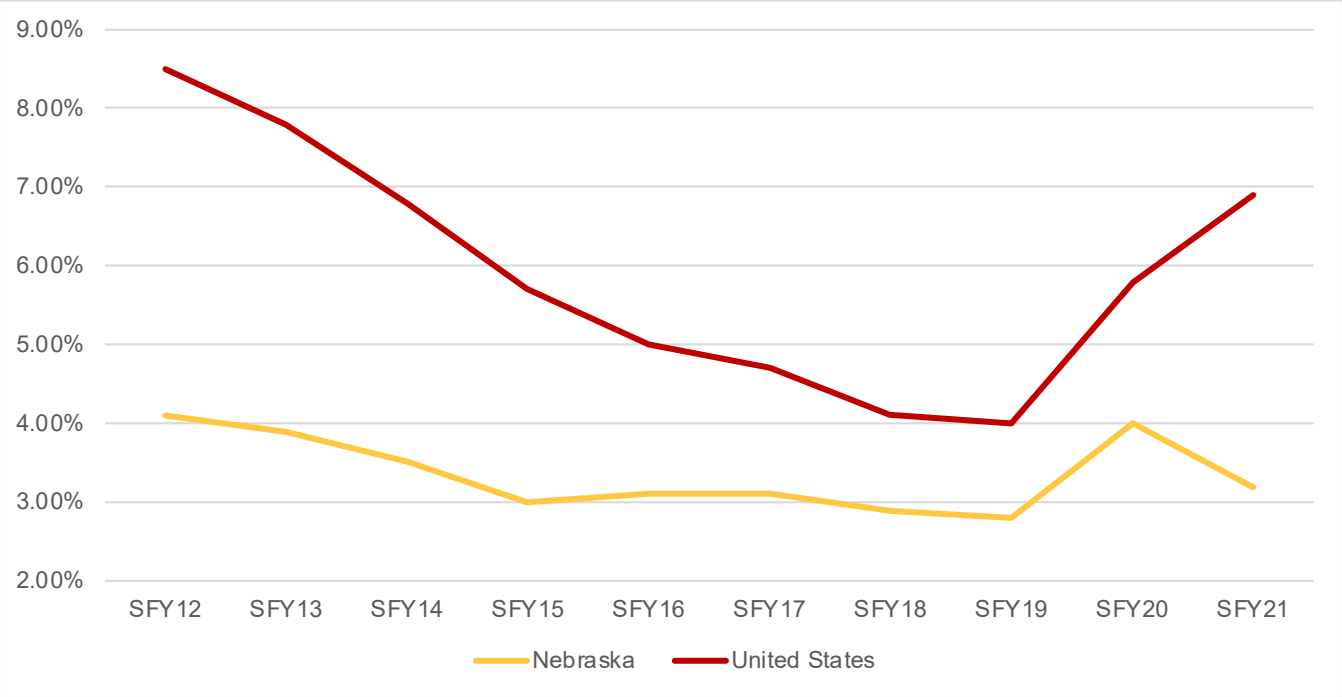
10. CONCLUSION

MLTC takes its role in supporting the delivery of quality health care to Nebraskans in need seriously. 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 addition of new therapies for substance use disorder, implementation of new benefits for Heritage Health Adult beneficiaries, changes to the MIWD program, and outreach to some of the most vulnerable Medicaid beneficiaries are all examples of purposeful efforts to align the division's actions with this role. Upcoming initiatives like the Medical Care Advisory Committee (MCAC) and Behavioral Health review project will ensure MLTC is positioning itself to be able to continue to evaluate and improve on services, the delivery system, and processes in the years to come.

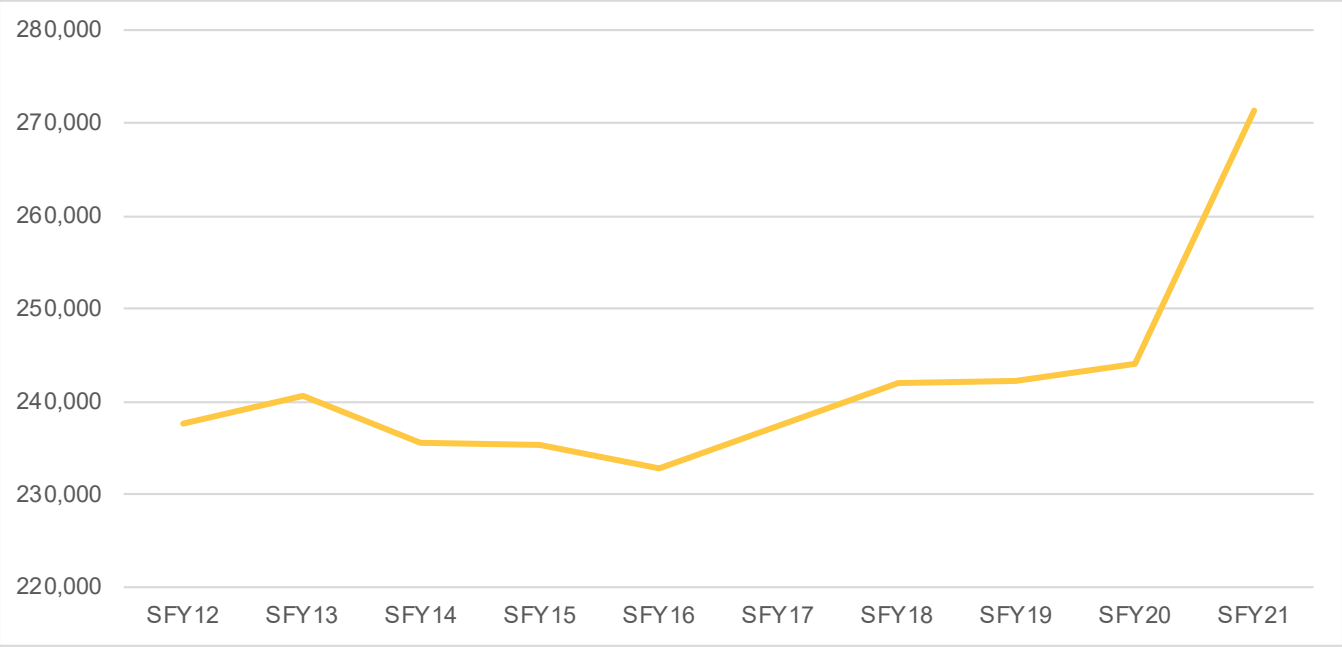
Additionally, MLTC is committed to transparency and providing information to the Legislature and the public as it continues to enhance and evolve its operations. MLTC looks forward to continuing to work with the Governor's Administration, the Legislature, and stakeholders to improve and sustain Nebraska's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

APPENDIX

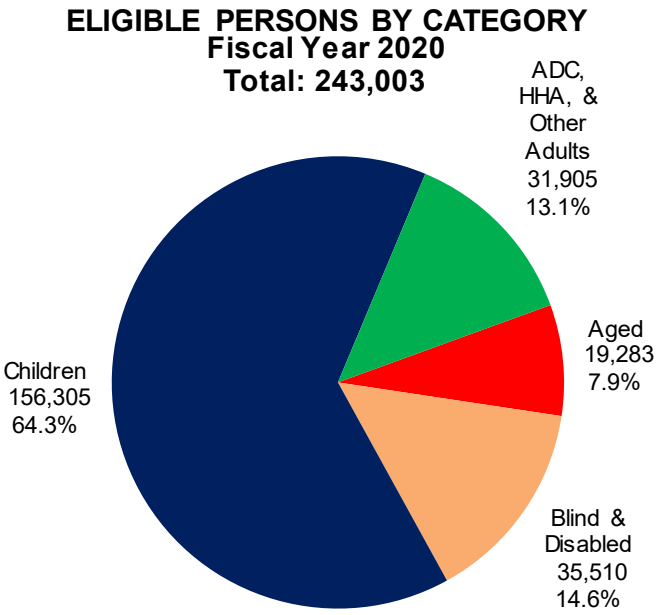
Appendix 1. Average Unemployment Levels

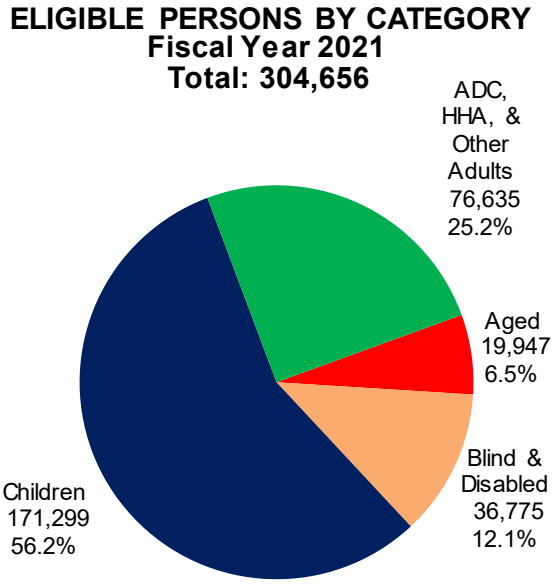


Appendix 2. Average Monthly Nebraska Medicaid Clients by SFY



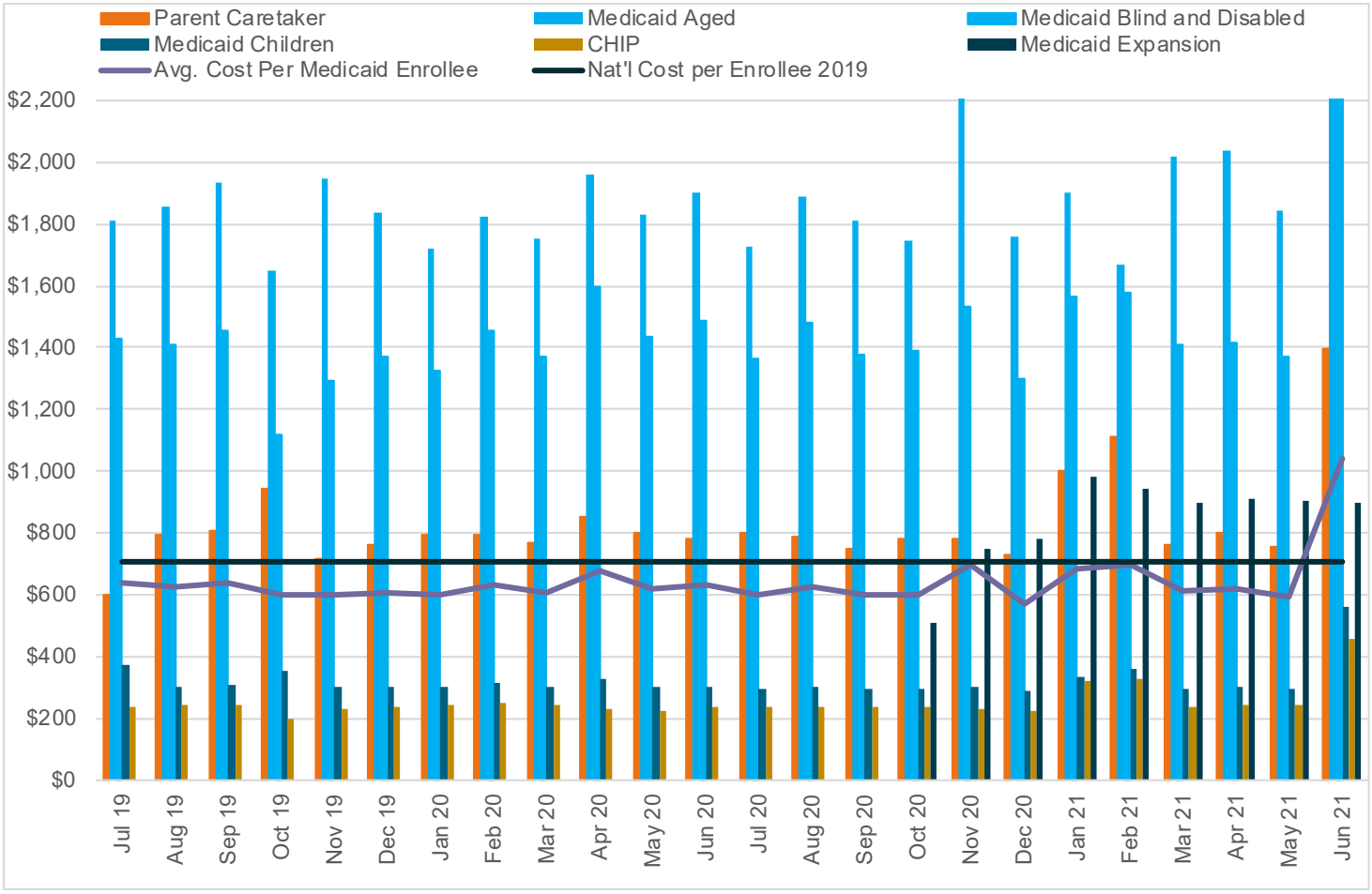
Appendix 3. Average Nebraska Monthly Enrollment for Medicaid and CHIP, SFY20 and SFY21[5]





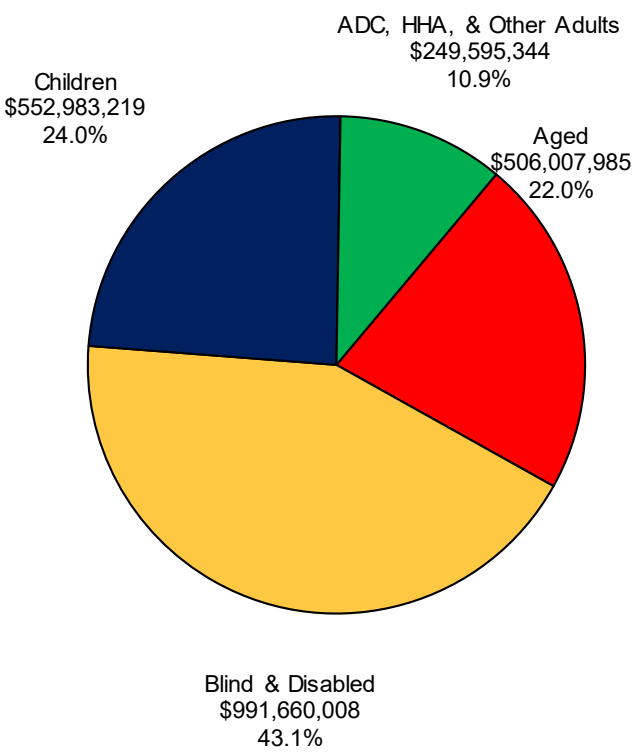
[5] ADC: Adults with Dependent Children;
HHA: Heritage Health Adult (Medicaid Expansion)

Appendix 4. Nebraska Medicaid Cost per Enrollee

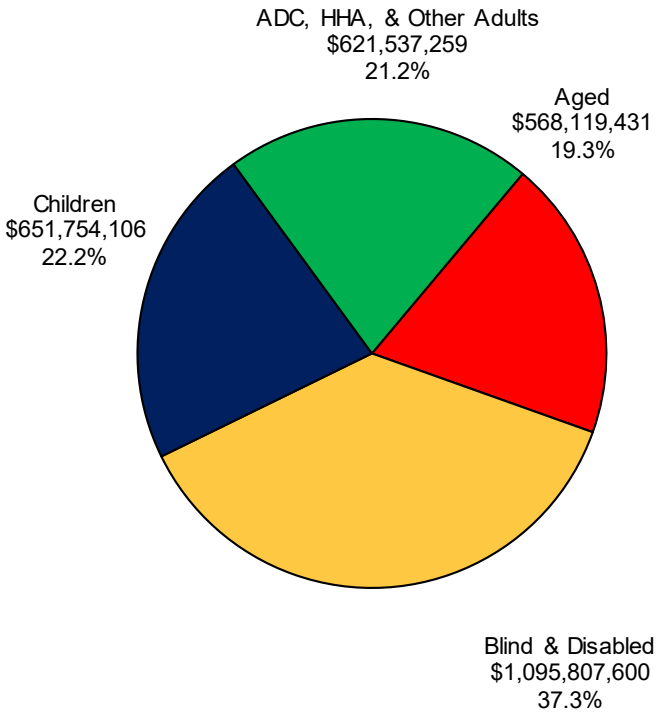


Appendix 5. Nebraska Medicaid and CHIP Annual Cost by Eligibility Category

Fiscal Year 2020
Total: $2,300,246,556



Fiscal Year 2021
Total: $2,937,218,397

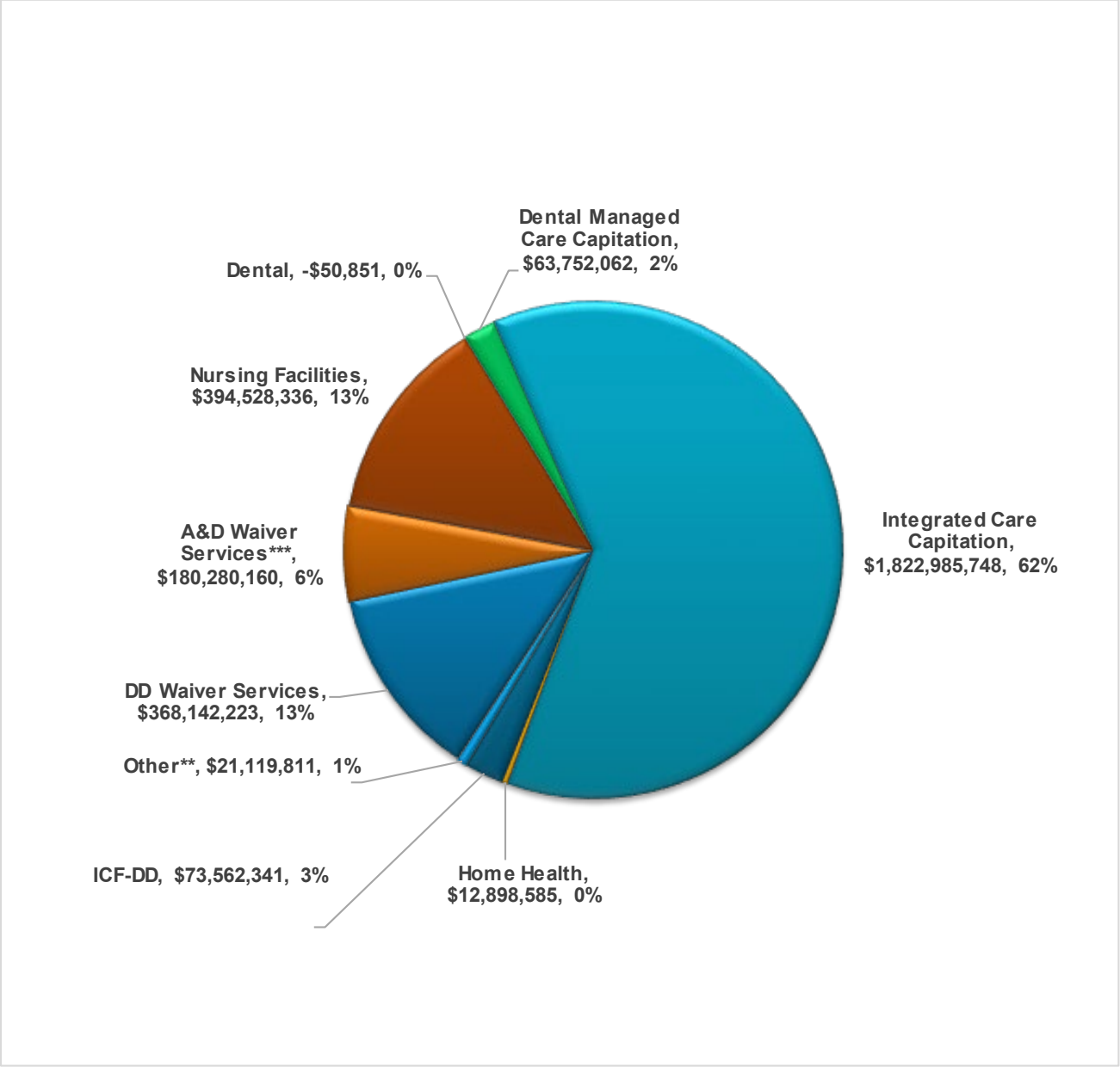


Appendix 6. Nebraska Medicaid Providers by Type, October 2021

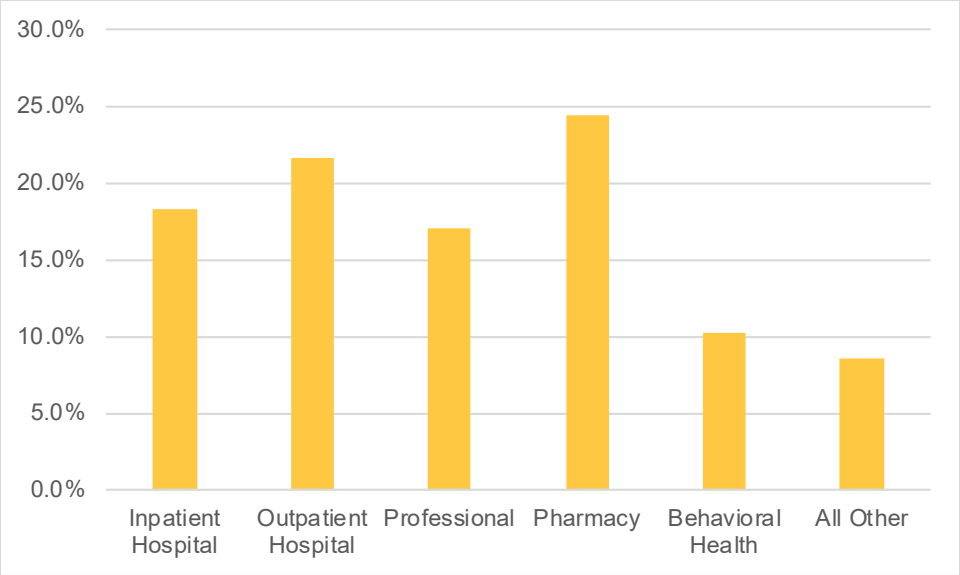
Provider Type Description	Nebraska	Out of State
Ambulatory Surgical Centers	52	9
Hospitals	154	647
Dialysis Centers (specialty 68)	40	13
Nursing Homes (Specialty 87)	206	10
Assisted Living (Specialty 75)	241	0
Intermediate Care Facility (Specialty 88)	11	10
Hospice in Nursing Facility (Specialty 82)	682	0
Home Health Agency	80	3
Laboratory	31	348
Federally Qualified Health Center	59	17
Rural Health Clinic-Provider Based (Less Than 50 Beds)	122	31
Rural Health Clinic-Independent	18	14
Rural Health Clinic-Provider Based (Over 50 Beds)	6	0
Indian Health Hospital Clinic	0	5
Tribal 638 Clinic	11	0
Assertive Community Treatment - MRO Program	4	0
Day Rehabilitation - MRO Program	22	0
Residential Rehabilitation	17	1
Substance Abuse Treatment Center	98	3
Pharmacy	479	270
Opioid Treatment Program (OTP)	3	1
Medically Monitored Inpatient Withdrawal (MMIW)	1	0
Multi-Systemic Therapy	0	0
Hospice	40	5
Non-Emergency Medical Transportation (specialty 94-96)	215	10
Ambulance (specialty 59)	304	83
Medicaid in Public Schools Transportation (specialty 49)	6	0
Rental and Retail Supplier	158	233
Orthopedic Device Supplier	5	14
Optical Supplier	42	3
Qualified Health Maintenance Organization	3	4
Case Management	15	0
Other Prepaid Health Plan	3	3
Day Treatment Provider	17	1
Treatment Crisis Intervention	3	1
Therapeutic Treatment Home	2	0
Psychiatric Residential Treatment Facility	1	21
Freestanding Birth Centers	1	2
NFOCUS Provider	4811	100

Provider Type Description	Groups		Group Members		Solo Providers	
	In state	Out of State	In state	Out of State	In state	Out of State
Physicians	268	243	19321	11827	138	197
Doctors of Osteopathy	4	5	1703	878	9	17
Doctors of Chiropractic Medicine	310	21	537	88	155	9
Optometrists	239	21	867	92	56	2
Doctors of Podiatric Medicine	61	12	176	62	23	2
Clinic	338	161				
Professional Clinic	2646	753				
Medicaid in Public Schools (specialty 49) Direct Care Staff	275	0				
Anesthesiologist	177	78	2077	1240	17	31
Dispensing Physician			11	30		
Physician Assistant			5379	1589		
Nurse Midwife			234	98		
Nurse Practitioner	99	8	9065	3215	78	22
Registered Nurse	6	0	504	23	16	0
Licensed Practical Nurse			98	2	2	0
Registered Physical Therapist	374	25	4686	391	9	
Personal Care Aide - Schools			2303			
Community Treatment Aid/Peer Support			476	0		
MHSA Direct Care Staff/BCBA/BCaBA/RBT			564	2	1	0
Licensed Mental Health Practitioner			1341	259	13	1
Mental Health Professional/Masters Level Equivalent			2092	77	20	0
PhD Intern			1	0		
Licensed Independent Mental Health Practitioner	206	9	3302	154	372	17
Doctor of Dental Surgery - Dentist	286	39	1570	201	315	14
Licensed Dental Hygienist	10	0	73	1	7	0
Community Support - MRO Program	42	0	578	0		
Day Rehabilitation - MRO Program	12	0	11	0		
Adult Substance Abuse	11	42				
Pharmacist			26	2		
Peer Support Specialist			7	0		
Psychological Assistant/Associate	0	0	0	0	0	0
Provisionally Licensed PHD			175	6		
Provisionally Licensed Drug & Alcohol Counselors			203	0		
Hearing Aid Dealer	42	5	107	17	6	0
Licensed Medical Nutrition Therapist	10	1	146	141		
Specially Licensed PHD/Psychology Resident			14	0		
Licensed Psychologist	54	3	937	229	75	2
Speech Therapy Health Service	163	13	1896	96	14	1
Occupational Therapy Health Services	202	11	1391	114	2	0
Licensed Drug & Alcohol Counselor			270	7		
Professional Resource Family Care	2	1				

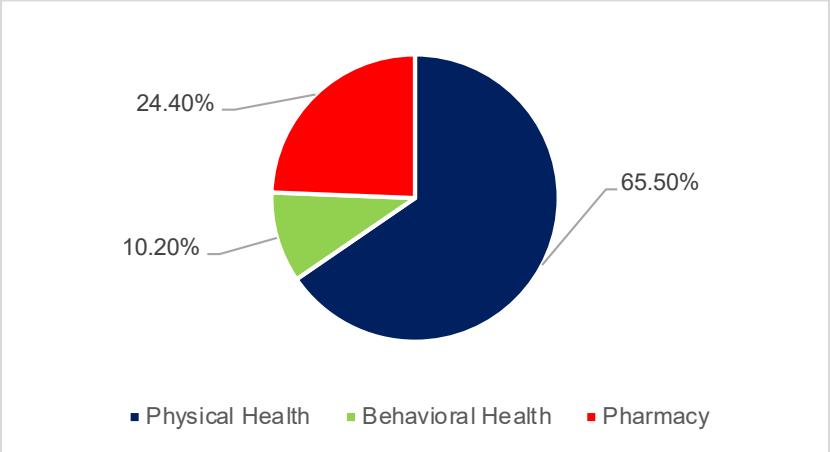
Appendix 7. SFY21 Medicaid and CHIP Expenditure by Service



Appendix 8. Percentage of Capitated Health Spend by Service Category

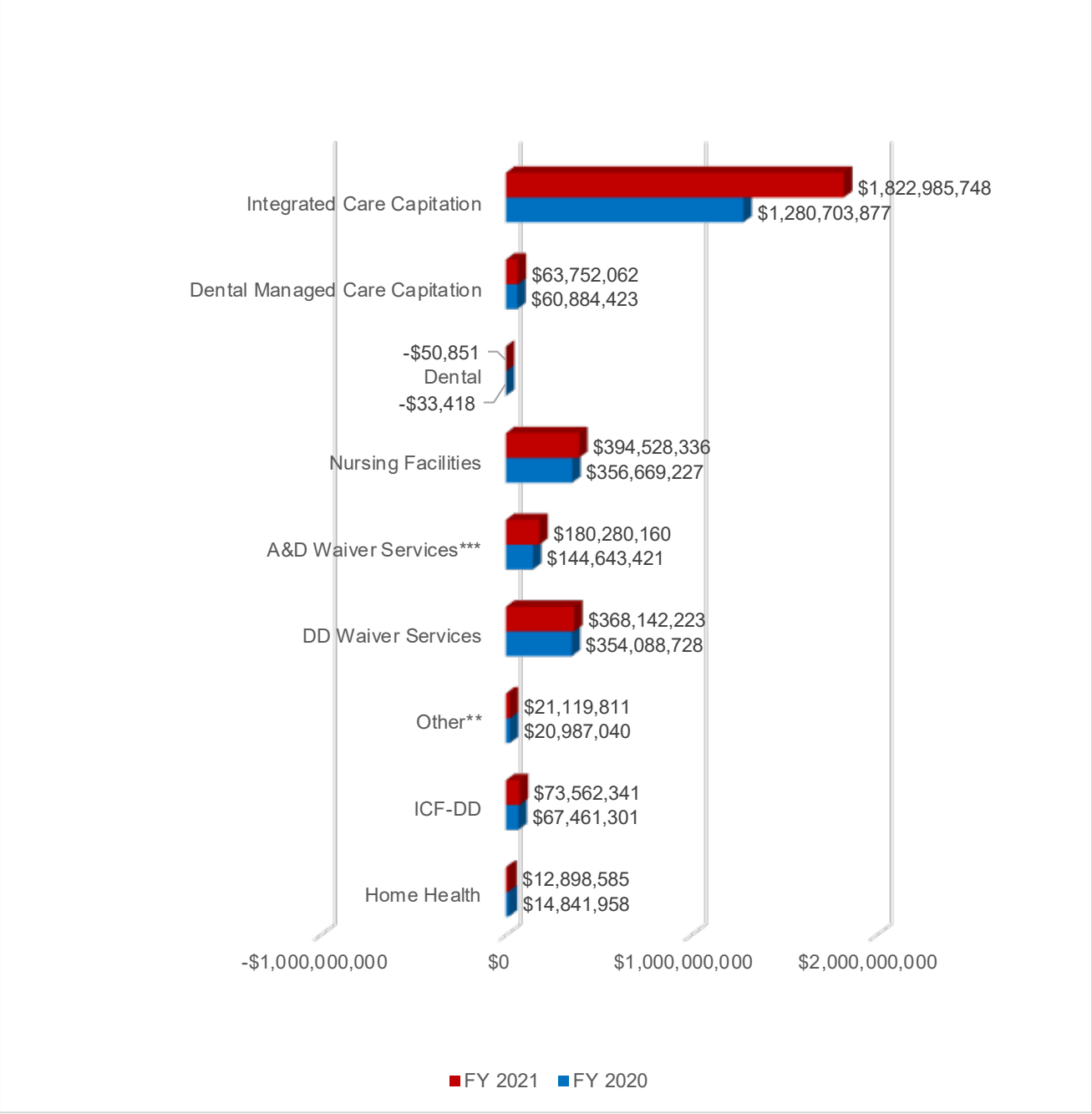


Appendix 9. Heritage Health Medical Services by Relative Cost[6]



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

Appendix 10. Medicaid and CHIP Expenditures SFY20 and SFY21[7]



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

Appendix 11. SFY21 Medicaid Expenditures for LTC Services