State Fiscal Year 2022

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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).

We are grateful for 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.

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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 19 percent of Nebraskans, who were Medicaid beneficiaries in state fiscal year 2022 (SFY22). The program serves low-income children and adults, the aged, and individuals with disabilities. Approximately 55,000 providers are enrolled with Nebraska Medicaid.

MLTC continues to work through the challenges of the COVID-19 pandemic, supporting health care providers with American Rescue Plan Act funds. The federal COVID-19 public health emergency has 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 the healthcare system overall.

Nebraska Medicaid has made great strides this year in expanding its community outreach and engagement. Ensuring that relevant organizations have access to key information and points of contact continues to be a priority for the program. This outreach has been directed at Medicaid members, providers, Tribes, community partners, and other advocates. These external relationships enable the program to quickly identify and solve problems.

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 SFY22, there has been continued interest in recent projects the program has implemented. Medicaid Expansion continues to grow, with over 75,000 Nebraskans now enrolled. Additionally the program re-established the Medical Care Advisory Committee. This committee offers providers, beneficiaries, and their advocates an opportunity to engage with and make recommendations to the program.

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.

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 19% of Nebraskans.

MLTC has over 600 full-time employees, and collaborates 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.
- **Communications and Compliance:** Communications and Compliance helps our members, stakeholders, and the public know what we do and how we help people. Additionally, this section 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.

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 SFY22:

- 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 the past two years as a result of the launch of Medicaid expansion, 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, 2021

	Nebraska	United States	Percent of Nebraskans	Percent of Entire US
Under 100% FPL	195,400	41,384,700	10.2%	12.8%
100% to 199% FPL	300,000	51,156,900	15.7%	15.8%
200% to 399% FPL	615,600	94,470,000	32.3%	29.2%
Above 400% FPL	796,100	136,164,100	41.7%	42.1%

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. 2022 Federal Poverty Level (FPL) Annual Income Guidelines

Household Size	50% FPL	100% FPL	138% FPL	200% FPL
1	$6,795	$13,590	$18,754.20	$27,180
2	$9,155	$18,310	$25,267.80	$36,620
3	$11,515	$23,030	$31,781.40	$46,060

4	$13,875	$27,750	$38,295	$55,500
5	$16,235	$32,470	$44,808.60	$64,940
6	$18,595	$37,190	$51,322.20	$74,380
7	$20,955	$41,910	$57,835.80	$83,829

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
Children's Health Insurance Program (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 (Medicaid Expansion)	Adults between the ages of 19 and 64 who meet income, residency,	138% of the FPL

	and citizenship requirements who are not otherwise eligible for another Medicaid category.	

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.
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 2021 and 2022. Total Medicaid and CHIP enrollment increased from 304,656 in SFY21 to 344,714 in SFY22, a 13.2 percent increase. This increase is a result of Medicaid Expansion as well as Medicaid cases staying open while the COVID-19 public health emergency remains in effect. Throughout the public health emergency, Medicaid has not ended coverage for any members unless they request to be disenrolled, move out of state, or pass away.

The adult category showed the largest change year over year in terms of total number of eligible individuals, growing by 76 percent. The Aged, Blind, and Disabled categories saw a slight decrease: 1.4 percent decrease for Aged, and 2.3 percent decrease for Blind & Disabled. Children's enrollment increased by 6.3 percent.

Appendices 4 and 5 compare the cost of different eligibility categories. While the Aged and the Blind & Disabled categories represent 16.1 percent of beneficiaries, they account for 48.1 percent of expenditures. In contrast, children account for 52.8 percent of beneficiaries, but only 19.6 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).

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
	Hearing screening services for newborn and infant children
	School-based administrative expenses

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.

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 SFY22, there were three MCEs available for beneficiaries: Nebraska Total Care, UnitedHealthcare Community Plan, and Healthy Blue Nebraska. 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.

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.

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 November 2022, there were 55,581 Medicaid providers, accounting for both in and out-of-state providers. 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
- 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 2022 as specified in the table below. Nursing facilities were also appropriated an additional $12.28 million for rate increases and to 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 6. 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.
2022	Rates for Medicaid services increased by 2.0% Nursing Facilities also received a specified appropriation increase of $12.28 Million for increasing rates and utilization changes.

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) 2022 was 57.80 percent for Medicaid and 70.46 percent for CHIP. Table 8 shows the FMAP for both Medicaid and CHIP for FFY16 through FFY23.

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%
FFY23	57.87%	70.51%

Total SFY22 vendor payments for Medicaid and CHIP expenditures were $3,363,256,100. This total includes drugs, inpatient and outpatient hospital, physicians, practitioners, and early and periodic screening, diagnostic, and treatment. A&D Waiver includes $629,269 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 the expenditure distribution to vendors arranged by service type.

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 SFY22, Medicaid received a total of $202.7 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 SFY22, Medicaid paid $13.4 million through the DSH program, a 68.5 percent decrease compared to $42.5 million paid in SFY21;
- Medicaid pays the Medicare Part B premium for beneficiaries that are dually eligible for Medicare and Medicaid. In SFY22, Medicaid paid $71,706,774 for Medicare premiums, a 15.7 percent increase from the $61,954,969 for Medicare premiums paid in SFY21.

Monthly premiums were $148.50 for calendar year 2021 and $170.10 for calendar year 2022; 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 SFY22, clawback payments totaled $61,416,473, an 8 percent increase from the $56,871,451 paid in SFY21. 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 SFY21 and SFY22.

LONG-TERM CARE SERVICES

Long-term care (LTC) services support individuals with chronic or ongoing health needs related to age or disability. In SFY22, Medicaid expenditures for LTC services totaled $671,419,118. 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.

Highlights and Accomplishments

New Managed Care Contracts

Nebraska Medicaid selected three new health plans for its capitated managed care program. These plans are Molina Healthcare, Nebraska Total Care, and UnitedHealthcare. Medicaid is working with the newly selected plans on the upcoming transition, starting January 1, 2024. This timeframe will ensure a smooth transition for beneficiaries and providers.

There are a number of new changes to highlight with the new contracts:

- Health plans will be responsible for covering dental services.
- Medicaid is removing the annual dental benefit maximum of $750.
- Health plans will be standardizing provider credentialing across health plans to reduce administrative burden on providers
- New contracts focus in on improving access to providers across Nebraska, specifically dental and behavioral healthcare.

Statewide Listening Tours

Nebraska Medicaid hosted two separate listening tours in January and October of 2022. These two tours visited the cities of Lincoln, Omaha, Scottsbluff, North Platte, Hastings, Kearney, Norfolk, South Sioux City, and Fremont. Multiple virtual listening sessions were offered as well.

The first tour focused on collecting feedback to include in Medicaid's request for proposals for new managed care contracts. The second tour recapped the changes made based on stakeholder feedback and engaged with providers and beneficiaries on what other areas can be improved. The second tour also announced the selection of the new managed care contracts with Molina Healthcare, Nebraska Total Care, and UnitedHealthcare.

Medical Care Advisory Committee

Earlier this year, Nebraska Medicaid re-established an advisory committee comprised of providers and beneficiaries of the program. After an initial meeting in January, the committee began meeting every other month starting in April. The members, who come from around the state, discuss topics such as the nursing shortage, legislative items, and other areas they believe Nebraska Medicaid needs to focus on. During these meetings, the members converse amongst themselves, as well as consult representatives from Nebraska Medicaid.

Tribal Health Outreach

Nebraska Medicaid continues to prioritize working with Native American Medicaid beneficiaries, tribal providers, Indian Health Service (IHS), and other stakeholders. Medicaid's team has been collaborating during monthly and quarterly meetings to ensure tribal providers are well equipped to serve their communities. 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 have also been an opportunity for Medicaid to share information on CMS initiatives regarding health equity.

Medicaid continues to build new informational resources to help assist tribal providers. From presentations on personal assistance services to flyers on non-emergency medical transportation, these resources help continue to build out the webpages developed in 2021.

Substance Use Programs

Nebraska Medicaid began the Substance Use Disorder (SUD) program July 1, 2019. The SUD Program covers SUD residential services in institutions for mental diseases for Medicaid-enrolled adults ages 21-64 not otherwise covered by Medicaid. Nebraska created this program to address the growing need for SUD services and improve the continuum of care for Medicaid beneficiaries.

In 2021, Medicaid 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 SUD treatment.

Medicaid Expansion

Enrollment in Medicaid Expansion continues to grow, with over 75,000 Nebraskans enrolled since October 1, 2020. Low-income Nebraskans between the ages of 19-64 are able to receive comprehensive healthcare coverage. The rollout and implementation of Medicaid Expansion, also known as Heritage Health Adult (HHA), happened during the COVID-19 pandemic. It would not have been possible without the hard work and dedication of DHHS teammates and countless healthcare community workers and application assisters.

Home and Community Based Services

Nebraska Medicaid has utilized additional federal funding from the American Rescue Plan Act to invest in needed home and community based services (HCBS) throughout the state.

- Funding for telehealth equipment
- Funding to convert or renovate facilities.
- State Unit on Aging providing Community Living grants for Area Agencies on Aging throughout the state.
- Millions of dollars to address labor shortages for Nebraska’s waiver services.
- Relief payments to home health and personal assistance services providers.

More information can be found in Medicaid’s HCBS Spend Plan quarterly reports.

Looking Ahead

New Managed Care Contracts

While the selection of new health plans is complete, the work to build out and implement their contracts has only recently started. Numerous contract changes need to be accounted for such as simplified credentialing and integrating dental care into each health plan's covered services. Nebraska Medicaid is working to ensure that there is a smooth transition between Molina and Healthy Blue on January 1, 2024. This will be a key focus for the program looking ahead to 2023.

COVID-19 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.

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 remained 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.

Additional Community Outreach

Over the past year, Nebraska Medicaid has prioritized a broad range of community outreach. This engagement and collaboration ensures that the program is able to identify gaps and difficulties and quickly overcome them. It's important for Medicaid to assess stakeholder needs and ensure that beneficiaries, advocates, providers, and community partners know the best way to reach out when encountering issues.

Looking ahead, Nebraska Medicaid is planning additional listening tours and community collaborations to continue to build off the progress made over the past year.

Conclusion

Nebraska Medicaid 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, the program continues to focus on improving all aspects of its operations.

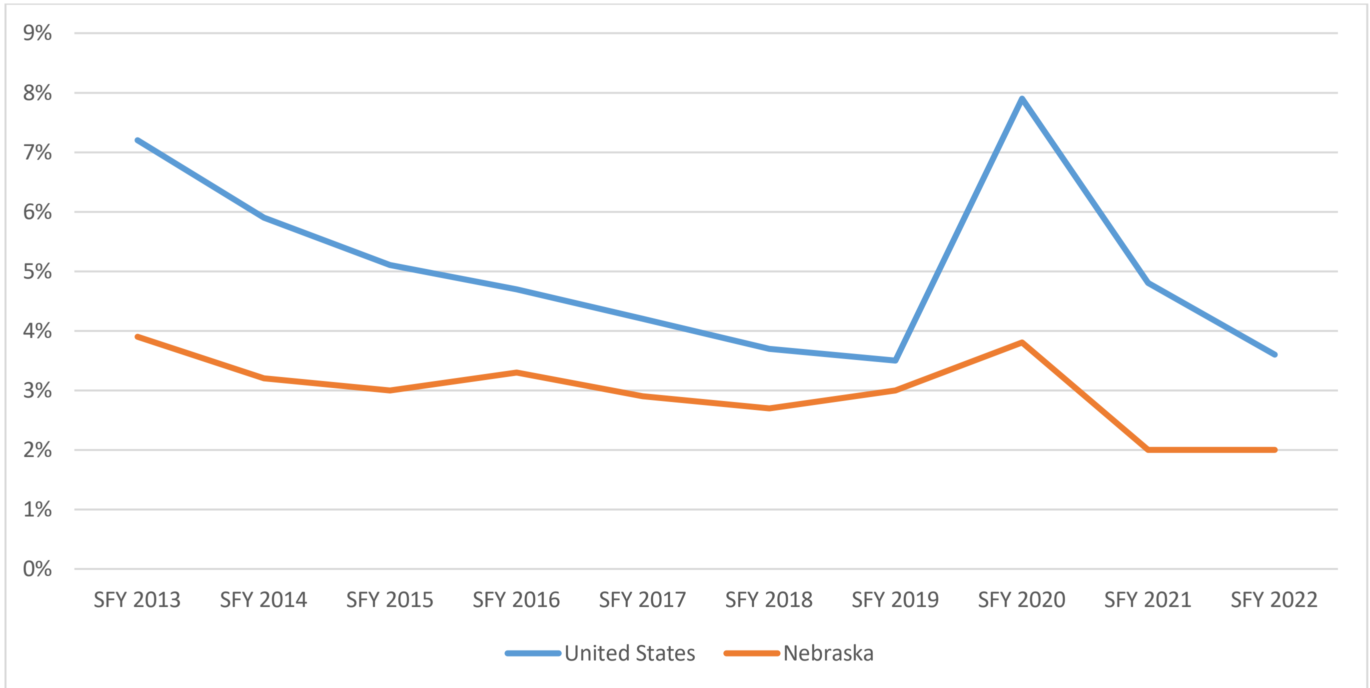
From the expanded community outreach and continued successes of popular initiatives, there are many examples of Medicaid's purposeful efforts to align the division's actions with its role. Upcoming initiatives like Nebraska's new managed care contracts will ensure MLTC is positioning itself to improve customer services, the delivery system, and processes in the years to come.

Additionally, there are upcoming challenges that the program will need to overcome. The anticipated end to the COVID-19 Public Health Emergency will have impacts on staff capacity throughout the division. Continued collaboration with community partners and stakeholders will be incredibly important as this transition approaches.

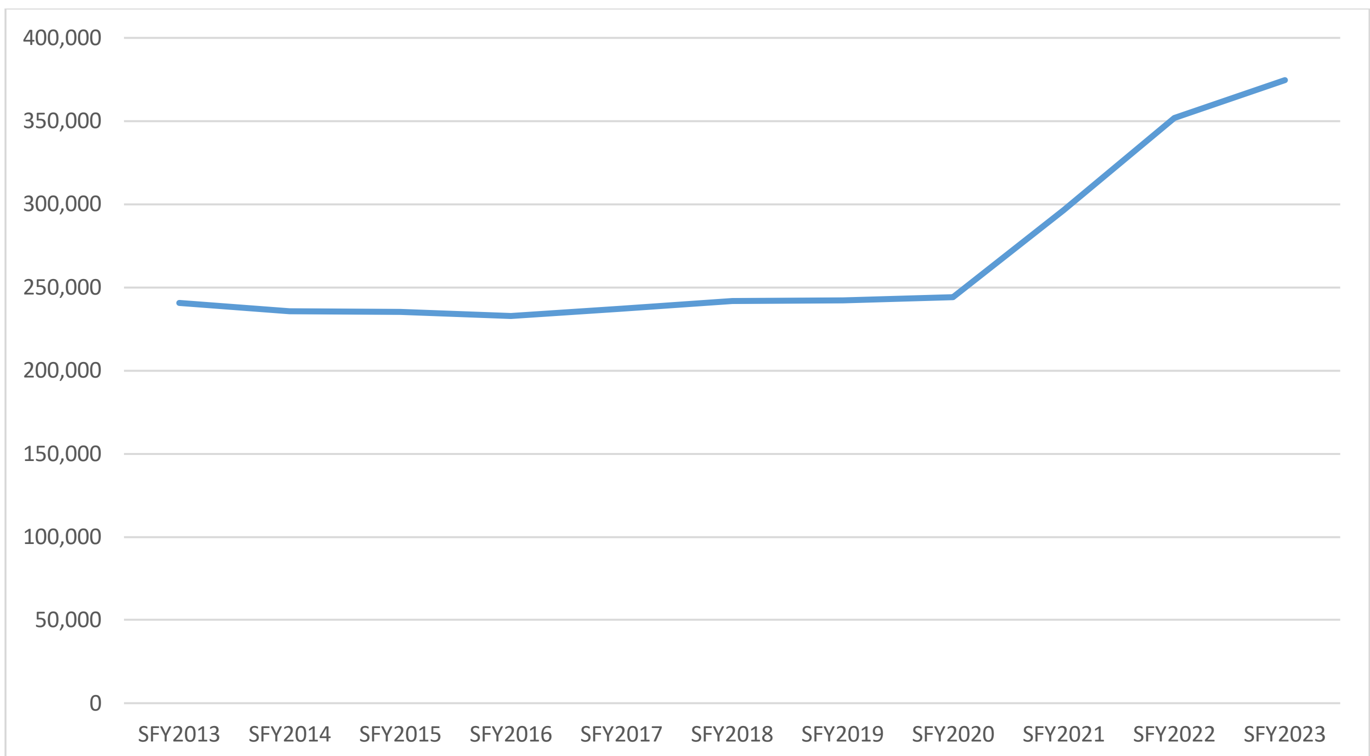
Additionally, MLTC is committed to transparency and providing information to the Legislature and the public as it continues to enhance and evolve its operations. MLTC looks forward to continuing to work with the new Governor's Administration, the Legislature, and stakeholders to improve and sustain Nebraska's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

Appendix

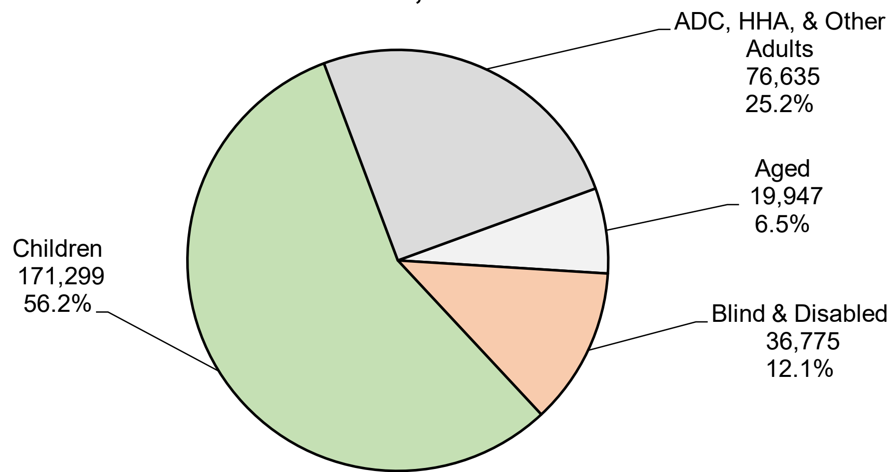
Appendix 1. Average Unemployment Levels by State Fiscal Year (SFY)

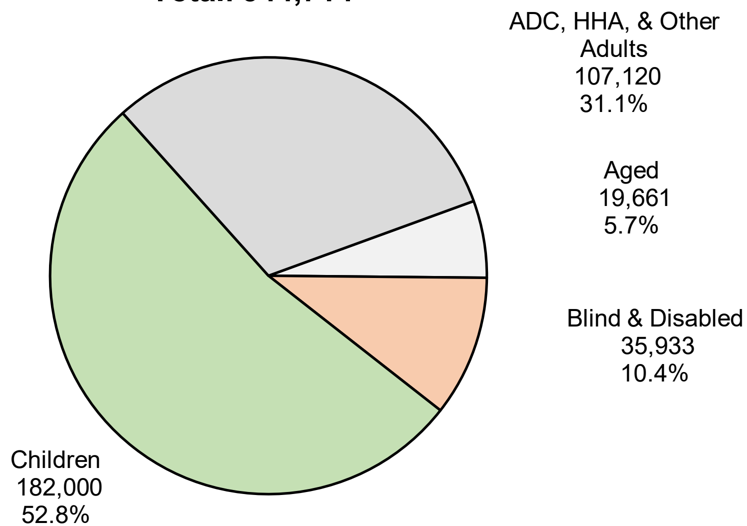


Appendix 2. Average Monthly Nebraska Medicaid Clients by State Fiscal Year (SFY)

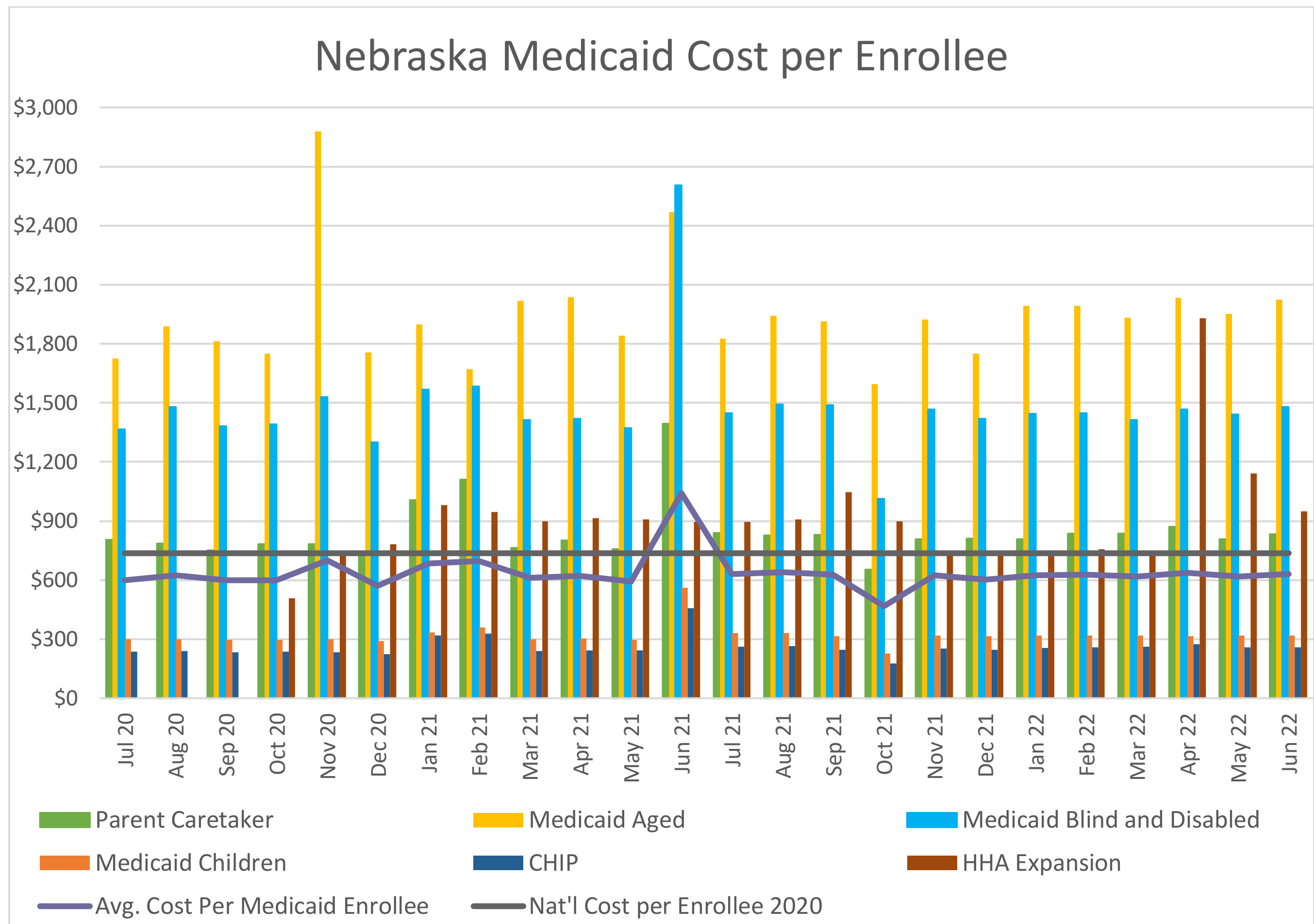


Appendix 3. Average Nebraska Monthly Enrollment for Medicaid and CHIP, SFY21 and SFY22



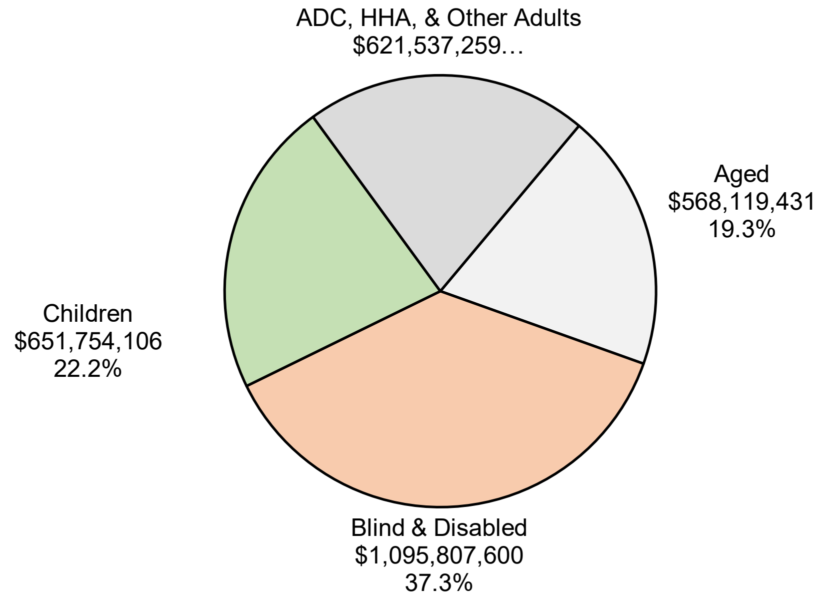


Appendix 4. Nebraska Medicaid Cost per Enrollee

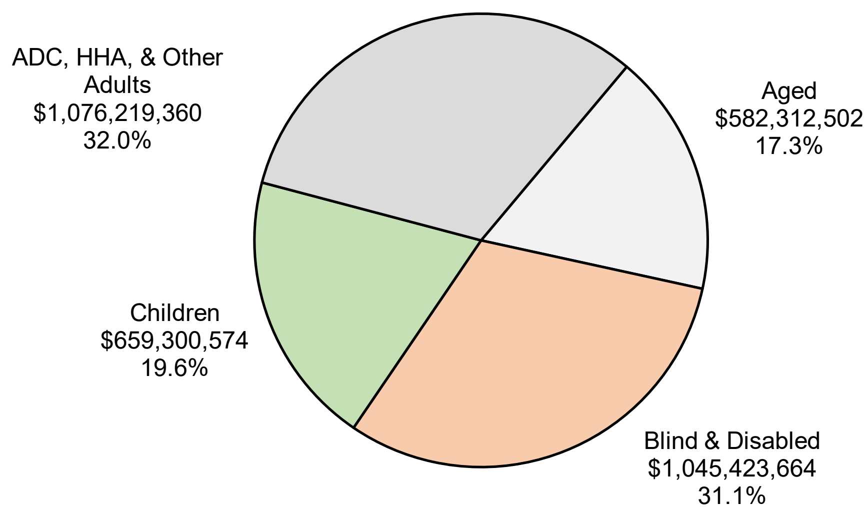


Appendix 5. Nebraska Medicaid and CHIP Annual Cost by Eligibility Category

NEBRASKA MEDICAID AND CHIP VENDOR EXPENDITURES BY ELIGIBILITY
Fiscal Year 2021
Total: $2,937,218,397



NEBRASKA MEDICAID AND CHIP VENDOR EXPENDITURES BY ELIGIBILITY
Fiscal Year 2022
Total: $3,363,256,100



Appendix 6. Nebraska Medicaid Providers by Type

Provider Type Description	Nebraska	Out of State
Ambulatory Surgical Centers (ASC)	52	8
Dialysis Centers (specialty 68)	40	14
Hospitals (HOSP)	191	706
Intermediate Care Facility (specialty 88)	11	10
Nursing Homes (specialty 87)	202	11
Assisted Living (specialty 75)	235	0
Hospice in Nursing Facility (specialty 82)	561	0
Clinic (CLNC) (Hospital Based Clinic, Licensed Mental Health Centers)	240	150
Medicaid in Public Schools Direct Care Staff (specialty 49)	272	6
Professional Clinic (PC)	2222	709
Home Health Agency (HHAG)	77	6
Laboratory (LAB) (Independent)	35	367
Federally Qualified Health Center (FQHC)	62	17
Rural Health Clinic-Provider Based (PRHC) (Less Thank 50 Beds)	117	32
Rural Health Clinic-Independent (IRHC)	19	13
Rural Health Clinic-Provider Based (RHCP) (Over 50 Beds)	6	0
Indian Health Hospital Clinic (IHSH)	0	5
Tribal 638 Clinic (T638)	11	0
Specialized Add-On Services (in NFs)	0	0
Adult Day Care (specialty 79)	1	0
Assertive Community Treatment (ACT) MRO Program	4	0
Day Rehabilitation (DAYR) MRO Program	11	0
Residential Rehabilitation (REST)	16	0
Substance Abuse Treatment Center (SATC)	93	4
Pharmacy (PHCY)	478	284
Opioid Treatment Program (OTP)	3	1
Medically Monitored Inpatient Withdrawal (MMIW)	2	0
Multi-Systemic Therapy	0	0
Hospice (HSPC)	41	5
Medicaid in Public Schools Transportation (specialty 49)	8	1
Non-Emergency Medical Transportation (specialty 94-96)	200	10
Ambulance (specialty 61)	297	95
Rental and Retail Supplier (RTLR)	148	240
Orthopedic Device Supplier (ORTH)	6	14
Optical Supplier (OPTC)	43	4
Qualified Health Maintenance Organization (QHMO)	7	3
Case Management	11	0
Other Prepaid Health Plan (OPHP)	3	2
Day Treatment Provider (DAY)	16	0
Treatment Crisis Intervention (TCI)	3	1

Therapeutic Treatment Home (THGH), Formerly-Treatment Group Home (TGH)	2	0
Professional Resource Family Care	2	1
Psychiatric Residential Treatment Facility	1	27
Freestanding Birth Centers	3	0
NFOCUS Provider	4764	94

Provider Type Description	Groups		Group Members		Solo Providers	
	In state	Out of State			In state	Out of State
Physicians (MD)	189	184	21033		137	##
Doctors of Osteopathy (DO)	5	5	1971		10	19
Doctors of Chiropractic Medicine (DC)	334	22	529		162	11
Optometrists (OD)	202	20	424		57	3
Doctors of Podiatric Medicine (DPM)	55	11	154		22	2
Anesthesiologist (ANES)	129	77	1896		12	30
Dispensing Physician (MD)			32			
Physician Assistant (PA)			4462			
Nurse Midwife (NW)			191			
Nurse Practitioner (NP)	99	10	7925		83	22
Registered Nurse (RN)			433		8	
Licensed Practical Nurse (LPN)			88		2	
Registered Physical Therapist (RPT)	295	23	1677		13	
Personal Care Aide (PCA) - Schools (specialty 87)			1682			
Community Treatment Aide/Per Support			319			
MHSA Direct Care Staff			856			
Licensed Mental Health Practitioner (LMHP)			1096		26	6
Mental Health Professional/Masters Level Equivalent (MHP)			1409		57	
PhD Intern			6			
Licensed Independent Mental Health Practitioner	231	10	2345		411	21
Doctor of Dental Surgery - Dentist (DDS)	283	39	1148		306	14
Licensed Dental Hygienist (LDH)	10		57		9	
Community Support (CSW) MRO Program	40		429			
Adult Substance Abuse	42	4				
Pharmacist (PHMS)			29			
Peer Support Specialist			53			
Psychological Assistant/Associate			1			
Provisionally Licensed PHD-PPHD			88		1	

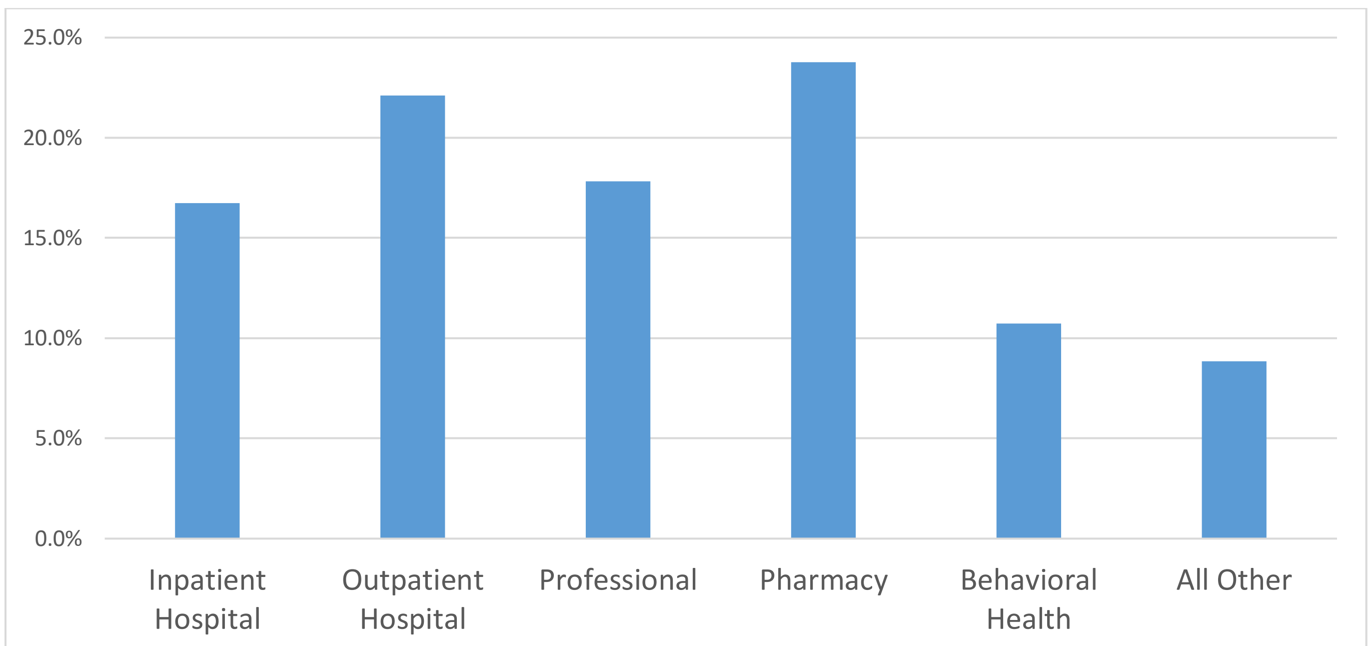
Provisionally Licensed Drug & Alcohol Counselors (PDAC)			123		
Hearing Aid Dealer (HEAR)	37	5	1	8	1
Licensed Medical Nutrition Therapist (LMNT)	10	1	119	7	
Specially Licensed PHD/Psychology Resident (SPHD)			1		
Licensed Psychologist (PHD)	56	4	795	73	1
Speech Therapy Health Service	155	12	1360	19	1
Occupational Therapy Health Services (OTHS)	157	12	880	3	
Licensed Drug & Alcohol Counselor (LDAC)			174		
Board Certified Behavior Analyst (BCBA)			6		
Board Certified Associate Behavioral Analyst (BCABA)					
Registered Behavioral Technician			18		

Appendix 7. SFY22 Medicaid and CHIP Expenditure by Service

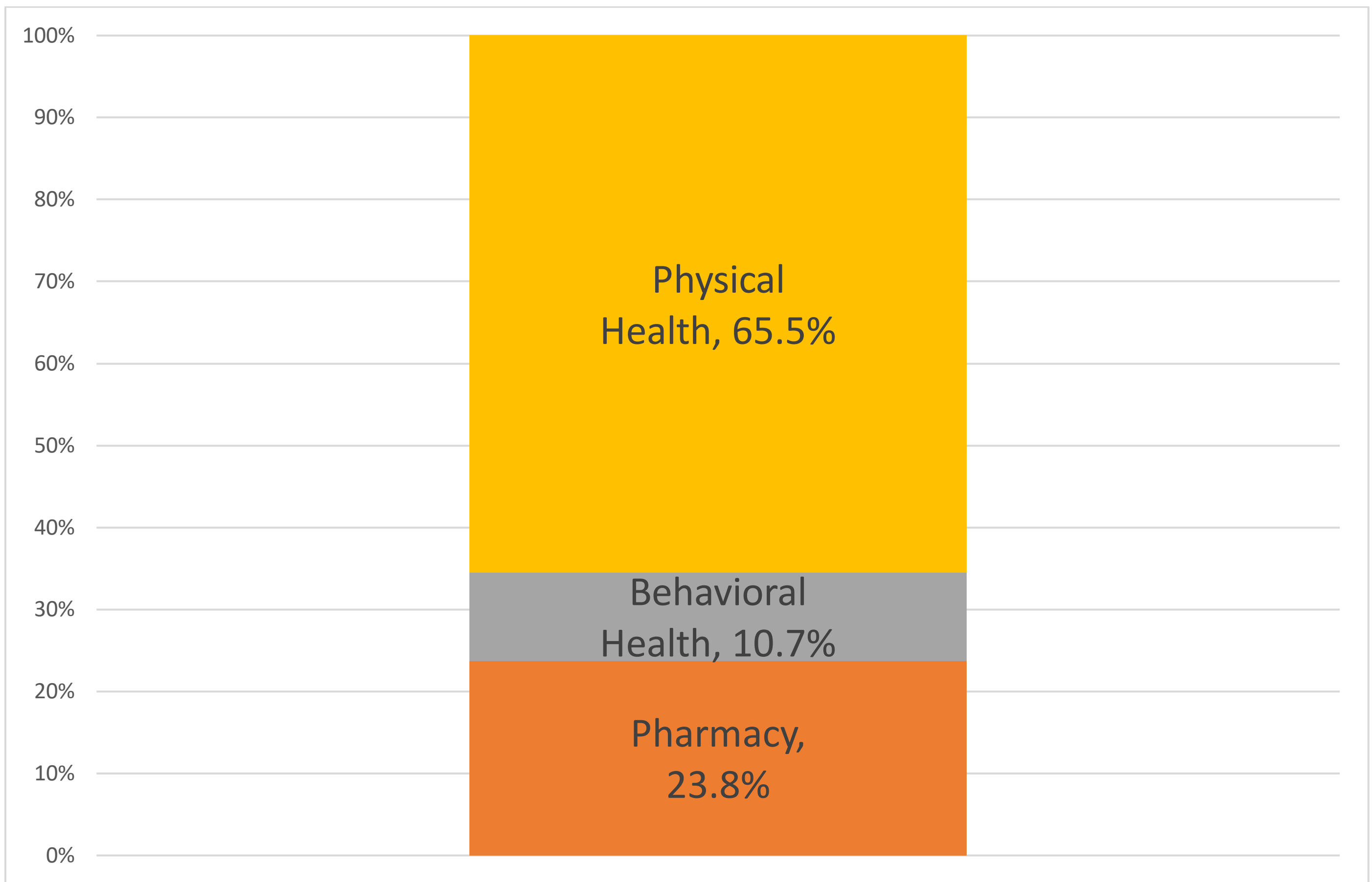
SFY22 Medicaid and CHIP Expenditures by Service

Dental Managed Care Capitation, $78,954,678, 2%
Dental, -$65,036, 0%
Nursing Facilities, $416,685,639, 13%
A&D Waiver Services***, $204,102,915, 6%
DD Waiver Services, $349,748,962, 11%
Other**, $7,946,922, 0%
ICF-DD, $64,965,164, 2%
Home Health/Personal Assistance Services, $10,717,370, 0%
Integrated Care Capitation, $2,230,199,562, 66%

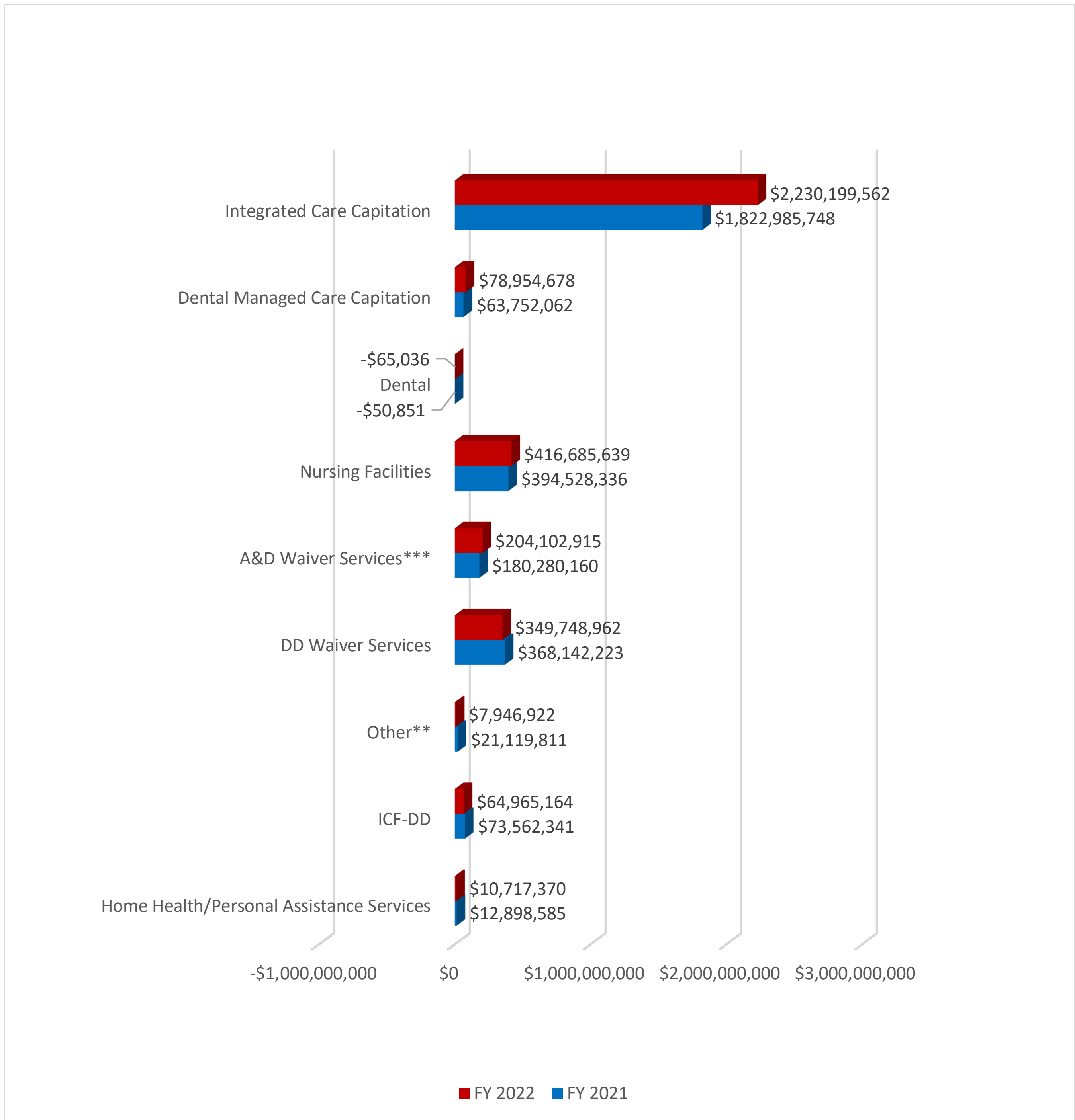
Appendix 8. Percentage of Capitated Health Spend by Service Category



Appendix 9. Heritage Health Medical Services by Relative Cost



Appendix 10. Medicaid and CHIP Expenditures, SFY21 and SFY22



Appendix 11. SFY22 Medicaid Expenditures for Long-Term Care Services