NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

Jim Pillen, Governor

December 1, 2024

The Honorable Jim Pillen
Governor of Nebraska
P.O. Box 94848
Lincoln, NE 68509

Mr. Brandon Metzler
Clerk of the Legislature
P.O. Box 94604
Lincoln, NE 68509

Subject: Nebraska Medicaid Annual Report

Dear Governor Pillen and Mr. Metzler:

In accordance with the Nebraska Revised Statute § 68-908(4), please find the attached report on the state fiscal year Medicaid Annual Report.

We are grateful for our partners in the Nebraska Legislature, communities across the state, and 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 doing its part to improve the lives of the state's Medicaid members.

Sincerely,

Matthew Ahern
Interim Director, Division of Medicaid and Long-Term Care

Attachment

Department of Health and Human Services
Report

NEBRASKA
Good Life. Great Mission.

Division of Medicaid and Long-Term Care

Nebraska Medicaid Annual Report

December 2024

Neb. Rev. Stat. § 68-908

Table of Contents

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 program currently represents a roughly $4 billion investment into the health of our communities – particularly for the over 350,000 Nebraskans who were Medicaid members in the state fiscal year 2024 (SFY24). The program serves low-income children and adults, the aged, and individuals with disabilities. Additionally, approximately 60,000 providers are under contract with Nebraska Medicaid.

The Department integrated dental services into managed care with the new managed care contracts that went into effect January 1, 2024. Integration has improved efficiency and increased access to dental services. Concurrently, the Department has made dental program enhancements to benefit providers in billing and providing care and members in receiving the care needed.

The continuous coverage requirement in effect during the COVID-19 federal Public Health Emergency (PHE) ended on March 31, 2023. In April 2023, Nebraska Medicaid resumed regular eligibility reviews, and Nebraskans, no longer eligible for Medicaid, began to be disenrolled. Medicaid eligibility reviews continued through August 2024**.**

MLTC had great success in executing the unwind process. As of August 2024, 99 percent of Medicaid member cases have been reviewed, with 65 percent of those members remaining enrolled. The Department has seen less than 10% of disenrolled members reapply for Medicaid.

The Department frequently engages with stakeholders, providers, and community members to ensure that Medicaid members know about the ongoing renewal process. The Medicaid unwind website comes complete with resources and monthly data published on the MLTC website at: https://dhhs.ne.gov/Pages/Medicaid-MOE.aspx.

Nebraska Medicaid has made great strides this year, proactively expanding community outreach and engagement. A priority for the program is to continue to ensure that relevant organizations have access to crucial information and points of contact. This outreach has focused on Medicaid members, providers, Tribes, community partners, and advocates. These external relationships enable the program to identify opportunities for improvement and address challenges quickly.

MLTC is a steward for stakeholders and taxpayers by facilitating access to high quality and cost-efficient health care. 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.

Looking forward, MLTC continues plotting its strategic plan for the next several years. The division thanks its many stakeholders and is eager to continue providing the community with comprehensive healthcare and exceptional customer service for 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 18%[1] of Nebraskans.

MLTC has over 650 full-time employees and collaborates with the Office of Economic Assistance (OEA) for Eligibility Operations.

OEA and MLTC merged their Eligibility Operations (EO) staff into a single, unified team within OEA. This change is designed to enhance our service delivery and operational efficiency. The long-term goals for the unified team are:

- Reduce Redundancies;
- Create a Seamless Customer Experience;
- Reduce Administrative Burden; and
- Improve Access.

The decision to merge reflects a commitment to providing the best possible service to Nebraskans and ensuring the most efficient use of resources.

Division Structure

Policy and Plan Management

Policy and Plan Management is responsible for overseeing the Heritage Health managed care program, regulatory compliance, and ensuring compliance with the state and federal authorities under which the Medicaid program operates. This includes proposing updates to the Medicaid state plan and monitoring legislation.

Eligibility Operations

Eligibility Operations is responsible for determining eligibility for Medicaid programs. Eligibility Operations is managed within the Office of Economic Assistance as of September 2024.

Finance and Program Integrity

Finance and Program Integrity is responsible for the financial operations of the division including analysis, planning, budgeting, and reporting. Additionally, the unit is responsible for provider screening and enrollment rates and reimbursement policies as well as fee-for-service (FFS) claims processing. This section is also responsible for monitoring Medicaid provider fraud, waste, and abuse.

[1] Calculated using the SFY 2024 total Medicaid enrollment found in Appendix 3 and US Census population projections.

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 ensures that Medicaid-covered services adhere to evidence-based standards of care.

Population Health

Population Health is responsible for assessing health outcomes across the Medicaid population. Population Health includes medical, behavioral health, pharmacy, dental, long-term care, and home and community-based services.

Communications and Compliance

Communications and Compliance helps members, stakeholders, and the public understand Nebraska Medicaid and the services it provides to Nebraskans. Additionally, this section is primarily responsible for aligning policies, procedures, guidance documents, and other internal and public-facing information to ensure that 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. This system helps members live in a setting of their choice so they can continue to contribute to their community. The State Unit on Aging is managed by the Division of Developmental Disabilities.

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 SFY24:

- 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 before SFY21. However, average enrollment climbed in the past several years due to the launch of Medicaid expansion and Medicaid cases remaining open when the

federal public health emergency (PHE) declaration related to COVID-19 was in place. Resumption of eligibility determinations has decreased average enrollment. Average monthly enrollment decreased by 6%, from 387,311 in SFY23 to 364,255 in SFY24 (see Appendix 2).

Most 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 them with eligibility for state or federal insurance marketplaces. Other Medicaid eligibility groups in the state, such as those who qualify based on age or disability, are subject to different criteria. Tables 1, 2 and 3 explain several Nebraska Medicaid programs and their eligibility requirements.

Table 1. 2024 Federal Poverty Level (FPL) Annual Income Guidelines

Household Size	50% FPL	100% FPL	138% FPL	200% FPL
1	$7,530	$15,060	$20,782	$30,120
2	$10,220	$20,440	$28,207.20	$40,880
3	$12,910	$25,820	$35,631.60	$51,640
4	$15,600	$31,200	$43,056	$62,400
5	$18,290	$36,580	$50,480.40	$73,160
6	$20,980	$41,960	$57,904.80	$83,920
7	$23,670	$47,340	$65,329.20	$94,680

Table 2. 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 age 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	Pregnant women Medicaid eligible through a 60-day postpartum period. Beginning January 1, 2024, the 60-day period will extend to 12 months. There is continuous eligibility for a newborn through the 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

Program	Description	Income Limit
Children's Health Insurance Program (CHIP)	CHIP was created in 1997 under Title XXI of the Social Security Act. In Nebraska, CHIP uses the same delivery system, benefits package, and regulations as Medicaid. Eligible children must be uninsured.	213% of the FPL
599 CHIP	This CHIP program covers prenatal and delivery services for the unborn not yet Medicaid eligible.	197% of the FPL
Heritage Health Adult (Medicaid Expansion)	Adults between ages 19 and 64 who meet income, residency, and citizenship requirements and are ineligible for another Medicaid category.	138% of the FPL

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

Program	Description	Income Limit
Former Foster Care	An individual under twenty-six, was in foster care and receiving Medicaid at age eighteen or nineteen, and ineligible for Medicaid under another program.	No income or resource guidelines; must meet general eligibility requirements (citizenship, residency, etc)
Transitional Medical Assistance (TMA)	12 months of transitional coverage for parent/caretaker relatives no longer Medicaid eligible due to earned income. In the second 6 months, if income is above 100% FPL, family may pay a premium and become Medicaid eligible.	The first six months are without regard to income. The second 6 months, 185% of the FPL
Aged, Blind, and Disabled	Individuals who 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	Individuals with medical needs and exceed income requirements for other Medicaid categories. This category allows individuals to obligate their income above the standard on their 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 working but need their Medicaid coverage to enable them to work.	200% of the FPL Between 200% FPL and 250%, they must pay a premium.

Program	Description	Income Limit
Katie Beckett	Are aged 18 or younger with severe disabilities who live with their parent(s), but who would otherwise require hospitalization or institutionalization due to their high level of healthcare needs.	The parent's income is waived under the Tax Equity and Fiscal Responsibility Act (TEFRA.)
Breast and Cervical Cancer	Women who were screened for breast or cervical cancer by the Every Women Matters Program and found in need of care.	Women are below 225% FPL using EWM criteria.
Emergency Medical Services for Aliens	Individuals are ineligible due to citizenship or immigration status and have a condition requiring emergency medical care (including emergency labor and delivery).	Income and resources vary depending on the category of eligibility
Subsidized Adoption	Children under 18 with an adoption assistance agreement in effect or with foster care maintenance payments made under Title IV-E of the Act - A medical review is required for non IV-E.	No income or resource guidelines.
Subsidized Guardianship	Children under 18 for whom kinship guardianship assistance maintenance payments are made under Title IV-E of the Act.	No income or resource guidelines.

The adult category continues to show the most significant change year over year in total number of eligible individuals, decreasing by 10 percent from SFY23 to SFY24 due to the impact of unwinding the PHE and resuming eligibility determinations. The Aged, Blind, and Disabled categories saw a slight increase: a 1 percent increase for Aged and a 2 percent increase for Blind & Disabled. Children's enrollment also increased by 7 percent. Overall, enrollment decreased by 20 percent due resuming normal eligibility operations and renewals.

Appendices 4 and 5 compare the cost of different eligibility categories. While the Aged and the Blind & Disabled categories represent 15.5 percent of members, they account for 48.6 percent of expenditures. In contrast, children account for 49.2 percent of members but only 18.2 percent of expenditures. Further cost-per-enrollee details are included in Appendix 4.

Appendix 5 does not account for all Medicaid and CHIP expenditures, partly because some payments and refunds are not specific to a recipient or eligibility category. Examples of transactions not included are drug rebate payments made outside the Medicaid Management Information System (MMIS)[2], and premium payments paid on behalf of persons eligible for Medicare. Beneficiary demographic data is not available for these expenditures. This means some expenditures, particularly in the Aged and the Blind & Disabled categories, are understated.

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

Nebraska Annual Summary

Following are the Nebraska Medicaid annual summary data for state fiscal year (SFY) 2024.

Nebraska Medicaid received a total of 159,549 initial applications for eligibility with 86,911 approved applications and 72,638 denied applications.

Nebraska Medicaid completed 331,522 eligibility determinations, also known as Medicaid renewals, with 221,013 members retaining eligibility and 110,509 members losing eligibility (case closures). Please reference appendix 6 for the specific reasons for the case closure broken down by eligibility category, race/ethnicity, gender, age, county classification, and local health district.

Nebraska Medicaid had 465,349 enrollees, representing the unique number of members with Medicaid eligibility for at least one month between July 2023 and June 2024. Please reference appendix 6 for enrollment broken down by eligibility category, race/ethnicity, gender, age, county classification, and local health district.

DHHS estimates that Nebraska Medicaid had an average ex parte rate of 40% for renewals. DHHS is only able to the average ex parte rate at this time as the information captured in the Medicaid eligibility system provides a proxy for whether a renewal was completed ex parte. DHHS is federally required to implement the necessary system changes to comply with ex parte requirements by December 2026 and will provide the requested information once the system changes are implemented.

Nebraska Medicaid's median processing days for MAGI and Non-MAGI initial applications was six and seven days respectively.

Of the 110,509 Nebraska Medicaid members who lost Medicaid coverage, 8,616 (7%) member regained coverage with 4,775 (4%) regaining coverage within ninety (90) days and 3,841 (3%) regaining coverage within twelve (12) months. Please reference appendix 6 for members who regained coverage within ninety (90) days and twelve (12 months) broken down by eligibility category, race/ethnicity, gender, age, county classification, and local health district.

Nebraska Medicaid received a total of 432,932 client calls and answered 389,912 (90%) with 42,221 (10%) abandoned calls. The average client call duration was 18 minutes, and the average client call wait time was three minutes.

Nebraska Medicaid received 216 fair hearing requests for Medicaid eligibility and State Review Team (SRT) disability related determinations. For requests resulting in a dismissal and affirmation the average days from receipt of the fair hearing request until final disposition was 29 days and 67 days respectively. Please note that for SFY 2024 DHHS did not capture and

maintain the information necessary to report breakouts by eligibility category. Starting with SFY 2025 DHHS will provide breakouts by eligibility category.

DHHS created a new web page on the department's website that includes the Nebraska Medicaid's program fair hearing decisions that have been redacted to protect private and health information; https://dhhs.ne.gov/Pages/Medicaid-Fair-Hearing-Decisions.aspx.

Benefits Package

Federal Medicaid statutes mandate that states provide certain services, while also allowing states the option to provide additional services. The Nebraska Medical Assistance Act (68-901 to 68-975) and the Medicaid State Plan outline the mandatory and optional services available to Medicaid and CHIP recipients in Nebraska. These mandatory and optional services are noted below in Table 4.

Table 4. Federal Medicaid Mandatory and Optional Services Covered in Nebraska

Mandatory Services	
Certified Pediatric and Family Nurse Practitioner Services	Medical Transportation Services
Family Planning Services	Nurse Midwife Services
Freestanding Birth Center Services (when licensed or otherwise recognized by the state)	Nursing Facility Services
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT, Health Check)	Physician Services
Home Health Agency Services	Services Provided by Clinics • Rural Health Clinics • Federally Qualified Health Centers (FQHC)
Hospital Services • Inpatient • Outpatient	Tobacco Cessation Counseling for Pregnant Women
Laboratory and Radiology (X-ray) Services	
Optional Services	
Ambulance Services	Podiatry Services
Chiropractic Services	Prescribed Drugs
Dental Services	Private-Duty Nursing Services
Durable Medical Equipment, Orthotics, Prosthetics, and Medical Supplies	Adult Psychiatric, Substance Use Disorder, and Medicaid Rehabilitation
Hearing Aid Services	Screening Services (Mammograms)

Optional Services	
Hospice Services	Services Provided by Clinics • Community Mental Health Centers • Indian Health Service (IHS) Facilities
Intermediate Care Facilities for Persons with Intellectual Disabilities (ICF/DD) Services	Therapies • Physical • Occupational • Speech Pathology • Audiology
Mental Health and Substance Abuse Services for Children and Adolescents (aged 0-20)	Vision Care Services
Nurse Practitioner Services	

Nebraska Medicaid evaluates covered services to ensure that comprehensive healthcare services are provided to Nebraskans as efficiently as possible, aligning with best medical practices. The division collaborates with sister divisions, providers, beneficiaries, managed care partners, and other stakeholders to identify potential service gaps and policy implications. Through these evaluations and legislative mandates, Nebraska Medicaid has made programmatic changes in SFY24 to the service array:

Extended Postpartum Coverage and Extended Continuous Eligibility for Children

Effective January 1, 2024, Medicaid extended the continuous postpartum coverage for individuals who received Medicaid while they were pregnant. This extended the postpartum period from 60 days to 12 months.

Also, effective January 1, 2024, the continuous eligibility period for children enrolled in Medicaid and CHIP was extended from 6 months to 12 months. Children born to mothers covered by Medicaid or CHIP continue to receive one full year of continuous eligibility.

Katie Beckett

On March 29, 2024, Governor Pillen announced activities to eliminate the Developmental Disabilities (DD) Registry. The registry served as a waitlist for individuals to be enrolled in the Comprehensive DD waiver program, but could not be enrolled due to limited funding. Nebraska MLTC worked extensively with the Division of Developmental Disabilities to identify children on the DD Registry that may be eligible for Medicaid through the expansion of the Katie Beckett program and began enrolling children in July 2024.

Prenatal Plus Program

Nebraska has submitted a state plan amendment to create the Nebraska Prenatal Plus Program as a result of the passage of LB857 (2023). The Prenatal Plus Program will target pregnant individuals who are determined by a health care provider to be at risk of having a negative maternal or infant health outcome by offering targeted case management, nutrition counseling, psychosocial counseling and support, general client education and health promotion, and breastfeeding support. This program will be implemented January 1, 2025.

Therapeutic Family Care

Nebraska has submitted a state plan amendment to create the Therapeutic Family Care program. Nebraska's Therapeutic Family Care (TFC) program will serve Medicaid eligible children up to age 19 who are at the intensive plus or specialized level of foster care and meet additional needs-based criteria. Services for youth in the TFC program include crisis services maintenance and response and mobile crisis.

Justice Involved Youth

The Consolidated Appropriations Act, 2023 (CAA), Section 5121, requires Medicaid and CHIP programs to have a plan in place and in accordance with such plan, to provide within 30 days of an eligible juvenile being released from incarceration screening and diagnostic services as well as targeted case management services, including referrals to the appropriate care and services available near their home or residence, both in the 30-day period before and after release. These requirements go into effect on January 1, 2025.

MLTC is focused on developing its implementation plan for Sec. 5121. Included in this plan are State Plan and Managed Care Organizations (MCOs) contract amendments, technology system enhancements, and new provider payment methodologies, among other components. State staff are meeting with representatives from CMS in order to communicate the state's readiness to implement Sec. 5121. Similarly, MLTC is developing a survey to send to carceral facilities across Nebraska to help the Medicaid program plan for implementation. The goal of this initiative is to help justice-involved youth return from incarceration healthier and better able to participate in their communities.

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. MCOs are responsible for managing and providing specific Medicaid-covered services and use population health and care management strategies to manage their member population in quality and cost-conscious manners. Nationally, 41 other states (including the District of Columbia) contract similarly with MCOs to cover Medicaid services using a managed care delivery system.

Nebraskans on Medicaid receive physical health, behavioral health, dental services, and pharmacy benefits under Heritage Health. In SFY24, three MCOs provided healthcare services to Medicaid members: Nebraska Total Care, UnitedHealthcare Community Plan, and Molina Healthcare.

Nebraska integrated dental services into managed care and made significant changes to the dental program. Dental services were previously carved into managed care through a prepaid ambulatory health plan (PAHP) with 1915(b) authority; however, Nebraska received federal approval for managed care integration in November 2023 for January 2024 implementation. These changes increased efficiency for dental providers and increased access to care for Medicaid members.

The changes to the dental program that went into effect on January 1, 2024:

- Removal of the $750 annual adult benefit maximum (ABM);
- Incremental payments for dentures;
- Asymptomatic wisdom tooth extraction; and
- Expanded services provided by Public Health Dental Hygienists.

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.

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

These performance metrics include:

- Member engagement;
- Provider engagement;
- Network adequacy;
- Claims adjudication;
- Care management;
- Quality of care;
- Utilization management; and
- Financials.

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

Medicaid members enrolled in home and community-based waiver programs and those living in long-term care settings such as nursing homes or intermediate care facilities (ICF) still have certain services provided via fee-for-service (FFS). While physical and behavioral health and pharmacy services are delivered through the Heritage Health MCOs, the management and reimbursement of all Medicaid long-term services and supports (LTSS) remain FFS in Nebraska Medicaid.

Quality Measurement and Performance

Nebraska Medicaid utilizes a variety of national quality measures to assess program success. These measure sets include:

- Centers for Medicare and Medicaid Services (CMS) Adult Core Set;
- CMS Child Core Set, Consumer Assessment of Healthcare Providers and Systems (CAHPS®);
- Healthcare Effectiveness Data and Information Set (HEDIS®); and
- Dental Quality Alliance (DQA).

These quality measurement sets allow Nebraska Medicaid to compare the program and individual MCOs to their respective peers across the nation, as well as give insight into beneficiary experiences. All the quality measurement sets come from external measure stewards and are curated by the their respective organizations. The CMS Adult and Child Core Sets and CAHPS survey are required reporting by CMS, the HEDIS measures are required as part of the MCO's accreditation, and the DQA measures are considered best practice measurements for dental services.

Below in Tables 5 and 6 are a selected set of measures that generally align with either the Nebraska Medicaid Quality Strategy or with other current initiatives. All measures are annually collected either from the CAHPS survey or from the HEDIS measures. The CAHPS survey allows Nebraska Medicaid to assess beneficiary satisfaction while the HEDIS measures primarily measure the MCOs and, by extension of the vast majority of beneficiaries receiving services via managed care, the overall program.

Table 5. CAHPS Survey, 2023

CAHPS Child Survey	**2023 Statewide***
Getting Needed Care (Usually + Always)	87.8%
Getting Care Quickly (Usually + Always)	89.2%
Health Plan Customer Service (Usually + Always)	87.6%
Rating of All Health Care (9 + 10)	71.9%
Rating of Health Plan (9 + 10)	72.6%
CAHPS Adult Survey	**2023 Statewide***
Getting Needed Care (Usually + Always)	86.1%
Getting Care Quickly (Usually + Always)	85.4%
Health Plan Customer Service (Usually + Always)	88.1%
Rating of All Health Care (9 + 10)	58.6%
Rating of Health Plan (9 + 10)	65.2%
*These metrics include only UHC and NTC	

Table 6. Quality Measures, 2023

Quality Metrics Maternal Health	2023
Prenatal and Postpartum Care: All Ages - Timeliness of Prenatal Care (PPC): The percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in Medicaid/CHIP.	82.3%
Prenatal and Postpartum Care: All Ages - Postpartum Care (PPC): The percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year that had a postpartum visit on or between 7 and 84 days after delivery.	78.2%
Quality Metrics Child	**2023**
Well-Child Visits in the First 30 Months of Life: Well-Child Visits in the First 15 Months (W30): The percentage of children who had six or more well-child visits with a primary care practitioner (PCP) during the last 15 months.	67.6%
Well-Child Visits in the First 30 Months of Life: Well-Child Visits for Age 15 Months–30 Months (W30): The percentage of children who had two or more well-child visits with a primary care practitioner (PCP) during the last 15 months.	70.8%
Child and Adolescent Well-Care Visits (WCV): The percentage of adolescents ages 12-17 who had at least one comprehensive well-care visit with a primary care practitioner (PCP) or an obstetrician/gynecologist (OB/GYN) during the measurement year.	55.1%
Immunizations: Combo 10 in Children (CIS): The percentage of children 2 years of age who had a four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.	42.2%
Immunizations: Combo 2 in Adolescents (IMA): The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series (i.e., at least two doses) by their 13th birthday	32.0%
Oral Evaluation, Dental Services (OEV): The percentage of children under age 21 who received a comprehensive or periodic oral evaluation within the measurement year.	48.2%
Lead Screening in Children (LSC): The percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.	70.8%

Follow-up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD): The percentage of children ages 6 to 12 newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Initiation Phase: Beneficiaries receiving a follow up visit with a prescribing provider within 30 days of receiving their medication	45.9%
Follow-up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD): The percentage of children ages 6 to 12 newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Continuation and Maintenance Phase: Beneficiaries who continue taking ADHD medication during the nine months after the initiation phase and receiving two additional follow up visits within those nine months	52.0%
Quality Metrics Adult	**2023**
Controlling High Blood Pressure (CBP): The percentage of beneficiaries ages 18 to 85 who had a diagnosis of hypertension and whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement year.	65.9%
Hemoglobin A1c Control for Patients with Diabetes (HBD): The percentage of beneficiaries ages 18 to 75 with diabetes (type 1 and type 2) whose hemoglobin A1c (HbA1c) level was at <8.0%.	60.0%
Breast Cancer Screening (BCS): The percentage of women ages 50 to 74 who had a mammogram to screen for breast cancer.	53.8%
Follow-Up After Hospitalization for Mental Illness - Total Ages 6 and Older (FUH): The percentage of discharges for beneficiaries age 6 and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider. 30 Day Follow-Up	63.8%
Follow-Up After Emergency Department Visit for Mental Illness - Total Ages 6 and Older (FUM): The percentage of emergency department (ED) visits for beneficiaries age 6 and older with a principal diagnosis of mental illness or intentional self-harm and who had a follow-up visit for mental illness. 30 Day Follow-Up	58.3%
Plan All-Cause Readmissions: Observed Readmission Rate (PCR): For beneficiaries ages 18 to 64, the rate of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days.	9.9%

Providers

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

In October 2024, there were 60,150 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 7.

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 services;
- Federally qualified health centers (FQHCs) are reimbursed via the alternative payment methodology;
- Rural health clinics (RHCs) are reimbursed their cost directly or at 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 at 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.

As specified in Table 7 below, Medicaid rates saw an across-the-board increase of 3 percent in FY 2024-25. In FY 2025-26, rates will remain the same and will see no increase.

Each MCO 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 to 2.25% to a maximum of 100% of Medicare rates as of January 1, 2013.
2014	Rates increased to 2.25% to a maximum of 100% of Medicare rates as of January 1, 2014.

SFY	Rate Increase
2015	Rates increased 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 to 2% to a maximum of 100% of Medicare rates.
2016	Rates increased 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 to 2% to a maximum of 100% of Medicare rates.
2017	Rates increased 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 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.
2023	Rates for the majority Medicaid services increased by 2.0%. Rates for Dental services increased by 10%. Rates for Behavioral Health services increased by 17%. Nursing Facilities also received a specified appropriation increase of $73.19 Million for increasing rates and utilization changes.
2024	Rates for Medicaid services increased by 3.0%

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, varying from 52.5 percent to 82.86 percent. Nebraska's FMAP in federal fiscal year (FFY) 2024 was 58.60 percent for Medicaid and 71.02 percent for CHIP. Table 8 shows the FMAP for Medicaid and CHIP for FFY16 through FFY25.

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%
FFY24	58.60%	71.02%
FFY25	57.52%	70.26%

Total SFY24 vendor payments for Medicaid and CHIP expenditures were $4,060,277,348. This includes the cost of drugs, inpatient and outpatient hospital care, payments to physicians and practitioners, and early and periodic screening, diagnostic, and treatment (EPSDT). A&D Waiver includes $328,983,450 of expenditures, a 23.2 percent increase from SFY23. 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 8 shows the expenditure distribution to vendors arranged by service type.

Not all Medicaid and CHIP expenditures have been detailed in Appendix 8. 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 SFY24, Medicaid received $378.7 million in drug rebates, a 16.9 percent increase from the $323.9 million in rebates received in SFY23;
- Disproportionate share hospital (DSH) payments are additional payments to hospitals serving many Medicaid and uninsured patients. In SFY24, Medicaid paid $205.7 million through the DSH program, a 97.8 percent increase compared to $104 million paid in SFY23;
- Medicaid pays the Medicare Part B premium for beneficiaries that are dually eligible for Medicare and Medicaid. In SFY24, Medicaid paid $77,191,034 for Medicare premiums, a 0.5 percent decrease from the $77,610,719 for Medicare premiums paid in SFY23; and
- Medicare Part D Phased-Down state contributions (“clawback”) are required monthly payments to CMS for each person dually eligible for Medicare and Medicaid. Funding for this comes entirely from state general funds, and 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 SFY24, clawback payments totaled $83,850,977, a 25.3 percent increase from the $66,926,324 paid in SFY23. 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 8, most of MLTC's expenditures come in the form of capitation payments for managed care. Appendices 9 and 10 note the relative cost of services covered via capitated managed care.

Appendix 11 compares vendor expenditures from SFY23 and SFY24.

Long-Term Care Services

Long-term care (LTC) services support individuals with chronic or ongoing health needs related to age or disability. In SFY24, Medicaid expenditures for LTC services totaled $852,285,305, an increase of 7 percent from SFY23, $794,949,381. 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 support or nursing facilities. Home and community-based care is generally 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 promote home and community-based alternatives to facility care are resulting in a gradual rebalancing of LTC expenditures.

Table 9 below defines the LTC service categories. Appendix 12 shows the cost of Medicaid expenditures for LTC services.

Table 9. Definitions of Long-Term Care Service Expenditure Categories

Category	Definition
Nursing Facility	Payment made to nursing facility services for aged and disabled Medicaid-eligible members.
ICF-DD	Payment made to intermediate care facility services for intellectually and developmentally disabled Medicaid-eligible members.
DD Waivers	Payment made for an array of home and community-based services for intellectually and developmentally disabled Medicaid-eligible members; Medicaid offers three 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 members 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 members to support living independently in their own home.

Category	Definition
Waiver Assisted Living	Payment made for the assisted living service within the Aged and Disabled waiver, payment allows members 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

On January 1, 2024, the new contracts for Nebraska Medicaid's capitated managed care program went into effect. Nebraska Medicaid chose Molina Healthcare, Nebraska Total Care, and UnitedHealthcare to provide services to Nebraskans for the next five years.

There are several new changes to highlight with the new contracts:

- Health plans are responsible for covering dental services, and the dental benefit maximum of $750 was removed.
- Health plans will standardize provider credentialing across health plans to reduce the administrative burden on providers.
- New contracts focus on improving access to providers across Nebraska, specifically for dental and behavioral healthcare.
- Requirement that all MCOs must have a Highly Integrated Dual Eligible Special Needs Plan (HIDE-SNP) in place no later than January 1, 2024.

The addition of a HIDE-SNP Plan is new to Nebraska Medicaid. A HIDE-SNP is a type of Medicare Advantage plan that provides coordinated coverage for members that have both Medicare and Medicaid. The HIDE-SNP in Nebraska includes the integration of behavioral health benefits with physical health. In addition, HIDE-SNPs may provide coverage for additional benefits like dental, vision, hearing, and prescriptions, with $0 copays on primary care providers, specialists, and emergency room visits. Through these plans, Nebraskans are provided care coordination leading to better health outcomes.

Community Outreach and Engagement

Nebraska Medicaid continuously engages with providers, members, and community partners to ensure that Nebraskans understand the services provided by the Medicaid program.

In addition to weekly and monthly communication efforts, Nebraska Medicaid hosted two separate listening tours throughout the fall of 2023 and spring of 2024. These two tours visited the cities of Lincoln, Omaha, Scottsbluff, Grand Island, Santee, Red Cloud, McCook, Ogallala, Broken Bow, Beatrice, North Platte, Sidney, Alliance, Ord, and South Sioux City. Multiple virtual listening sessions were offered as well.

The first tour focused on the upcoming managed care and policy changes for calendar year 2024, providing community members the opportunity to ask questions about their Medicaid program changes

and what it means for them and their families. The program changes were made based on previous feedback received from stakeholders and bringing the upcoming changes directly to the communities helped ensure proper education prior to the changes.

The second tour centered on the end of the PHE unwind, reviewing changes to the Medicaid program that occurred at the beginning of the calendar year, and sharing information regarding current projects for improving the Medicaid program. Resources were provided during these meetings, as well as during additional engagement sessions with communities.

Medicaid Advisory Committee (MAC)

In April 2024, the Centers for Medicare and Medicaid Services (CMS) finalized its Managed Care and Access final rules. The Access final rule established a new requirement that states establish a Medicaid Advisory Committee (MAC), replacing the existing Medical Care Advisory Committee (MCAC). One main purpose of the final rule in establishing the MAC is to expand the scope of the Committee's advisory role beyond health and medical care to include a broad range of topics such as access to and quality of services, eligibility and enrollment processes, health related social needs, program communications, and other issues that impact the provision or outcomes of health and medical services. In addition to this, the Access final rule also requires states to establish a new Beneficiary Advisory Council (BAC) which would be comprised exclusively of Medicaid enrollees and their family members or caregivers. The BAC would identify key issues to bring to the MAC, in addition to advising the state directly on Medicaid policy and administration. The requirements for the MAC and the BAC are required to be in effect by July 2025.

Since CMS published the Access final rule, Medicaid has worked with the MCAC to transition the group to meet the requirements of the MAC. The Committee has continued its regular meetings amidst these ongoing efforts and is still composed of providers, members, and member representatives. During these meetings, committee members discuss the status of Medicaid for Nebraskans and consult representatives from Nebraska Medicaid. During 2024, the committee has continued to advise the Medicaid agency regarding key topics on which they are interested in advocating. The group has established subcommittees to discuss maternal health, dental care, and access to waiver services.

Tribal Health Outreach

Nebraska Medicaid continues prioritizing its work with Native American Medicaid members, tribal providers, the Indian Health Service (IHS), and other related stakeholders. Medicaid's team has collaborated during monthly and quarterly meetings to ensure tribal providers are well-equipped to serve their communities. These meetings serve as a forum for Medicaid to engage in meaningful consultation with the Tribes and tribal stakeholders, and where tribal providers can receive clarification and assistance on day-to-day problems, such as issues with billing for services. These meetings have allowed Medicaid to share information on CMS initiatives.

Medicaid continues to build on its partnership with the Tribes and IHS/Tribal providers and to develop new informational resources to help assist tribal providers. In 2024, Medicaid worked collaboratively with the Tribes and MCOs to develop billing processes and a corresponding guidance document related to changes in the billing and reimbursement of dental services now covered under the three MCOs. Web pages developed in 2021 continue to be expanded to ensure that tribal providers serving tribal Medicaid

beneficiaries are accurately represented and have access to the resources they need.

iServe Nebraska

During the 2024 fiscal year, iServe Nebraska made great strides towards developing and releasing new, beneficiary facing functionality in addition to providing ongoing maintenance and production support to the integrated benefits application. Since its release in October of 2023, 138,343 initial integrated benefits applications have been received with a less than 1% incompletion rate. The PIN Validation and Recovery features aid Nebraskans in accessing their required PIN and the Preferences feature allows Nebraskans to change their contact preferences - USPS, phone, text, and email - using their iServe account. Released in July 2024, the Client Benefit Inquiry (CBI) dashboard has resulted in 143,733 unique sessions to date, allowing Nebraskans to use their iServe account to better access their personal contact information, check their benefits status, view received correspondence, and review items they may need to take timely action on. Additionally, the Economic Assistance Review and Recertification process was fully brought online - and mobile friendly - complete with a saved draft option. Nebraskans have submitted 6,658 benefits recertifications since April 2024 with a less than 1% incompletion rate. 66% of the submitted certifications were made using a mobile device.

Robotic Process Automation

In 2023, the Division of Medicaid and Long-Term Care launched a Robotic Process Automation (RPA) initiative aimed at improving efficiency and accuracy in Medicaid eligibility and enrollment tasks. By leveraging automation, the RPA team has successfully reduced or eliminated repetitive tasks such as manual case assignments, SSI desk reviews, and high-priority alerts. This strategic use of automation has significantly decreased the manual workload for Eligibility Operations staff in areas where bots have been deployed, allowing them to focus on more complex, value-driven tasks that enhance overall service quality for Medicaid beneficiaries.

As of October 2024, RPA implementations are projected to save over 14,000 staff hours annually, with additional bots under development to further streamline operations. The initiative continues to identify new opportunities for automation, further supporting the division’s mission to deliver timely and accurate services.

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. With the funding, Medicaid and other DHHS agencies have 26 initiatives, seven of which are completed. These initiatives have assisted in bringing investments to HCBS through one-time grants, enhancement programs, training programs, rate studies, assessment tools, and service expansion programs.

More information can be found in Medicaid’s HCBS Spend Plan quarterly reports and on the Medicaid Providers website: https://dhhs.ne.gov/Pages/Medicaid-Providers.aspx

Conclusion

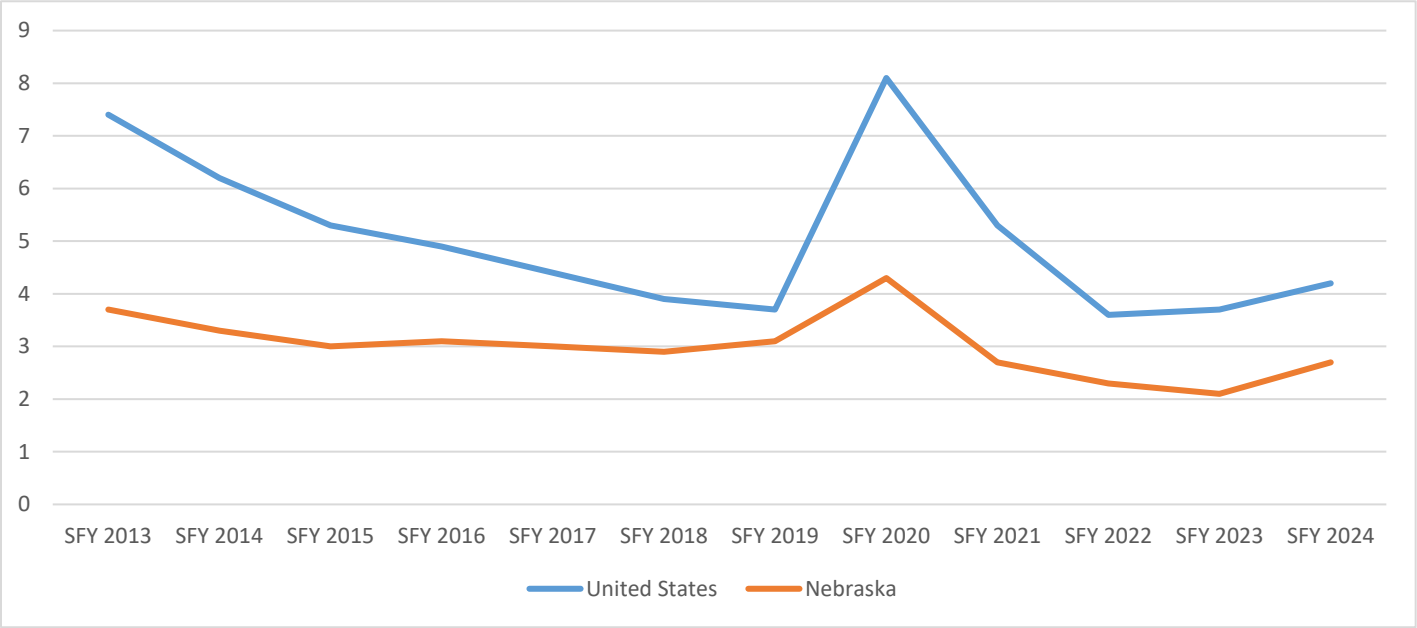
Nebraska Medicaid takes its role in supporting the delivery of quality health care to Nebraskans in need seriously. To meet this commitment to all of Medicaid's stakeholders, including beneficiaries, providers, and taxpayers, the State Medicaid agency focuses on improving all aspects of operations.

From the expanded community outreach and continued success of popular initiatives, there are many examples of Medicaid's purposeful efforts to align the division's actions with its role. Upcoming initiatives ensure MLTC is positioning itself strategically to improve customer services, the delivery system, and processes in the future.

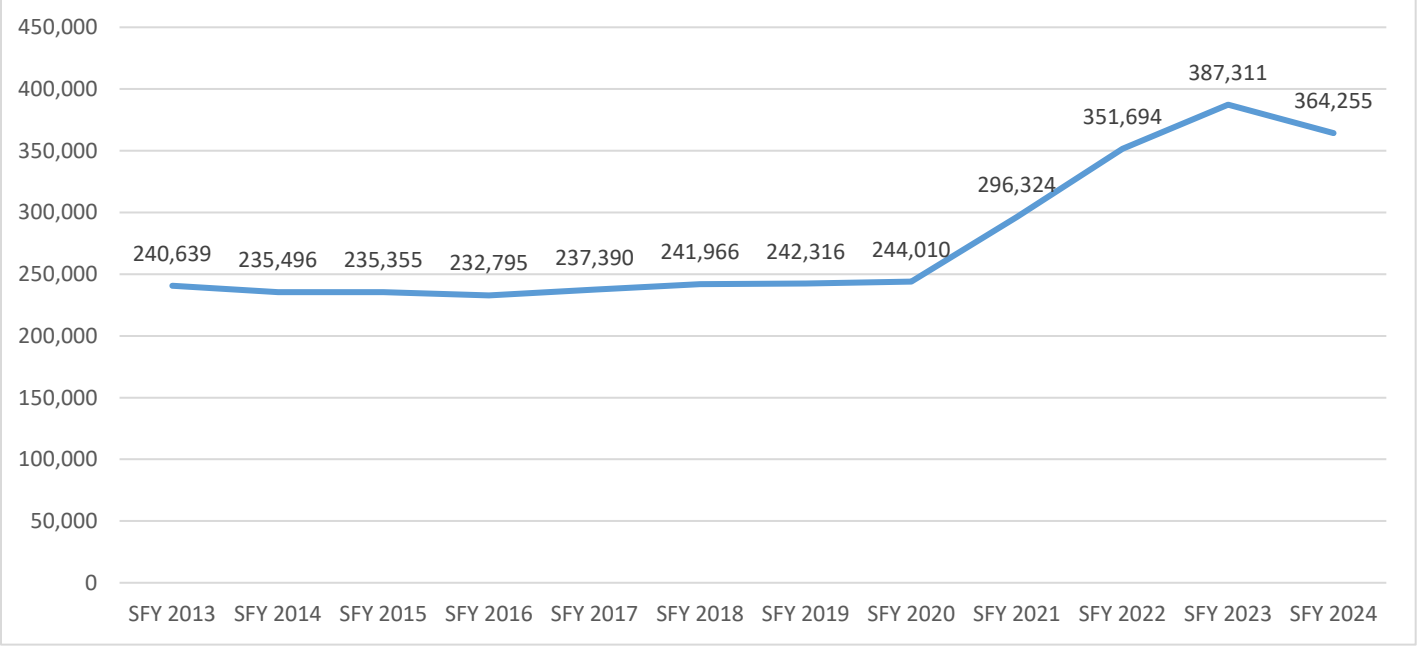
Additionally, there are upcoming challenges that the program will need to overcome. As we continue to complete the ongoing projects, regulation and policy updates, and programmatic improvements, the increased workload for eligibility operations and programs will impact staffing capacity throughout the division. Continued collaboration with community partners and stakeholders will be essential as we continue to ensure members receive needed services.

Appendix

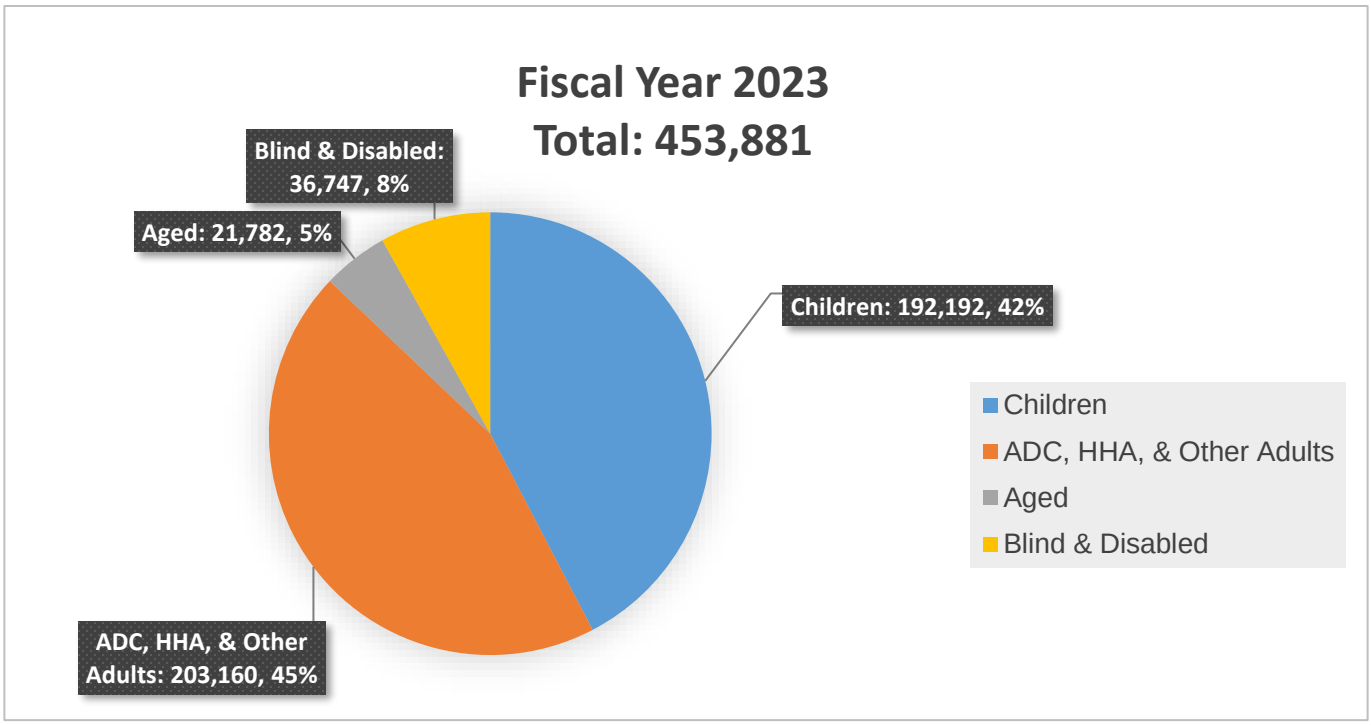
Appendix 1. Average Unemployment Levels by State Fiscal Year (SFY)

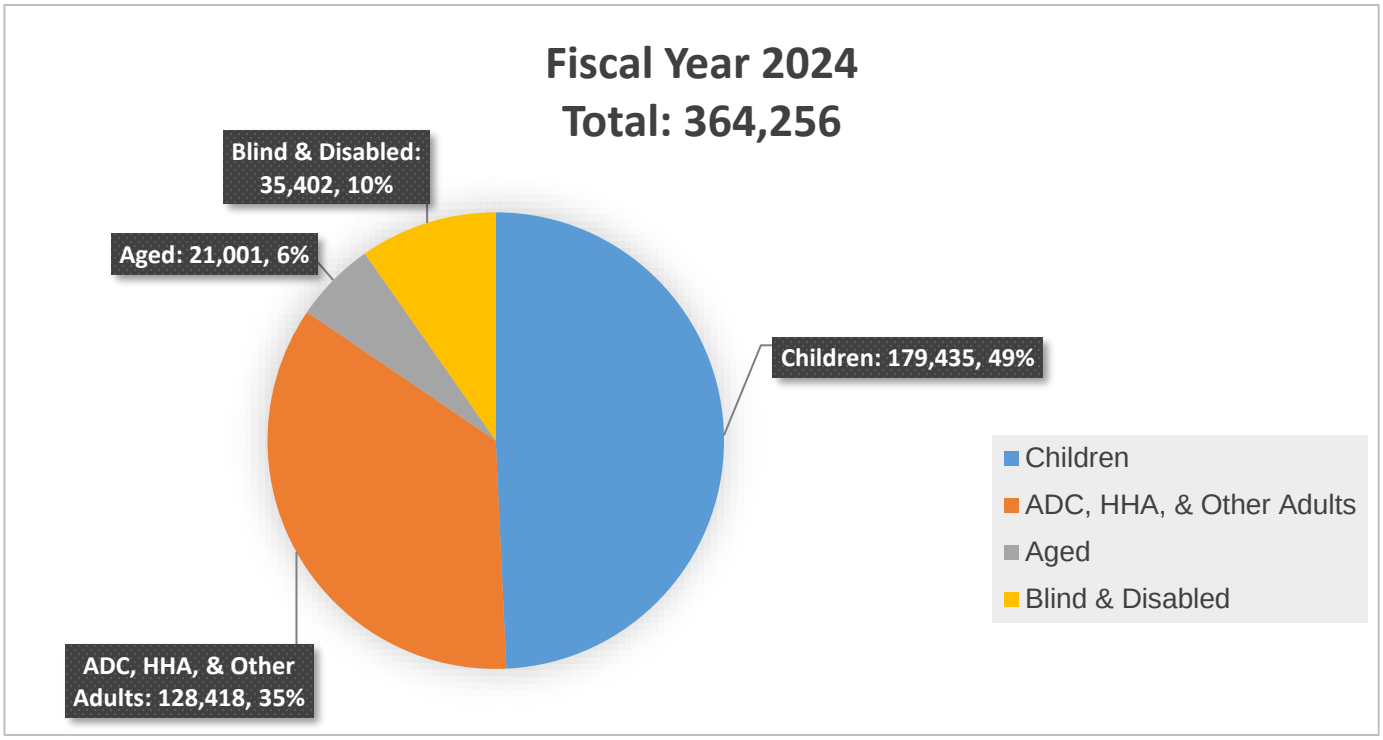


Appendix 2. Average Monthly Nebraska Medicaid Members by State Fiscal Year (SFY)

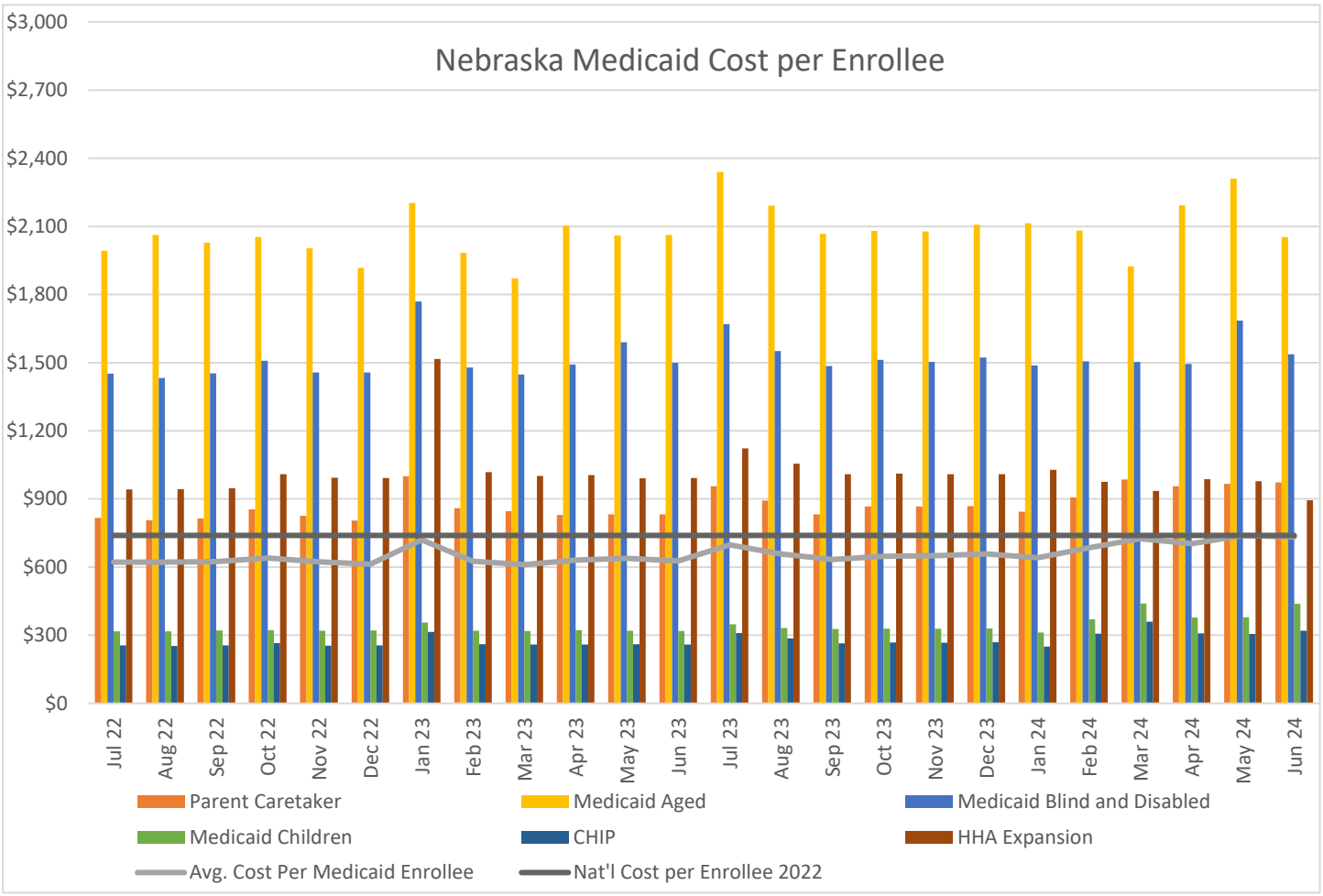


Appendix 3. Average Nebraska Monthly Enrollment for Medicaid and CHIP by Category, SFY23 AND SFY24

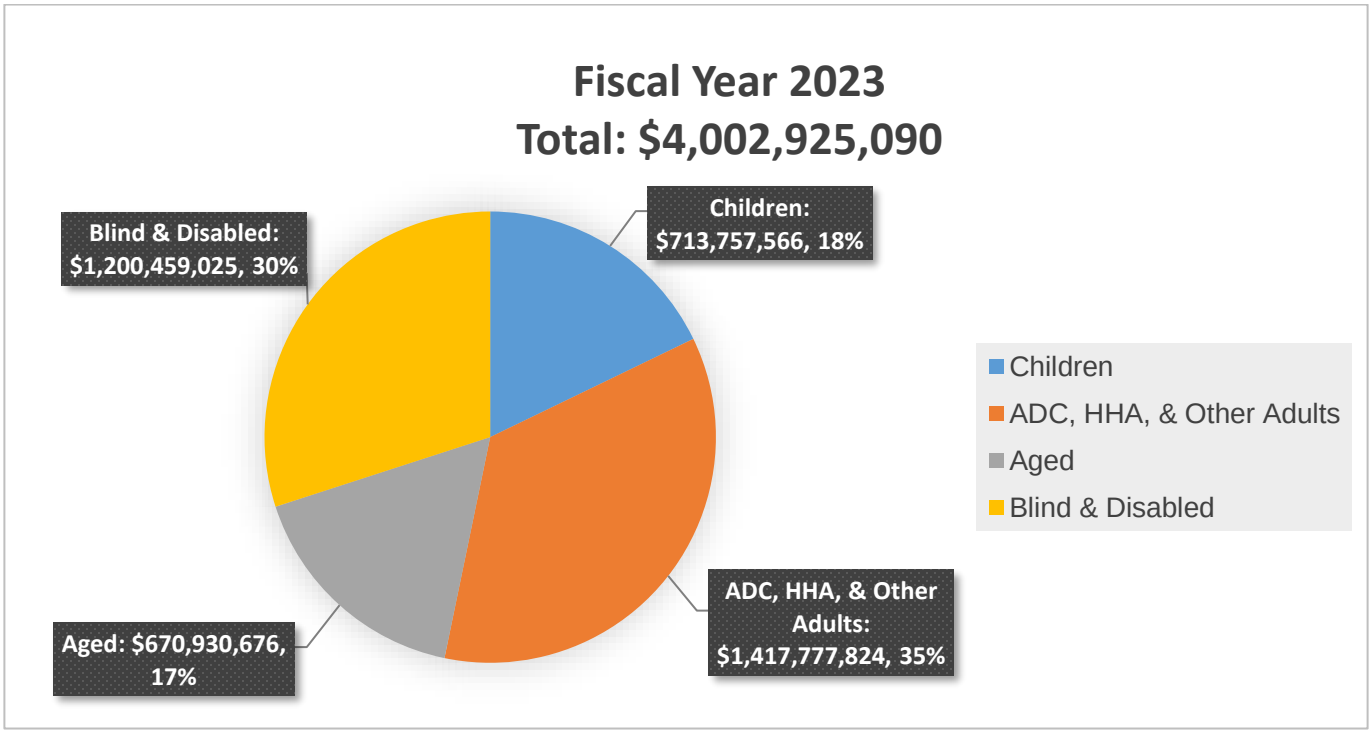


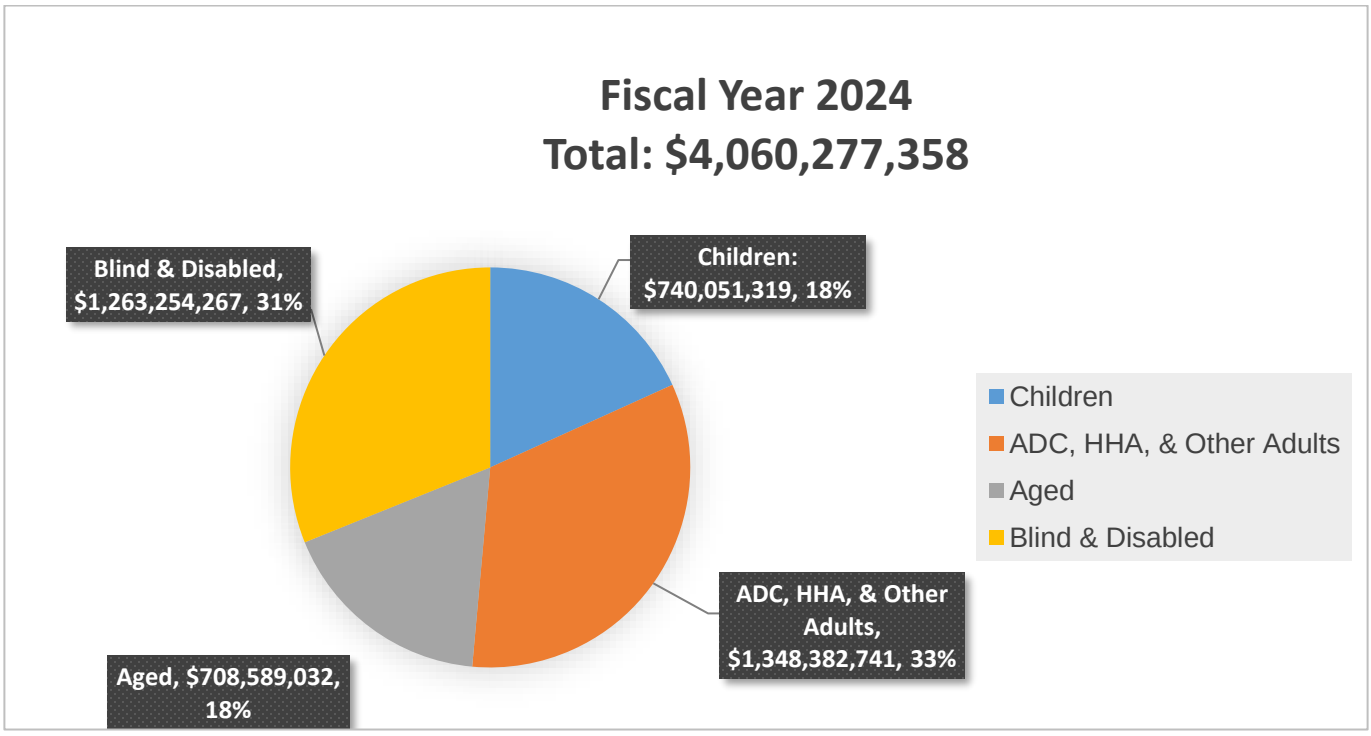


Appendix 4. Nebraska Medicaid Average Cost per Enrollee



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

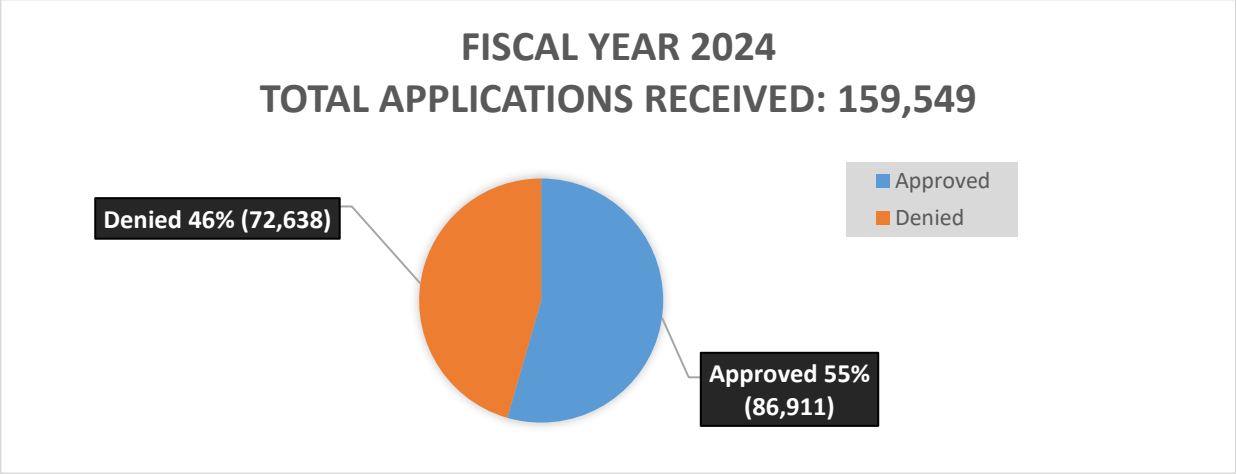




Appendix 6. Nebraska Medicaid Annual Summary

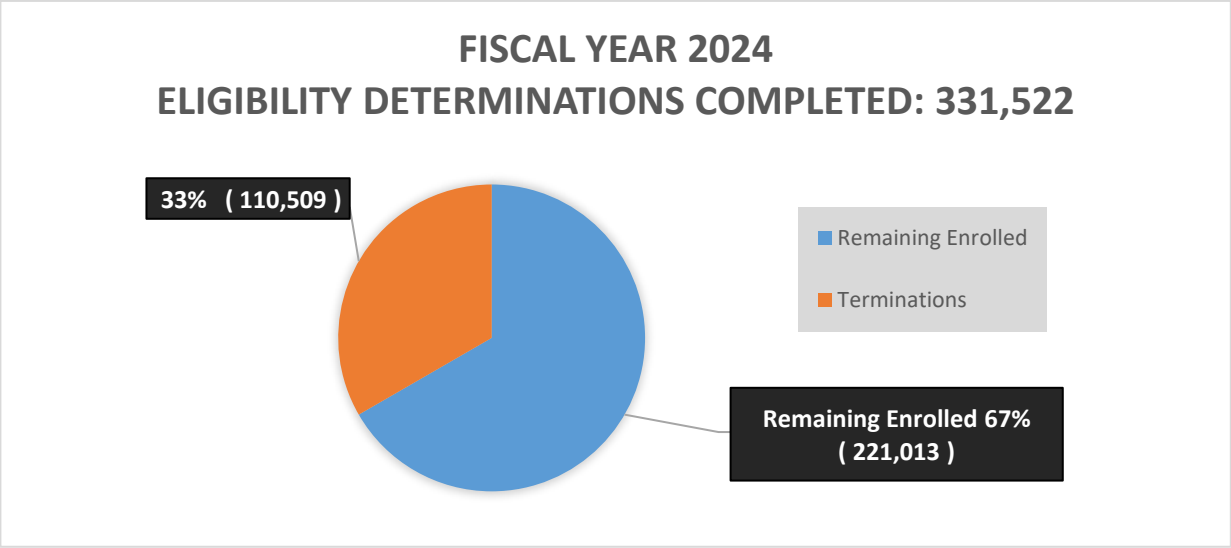
a) Applications

For SFY 2024 Nebraska Medicaid received a total of 159,549 initial applications, averaging over 13K applications per month.



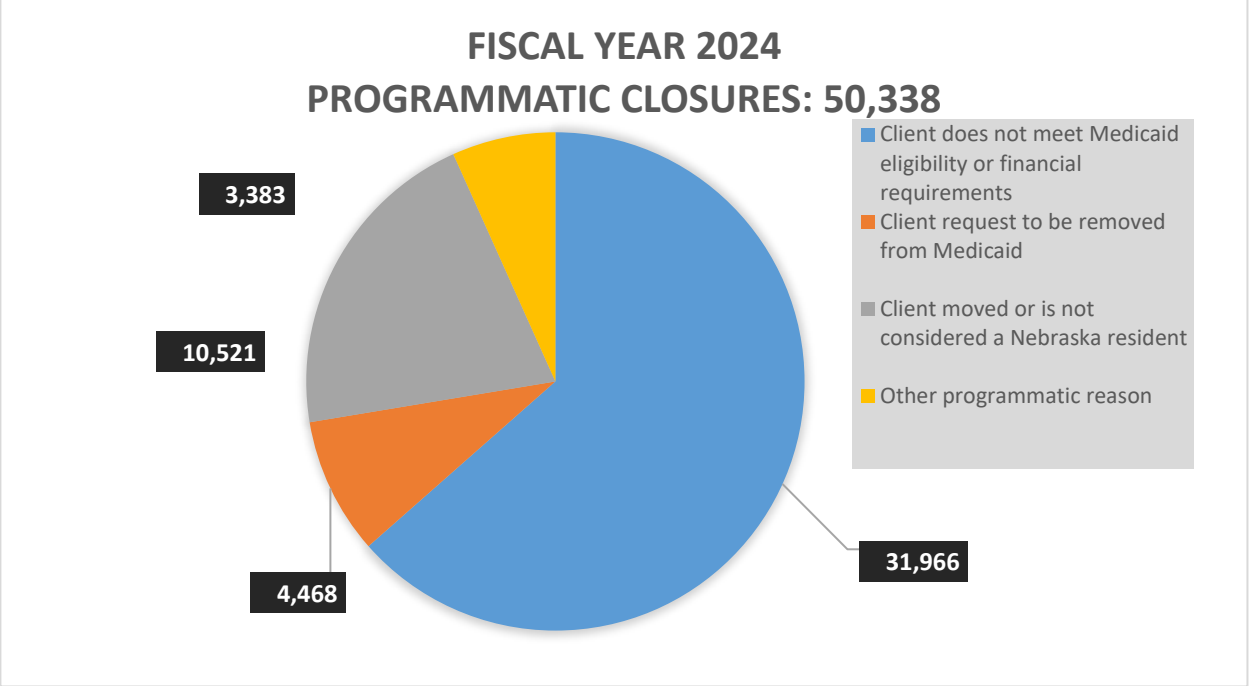
b) Eligibility Determinations (Renewals)

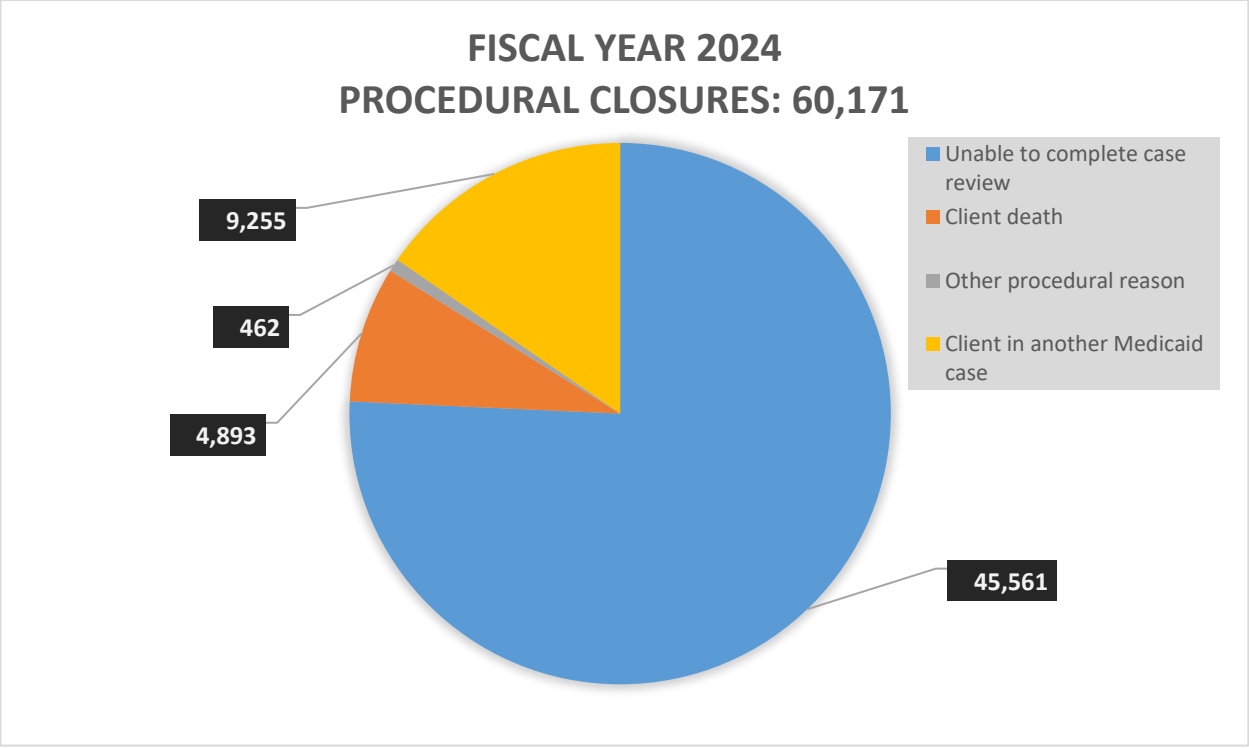
For SFY 2024 Nebraska Medicaid completed 331,522 eligibility determinations, also known as Medicaid renewals. SFY 2024 overlapped with the unwinding of the maintenance of eligibility (MOE) requirements observed during the COVID-19 Public Health Emergency (PHE). During the PHE Medicaid programs were required to keep people continuously covered through the end of the month in which the PHE ends (May 2023), in exchange for enhanced Federal Medical Assistance Percentage (FMAP) funding. The PHE and unwinding of the continuous enrollment requirements resulted in an unprecedented number of people losing Medicaid coverage.



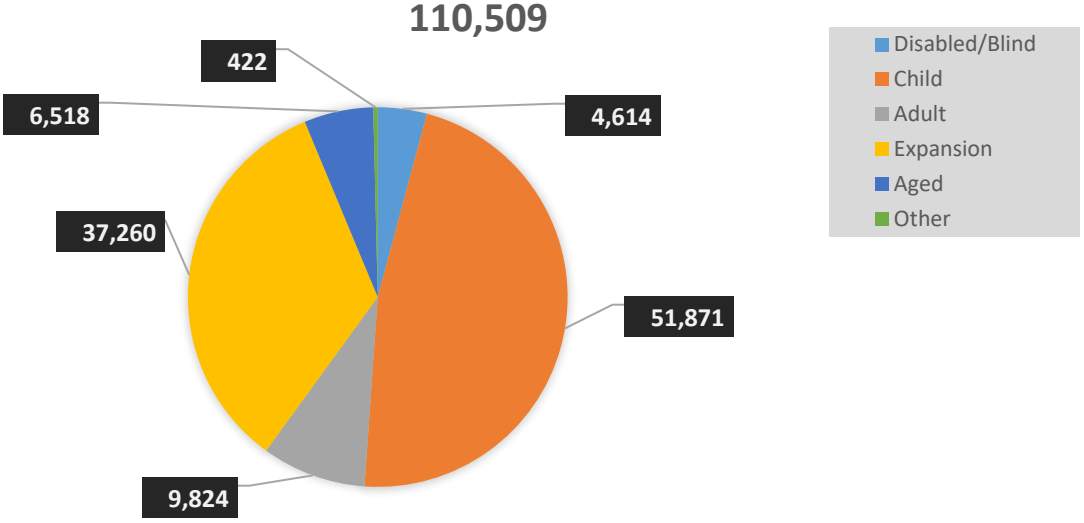
c) Case Closures

For SFY 2024 Nebraska Medicaid had 110,509 case closures (terminations resulting from a Medicaid renewal). 46% or 50,338 members were closed for programmatic reasons and 54% or 60,171 members were closed for procedural reasons.

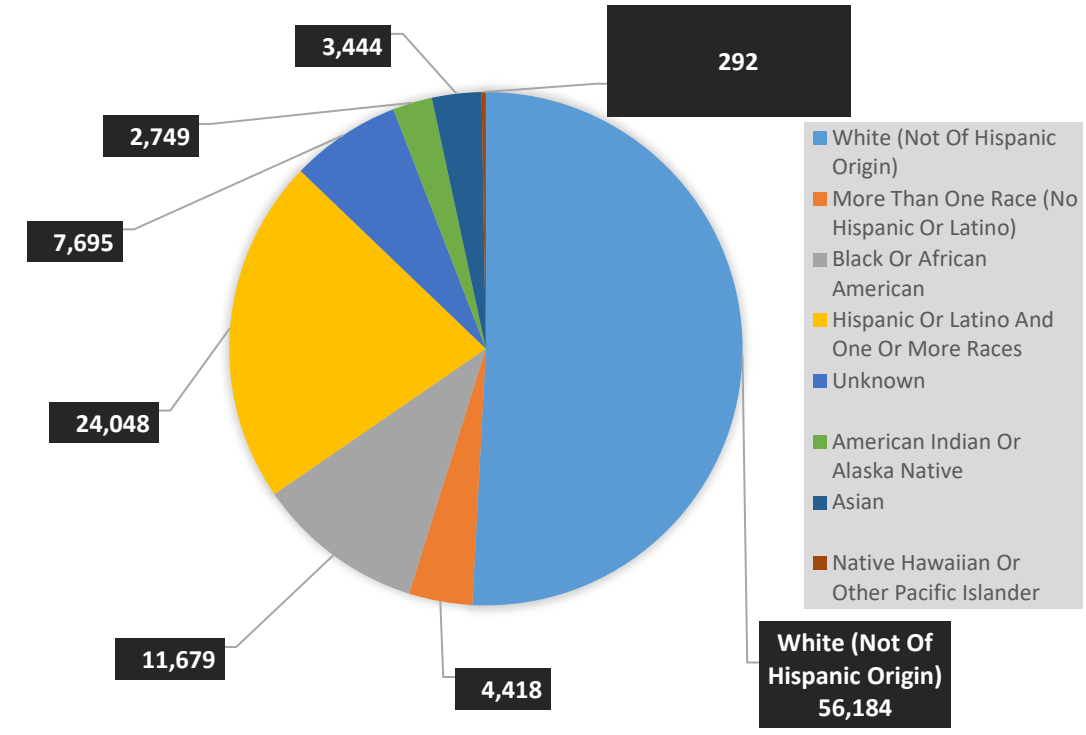


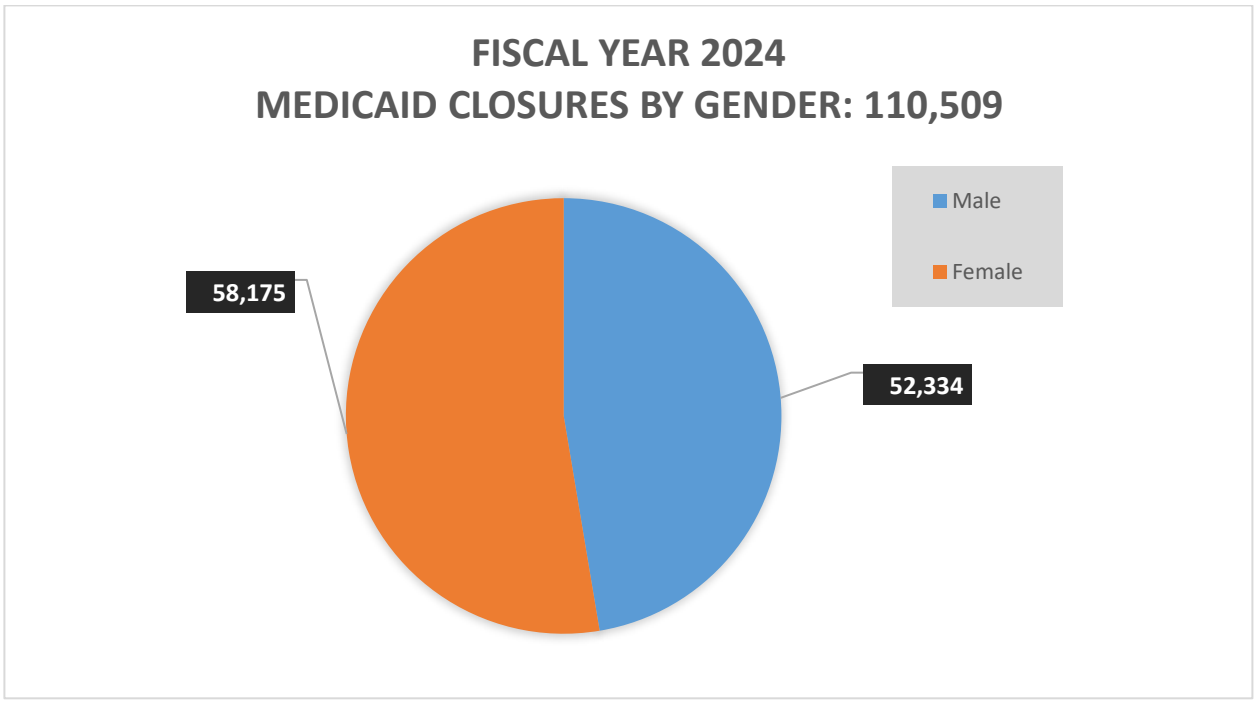


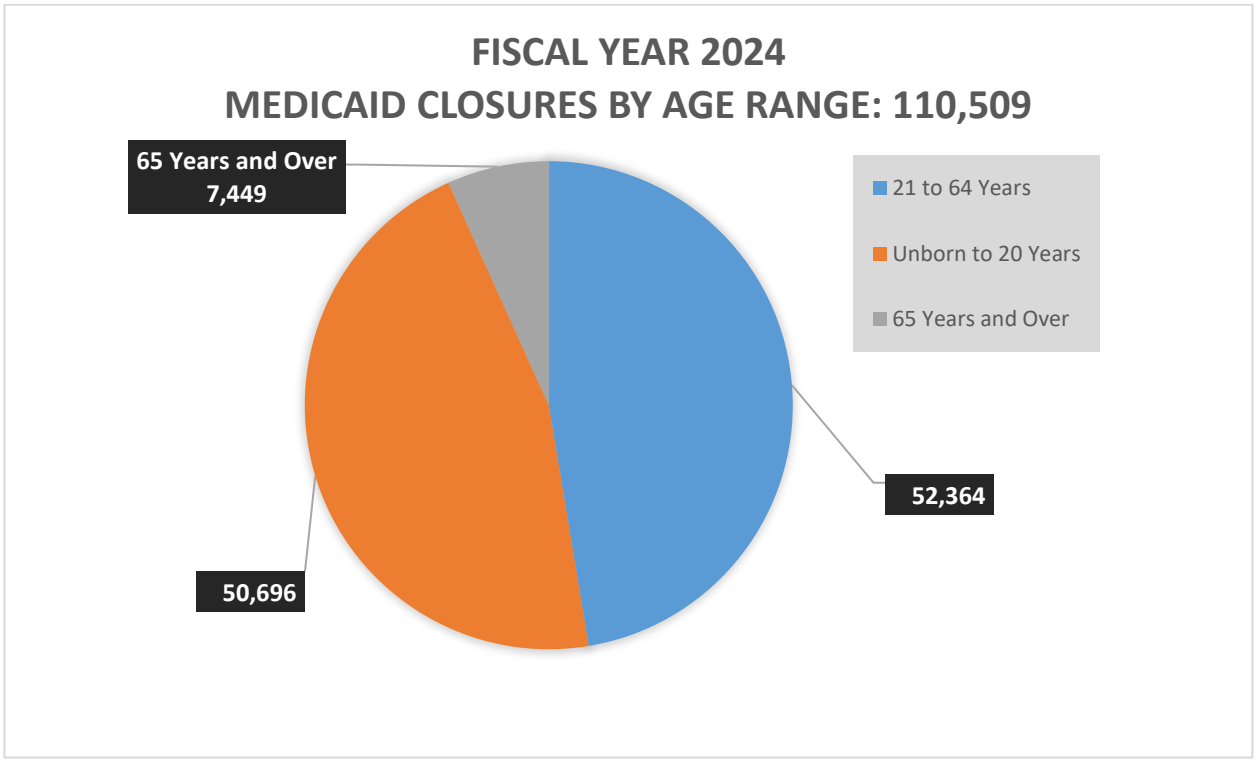
FICAL YEAR 2024
MEDICAID CLOSURES BY ELIGIBILITY CATEGORY: 110,509

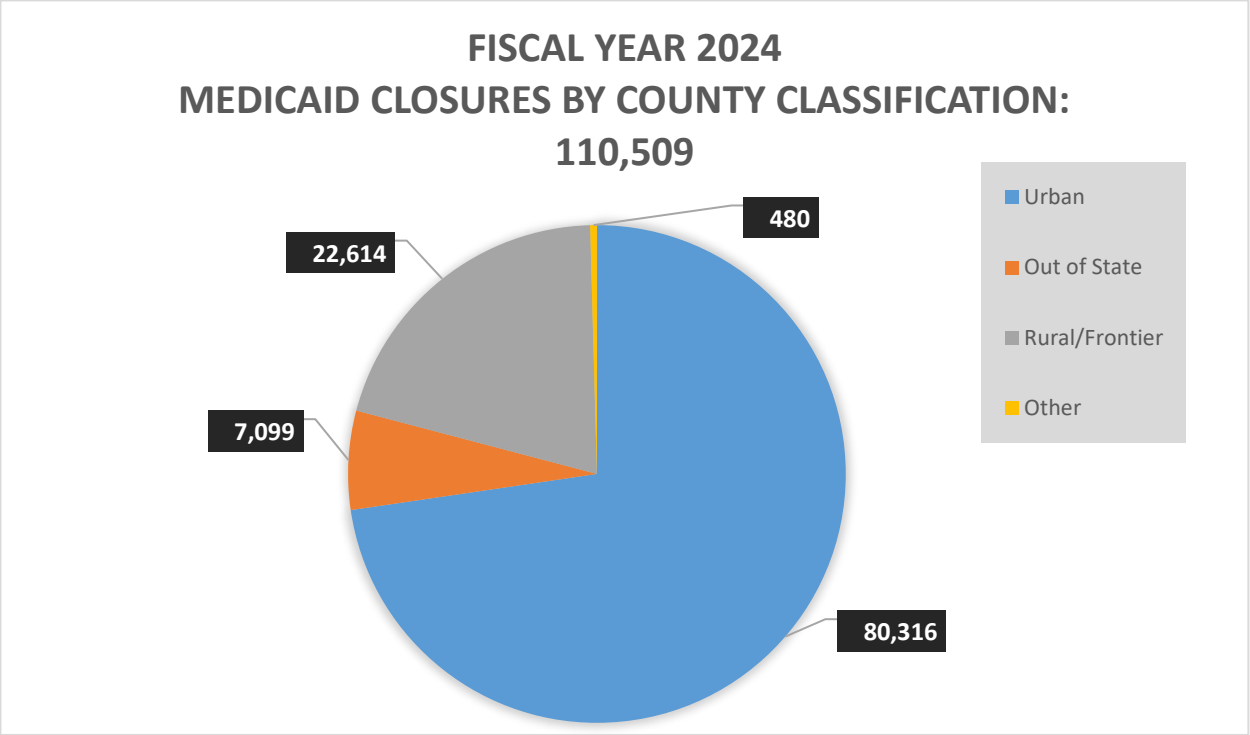


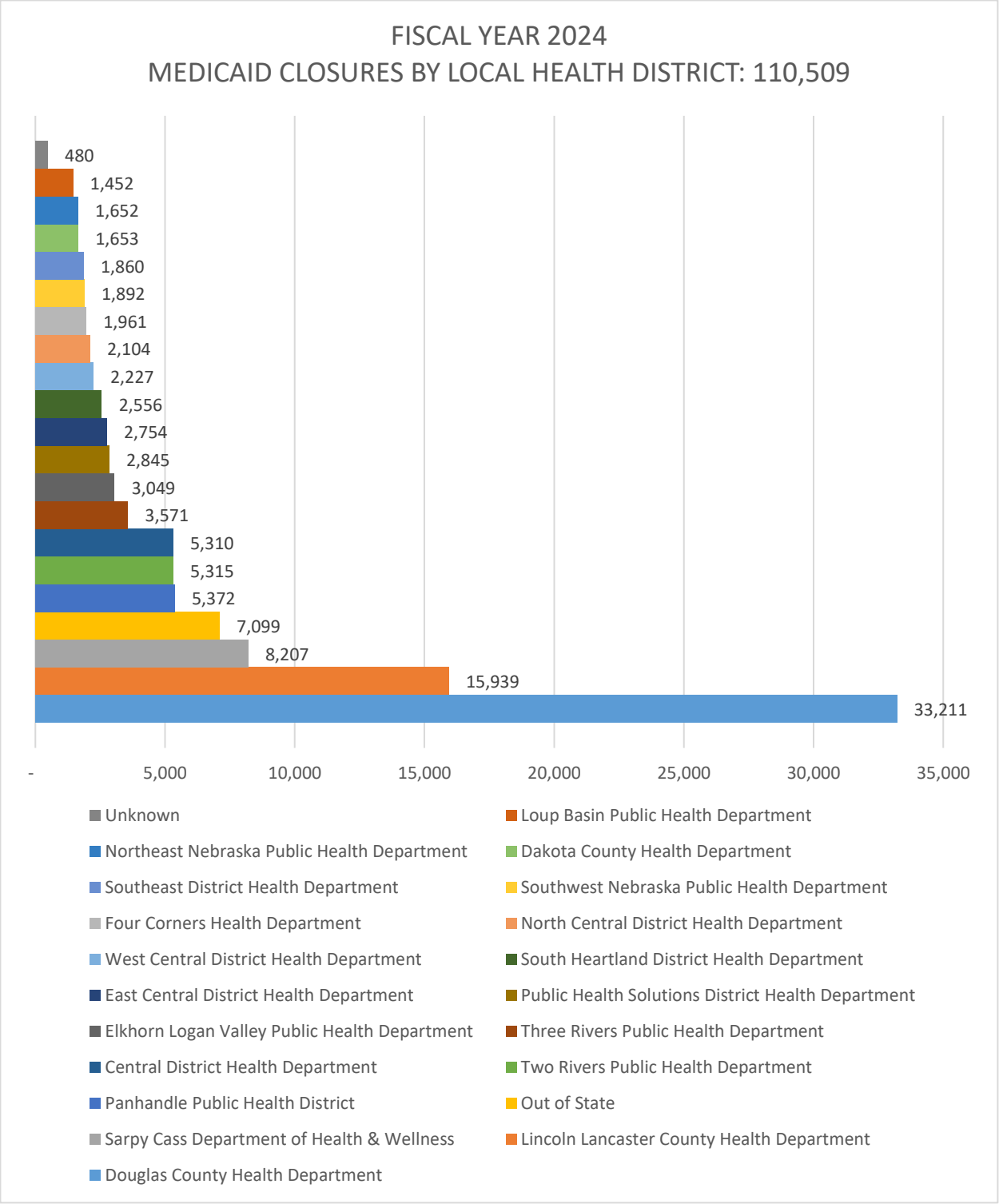
FISCAL YEAR 2024
MEDICAID CLOSURES BY RACE/ETHNICITY: 110,509




FISCAL YEAR 2024
MEDICAID CLOSURES BY GENDER: 110,509
Male
Female
58,175
52,334

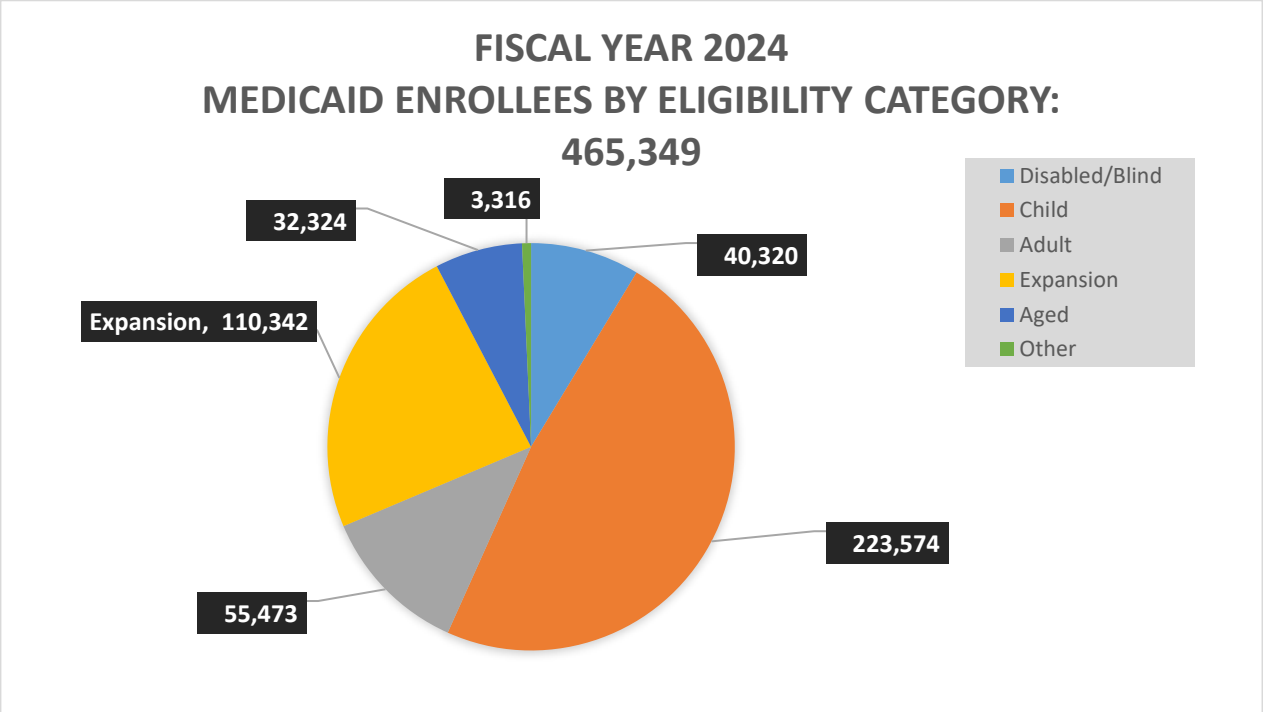

FISCAL YEAR 2024
MEDICAID CLOSURES BY AGE RANGE: 110,509
65 Years and Over
7,449
21 to 64 Years
Unborn to 20 Years
65 Years and Over
52,364
50,696

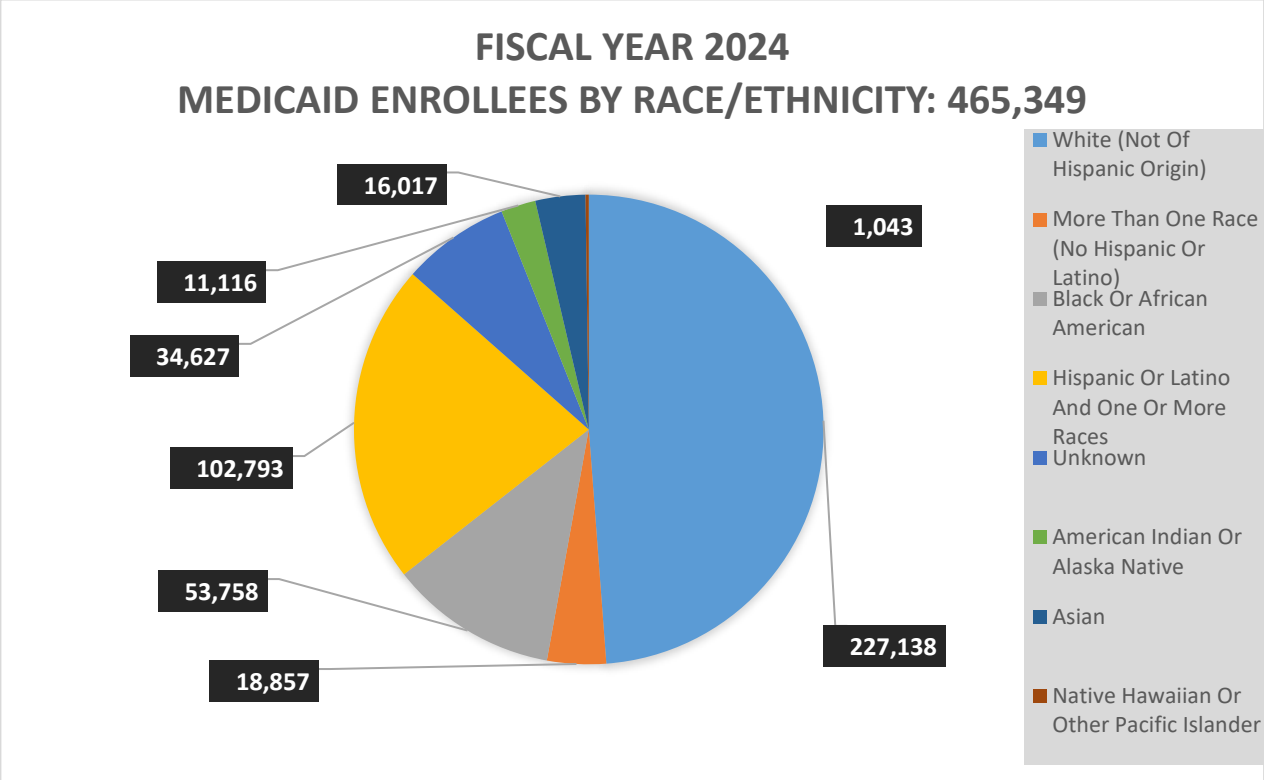

FISCAL YEAR 2024
MEDICAID CLOSURES BY COUNTY CLASSIFICATION:
110,509
480
22,614
7,099
80,316
Urban
Out of State
Rural/Frontier
Other

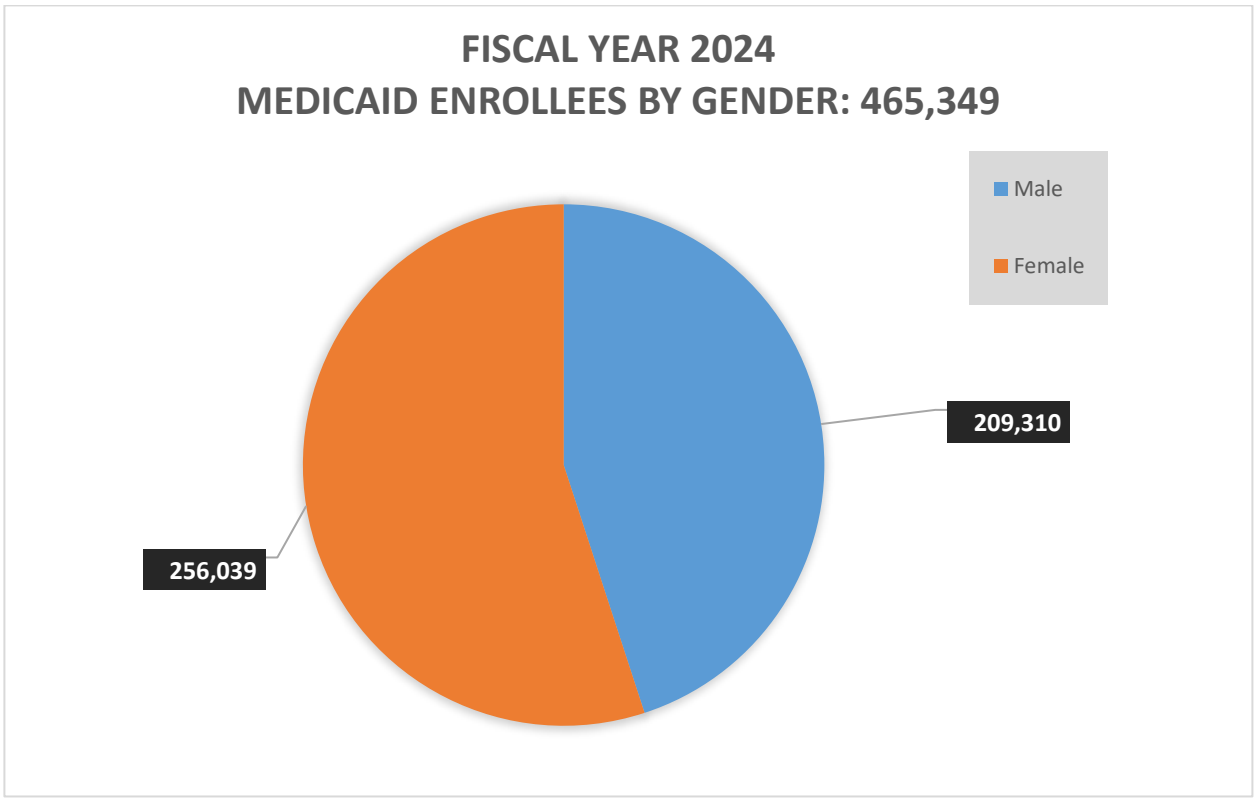

FISCAL YEAR 2024
MEDICAID CLOSURES BY LOCAL HEALTH DISTRICT: 110,509
480
1,452
1,652
1,653
1,860
1,892
1,961
2,104
2,227
2,556
2,754
2,845
3,049
3,571
5,310
5,315
5,372
7,099
8,207
15,939
33,211
-
5,000
10,000
15,000
20,000
25,000
30,000
35,000
Unknown
Loup Basin Public Health Department
Northeast Nebraska Public Health Department
Dakota County Health Department
Southeast District Health Department
Southwest Nebraska Public Health Department
Four Corners Health Department
North Central District Health Department
West Central District Health Department
South Heartland District Health Department
East Central District Health Department
Public Health Solutions District Health Department
Elkhorn Logan Valley Public Health Department
Three Rivers Public Health Department
Central District Health Department
Two Rivers Public Health Department
Panhandle Public Health District
Out of State
Sarpy Cass Department of Health & Wellness
Lincoln Lancaster County Health Department
Douglas County Health Department

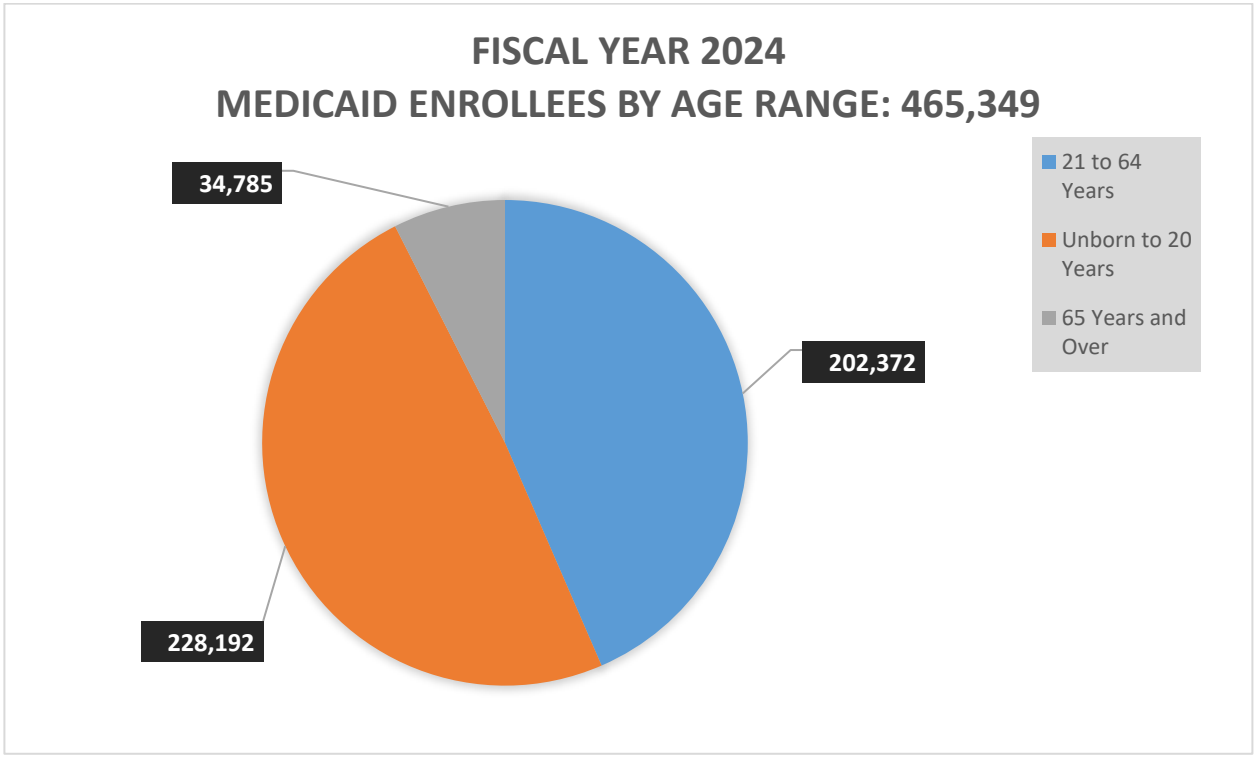
d) Enrollees

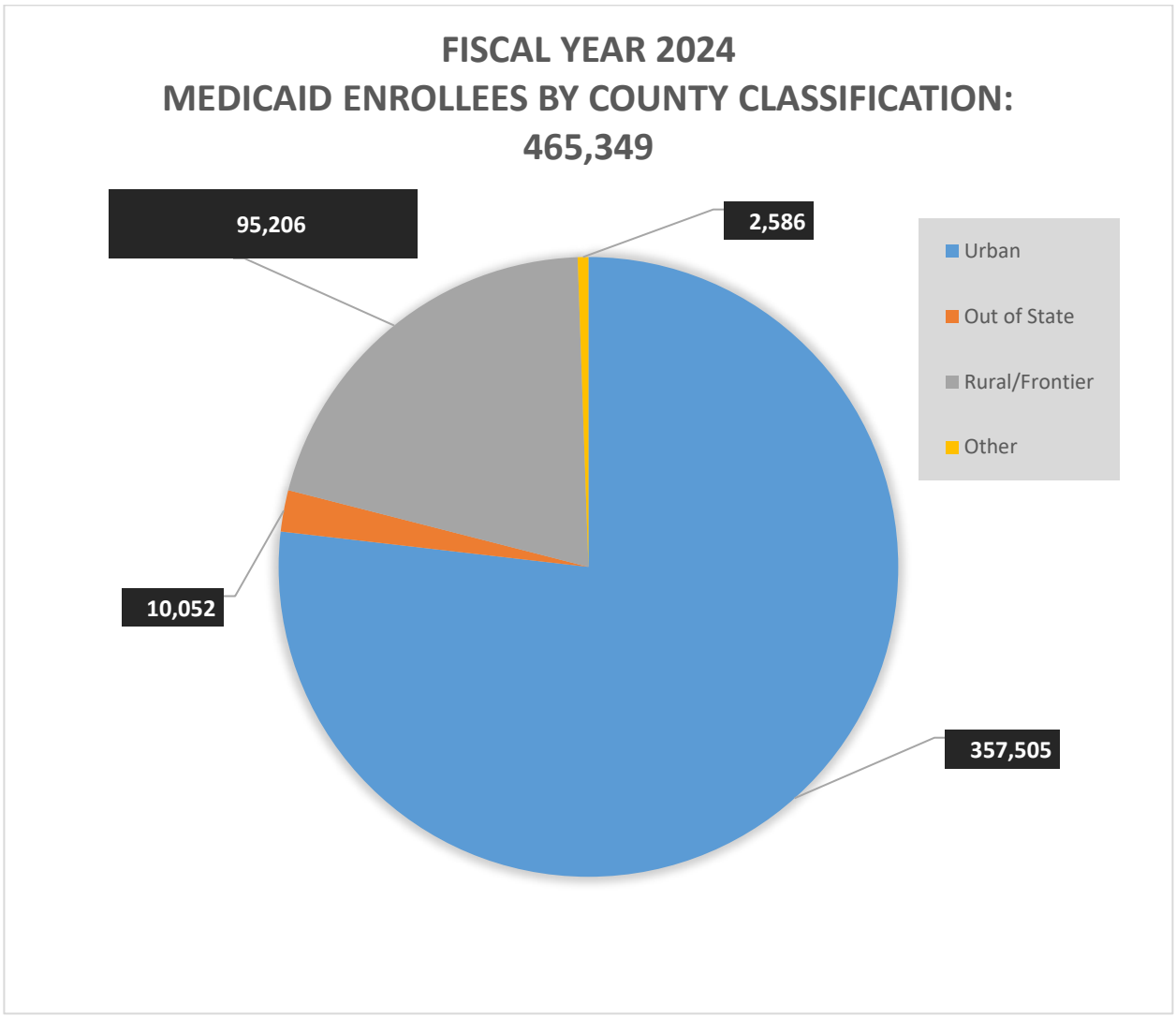
For SFY 2024 Nebraska Medicaid has 465,349 enrollees, representing the unique number of members with Medicaid eligibility for at least one month between July 2023 and June 2024.

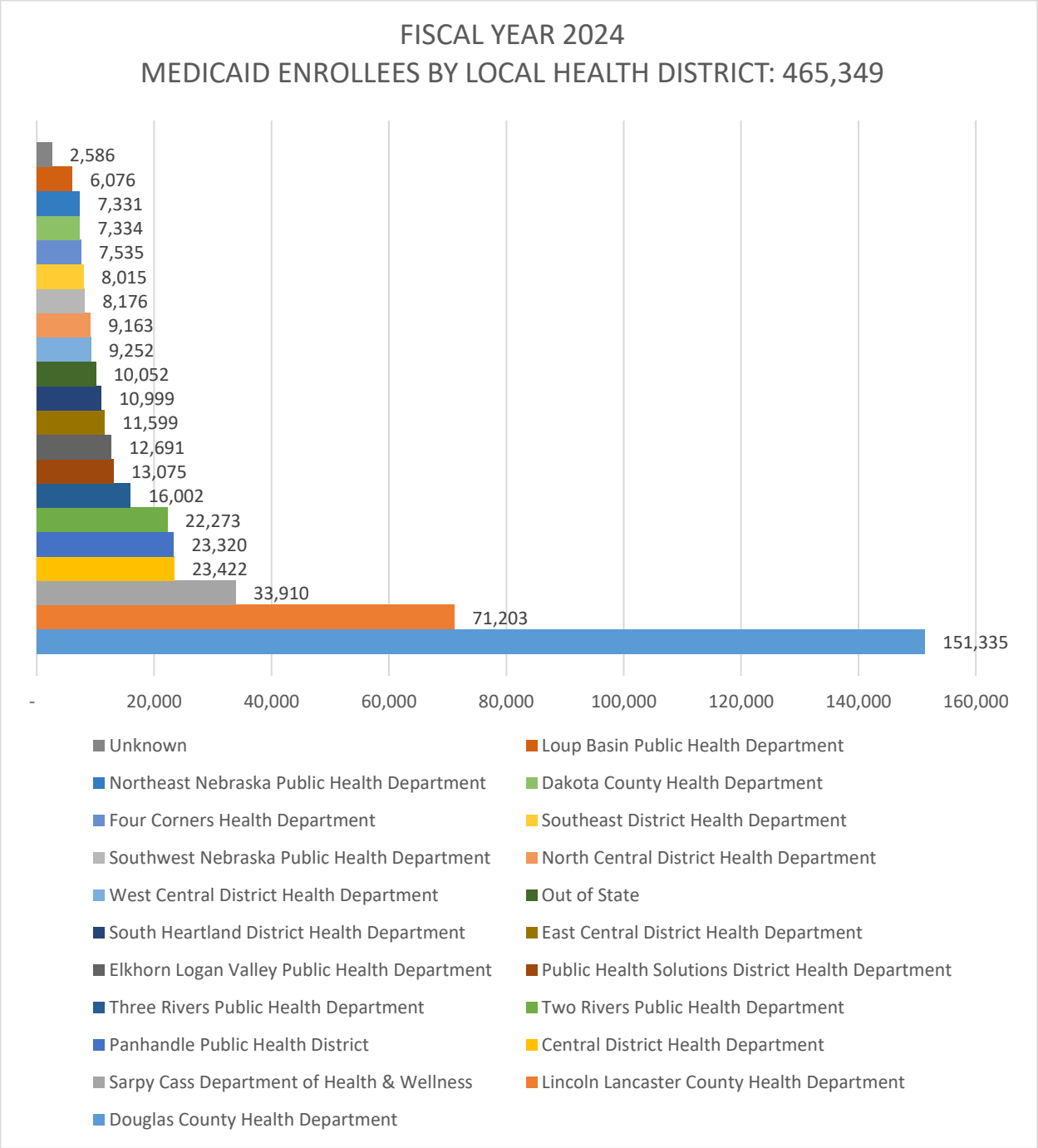





FISCAL YEAR 2024
MEDICAID ENROLLEES BY GENDER: 465,349
Male
Female
209,310
256,039


FISCAL YEAR 2024
MEDICAID ENROLLEES BY AGE RANGE: 465,349
21 to 64 Years
Unborn to 20 Years
65 Years and Over
34,785
202,372
228,192


FISCAL YEAR 2024
MEDICAID ENROLLEES BY COUNTY CLASSIFICATION:
465,349
95,206
2,586
10,052
357,505
Urban
Out of State
Rural/Frontier
Other



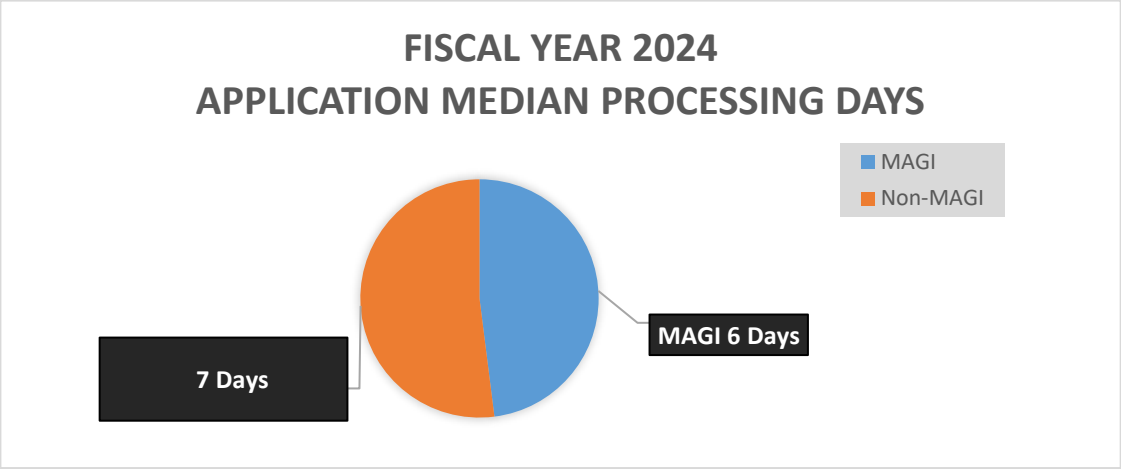
e) Ex Parte Renewals

An ex parte Medicaid renewal is a process that allows states to verify a beneficiary's Medicaid eligibility without requiring the beneficiary to submit documentation or complete a form. This is primarily done by using electronic data sources to confirm eligibility. During the maintenance of eligibility (MOE) unwind the Department implemented federally required mitigations to comply with ex parte requirements. However, these mitigations are manually completed by operations

staff and are not recorded in the eligibility system. The Department estimates that currently an average of 40% of renewals are completed ex parte, and during the MOE unwind an average of 27% were completed ex parte.

f) Application Processing Times

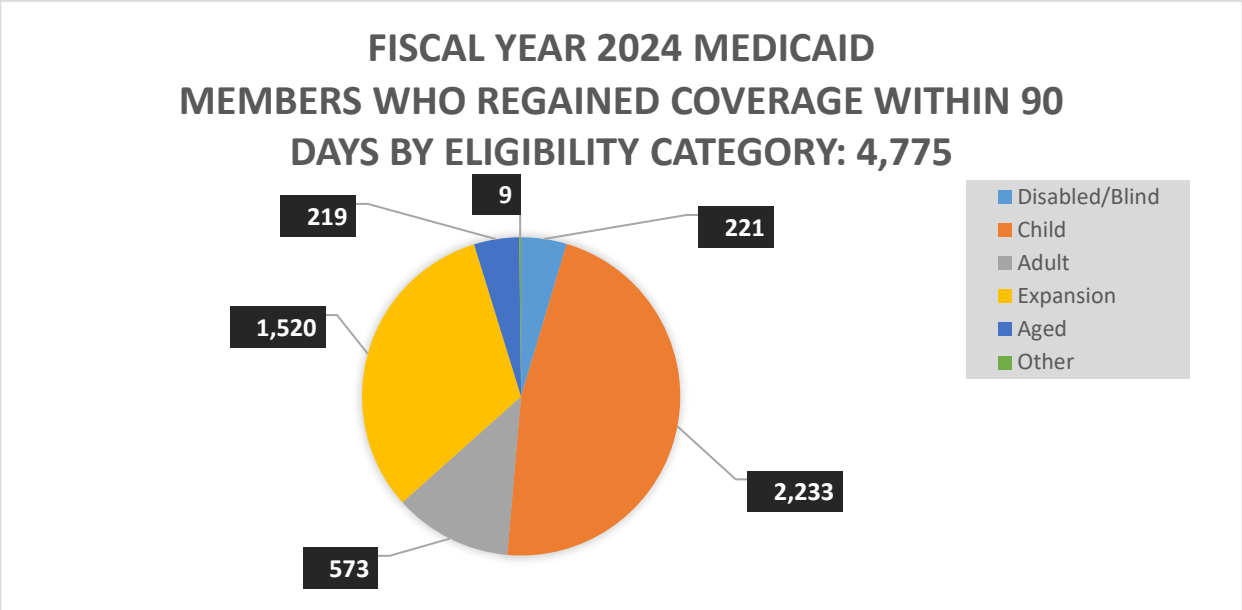
For SFY 2024 Nebraska Medicaid's median processing days for initial applications for MAGI and Non-MAGI was 6 and 7 days respectively. Median is defined as the number of calendar days elapsed between the day the Medicaid agency received the application and the day the final determination was made.

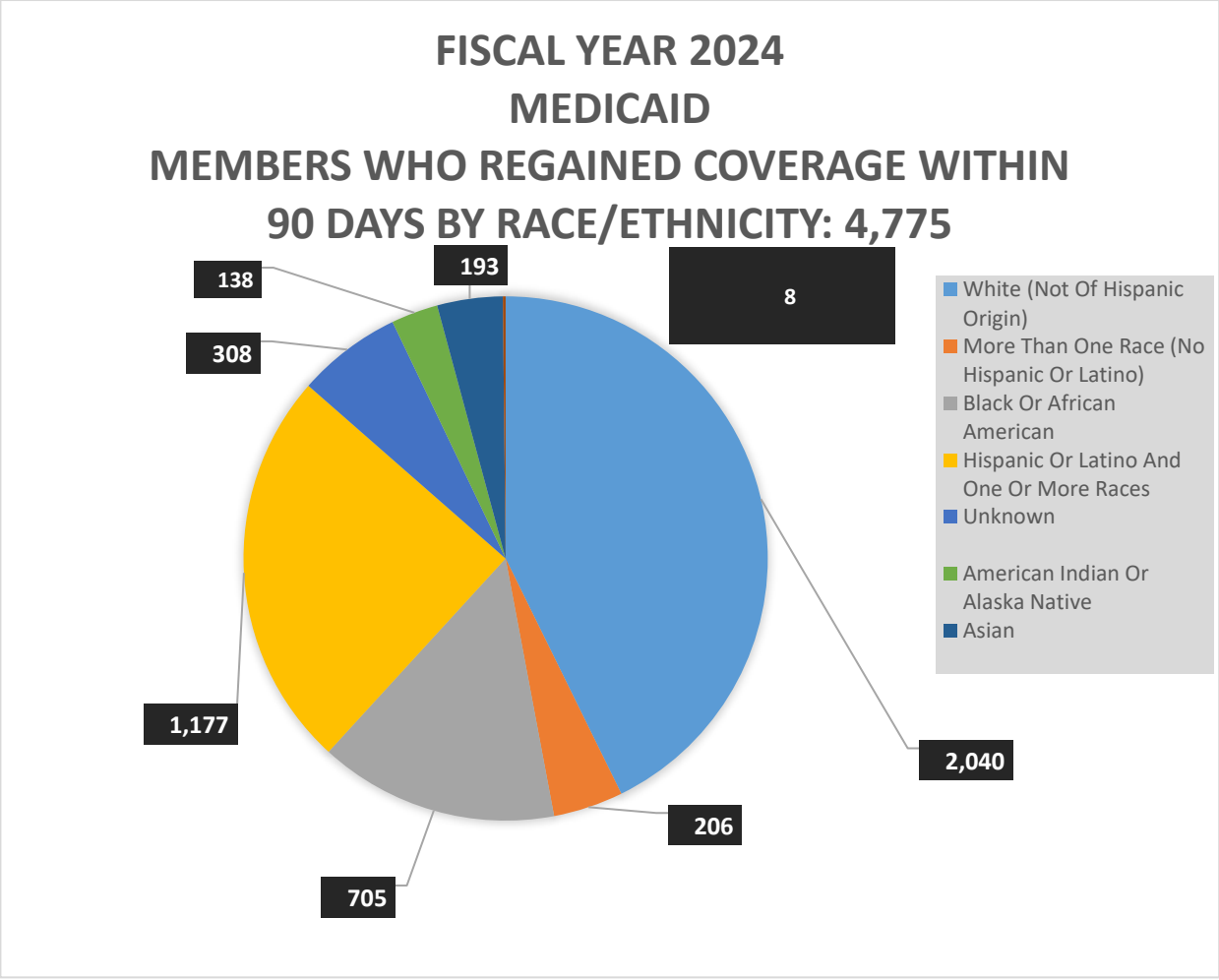


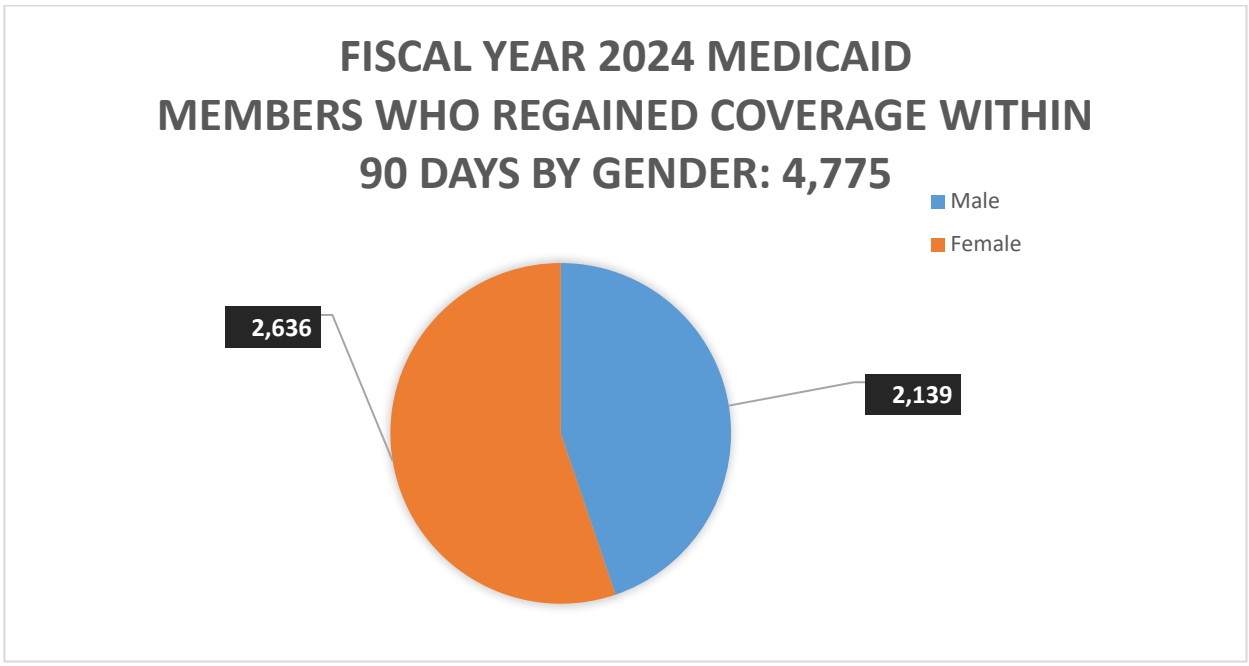
g) Rate of Re-Enrollment

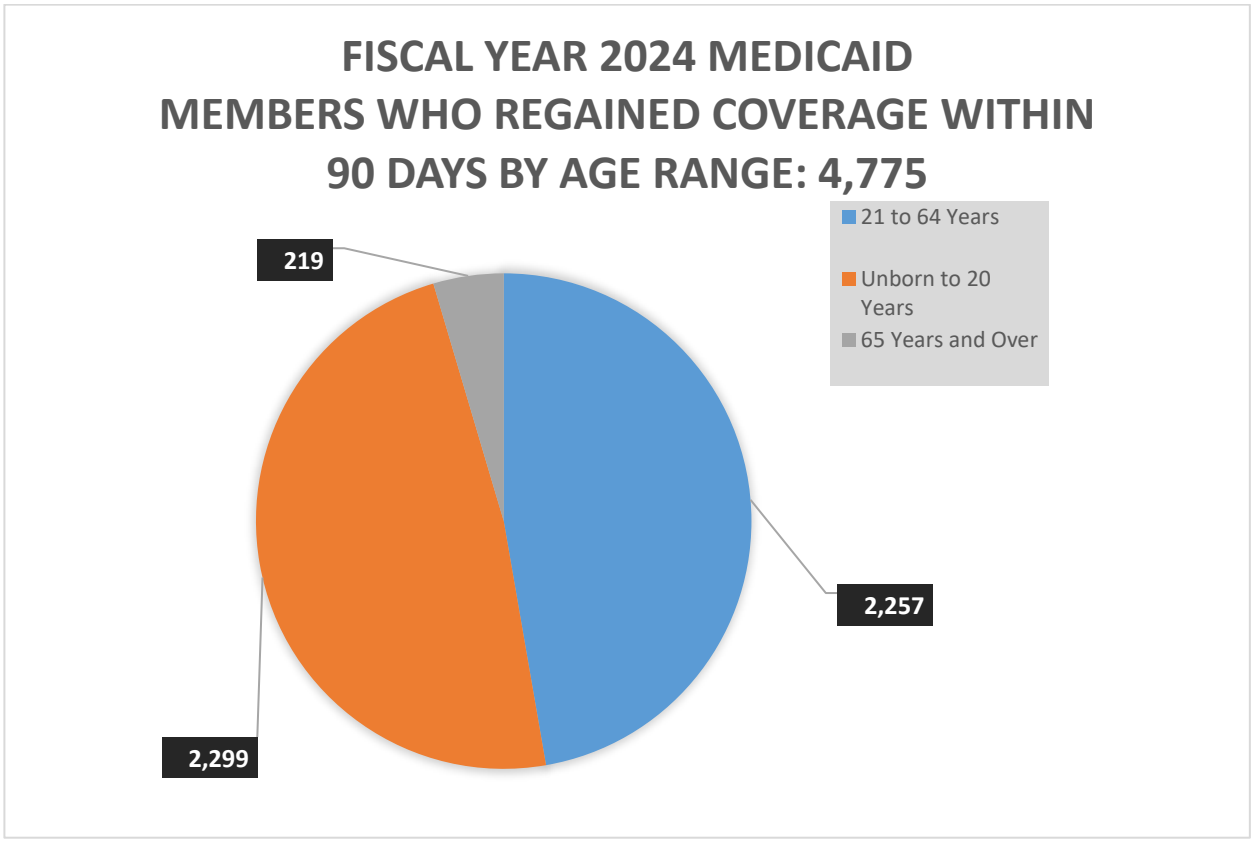
For SFY 2024 of the 110,509 Nebraska Medicaid members who lost Medicaid coverage 7% or 8,616 members regained coverage within twelve (12 months). Of the 8,616 members 4% or 4,775 regained coverage within ninety (90) days and 3% or 3,841 regained coverage within twelve (12) months.

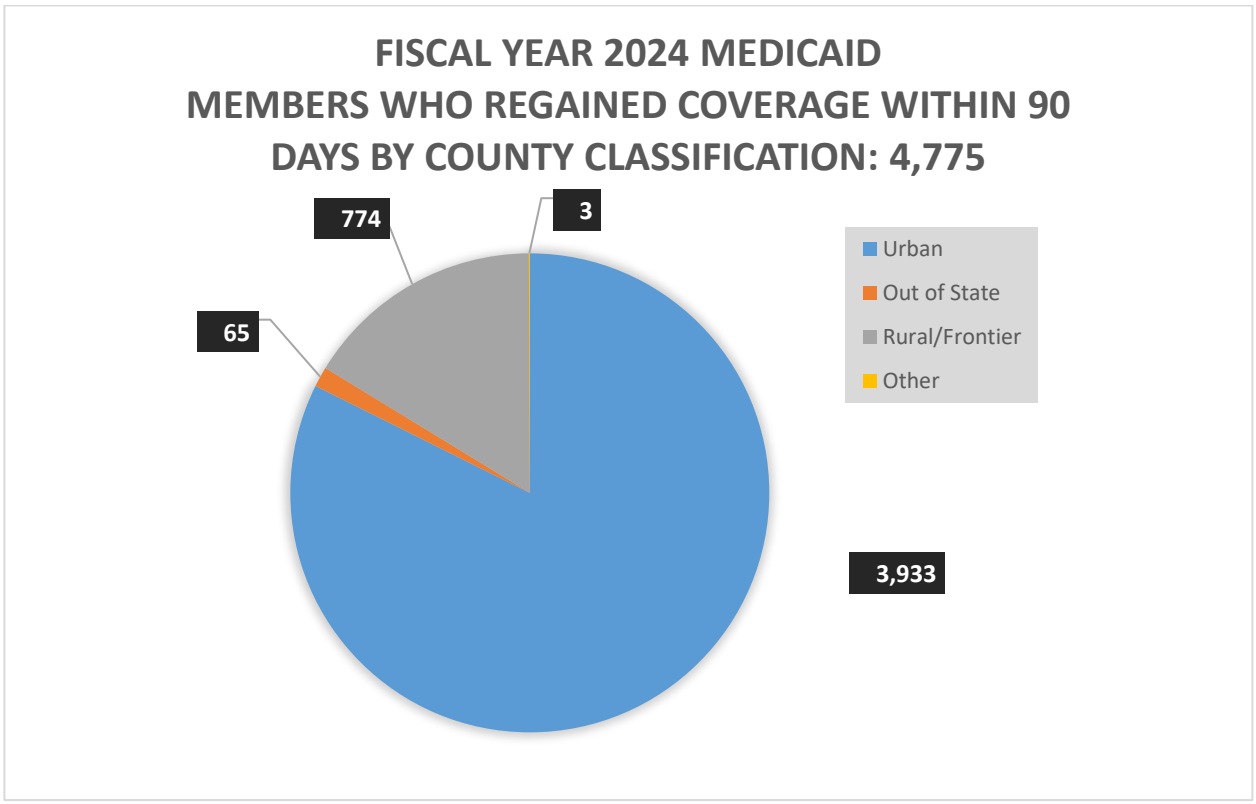
Demographics for Members Regaining Coverage within 90 Days

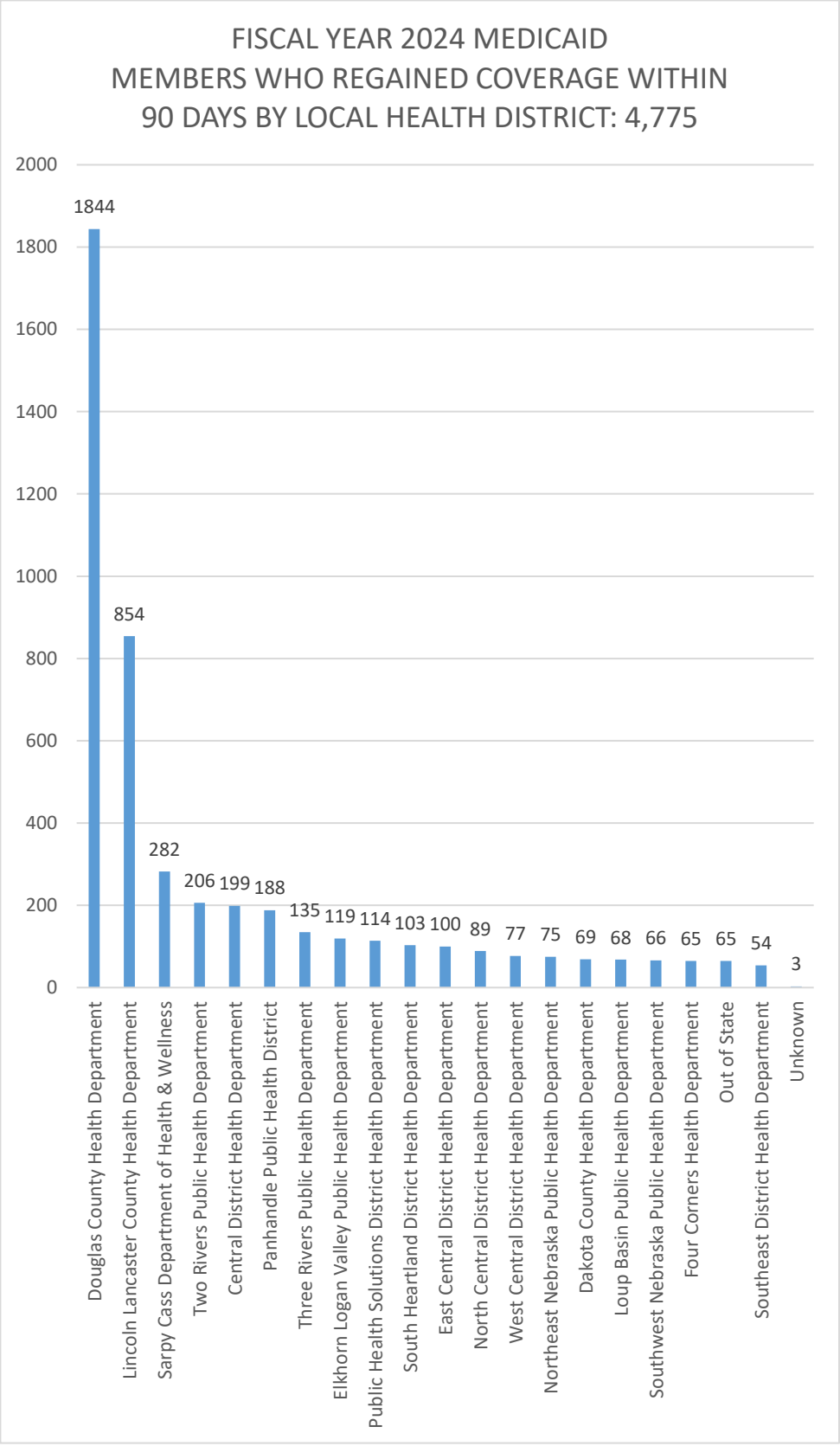




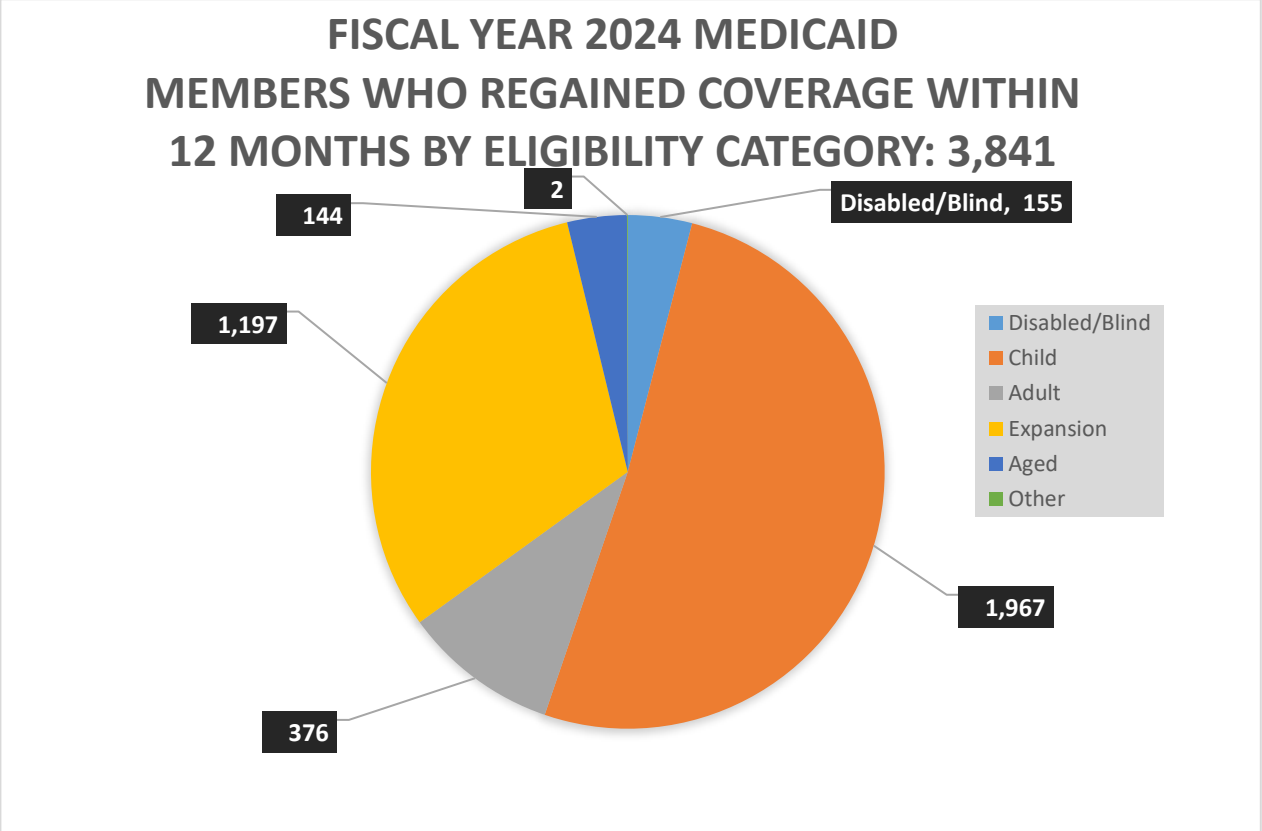

FISCAL YEAR 2024 MEDICAID MEMBERS WHO REGAINED COVERAGE WITHIN 90 DAYS BY GENDER: 4,775
Male
Female
2,636
2,139


FISCAL YEAR 2024 MEDICAID MEMBERS WHO REGAINED COVERAGE WITHIN 90 DAYS BY AGE RANGE: 4,775
21 to 64 Years
Unborn to 20 Years
65 Years and Over
219
2,257
2,299

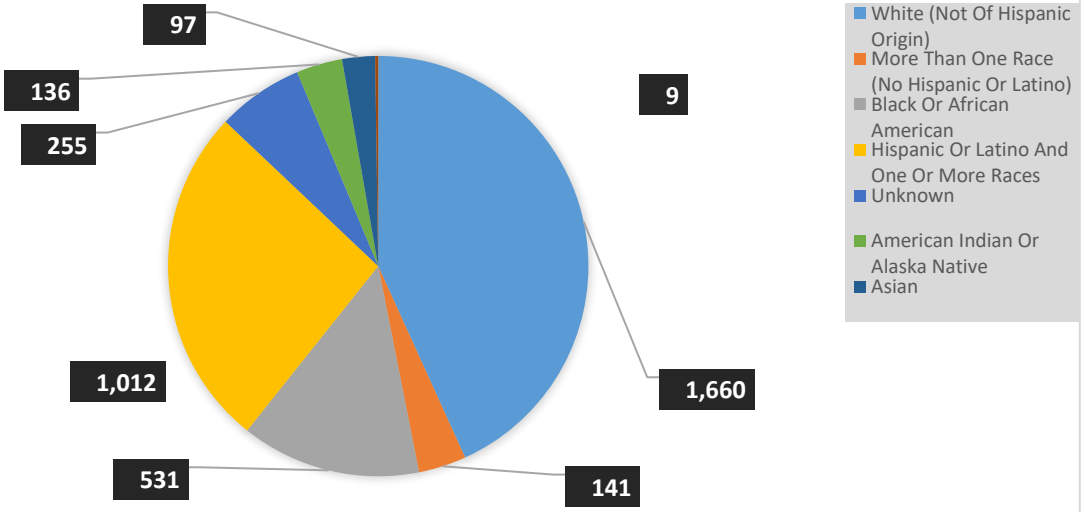

FISCAL YEAR 2024 MEDICAID
MEMBERS WHO REGAINED COVERAGE WITHIN 90
DAYS BY COUNTY CLASSIFICATION: 4,775
774
3
65
3,933
Urban
Out of State
Rural/Frontier
Other


FISCAL YEAR 2024 MEDICAID
MEMBERS WHO REGAINED COVERAGE WITHIN
90 DAYS BY LOCAL HEALTH DISTRICT: 4,775
2000
1800
1600
1400
1200
1000
800
600
400
200
0
1844
854
282
206
199
188
135
119
114
103
100
89
77
75
69
68
66
65
65
54
3
Douglas County Health Department
Lincoln Lancaster County Health Department
Sarpy Cass Department of Health & Wellness
Two Rivers Public Health Department
Central District Health Department
Panhandle Public Health District
Three Rivers Public Health Department
Elkhorn Logan Valley Public Health Department
Public Health Solutions District Health Department
South Heartland District Health Department
East Central District Health Department
North Central District Health Department
West Central District Health Department
Northeast Nebraska Public Health Department
Dakota County Health Department
Loup Basin Public Health Department
Southwest Nebraska Public Health Department
Four Corners Health Department
Out of State
Southeast District Health Department
Unknown

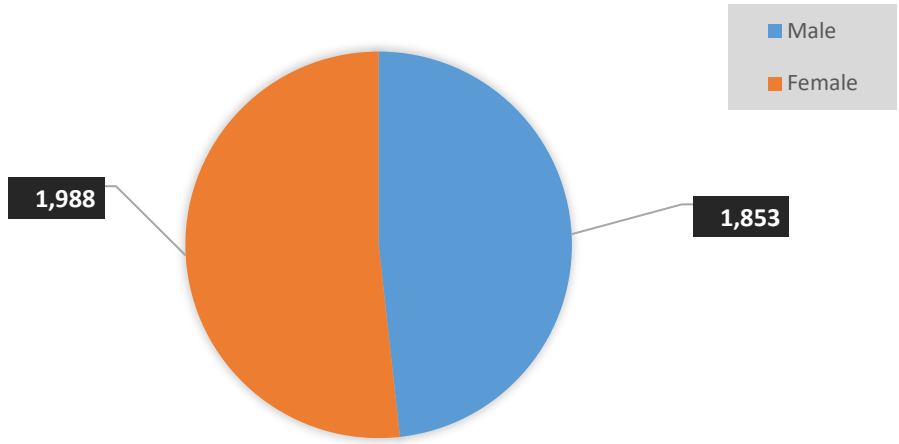
Demographics for Members Regaining Coverage within 12 Months



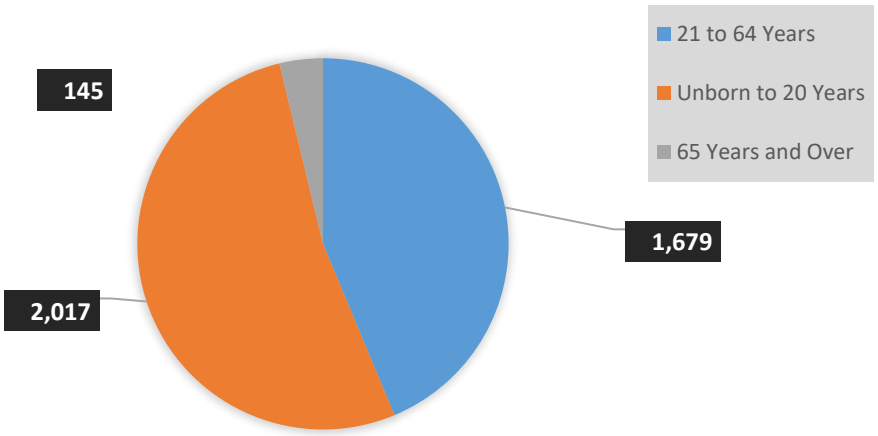
FISCAL YEAR 2024 MEDICAID MEMBERS WHO REGAINED COVERAGE WITHIN 12 MONTHS BY RACE/ETHNICITY: 3,841



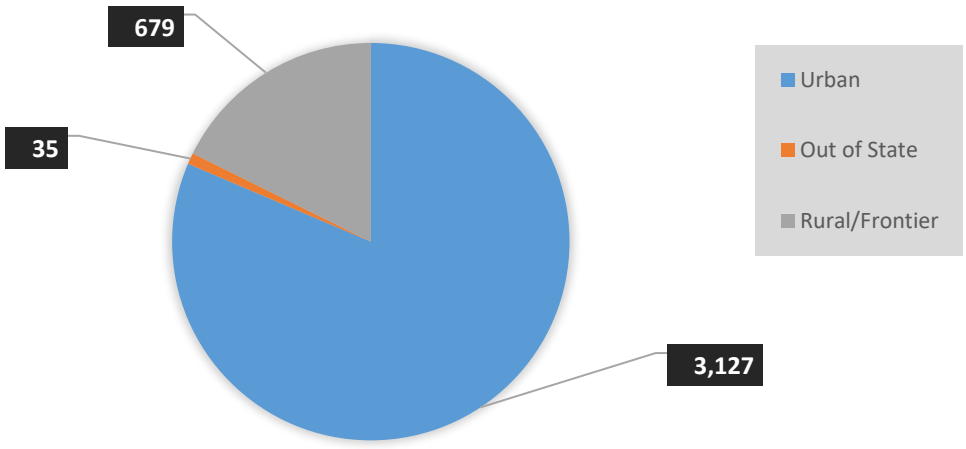
FISCAL YEAR 2024 MEDICAID MEMBERS WHO REGAINED COVERAGE WITHIN 12 MONTHS BY GENDER: 3,841

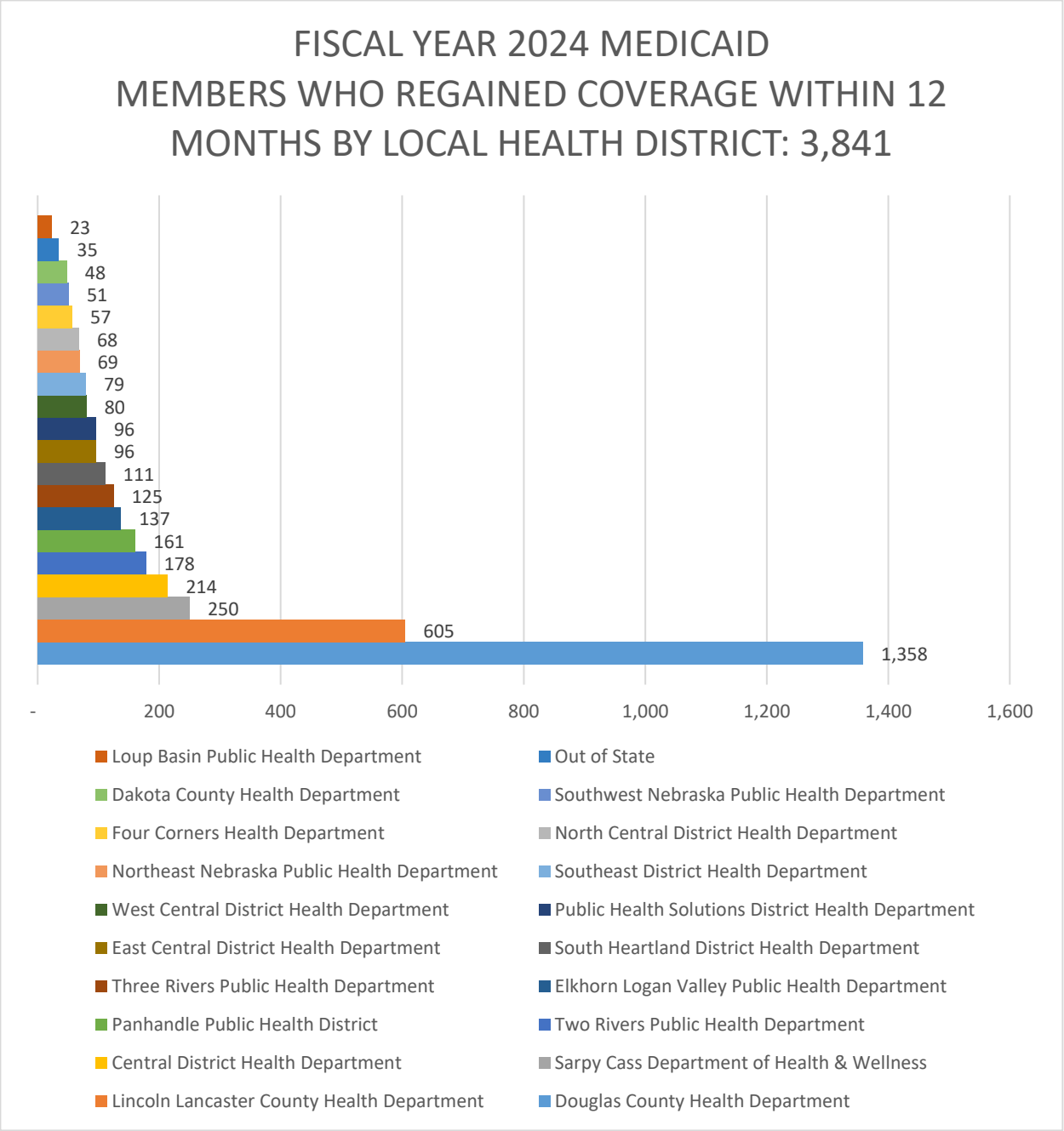


FISCAL YEAR 2024 MEDICAID MEMBERS WHO REGAINED COVERAGE WITHIN 12 MONTHS BY AGE RANGE: 3,841



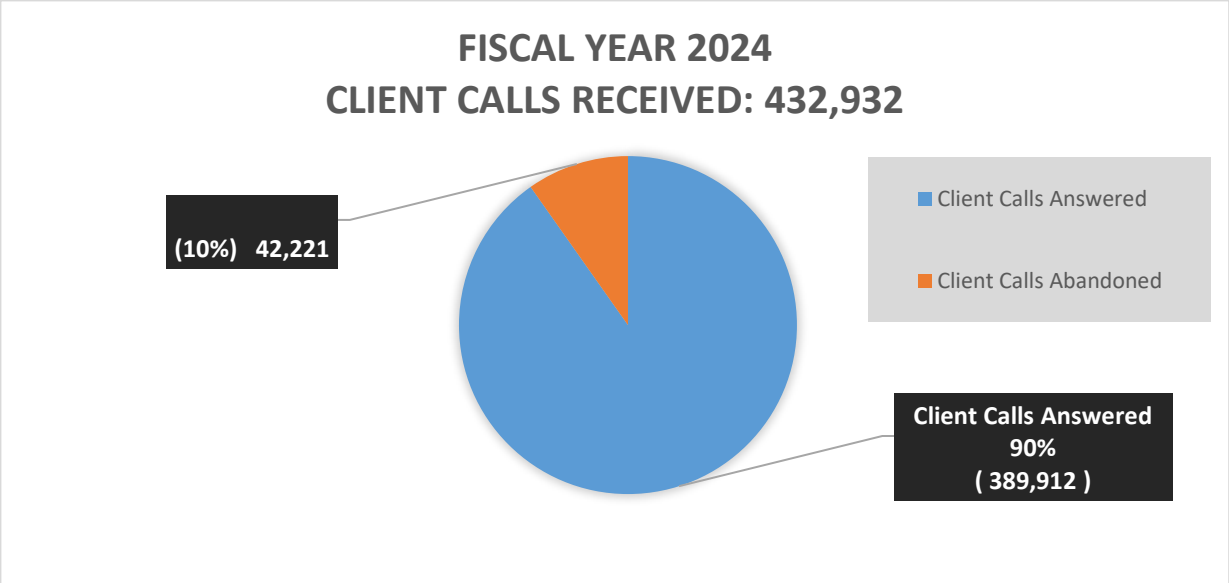
FISCAL YEAR 2024 MEDICAID MEMBERS WHO REGAINED COVERAGE WITHIN 12 MONTHS BY COUNTY CLASSIFCATION CATEGORY: 3,841





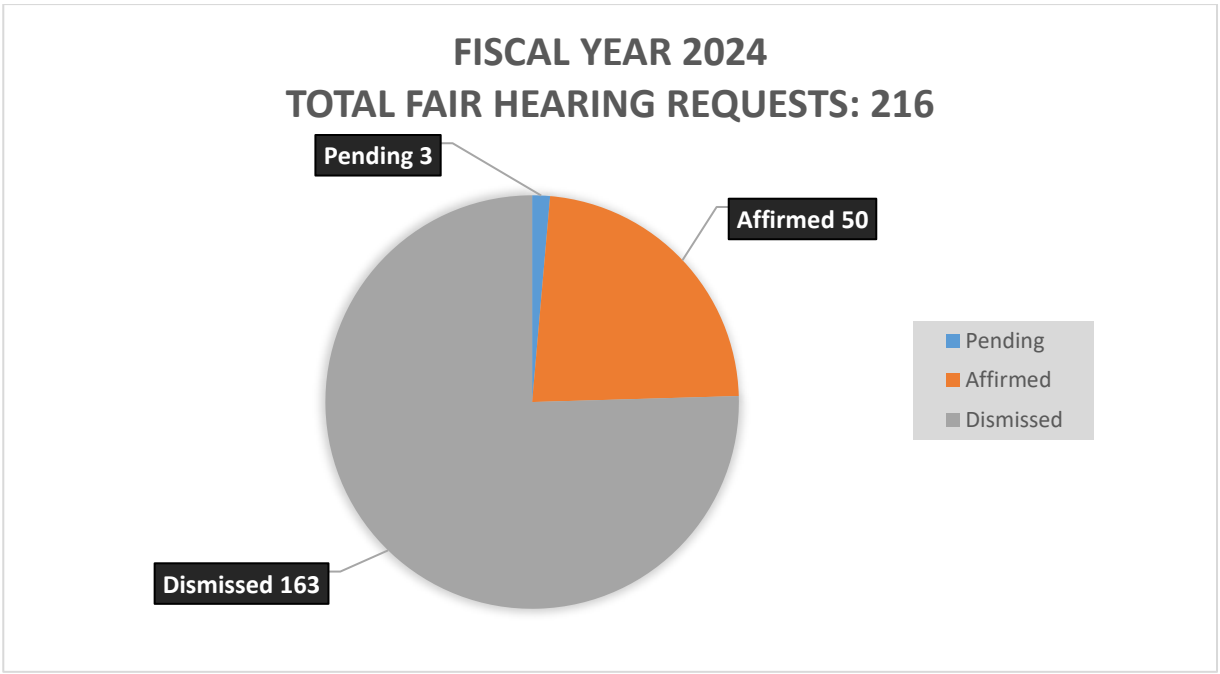
h) Client Call Information

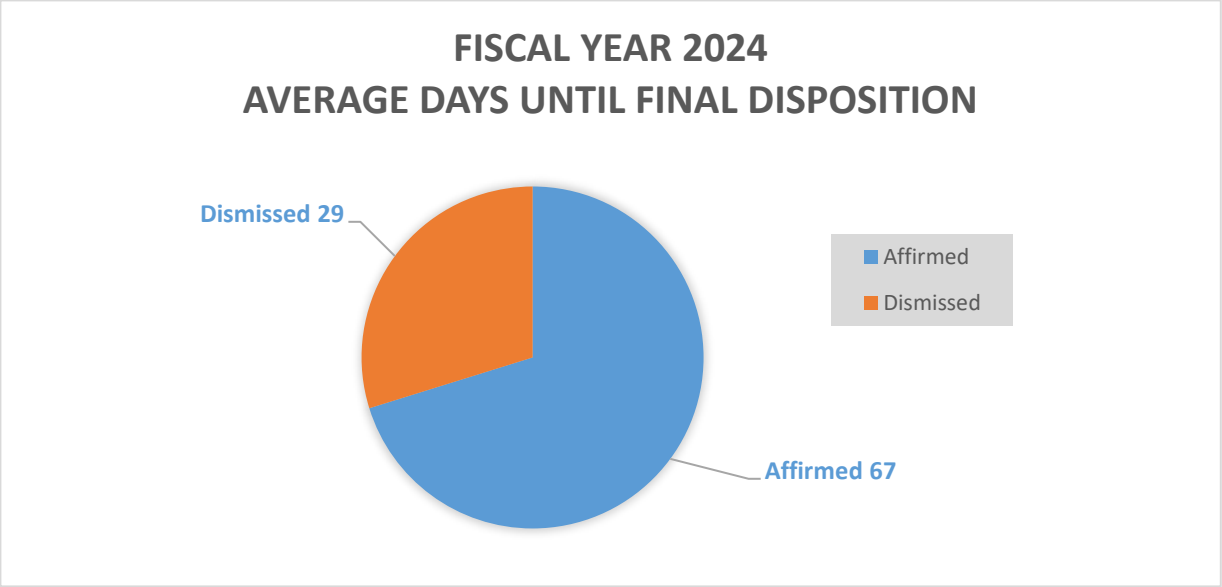
For SFY 2024 Nebraska Medicaid operated four (4) call centers; 1 state administered call center and 3 (contracted) external call centers. Nebraska Medicaid received a total of 432,932 client calls and answered 389,912 (90%) with 42,221 (10%) abandoned calls. The average client call duration was 18 minutes and the average client call wait time was 3 minutes.



i) Fair Hearings

For SFY 2024 Nebraska Medicaid received 216 fair hearing requests for Medicaid eligibility and State Review Team (SRT) disability related determinations. For requests resulting in a dismissal and affirmation the average days from receipt of the fair hearing request until final disposition was 29 days and 67 days respectively.





Appendix 7. Nebraska Medicaid Providers by Type

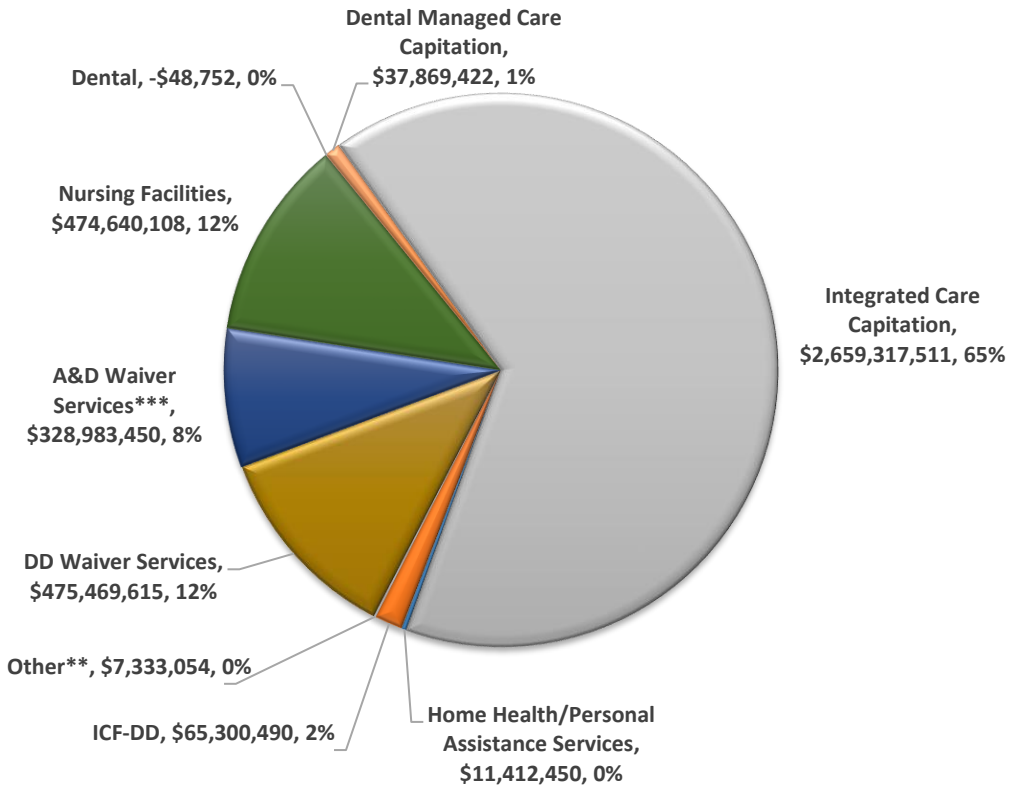
Provider Type Description	Nebraska	Out of State
Adult Day Care (specialty 79)	1	0
Ambulance (specialty 61)	307	87
Ambulatory Surgical Centers (ASC)	50	9
Assertive Community Treatment (ACT) MRO Program	3	0
Assisted Living (specialty 75)	226	0
Case Management	16	0
Clinic (CLNC) (Hospital Based Clinic, Licensed Mental Health Centers)	312	178
Day Rehabilitation (DAYR) MRO Program	11	24
Day Treatment Provider (DAY)	21	0
Dialysis Centers (specialty 68)	38	14
Federally Qualified Health Center (FQHC)	61	15
Freestanding Birth Centers	2	1
Home Health Agency (HHAG)	77	6
Hospice (HSPC)	46	4
Hospice in Nursing Facility (specialty 82)	690	0
Hospitals (HOSP)	228	615
Indian Health Hospital Clinic (IHSH)	1	4
Intermediate Care Facility (specialty 88)	11	9
Laboratory (LAB) (Independent)	18	338
Medicaid in Public Schools Direct Care Staff (specialty 49)	256	0
Medicaid in Public Schools Transportation (specialty 49)	7	1
Medically Monitored Inpatient Withdrawal (MMIW)	3	0

Multi-Systemic Therapy	1	0
NFOCUS Provider	4279	89
Non-Emergency Medical Transportation (specialty 94-96)	153	6
Nursing Homes (speciatly 87)	195	12
Opiod Treatment Program (OTP)	3	1
Optical Supplier (OPTC)	38	1
Orthopedic Device Supplier (ORTH)	7	11
Other Prepaid Health Plan (OPHP)	3	2
Pharmacy (PHCY)	479	314
Professional Clinic (PC)	2899	656
Professional Resource Family Care	4	1
Psychiatric Residential Treatment Facility	1	36
Qualified Health Maintenance Organization (QHMO)	6	3
Rental and Retail Supplier (RTLR)	152	232
Residential Rehabilitation (REST)	12	2
Rural Health Clinic-Independent (IRHC)	17	10
Rural Health Clinic-Provider Based (PRHC) (Less Thank 50 Beds)	118	32
Rural Health Clinic-Provider Based (RHCP) (Over 50 Beds)	5	2
Specialized Add-On Services (in NFs)	14	0
Substance Abuse Treatment Center (SATC)	52	4
Therapeutic Treatment Home(THGH), Formerly-Treatment Group Home (TGH	1	4
Treatment Crisis Intervention (TCI)	3	0
Tribal 638 Clinic (T638)	14	0

Provider Type Description	Groups		Group Members		Solo Providers	
	In state	Out of state			In state	Out of State
Physicians (MD)		253	277		11206	
Doctors of Osteopathy (DO)		5	4		1131	
Doctors of Chiropractic Medicine (DC)		334	18		557	
Optometrists (OD)		244	19		349	
Doctors of Podiatric Medicine (DPM)		70	10		102	
Anesthesiologist (ANES)		166	60		1478	
Dispensing Physician (MD)					22	
Physician Assistant (PA)					2033	
Nurse Midwife (NW)					78	
Nurse Practitioner (NP)		151	10		3575	
Registered Nurse (RN)					762	
Licensed Practical Nurse (LPN)					178	
Registered Physical Therapist (RPT)		350	25		1492	
Personal Care Aide (PCA) - Schools (specialty 87)					4174	
Community Treatment Aide/Per Support					688	
MHSA Direct Care Staff					660	

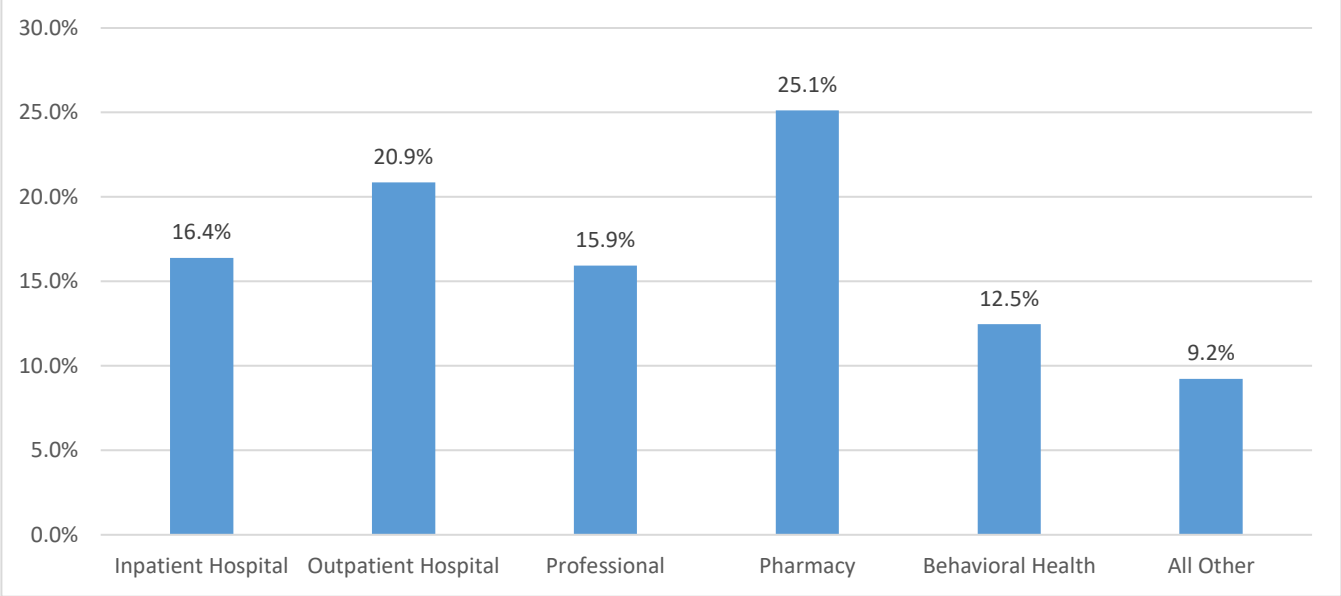
Licensed Mental Health Practitioner (LMHP)					1594	
Mental Health Professional/Masters Level Equivalent (MHP)					2341	
PhD Intern					15	
Licensed Independent Mental Health Practitioner		350	14		2234	
Doctor of Dental Surgery - Dentist (DDS)		288	30		1082	
Licensed Dental Hygienist (LDH)		10			78	
Community Support (CSW) MRO Program		40			875	
Adult Substance Abuse		46	12			
Pharmacist (PHMS)					86	
Peer Support Specialist					74	
Psychological Assistant/Associate					3	
Provisionally Licensed PHD-PPHD					151	
Provisionally Licensed Drug & Alcohol Counselors (PDAC)					283	
Hearing Aid Dealer (HEAR)		29	3		88	
Licensed Medical Nutrition Therapist (LMNT)		31	1		109	
Specially Licensed PHD/Psychology Resident (SPHD)					8	
Licensed Psychologist (PHD)		73	3		506	
Speech Therapy Health Service		155	13		1561	
Occupational Therapy Health Services (OTHS)		166	9		936	
Licensed Drug & Alcohol Counselor (LDAC)					284	
Board Certified Behavior Analyst (BCBA)					290	
Board Certified Associate Behavioral Analyst (BCABA)					16	

Appendix 8. SFY24 Medicaid and CHIP Expenditure by Service

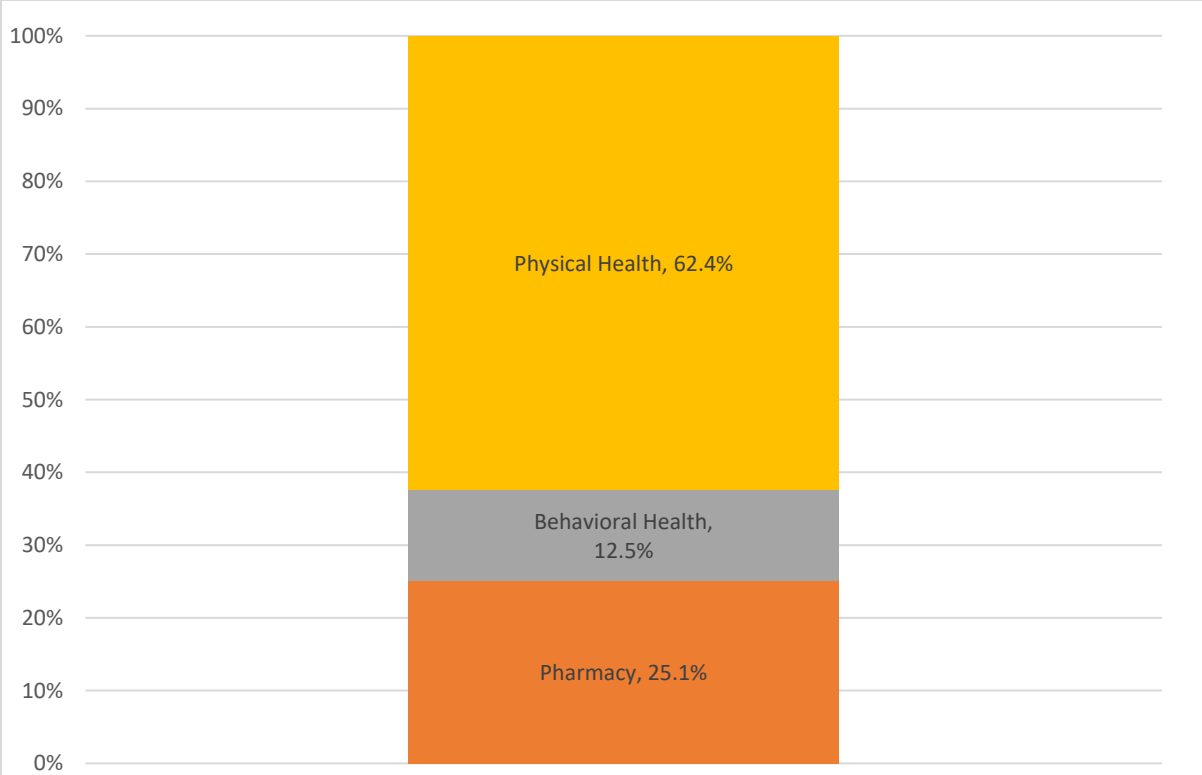


Appendix 7 Effective January 1, 2024 (halfway through SFY2024) managed care dental services transitioned from a stand-alone dental managed benefit, to being included in the integrated Heritage Health Managed Care delivery system. This results in part of the SFY managed dental expenditures represented in this chart separately as Dental Capitation, and the other half as being included in the Heritage Health Capitation. The approximate value of dental services included in the Heritage Health capitation is $32,880,282.

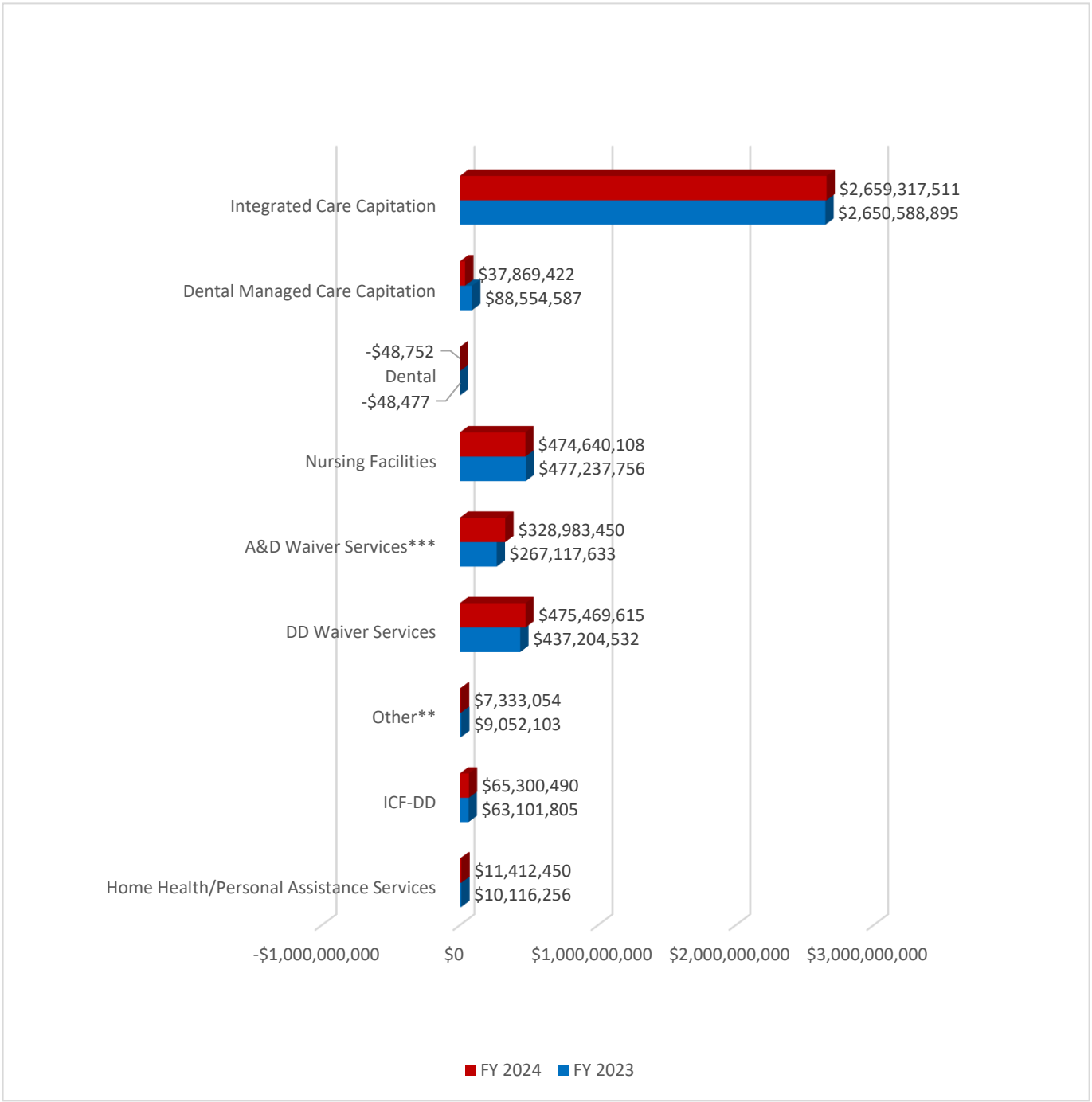
Appendix 9. Percentage of Capitated Health Spend by Service Category



Appendix 10. Heritage Health Medical Services by Relative Cost



Appendix 11. Medicaid and CHIP Expenditures, SFY23 and SFY24



Appendix 12. SFY24 Medicaid Expenditures for Long-Term Care Services