NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

Division of Medicaid & Long-Term Care

Nebraska Medicaid Reform Annual Report for State Fiscal Year 2015-2016

December 1, 2016

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

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DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

December 1, 2016

I am pleased to present the state fiscal year 2015-2016 Medicaid Annual Report.

As outlined in this report, the Division of Medicaid and Long-Term Care (MLTC) continues its commitment to increase efficiency, improve the delivery of services, and manage costs of the Medicaid program in Nebraska. This report offers a review of the ongoing work of the Division, highlighting the year's major initiatives, and describing the major projects for this fiscal year.

Our focus for this fiscal year is on improving the delivery of health care in Nebraska. The work of MLTC this year and next is to evaluate our programs and make changes to better support quality health care delivery in the state. Internally, we have worked to provide better fiscal and program information to the legislature and the public. Through initiatives like Heritage Health, Long-Term Care Redesign, and the MMIS modernization project, we are transforming Nebraska Medicaid to better meet the needs and challenges of the twenty-first century.

The Division looks forward to working with the legislature and our community partners in the year ahead as we undertake major initiatives to improve the provision of services to our clients. As we begin 2017, the Division is excited about the progress made and the work ahead. MLTC operates according to DHHS's mission, "Helping people live better lives," and we constantly strive to improve the quality of care provided to our state's most vulnerable populations.

Please contact me if you have any questions about this report.

Sincerely,

Calder A. Lynch, Director
Division of Medicaid & Long-Term Care
Department of Health and Human Services

Table of Contents

Charts

12. Managed Care Physical Health Regions

13. Heritage Health Timeline

14. Nebraska Medicaid Providers by Type

15. Medicaid Provider Rate Changes

16. Nebraska Medicaid Rate Increases

17. Nebraska FMAP Rates, FFY 2014 through 2019

18. Medicaid and CHIP Expenditures by Service

19. Medicaid and CHIP Expenditures SFY 2015 and SFY 2016

20. SFY 2016 Medicaid Expenditures for Long-Term Care Services

21. Nebraska Medicaid Aged, Blind, and Disabled Members and Long Term Services Expenditures by Living Arrangement

I. EXECUTIVE SUMMARY

The Division of Medicaid and Long-Term Care (MLTC), part of the Nebraska Department of Health and Human Services, is the administrator of the state's Medicaid program. With an appropriated budget of over two (2) billion dollars, MLTC provides health care to twelve percent (12%) of Nebraska's residents, including low-income children and their parents, the aged, and individuals with disabilities.

Every state outlines the eligibility, benefits, provider payments, and service delivery systems of its specific Medicaid program within guidelines set by the federal government. Although there are numerous federal requirements, eligibility, service delivery, and benefit packages can vary from state to state.

The greatest change coming to Nebraska Medicaid is its method of service delivery. Over the past twenty years, the method of delivery for Medicaid in the state has moved gradually from fee-for-service (FFS) to capitated managed care. Following an expansion of physical health managed care in 2012 and the coverage of behavioral health through capitated managed care in 2013, the state is now integrating physical health, behavioral health, and pharmacy services through three statewide managed care organizations (MCOs) in a program called Heritage Health. Beginning on January 1, 2017, nearly all Medicaid clients will be enrolled in managed care, including previously excluded populations. Additionally, most services will be delivered through managed care with the exception of long-term services and supports.

Medicaid is a significant payer of health services in Nebraska. Contracting with approximently 80,000 medical providers, MLTC has an important partnership with the medical community for the delivery of care. Nebraska Medicaid providers have consistently received rate increases over the past several years and the Medicaid MCOs are required to maintain robust provider networks by federal law and their contracts. In state fiscal year 2016, over $1.9 billion was paid for services by Nebraska Medicaid. Of this amount $815 million was from state funds and a little over $1 billion was from federal funds.

MLTC takes seriously the trust the state's safety-net population and taxpayers place in it to provide quality health care in a cost-efficient manner. To achieve this goal, MLTC is undertaking many reforms to its information technology systems to transform how program data is gathered, service payment is made, and program eligibility (for clients and providers) is determined. Additional reforms are being made in modernizing processes and program regulations.

MLTC has made tremendous strides over the past fiscal year and looks forward to continuing its work in state fiscal year 2017.

II. MLTC STRUCTURE

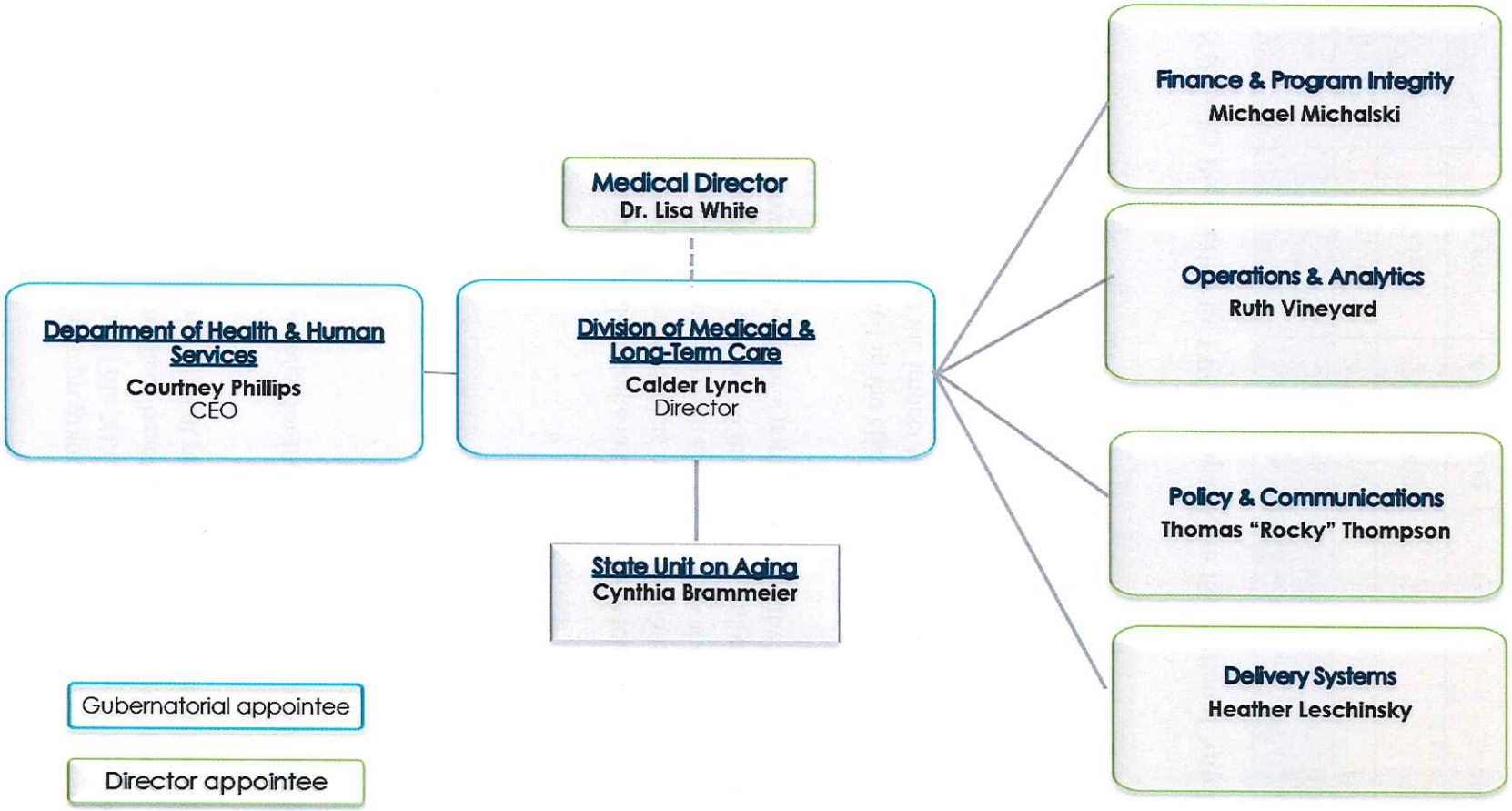
MLTC includes Medicaid and the Children's Health Insurance Program (CHIP), and the State Unit on Aging. Medicaid pays for health care services to eligible elderly, persons with disabilities, low-income pregnant women, and children and their parents, covering more than one in every ten Nebraskans. The Division also administers non-institutional home and community-based waivers including the aged, adults and children with disabilities, and infants and toddlers with special needs.

MLTC is divided into five sections with nearly six hundred full-time employees. During state fiscal year 2016, the Division was realigned to better manage the changing responsibilities as the State moves from payment of claims to contract administration. The Division is structured as follows:

- Delivery Systems: This section is responsible for oversight of the managed care program and its associated contracts (Heritage Health), home and community-based services, and benefit design.
- Operations and Analytics. This section has responsibility for eligibility and business operations, technology initiatives to improve operational effectiveness, data analytics and supporting functions.
- Policy and Communications. This section is responsible for external communications, regulatory compliance, and oversight over the federal authorities under which the Medicaid program operates.
- Finance and Program Integrity. This section oversees the program integrity unit, provider enrollment, financial analysis and reimbursement, budget, and associated reporting.

The Division also includes the State Unit on Aging, which collaborates with public and private service providers to ensure a comprehensive and coordinated community-based services system that will assist individuals to live in a setting of their choice and continue to be contributing members of their community.

Chart 1: MLTC Leadership



II. ELIGIBLITY AND POPULATIONS SERVED

Nebraska Medicaid is a public health insurance program that provides coverage for low-income individuals. Originally enacted in 1965 under Title XIX of the Social Security Act, Medicaid is an entitlement program (a program that guarantees benefits to anyone who meets the qualifications) covering a low-income population that primarily includes seniors, children, and individuals with disabilities.

Nebraska Medicaid, in general, provides coverage for individuals in the following eligibility categories:

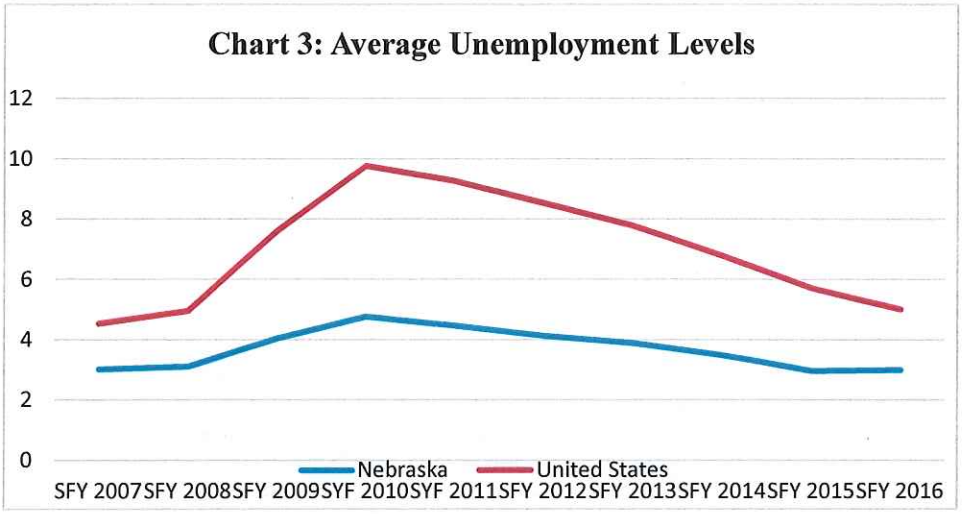
- Children,
- Former foster care youth,
- Aged, blind & disabled (ABD),
- Pregnant women, and
- Parent/caretaker relatives.

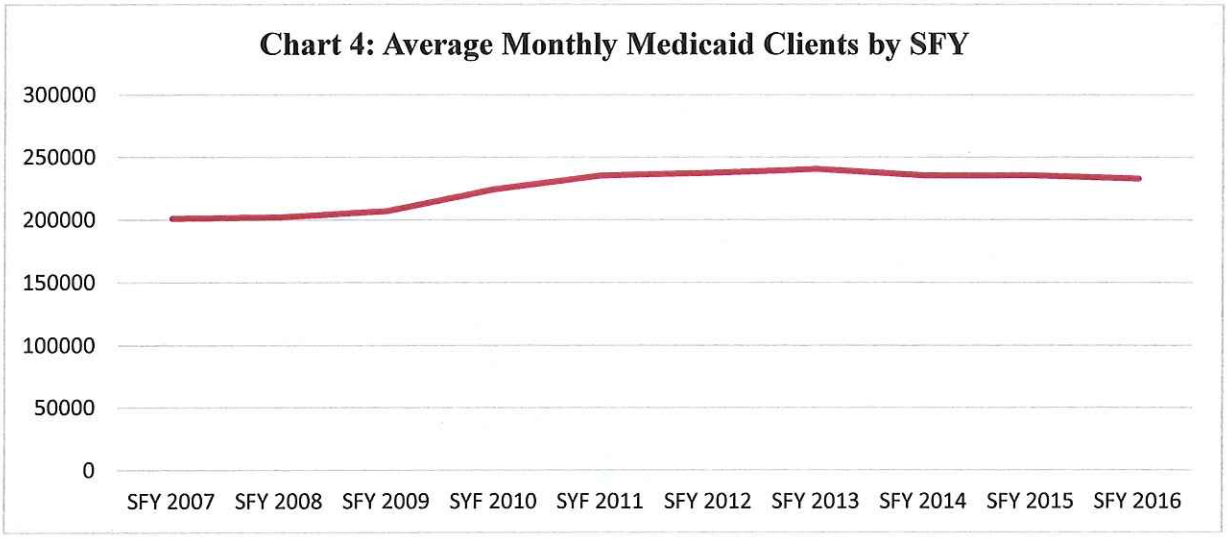
Eligibility factors vary by group and include income and resources. Medicaid enrollment and costs are closely related to the economy. Nebraska has had a fairly robust economy over the past several years, with both poverty rates and unemployment rates below the national average as reflected in chart 2 and 3. This is reflected in total Nebraska Medicaid enrollment remaining fairly low (a little over twelve percent of the state's population) and the total Medicaid enrollment being fairly stable in Chart 4.

The major changes to enrollment as reflected in the chart show a modest growth in program enrollment during the Great Recession and the impact to two new eligibility groups. Effective July 19, 2012, Nebraska implemented a separate CHIP program that added prenatal and delivery services for the unborn children of certain women who do not meet Medicaid eligibility criteria. In 2014, another separate CHIP program (2101(f) CHIP) was implemented to cover those children who would otherwise have lost eligibility due to new eligibility rules created through the Patient Protection and Affordable Care Act (ACA). This CHIP group expired at the end of 2015.

Chart 2: Nebraska Population by FPL Compared to the National Numbers

	Nebraska	United States	Percent of Nebraskans	Percent of Entire US
Under 100% FPL	229,000	47,021,300	12%	15%
100% to 199% FPL	329,600	58,690,600	18%	19%
100% to 399% FPL	593,800	92,283,700	32%	29%
Above 400% FPL	728,700	118,172,300	39%	37%





The majority of Nebraska Medicaid clients (including CHIP children, pregnant women and parents/caretaker relative group) are subject to modified adjusted gross income (MAGI) budgeting methodology. MAGI is required by the ACA. It uses federal income tax rules and tax filing status to determine an individual's eligibility for Medicaid. This change was to simplify eligibility for certain groups and align it with eligibility for the state insurance marketplaces. Other Medicaid eligibility groups in the state are still subject to other criteria, specifically groups that do not qualify subject solely to income. These are groups that qualify based primarily upon age or disability.

Chart 5 provides the 2016 federal poverty levels and Chart 6 explains several of the Medicaid programs. MAGI groups are in blue.

Chart 5: 2016 Poverty Guidelines

Household Size	50% FPL	100% FPL	138% FPL	200% FPL
1	$5,940.00	$11,880.00	$15,206.40	$23,760.00
2	$8,010.00	$16,020.00	$22,107.60	$32,040.00
3	$10,080.00	$20,160.00	$27,820.80	$40,320.00
4	$12,150.00	$24,300.00	$33,534.00	$48,600.00

Chart 6: Nebraska Medicaid Coverage Groups and Income Eligibility Requirements

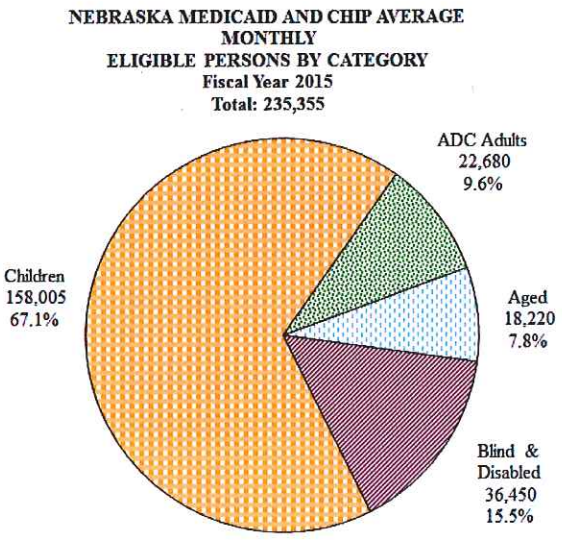
Program	Description	Income Limit
Subsidized Adoption and Guardianship Assistance (SAGA)	An individual who meets the eligibility requirements for the Bridge to Independence Program, who is between the ages of 19 and 21, who entered a subsidized adoption or guardianship on or after their sixteenth birthday and who meets all other eligibility criteria.	Twenty-three percent (23%) of the federal poverty level
Former Ward/IMD		Fifty-one percent (51%) of the federal poverty level
Parent/Caretaker Relatives	Parents and caretaker relative are eligible for Medicaid below a certain income	Fifty-eight percent (58%) of the federal poverty level
Pregnant Women	Pregnant women whose family income is below a certain amount are Medicaid-eligible. An eligible pregnant woman remain Medicaid-eligible through a sixty-day postpartum period. There is continuous eligibility for the newborn through his or her first birthday	Equal to or less than 194% of the federal poverty level
Newborn to Age One		162% of the federal poverty level
Children Ages One to Five		145% of the federal poverty level
Children Ages Six to Eighteen		133% of the federal poverty level
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.	Nebraska's CHIP provides health coverage for eligible uninsured children if they have income at or below 213% of the federal poverty level (FPL) -, are not eligible for Medicaid, and have no private insurance coverage.
599 CHIP	A separate CHIP program that adds prenatal and delivery services for the unborn children of certain women who do not meet Medicaid eligibility criteria.	The household income must meet or be below 197% of the federal poverty level.

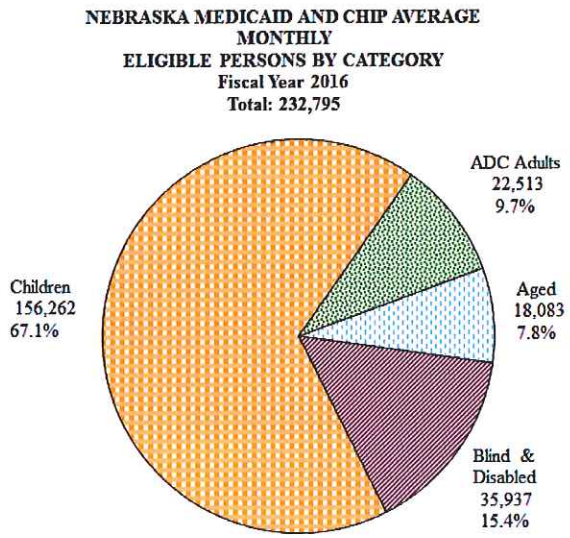
Former Foster Care	An individual who is under twenty-six, was in foster care and receiving Medicaid at age eighteen or nineteen, and is not eligible for Medicaid under another program.	No income or resource guidelines
Transitional Medical Assistance (TMA)	Parents/caretaker relatives who are no longer Medicaid-eligible due to earned income. They must have been Medicaid-eligible three out of the previous six months.	The first six months are without regard to income. In the next six months earned income must be below 185% of the Federal Poverty Level. All members of the family are eligible if their earned income is below 100% FPL, If above 100% FPL, the family can pay a premium and be Medicaid eligible.
Aged, Blind, and Disabled	Individuals 65 or older or under 65, but are determined blind or disabled by SSA.	At or above 100% of the federal poverty level 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% FPL, QI=135% FPL with resource limits.
Medically Needy	These are individuals who have a medical need and are not eligible under the 100% of the federal poverty level for the ABD population. This Medicaid category allows the individual to obligate their income above the standard on their own Medical bills and establish Medicaid eligibility	
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.	They are eligible without paying a premium up to 200% FPL, between 200% FPL and 250% FPL they must pay a premium.
Katie Beckett	Medicaid State plan amendment for children under 18 who would require institutional services and meet hospital level of care	
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	An emergency medical condition is defined as a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity where the absence of immediate medical attention could reasonably be expected to result in: 1. Serious jeopardy to the patient's health; 2. Serious impairment of a bodily function; or 3. Serious dysfunction of any body organ or part. The State Review Team (SRT) makes the determination that the client has an emergency medical condition. The client must meet all eligibility criteria except citizenship or qualified alien status. Income and resource vary depending on the category of eligibility.	

Chart 7, below, compares enrollment in different eligibility categories for SFYs 2015 and 2016. Total Medicaid and CHIP enrollment decreased from 235,356 to 232,795. The majority of this decrease is attributed to less children being enrolled. As discussed above, 2101(f) CHIP sunset in December 2015, which might account partly for this decrease in enrollment.

Chart 7: Average Nebraska Monthly Enrollment for Medicaid and CHIP, SFY 2015 and SFY 2016





Charts 8 and 9 compares the cost differences of different eligibility categories. While the ABD category represents 23% of clients, they account for 65.8% of expenditures. Children account for 67% of clients but only 27% of expenditures.

Chart 9 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), and premium payments paid on behalf of persons eligible for Medicare. Client demographic data is not available for these expenditures. This means some expenditures, particularly in the ABD categories, are understated.

Chart 8: Nebraska Medicaid Cost Per Enrollee

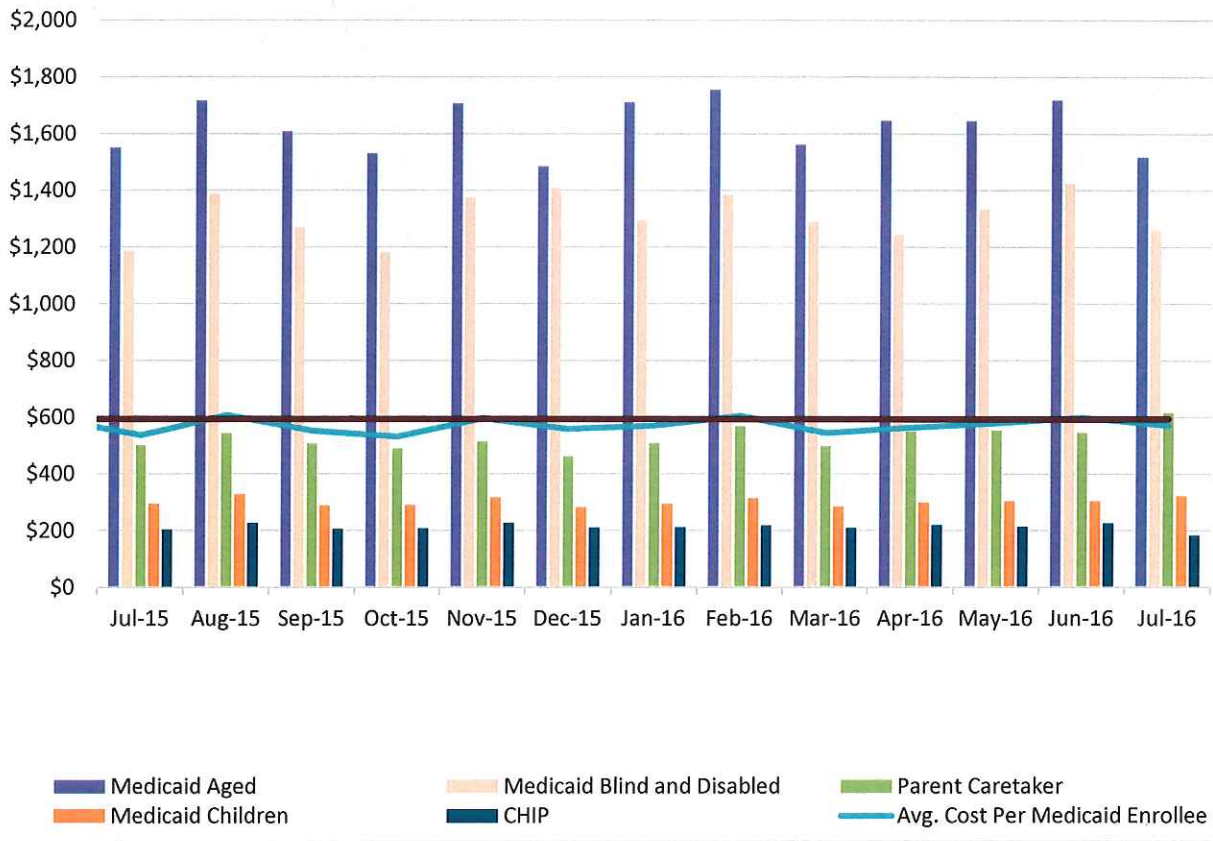
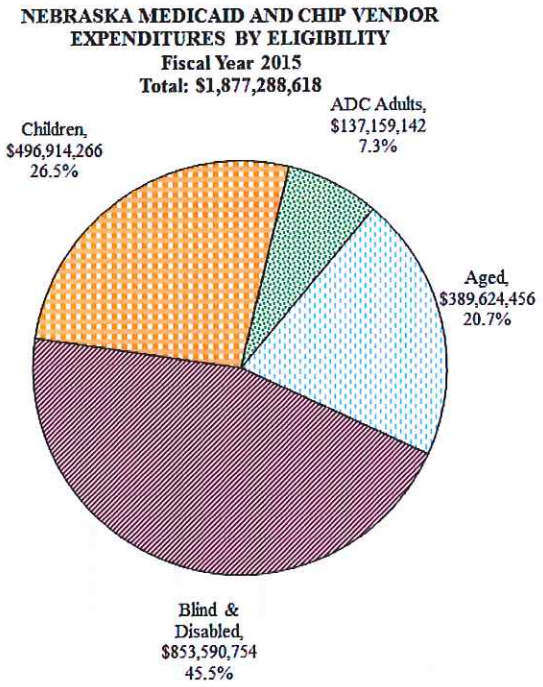
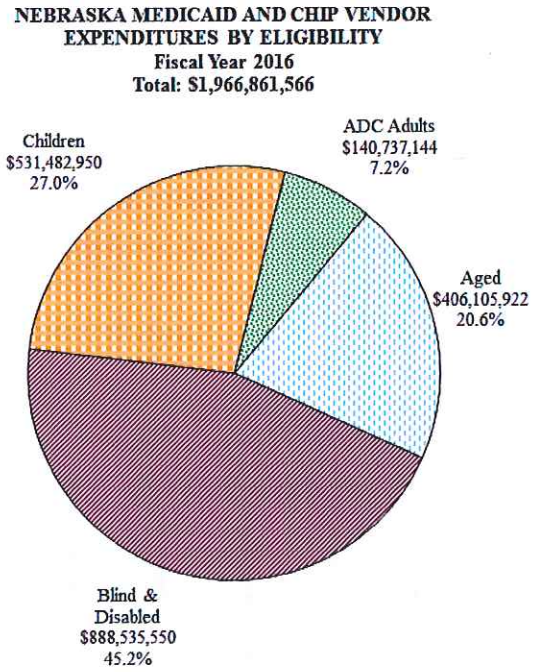


Chart 9: Nebraska Medicaid and CHIP Annual Cost by Eligibility Category





IV. BENEFIT PACKAGE

Federal Medicaid statutes mandate that states provide certain services and allow states the option of providing other services. The Nebraska Medical Assistance Act (68-901 to 68-975) and the Medicaid State Plan delineates the mandatory and optional services available to Medicaid and CHIP recipients in Nebraska. These mandatory and optional services are denoted in Chart 10.

Chart 10: Federal Medicaid Mandatory and Optional Services Covered in Nebraska Neb. Rev. Stat. 68-911

Mandatory Services	Nebraska Optional Services
• Inpatient and outpatient hospital services • Laboratory and x-ray services • Nursing facility services • Home health services • Nursing services • Clinic services • Physician services • Medical and surgical services of a dentist • Nurse practitioner services • Nurse midwife services • Pregnancy-related services • Medical supplies • Early and periodic screening and diagnostic treatment (EPSDT) services for children	• Prescribed drugs • Intermediate care facilities for the developmentally disabled (ICF/DD) • Home and community-based services for aged persons and persons with disabilities • Dental services • Rehabilitation services • Personal care services • Durable medical equipment • Medical transportation services • Vision-related services • Speech therapy services • Physical therapy services • Chiropractic services • Occupational therapy services • Optometric services • Podiatric services • Hospice services • Mental health and substance use disorder services • Hearing screening services for newborn and infant children • School-based administrative services

Recent and Upcoming Benefit Package Changes

MLTC continuously evaluates its benefit packages to make changes based on new medical procedures and best practices. Over this past fiscal year, several changes were announced, specifically concerning behavioral health services.

The state began covering behavioral modification services under early and periodic screening, diagnosis, and treatment (EPSDT) authority during state fiscal year 2016. Services approved for coverage include day treatment, community treatment aide, and outpatient therapy. Treatment models approved for coverage include cognitive behavioral therapy, comprehensive behavioral

intervention, and applied behavioral analysis for children. The state plan amendment covering these services had an effective date of October 1, 2015.

During state fiscal year 2017, Nebraska Medicaid will continue to expand its behavioral health service array to cover services directed towards at-risk youth. In 2015, the Nebraska Legislature passed LB 500. This bill required the Department to submit a Medicaid state plan amendment to cover multisystemic therapy (MST). MST is a juvenile crime prevention program to enhance parental skills and provide intensive family therapy to at-risk teens which empowers youth to cope with the family, peer, school, and neighborhood problems that they encounter in order to prevent recidivism. The state plan amendment was submitted on April 6, 2016, with an effective date of July 1, 2016. It also included coverage for functional family therapy (FFT) to help reduce out-of-home placements and prevent recidivism in juvenile offenders.

Nebraska Medicaid also is working with DHHS's Public Health and Behavioral Health Divisions to expand medication assisted treatment (MAT) and expand the provider base for addiction treatment services. The state also will begin coverage of peer support to its roster of available treatments for those with substance use disorder in 2017.

Chart 11: Timeline for Upcoming Benefits Changes

Behavioral Modification	October 2015
MST/FFT	July 2016
Peer Supports	2017

V. SERVICE DELIVERY

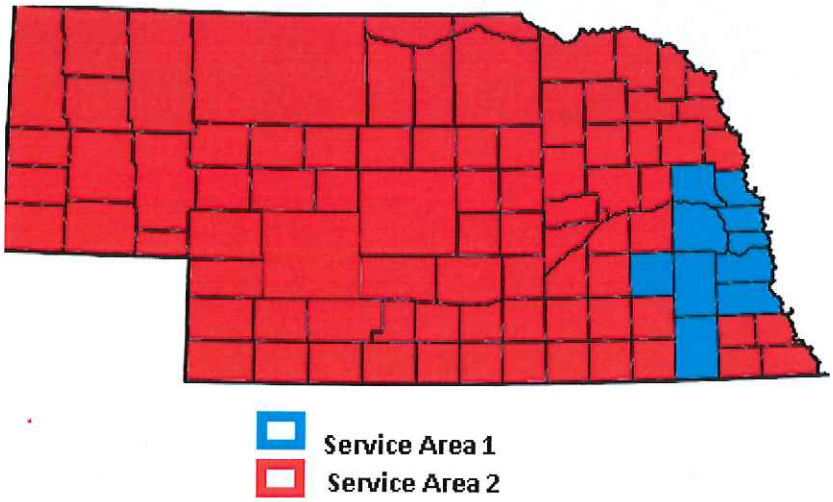
Nebraska delivers Medicaid primarily through risk-based managed care. Managed care is a health care delivery system in which the state pays a monthly set amount per member each month as payment to the managed care organizations (MCOs) to pay health care providers for medical services. In a risk-based managed care delivery system, MCOs are responsible for the management and provision of specific covered services. This is an alternative to fee-for-service (FFS), in which a state Medicaid department pays each Medicaid provider for each service provided per state and federal law. Nationally, thirty-eight other states (including the District of Columbia) contract with risk-based MCOs to provide Medicaid services to their enrollees.

The Nebraska Medicaid managed care program, implemented in July 1995, initially provided physical health benefits to Medicaid members in three counties. In August 2010, the state added managed care to seven surrounding counties. On July 1, 2012, Nebraska's managed care program was expanded statewide for physical health services. On September 1, 2013, Nebraska shifted its behavioral health program to an at-risk managed care model.

Today, approximately eighty (80%) of individuals who qualify for Medicaid receive their physical health benefits through managed care and almost all Medicaid members receive their behavioral health benefits through managed care.

Physical health services today are provided regionally by three MCOs, Aetna Better Health of Nebraska and UnitedHealth Community Plan in Service Area 1, and Aetna Better Health of Nebraska and Arbor Health Plan in Service Area 2. Behavioral health services are provided by a separate contractor, Magellan Health Solutions, statewide. The service areas are shown below on Chart 12.

Chart 12: Medicaid Managed Care Physical Health Regions



Managed care was implemented in Nebraska with the goal to improve the health and wellness of Medicaid members by increasing their access to comprehensive health services in a cost-effective manner. With this goal in mind, Nebraska requires the MCOs to report certain performance measures. The incumbent managed care programs have shown positive outcomes for the health of Nebraska Medicaid enrollees.

In October 2015, the Department released a request for proposal (RFP) to select qualified MCOs to provide statewide integrated medical, behavioral health, and pharmacy services to almost all Medicaid members. This program will be called Heritage Health. In April 2016, the state awarded contracts to Nebraska Total Care (Centene), UnitedHealthCare Community Plan, and WellCare of Nebraska. The program will begin operations on January 1, 2017. Having one health plan responsible for a more complete range of services for a member encourages investment in more cost-effective services to better address the health care needs of the whole person.

Chart 13: Heritage Health Timeline

Heritage Health will integrate the health care for groups of enrollees who were previously excluded from participation in the State's physical health managed care program, but who received their behavioral health services through the State's behavioral health managed care contractor. These groups include individuals with Medicare as their primary insurance, individuals who are enrolled in one of DHHS's home and community-based waiver programs for individuals with physical disabilities or developmental disabilities, as well as individuals who live in long-term care institutional settings such as nursing homes or intermediate care facilities for people with developmental disabilities.

While these individuals will have their physical, behavioral, and pharmacy health services coordinated by their Heritage Health plan, the administration of their long-term supports and services (such as their institutional care or in-home care) will continue to be administered as it is today.

As behavioral health services are integrated with the physical health delivery system, the state aims to continue decreasing reliance on emergency and inpatient levels of care by providing clients with evidence-based care options that emphasize early intervention and community-based treatment. MLTC also anticipates that integrated physical and behavioral health managed care will achieve the following outcomes:

- Improved health outcomes
- Enhanced integration of services and quality of care
- Emphasis on person-centered care, including enhanced preventive and care management services
- Reduced rate of costly and avoidable care
- Improved financially sustainable system

With the implementation of Heritage Health, MLTC projects that the Medicaid-eligible populations remaining in the FFS delivery system will constitute less than two percent (2%) of the overall Medicaid population. MLTC estimates that over the course of a calendar year, approximately 2,500 unique individuals will become Medicaid-eligible within those remaining FFS population categories. Of those 2,500 eligible individuals, MLTC anticipates that approximately fifty percent (50%) are likely to be beneficiaries who have a share of cost obligation that must be met before that individual becomes Medicaid-eligible.

VI. PROVIDERS

MLTC is works with Nebraska's medical providers to deliver health care to Medicaid members. As discussed above, the vast majority of Medicaid services are provided by managed care organization, or MCOs. The state pays premiums to MCOs that coordinate provider networks and provider reimbursements. Additionally, some legacy programs are paid for on a FFS basis.

As of July 2016, there were 68,125 Nebraska Medicaid enrolled providers that are "in-state." Of those, 15,753 were billing providers and 52,372 were group members. There were 12,208 Nebraska Medicaid enrolled providers that were out-of-state. Of those, 598 were billing providers and 11,610 were group members. Details about these providers are on Chart 14.

Chart 14: Nebraska Medicaid Providers by Type, July 2016

Provider Type	Provider Type of Practice	In State	Out of State
Adult Substance Abuse Provider	Group practice, members not billing independently	33	
Ambulatory Surgical Centers (ASC)		52	
Anesthesiologist (ANES)	Group practice, members not billing independently	188	22
	Group practice member, members not billing independently	1,970	454
	Individual or solo practice, members billing independently	29	
Assertive Community Treatment (ACT) Medicaid Reimbursement Option (MRO) Program	Group practice, members not billing independently	2	
		1	
Clinic (CLNC)	Group practice, members not billing independently	294	60
Community Support (CSW) MRO Program	Group practice, members not billing independently	47	
	Group practice member, members not billing independently	882	138
Day Rehabilitation (DAYR) MRO Program	Group practice, members not billing independently	4	2
		17	
Day Treatment Provider (DAY)		11	
Dispensing Physician (MD)	Group practice, members not billing independently	5	6
Doctor Of Dental Surgery - Dentist (DDS)	Group practice, members not billing independently	315	9
	Group practice member, members not billing independently	1,161	474
	Individual or solo practice, members billing independently	495	
Doctors Of Chiropractic Medicine (DC)	Group practice, members not billing independently	177	1
	Group practice member, members not billing independently	298	24

	Individual or solo practice, members billing independently	281	
Doctors Of Podiatric Medicine (DPM)	Group practice, members not billing independently	51	2
	Group practice members, members Not Billing Independently	155	21
	Individual or solo practice, members billing independently	38	
Doctors of Osteopathy (DO)	Group practice, members not billing independently	2	2
	Group practice members, members Not Billing Independently	1,357	217
	Individual or solo practice, members billing independently	7	
Federally Qualified Health Center (FQHC)	Group practice, members not billing independently	45	1
Hearing Aid Dealer (HEAR)	Group practice, members not billing independently	44	3
	Group practice members, members not billing independently	132	7
	Individual or solo practice, members billing independently	33	
Home Health Agency (HHAG)		93	1
Hospice (HSPC)		74	
Hospitals (HOSP)	Children's facility (hospital only)	9	
	Rehabilitation facility (hospital only)	8	
		401	84
Indian Health Hospital Clinic (IHSH)		3	
Laboratory (LAB) (Independent)		155	52
Licensed Dental Hygienist (LDH)	Group practice, members not billing independently	10	
	Group practice members, members not billing independently	25	23
	Individual or solo practice, members billing independently	10	
Licensed Drug & Alcohol Counselor (LDAC)	Group practice members, members not billing independently	386	96
Licensed Independent Mental Health Practitioner (IMHP)	Group practice, members not billing independently	25	
	Group practice members, members not billing independently	2,162	685
	Individual or solo practice, members billing independently	315	
Licensed Medical Nutrition Therapist (LMNT)	Group practice, members not billing independently	6	
	Group practice members, members not billing independently	53	5

	Individual or solo practice, members billing independently	2	
Licensed Mental Health Practitioner (LMHP)	Group practice, members not billing independently	3	
	Group practice members, members not billing independently	2,337	465
	Individual or solo practice, members billing independently	52	
Licensed Practical Nurse (LPN)	Group practice members, members not billing independently	8	3
	Individual or solo practice, members billing independently	7	
Licensed Psychologist (PhD)	Group practice, members not billing independently	20	1
	Group practice members, members not billing independently	1,043	286
	Individual or solo practice, members billing independently	127	
Mental Health Home Health Care Provider (CT)	Group practice members, members not billing independently	306	8
Mental Health Personal Care Aide (CTAI)	Group practice members, members not billing independently	25	154
Mental Health Professional/Masters Level Equivalent (MHP)	Group practice members, members not billing independently	1,842	638
	Individual or solo practice, members billing independently	2	
Nurse Midwife (NW)	Group practice members, members not billing independently	161	84
Nurse Practitioner (NP)	Group practice, members not billing independently	34	1
	Group practice members, members not billing independently	4,851	1,547
	Individual or solo practice, members billing independently	56	
Nursing Homes (NH)		1,114	
Occupational Therapy Health Services (OTHS)	Group practice, members not billing independently	399	2
	Group practice members, members not billing independently	1,353	224
	Individual or solo practice, members billing independently	1	
Optical Supplier (OPTC)		43	
Optometrists (OD)	Group practice, members not billing independently	190	8
	Group practice members, members not billing independently	564	82
	Individual or solo practice, members billing independently	89	
Orthopedic Device Supplier (ORTH)		1	5

Other Prepaid Health Plan (OPH)		2	
Pharmacy (PHCY)	Independent pharmacy	238	
	Large chain pharmacy	224	
	Other pharmacy	48	
	Professional pharmacy	10	
	Small chain pharmacy	148	
	Unit dose, independent pharmacy	7	
	Unit dose, large chain pharmacy	4	
Physician Assistant (PA)	Group practice members, members not billing independently	3,599	1,223
Physicians (MD)	Group practice, members not billing independently	64	13
	Group practice members, members not billing independently	21,638	3,309
	Group practice members, hospital affiliated, members not billing independently	2	
	Individual or solo practice, members billing independently	309	
Professional Clinic (PC)	Group practice, members not billing independently	2,954	231
Professional Resource Family Care (PRFC)	Group practice, members not billing independently	2	1
Provisionally Licensed Drug & Alcohol Counselors (PDAC)	Group practice members, members not billing independently	90	54
Provisionally Licensed PHD-PPHD	Group practice, members not billing independently	1	
	Group practice members, members not billing independently	127	35
	Individual or solo practice, members billing independently	1	
Psychiatric Residential Treatment Facility (PRTF)		8	1
Qualified Health Maintenance Organization (QHMO)		5	
Registered Nurse (RN)	Group practice, members not billing independently	3	
	Group practice members, members not billing independently	169	17
	Individual or solo practice, members billing independently	7	
		3	
Registered Physical Therapist (RPT)	Group practice, members not billing independently	572	7
	Group practice members, members not billing independently	2,658	1,005

	Individual or solo practice, members billing independently	14	1
Rental And Retail Supplier (RTLR)		285	51
NFOCUS Providers (Personal Assistance Services and HCBS)	Group practice members, members not billing independently	2	1
		1	
		4,283	
Residential Rehabilitation (REST)	Group practice, members not billing independently	2	
		15	
Rural Health Clinic-Independent (IRHC)	Individual or solo practice, members billing independently	26	4
Rural Health Clinic-Provider Based (PRHC)(Less Than 50 Beds)	Individual or solo practice, members billing Independently	125	8
Rural Health Clinic-Provider Based (RHCP) (Over 50 Beds)	Individual or solo practice, members billing independently	8	
Specially Licensed Phd/Psychology Resident (SPHD)	Group practice members, members not billing independently	15	3
Speech Therapy Health Service	Group practice, members not billing independently	416	4
	Group practice members, group practice, members not billing independently	2,941	318
	Individual or solo practice, members billing independently	23	
Substance Abuse Treatment Center (SATC)	Group practice, members not billing independently	81	1
Therapeutic Group Home (ThGH)		7	
Transportation		486	24
Treatment Crisis Intervention (TCI)		2	
Tribal 638 Clinic (T638)	Group practice, members not billing independently	9	
		68,125	**12,208**

The Nebraska Medicaid program uses different methodologies to reimburse different Medicaid FFS services. 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 a per diem based on a reasonable cost of providing the services. Effective January 1, 2016, federally qualified health centers (FQHCs) are reimbursed on the alternative payment methodology. Rural health clinics (RHCs) are reimbursed their cost

or a prospective rate depending on whether they are independent or provider-based. Outpatient hospital reimbursement is based on a percentage of the submitted charges. Nursing facilities are reimbursed a daily rate based on facility cost and client level of care. Intermediate care facilities for persons with developmental disabilities (ICF/DDs) are reimbursed on a per diem rate based on a cost model. HCBSs, including assisted living costs, are reimbursed at reasonable fees as determined by Medicaid.

In order to control costs, many states cut provider rates during the Great Recession and its aftermath, as shown in Chart 15. However, as shown in Chart 16, Nebraska Medicaid providers have received rate increases every year since SFY 2012 through 2016.

Primary care services increased nationally to Medicare rates in January 2013 as a result of the ACA. The federal government funded the difference between Medicaid rates and Medicare rates. This national rate bump expired in December 2014. However, Nebraska elected to continue this rate increase.

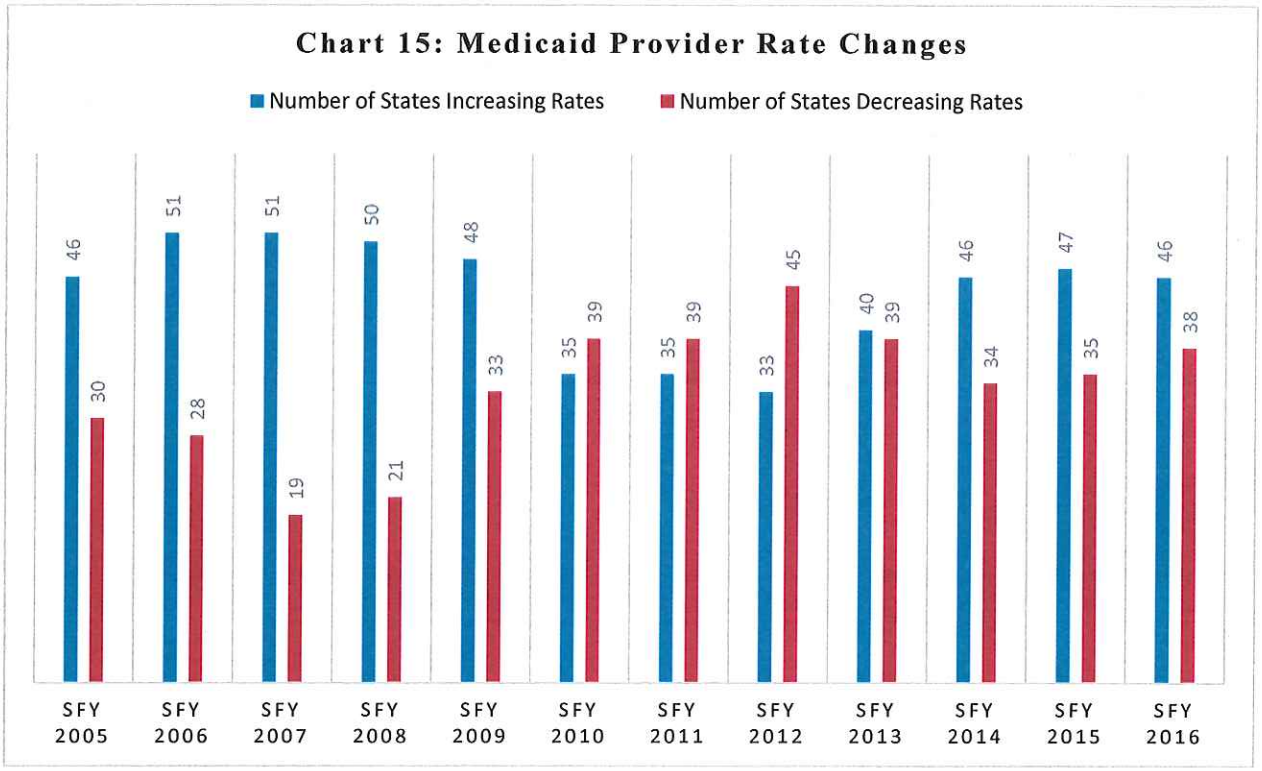


Chart 16: Nebraska Medicaid Rate Increases

SFY	Rate Increase
2012	Rates increased 1.54%
2013	Rates increased up to 2.25% to a maximum of 100% of Medicare rates as of January 1, 2013

2014	Rates increased up to 2.25% to a maximum of 100% of Medicare rates as of January 1, 2014
2015	Rates increased up to 2.25% to a maximum of 100% of Medicare rates for behavioral health, nursing facilities, assisted living, and ICF-DD providers. Other Medicaid services rates increased up to 2.00% 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 2.00% to a maximum of 100% of Medicare rates.

For most services paid for by managed care (the vast majority of services provided by Nebraska Medicaid), the MCOs are not bound by the state fee schedule. Each managed care organization must have an adequate provider network and may negotiate reimbursement rates with providers in its network.

VII. VENDOR EXPENDITURES

Medicaid and CHIP are financed jointly by the federal government and state governments, with the federal government matching state spending at a rate known as the Federal Medical Assistance Percentage (FMAP), which varies from state to state. FMAP is based on each state's per capita income relative to the national average and is highest in the poorest states, varying from 50% to 73%. Nebraska's FMAP in federal fiscal year (FFY) 2015[1] was 53.27% for Medicaid and 67.29% for CHIP. Due to the ACA, the CHIP FMAP has increased beginning in FFY 2016.

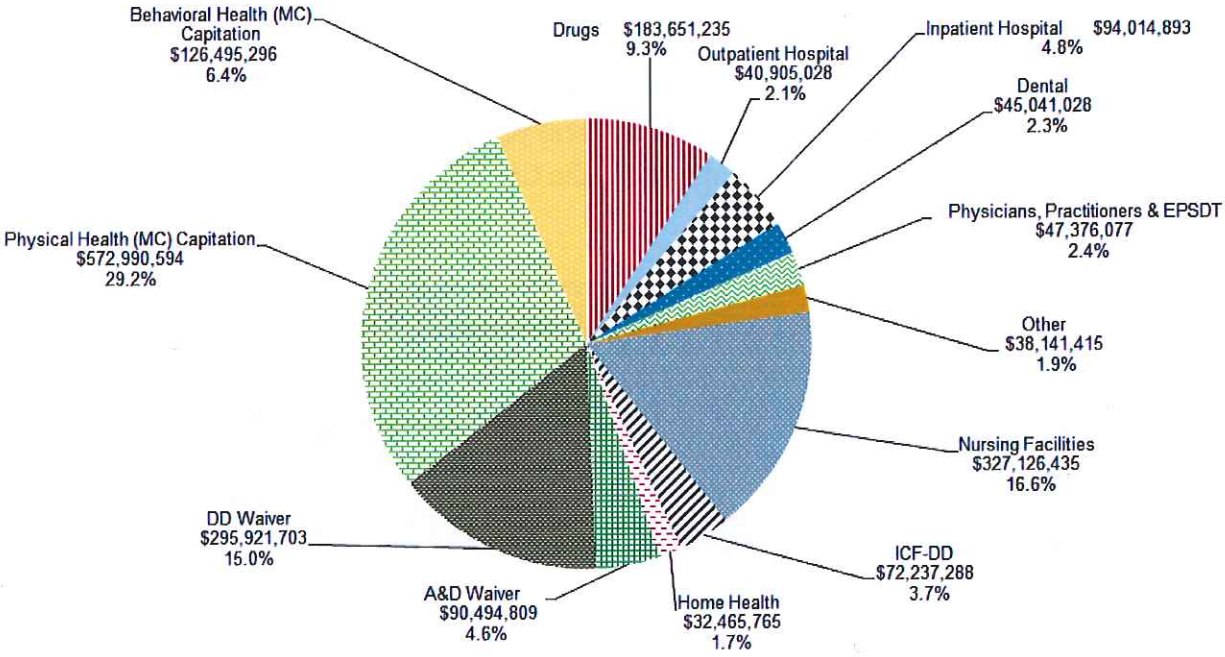
Chart 17: Nebraska FMAP Rates, FFY 2014 through 2019

Medicaid	FMAP	CHIP	FMAP
FY14	54.74%	FY14	68.32%
FY15	53.27%	FY15	67.29%
FY16	51.16%	FY16	88.81%
FY17	51.85%	FY17	89.30%
FY18 (Estimated)	52.58%	FY18 (Estimated)	89.81%
FY19 (Estimated)	52.58%	FY19 (Estimated)	89.81%

Chart 18 shows how the $1.966 billion in Medicaid/CHIP expenditures to vendors are distributed by vendor type.

[1] October 1, 2014 to September 30, 2015

Chart 18: Medicaid and CHIP Expenditures[2] by Service
SFY 2016
Total Vendor Payments $1,966,861,566[3]

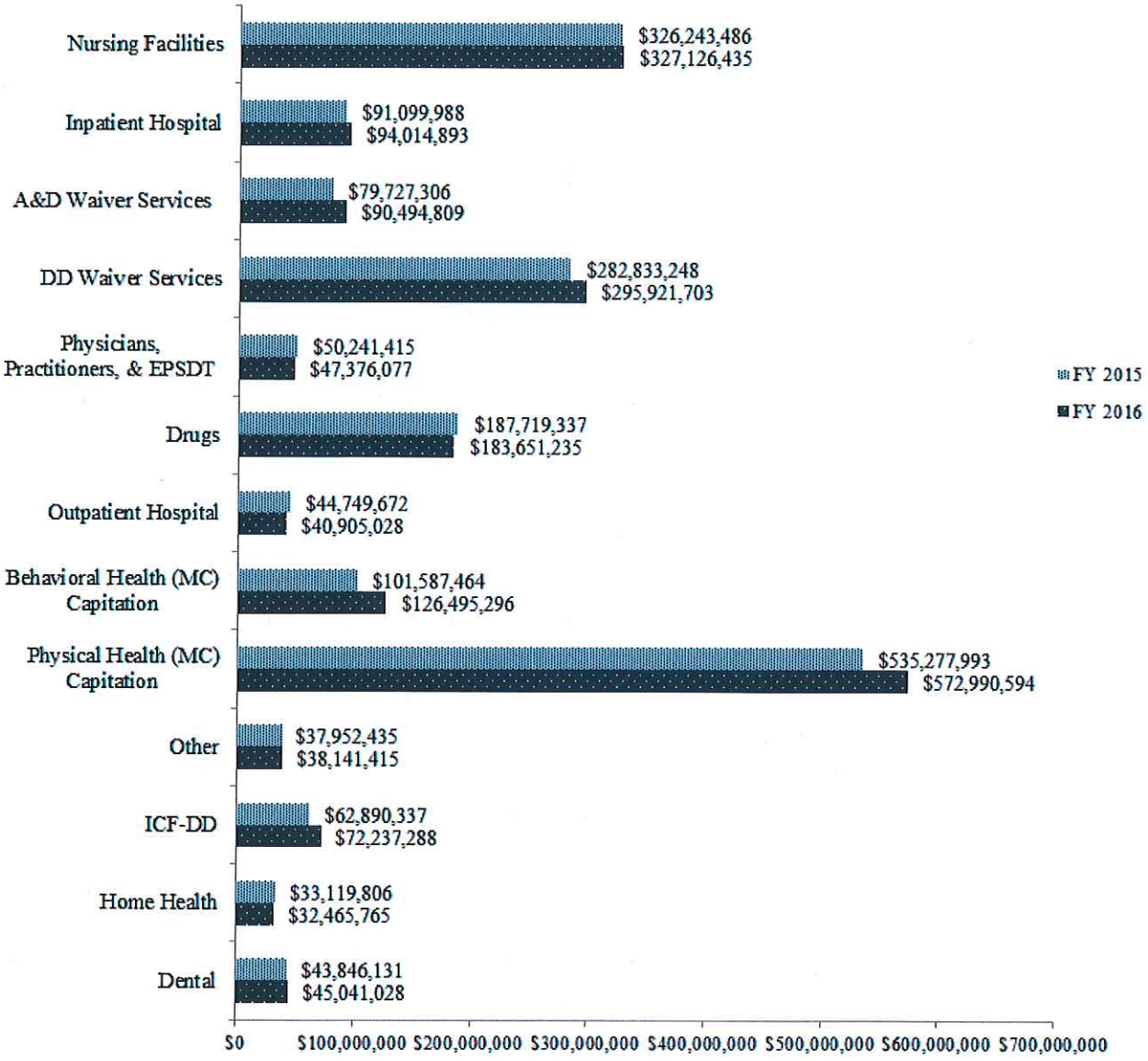


As discussed above, a significant shift in the management and administration of Medicaid services has taken place over the past several years with the growth of managed care. This expenditure is expected to continue to increase with the implementation of Heritage Health with reductions in other vendor categories. Chart 19 shows vendor expenditures from SFY 2014 and 2015 side by side.

[2] Includes payments to vendors only, not adjustments, refunds or certain payments for premiums or services paid outside the Medicaid Payment System (MMIS) or NFOCUS.

[3] For drugs, $106,955,169 million in offsetting drug rebates is not reflected in the drug expenditures of $183,651,235.
DSH payments of $45 million are not reflected in inpatient or outpatient hospital expenditures.
"Other" includes "Speech/ Physical Therapy," "Medical/Optical Supplies," "Ambulance," and "Lab/Radiology."
"AD Waiver" includes includes $694,746 of expenditures under the Traumatic Brain Injury waiver.

Chart 19: Medicaid and CHIP Expenditures SFY 2015 and SFY 2016[4]



Not all Medicaid and CHIP expenditures are captured in Chart 20. Several other transactions are highlighted below.

Drug rebates are reimbursements made by pharmaceutical companies to Medicaid and CHIP that reduce individual drug costs to a more competitive or similar price that is being offered to other

[4] A&D Waiver includes expenditures under the Traumatic Brain Injury waiver (FY14 = $699,938 & FY15 = $678,185). Physical Health Capitation includes Pace Nebraska

large drug payers, such as insurance companies. In SFY 2016, Medicaid received $106.9 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 SFY 2016, Medicaid paid $44,980,223 through the DSH program, a 5.7% increase compared to $42,519,315 paid in SFY 2015.

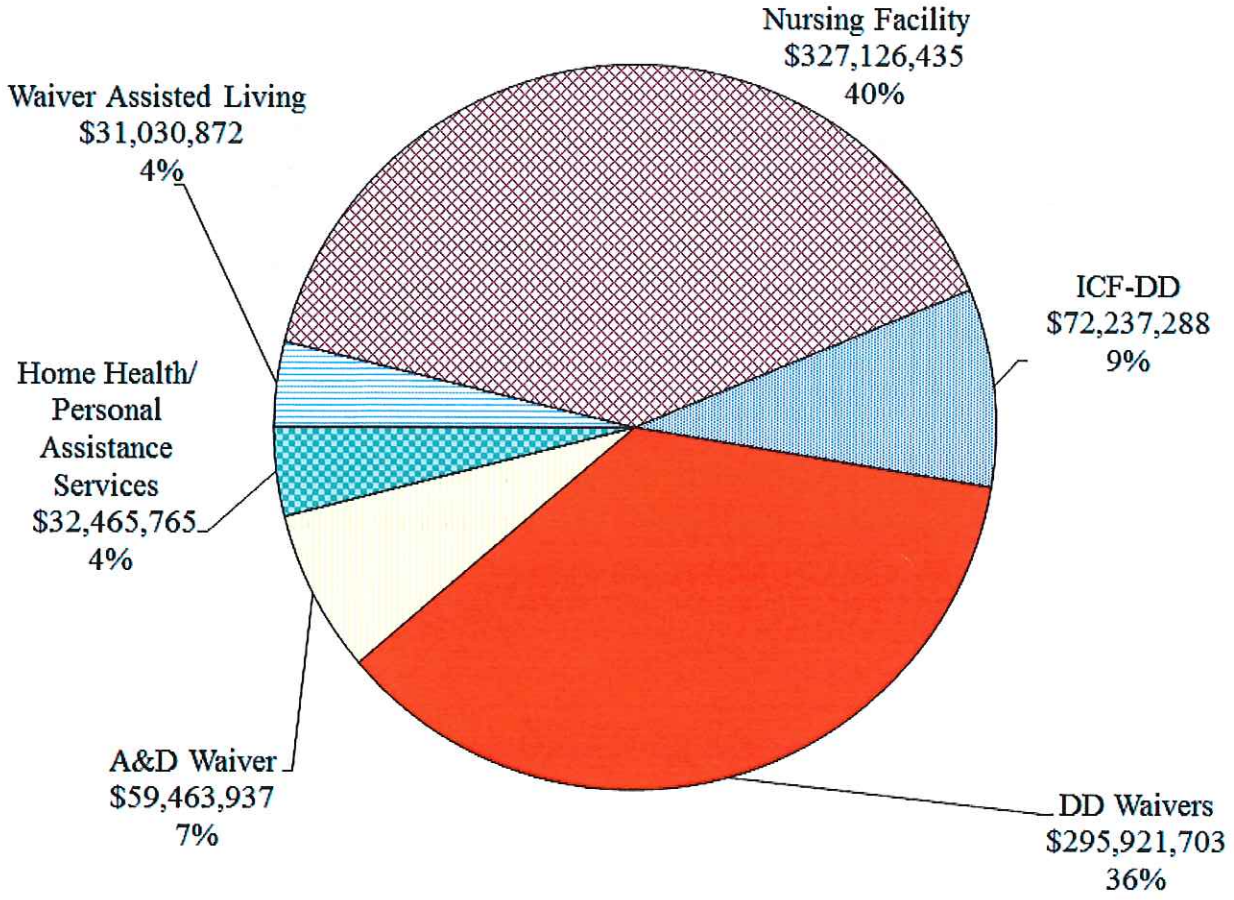
Medicaid pays the Medicare Part B premium for clients that are dually eligible for Medicare and Medicaid. In SFY 2016, Medicaid paid $45,768,262 for Medicare premiums, a 5.4% increase from the $43,414,909 for Medicare premiums, paid in SFY 2015. Part B premium amounts were $99.90 per month in calendar year (CY) 2012, $104.90 in CY 2013, CY 2014, and CY 2015. CY 2016 monthly premium amounts were $121.80 and CY 2017 monthly premium amounts are estimated to be $129.96.

Part D clawback payments are made to CMS to cover the State's share of prescription drugs for persons dually eligible for both Medicare and Medicaid. In SFY 2016, clawback payments totaled $54,776,185, a 7.3% increase from the $51,028,410 paid in SFY 2015. 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.

LONG-TERM CARE SERVICES

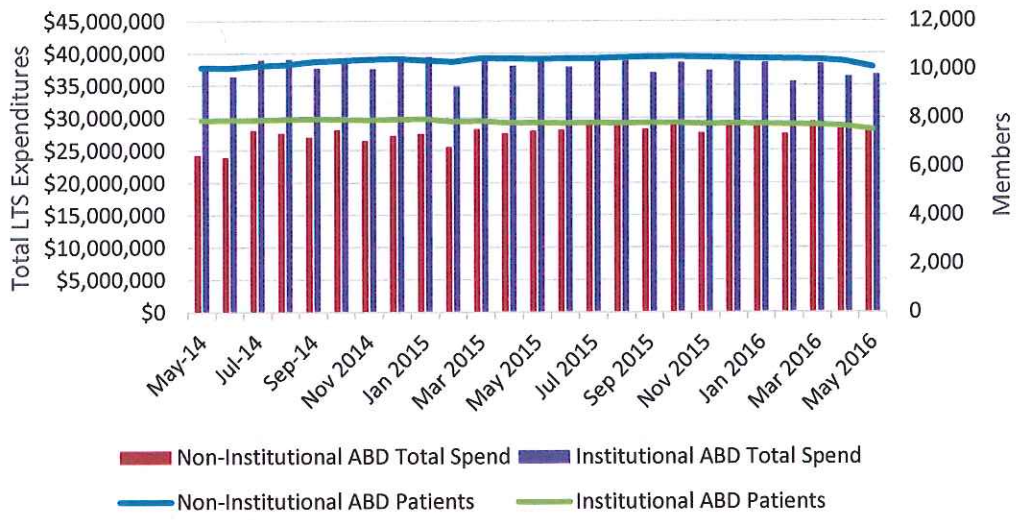
Long-term care (LTC) services support individuals with chronic or ongoing health needs related to age or disability. Services are geared to multiple levels of client need ranging from limited assistance with activities of daily living to complex nursing interventions. Assistance can be offered in a variety of settings from care in an individual's home, to care in small group settings with community supports, to care in a nursing facility or intermediate care facility for persons with developmental disabilities. 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 based-care are resulting in a gradual rebalancing of LTC expenditures. Chart 22 goes over, in detail, the cost of LTC services in Nebraska. Chart 20 goes over the SFY 2016 Medicaid expenditures for long-term care services. Chart 21 compares the cost of LTC services delivered in institutions compared to the cost of care delivered in home and community settings.

Chart 20: SFY 2016 Medicaid Expenditures for Long-Term Care Services[5]
Total: $818,246,000



[5] A&D Waiver includes expenditures under the Traumatic Brain Injury waiver (FY11 = $668,814 & FY16 = $694,746).

Chart 21: Nebraska Medicaid Aged, Blind, and Disabled Members and Long Term Services Expenditures by Living Arrangement



VIII. STATE FISCAL YEAR 2016 HIGHLIGHTS AND ACCOMPLISHMENTS

Enhanced Provider Enrollment and Screening

The ACA includes enhanced provider screening and enrollment requirements for all Medicaid service-rendering providers and those that order, refer, and prescribe services. Nebraska Medicaid implemented many of these requirements and is working with Maximus, Inc. to conduct provider screening and enrollment activities, including providing a web portal to simplify the application process, application and fee collection, database screening, and site visits. The implementation for the provider screening and enrollment web portal and other activities occurred on December 1, 2015. While the implementation has been challenging for some providers, the state is making steps to improve the experience for providers and to shorten enrollment times. CMS recently issued guidance about the ACA requirement to complete fingerprint based criminal background checks on providers (and the owners of those providers) determined to be high risk to commit Medicaid fraud. To comply with this requirement, MLTC worked with Nebraska State Patrol and Senator Sue Crawford on LB 869 of the 2016 Legislative Session. The provisions of this bill were placed in and passed as part of LB 698.

International Classification of Diseases Version 10 (ICD-10)

The federal DHHS-mandated transition from the International Classification of Diseases version 9 (ICD-9) to ICD-10 for all Health Insurance Portability and Accountability Act of 1996 (HIPAA) covered entities (health care providers, clearinghouses and payers). Working in collaboration with the DHHS Information & Technology (IS&T) unit, MMIS requirements were developed; coding was completed and policies, forms and contracts were revised. External interface testing with trading partners started in April 2014, and significant systems changes were implemented on October 1, 2014. Additional testing and development along with communication and provider outreach activities continue. ICD-10 was implemented on October 1, 2015 without significant complications.

Expanded Services in Physical Health Managed Care

Effective July 1, 2015, Nebraska Medicaid carved in the hospice (when provided in the home) and non-emergency transportation when provided by an ambulance services into the physical health managed care delivery system. In addition, clients eligible for Medicaid through the subsidized adoption and Women with Cancer programs became mandatory for enrollment into managed care for July 2015.

Managed Care Enrollment Broker

Nebraska Medicaid is expanding services available from the managed care enrollment broker. A RFP was released in early 2016 for these services and the contract was awarded to Automated Health Systems, Inc. in May 2016. The enrollment broker contract provides choice counseling

and education to Medicaid members enrolling in a Heritage Health plan. The broker provides services on an enrollment web portal and offers a call center to assist members in plan selection, primary care provider selection, and changing Heritage Health plans. The enrollment broker provides information and counselling regarding the Heritage Health and service providers enrolled with Nebraska Medicaid. The information assists members in health care management. The enrollment broker provides real time data exchange with the Medicaid eligibility system and the Heritage Health plans. This allows for immediate communication between parties to better serve the members. The enrollment broker services launched in September 2016.

Opioid Prescription Guidelines

During 2016, Medicaid has been working collaborately with its sister divisions to address opioid abuse in Nebraska. Beginning in May, patients identified as receiving more than 150 doses of a short-acting opioid, for example oxycodone (commonly known as Percocet) or hydrocodone (Vicodin) in a 30-day period (excluding cancer patients) were flagged, and every physician who was prescribed opioids for that patient was contacted. Beginning in October, Medicaid claims for more than 150 doses of short-acting opioids in thirty (30) days began to be rejected at pharmacies. These moves reflect an ongoing commitment by the entire Department to combat opioid abuse.

Renewal of the Home and Community-Based Services (HCBS) Waiver for Aged and Adults and Children with Diabilities

Nebraska Medicaid operates several waiver programs to deliver specialized services to different populations. This waiver serves individuals of all ages who have a disability or are aged and require a nursing facility (NF) level of care. Effective August 1, 2016, the waiver was renewed for five years. Major changes in this renewal include:

- Removal of $5,000 annual limit for Assistive Technology Supports and Home Modifications,
- Adding to contracted entities a Provider Enrollment Broker for executing Medicaid
- provider agreements, and
- Removed that service coordinators may also be service providers to address conflict of interest concerns.

IX. LOOKING AHEAD

Data Management & Analytics (DMA)

The current MMIS has served the state well for over thirty-five years, but has become outdated as the Medicaid program has evolved. The planning effort to replace the existing system with a solution that will meet the long-term goals of DHHS has continued with completion of a strategic analysis. This analysis included reviewing numerous replacement options, conducting cost benefit analysis, analyzing the marketplace for solution support and developing a phased-in/modular approach leveraging current vendor contracts and proposed program changes.

A primary focus of the MMIS replacement project is procuring data management and analytics tools to improve access to quality and timely data and enhance capabilities to ensure quality, medically necessary and cost-effective services are being provided. Managing the data, producing accurate and timely reports, and utilizing the data to make informed business decisions will continue to become more critical within the Medicaid program. The RFP for the DMA procurement was approved by all stakeholders and released to the public in June of 2016. The contractor is anticipated to start in February 2017. The DMA solution is anticipated to be operational in late 2018.

DMA Project Milestones	Target Completion
RFP released to public	June 2016
Proposals Due	September 2016
Publish intent to contract	November 2016
Submit contract to CMS for approval	December 2016
Finalize contract and start implementation	February 2017
Go-live	Late 2018

Claims Broker Services (CBS)

Additionally, as more individuals with Medicaid have their healthcare covered through Heritage Health, there will be less need for a traditional MMIS to process claims. The costs associated with building and operating a new system for small volumes of fee-for-service claims does not make financial sense. The Heritage Health contracts were awarded, with one Medicaid managed care organization (MCO), United Health Care, contracted to process fee-for-service claims. This solution capitalizes on United Health Care's capacity and technological infrastructure already developed and in place to pay claims through existing at-risk Nebraska Medicaid contracts.

DMA Project Milestones	Target Completion
Select Heritage Health Plan to perform as CBS	April 2016
Prepare organization to support implementation activities	January 2017

Start joint planning and implementation preparations with CBS	February 2017

Joint Independent Verification and Validation (IV&V)

Independent verification and validation (IV&V) is a process employed by a third-party for evaluating the accuracy and quality of a project throughout the project duration. For major information technology system projects receiving enhanced federal 90% match, CMS requires states contract with an IV&V contractor to perform these services. MLTC has released a joint procurement for IV&V services for the DMA project as well as the eligibility and enrollment systems (EES) project.

IV& V Project Milestones	Target Completion
Publish intent to contract	July 2016
Receive CMS contract approval	November 2016
Contract award	December 2016
Contractor begins work	December 2016

Eligibility and Enrollment System (EES)

The ACA requires significant changes to state Medicaid eligibility and enrollment (E&E) systems. Nebraska's current Medicaid eligibility system cannot meet the ACA requirements without significant modification and investment. As a result, Nebraska is implementing a new Medicaid E&E system. RFPs were issued for a new Medicaid eligibility solution and independent verification and validation (IV&V) activities associated with implementing a new Medicaid eligibility solution. The updated go-live date is now the fourth quarter of 2017. The revision will ensure the state is able to fully test and successfully implement the new system.

EES Project Milestones	Target Completion
Testing Begins	Spring 2017
Go-Live	Fall 2017

Transformed-Medicaid Statistical Information System (T-MSIS)

The T-MSIS project, started in January 2013, is the expansion of federal reporting measures from the states' Medicaid programs. The new report will be submitted to CMS monthly instead of quarterly as is the current practice. Report data has been expanded to include: eligibility information, health care quality measures, and managed care measures in addition to medical services claims..

T-MSIS Milestones	Target Completion
Project begins	Janaury 2013
Anticipated implementation	Fall 2017

Heritage Health

In October 2015, the Department released a request for proposal (RFP) to procure three statewide Managed Care Organizations (MCOs) who will provide integrated physical health, behavioral health, and the pharmacy benefits into the managed care delivery system. In addition, clients who receive LTSS will be carved into the integrated managed care delivery system for their physical, behavioral, and pharmacy services. The LTSS services will continue to be carved out of managed care and will continue to be reimbursed FFS. Contract awards are expected in spring 2016 and this program, Heritage Health, will launch January 1, 2017. (More information on the Heritage Health project is available in the managed care section above).

Heritage Health Project Milestones	Target Completion
RFP release	October 21, 2015
Proposals due	January 5, 2016
Evaluation period	January 12-29, 2016
Intent to award announcement	February 5, 2016
MCO contract award	April 2016
MCO readiness reviews	July 2016
MCO selection and enrollment	September to December 2016
Heritage Health start date	January 1, 2017

Long-Term Care (LTC) Redesign

In light of the CMS Home and Community-Based Services new regulations and the Department of Labor Home Care Rule, work has begun to examine the current delivery of long-term services and supports, the appropriate authorities for LTC, examine if duplication exists, and where gaps may exist with existing services. Examples of long-term care services are home and community based waiver services, nursing facility, the personal assistance service, the home health service, and the Private Duty Nursing service. The LTC redesign project is a collaborative initiative between MLTC, its sister divisions, and LTC stakeholders to evaluate the current LTC landscape, identify key opportunities for improvement, and redesign the system to meet the future challenges and growing demand for LTSS.

In January 2016, DHHS released a concept paper launching the redesign project. In May 2016, DHHS contracted with Mercer to provide technical assistance for the redesign project and provide recommendations on system improvements. Mercer and DHHS staff are meeting with stakeholders and making recommendations on the redesign which will be implemented beginning in 2018.

Long-Term Care (LTC) Redesign Milestones	Target Completion
Concept paper released	January 2016
RFP release for consulting contract	March 2016
Contract award	May 2016

First phase of stakeholder outreach	September to October 2016
Preliminary redesign plan released	December 2016
Second phase of stakeholder outreach	February to March 2017
Release of final redesign plan	June 2017
Implementation of changes begin	2018

Regulations Rewrite

Nebraska Medicaid's regulations are, in many places, contradictory, not meeting the requirements of state and federal law, or simply outdated and do not meet current best practices. Nebraska Medicaid is currently rewriting all of its Medicaid regulations to remove obsolete provisions and make sure they comply with federal and state law. As of November 2016, seventy-seven chapters are in process as part of this rewrite process. Five have been submitted to the Governor for his signature, two are being reviewed at the Attorney General's office, one is being prepared for public hearing, twenty-nine are being reviewed at the Governor's Policy Research Office, and the remainder are going through the internal DHHS process. This project is anticipated to be complete in late 2017.

Regulations Rewrite Project Milestones	Target Completion
First phase of regulations released for informal comment	February 2016
Public hearings for regulations begin	June 2016
Second phase of regulations released for informal comment	January 2017
Public hearings for second phase of regulations begin	March 2017
Finalized regulations are promugated	December 2017

Dental Benefits Manager

On July 1, 2017, MLTC is launching a new program that will transition the State's current FFS dental program to a managed care delivery system. The new program will be administered by a Dental Benefits Manager (DBM) that contracts with MLTC for the delivery of Medicaid dental benefits and services. In the new managed care system, dental providers will contract with the DBM as part of its network and the DBM will handle claims payment and prior authorizations and works with providers and Medicaid clients to coordinate the client's dental care.

The DBM program includes important initiatives aimed at improving care coordination and access to dental care for Medicaid-eligible individuals. The contracted DBM will be responsible for establishing a dental home program that strengthens the provider-patient relationship, encourages the utilization of preventative services, and promotes positive patient education. MLTC released a request for proposals for the DBM program in August 2016, and plans to award one contract through a competitive bidding process.

Dental Benefits Manager Milestones	Target Completion
RFP released	August 2016
Responses received	October 2016
Contract award	December 2016

Program launched	July 2017

Asset Verification Services

Implementing an AVS for Medicaid-eligibility determination is a Federal mandate per 42 U.S. Code § 1396w. Nebraska is currently implementing a new eligibility and enrollment solution (EES) that is targeted to go live in 2017. Through the AVS, the Medicaid eligibility determination process will be enhanced with the capability to electronically locate and verify assets for the aged, blind and disabled Medicaid population. MLTC will closely align EES and AVS implementation such that AVS goes live shortly after the EES. This strategy maximizes implementation resources and minimizes impact on Medicaid eligibility workers and clients.

Asset Verification Services (AVS) Milestones	Target Completion
SPA submitted	Spring 2017
AVS project begins	Fall 2017

X. CONCLUSION

MLTC continues to move forward and deliver better quality health care to Nebraska residents. As discussed in this report, MLTC takes its responsibilities seriously, which is why it has focused this fiscal year on improving the delivery of health care in the state. As MLTC provides health care services to over 230,000 of Nebraska's most vulnerable residents, the Division continuously seeks to improve processes and quality for Medicaid members, providers, and the state's taxpayers. Through initiatives like Heritage Health and long-term care redesign, procurements like the DMA and the DBM, and projects like the regulations rewrite, MLTC is getting in a better position to provide safety-net care and services in the twenty-first (21st) century.

Additionally, MLTC is committed to transparency and providing information to the legislature and the general public as the Division continues its transformation. The Division looks forward to continuing to work with the Governor, the Legislature and stakeholders to improve and sustain Medicaid for current and future generations.