Department of Health & Human Services

DHHS

NEBRASKA

Division of Medicaid & Long-Term Care

Nebraska Medicaid Reform Annual Report

December 1, 2015

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

December 1, 2015

We are pleased to present the Medicaid Annual Report for State Fiscal Year 2015, which also includes the Children's Health Insurance Program (CHIP).

As outlined in this report, the Division of Medicaid and Long-Term Care continues its commitment to increase efficiency and manage costs of the Medicaid program in Nebraska. Many of our initiatives in SFY2015 resulted from new federal requirements and state legislation, most with the same target of better fiscal management and more efficient service provision. This report offers a review of the ongoing work of the Division, highlighting the year's major initiatives, describing the larger projects for the year ahead, and detailing the persons served and services provided through the program.

The Division is looking 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. We would like to highlight two initiatives. One will be the implementation of Heritage Health, Nebraska's new managed care program, which combines the delivery of physical, behavioral, and pharmacy services. Beginning January 1, 2017, each contracted managed care organization will provide a full range of services including physical health, behavioral health, and pharmacy services. The Division is also undertaking an effort to redesign its long-term services and supports (LTSS) system, an effort that will be ongoing over the next several years.

As we begin 2016, the Division is excited about the progress made and the work ahead. 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

Nebraska Medicaid Annual Report
Neb. Rev. Stat. § 68-908(4)

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I. INTRODUCTION

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 Originally enacted in 1965 under Title XIX of the Social Security Act, Medicaid is an entitlement program (a program that guarantees benefits to anyone who meets the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 primarily including seniors, children and individuals with disabilities.

State Medicaid programs are administered by the states with oversight from the Centers for Medicare & Medicaid Services (CMS), part of the federal Department of Health and Human Services (HHS). Every state outlines the eligibility, benefits, provider payments, and service delivery systems of its specific Medicaid program within broad guidelines set by the federal government. Although there are numerous federal requirements, eligibility and benefit packages can vary widely from state to state.

The Children's Health Insurance Program (CHIP) was created in 1997 under Title XXI of the Social Security Act, and was designed to offer insurance coverage for low-income children with family income above Medicaid limits. States administer their CHIP programs in different ways. In Nebraska, CHIP is operated using the same delivery system, benefit package, and regulations as Medicaid.[1] Effective July 19, 2012, Nebraska implemented a separate CHIP program that adds 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). With both the CHIP expansion and stand-alone programs, Nebraska is now considered a CHIP combination state.

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[2] was 53.27% for Medicaid and 67.29% for CHIP.

[1] This is known as a "Medicaid expansion" unrelated to the Medicaid expansion in the Patient Protection and Affordable Care Act (ACA).

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

II. DISCUSSION

A. ELIGIBLE CLIENTS

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

- Children,
- Former Foster Care Youth,
- Aged, Blind & Disabled (ABD),
- Pregnant Women, and
- Parent/Caretaker Relatives.

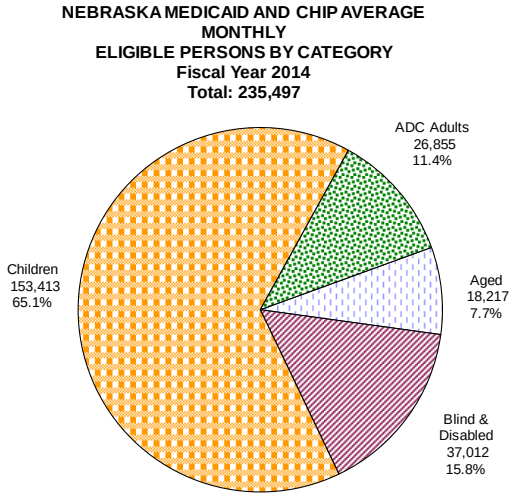
Eligibility factors vary by group and include income, resources, and employment status.

Nebraska's CHIP has operated since May 1998 and provides health coverage for eligible uninsured children if they have income at or below 213% of the federal poverty level (FPL) and are not eligible for Medicaid. As of July 2012, Nebraska implemented a separate CHIP program to provide coverage to the unborn children of women who are not otherwise eligible for Medicaid, have no creditable insurance, and meet financial requirements. The 2101(f) CHIP was implemented as a separate CHIP and expires on December 31, 2015.

The ACA requires the use of modified adjusted gross income (MAGI) as the income methodology for Medicaid and CHIP children, pregnant women and parents/caretaker relative groups. The ABD population is not subject to MAGI or other eligibility changes under the ACA.

ELIGIBLE POPULATIONS

FIGURE 1



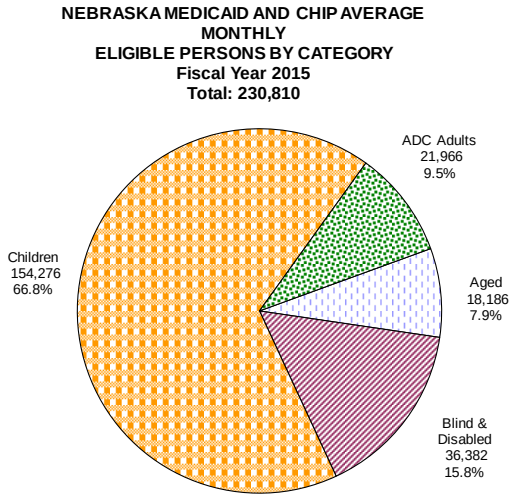
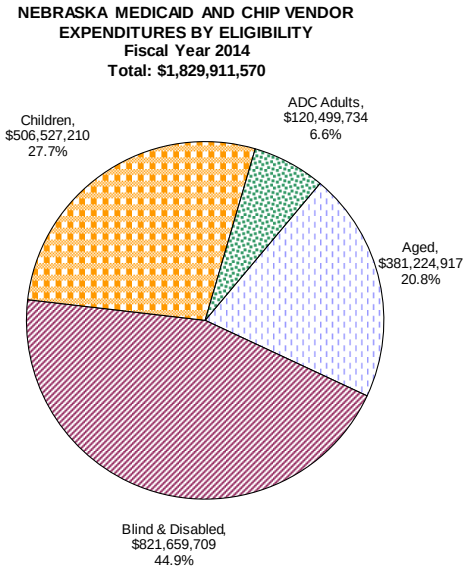


FIGURE 2



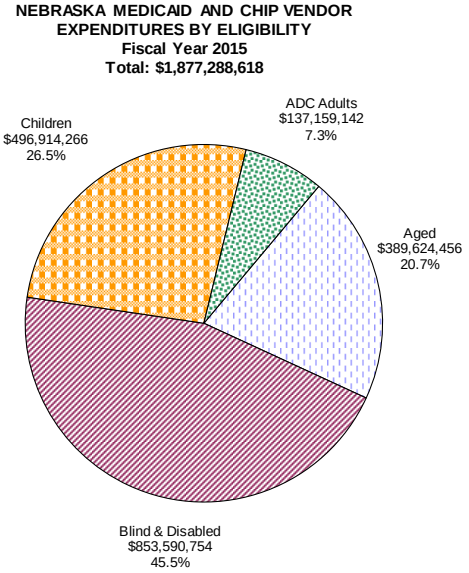


Figure 1 compares eligibility categories for state fiscal years[3] (SFYs) 2014 and 2015. The total decrease in average monthly eligibles from SFY 2014 to SFY 2015 was 2.0%. The largest percentage decrease was in the aid to dependent children (ADC) adults category, which was

[3] The state fiscal year runs from July 1st to June 30th.

reduced by 18.2%. Average monthly eligibles in the blind and disabled's category decreased by 1.7%. The children's category grew 0.6%, and the aged category decreased by 0.2%

Figure 2 compares vendor expenditures by eligibility category for SFYs 2014 and 2015. Viewing Figures 1 and 2 together provides insight into the cost differences of different eligibility categories. While the ABD category represents 23.7% of clients, they account for 66.2% of expenditures. This is almost the exact opposite of children, who account for 66.8% of clients but only 26.5% of expenditures.

Figure 2 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 are not available for these expenditures. This means that some expenditures, particularly in the ABD categories, are understated.

Categories expected to decrease as a result of the transition to managed care did show a decrease. These categories are outpatient health, physician services, and inpatient hospital. The disabled category also experienced a substantial increase in home and community-based services (HCBS) for persons with developmental disabilities.

The aged category was the third largest growing eligibility category with expenditures increasing 2.2% from $381,224,917 in SFY 2014 to $389,624,456 in SFY 2015. The largest increase was in ADC Adults at 13.8% from $120,499,734 in SFY 2014 to $137,159,142 in SFY 2015. Children declined 1.9% in expenditures from $506,527,210 in SFY 2014 to $496,914,266 in SFY 2015.

B. COVERED SERVICES

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

Figure 3

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

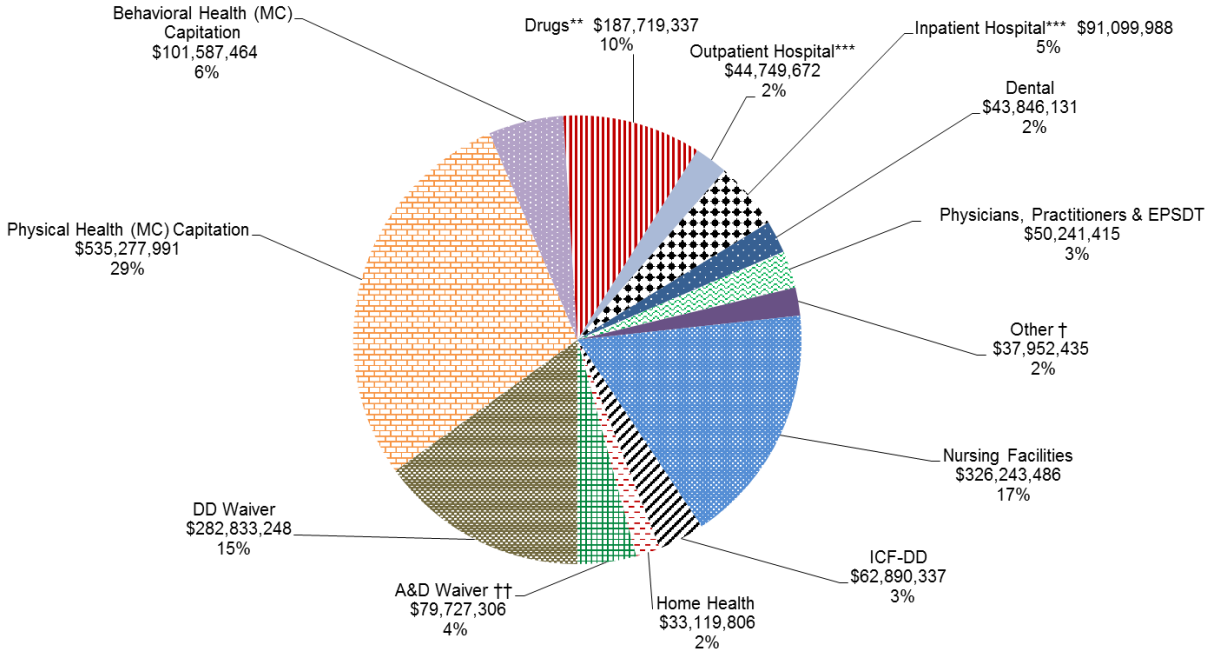
Mandatory Services	Nebraska Optional Services
• Inpatient and outpatient hospital services • Laboratory and x-ray services • Nursing facility services • Home health services • Nursing services • Clinic services • Physician services • Medical and surgical services of a dentist • Nurse practitioner services • 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

VENDOR EXPENDITURES

Figure 4 shows how the $1.88 billion in Medicaid/CHIP expenditures to vendors are distributed by vendor type. Total vendor payments increased $47,377,048 or 2.6% from SFY 2014 to SFY 2015. With the move to statewide managed care, there were service payments in SFY 2014 that became capitation payments in SFY 2015.

Figure 4

NEBRASKA MEDICAID AND CHIP VENDOR EXPENDITURES* BY SERVICE
FISCAL YEAR 2015
Total Vendor Payments $1,877,288,618



* Includes payments to vendors only, not adjustments, refunds or certain payments for premiums or services paid outside the Medicaid Payment System (MMIS) or NFOCUS.
** $106.7 million in offsetting drug rebates is not reflected in the drug expenditures of $187,719,337
*** DSH payments of $42.5 million are not reflected in Inpatient or Outpatient Hospital Expenditures
† Includes Speech/ Physical Therapy, Medical/Optical Supplies, Ambulance, and Lab/Radiology
†† A&D Waiver includes $678,185 of expenditures under the Traumatic Brain Injury waiver

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. Full risk managed care is a health care delivery system where managed care organizations (MCOs) are contracted to authorize, arrange, provide, and pay for the delivery of services to enrolled clients. Managed care facilitates access to a primary care provider, emphasizes preventive care and encourages the appropriate utilization of services in the most cost-effective setting. Nebraska Medicaid has utilized managed care in three urban counties since 1995, and added the seven surrounding counties in August 2010. As of July 1, 2012, Nebraska's managed care program was expanded statewide for physical health services. This move is projected to result in additional savings to Medicaid and CHIP over time. On September 1, 2013, Nebraska shifted its behavioral health program to an at-risk managed care model.

Figure 5 shows vendor expenditures from SFY 2014 and 2015 side by side. The expansion of physical health managed care to cover the remaining 83 counties explains the decrease in these services and the corresponding increase in managed care capitation payments.

Figure 5

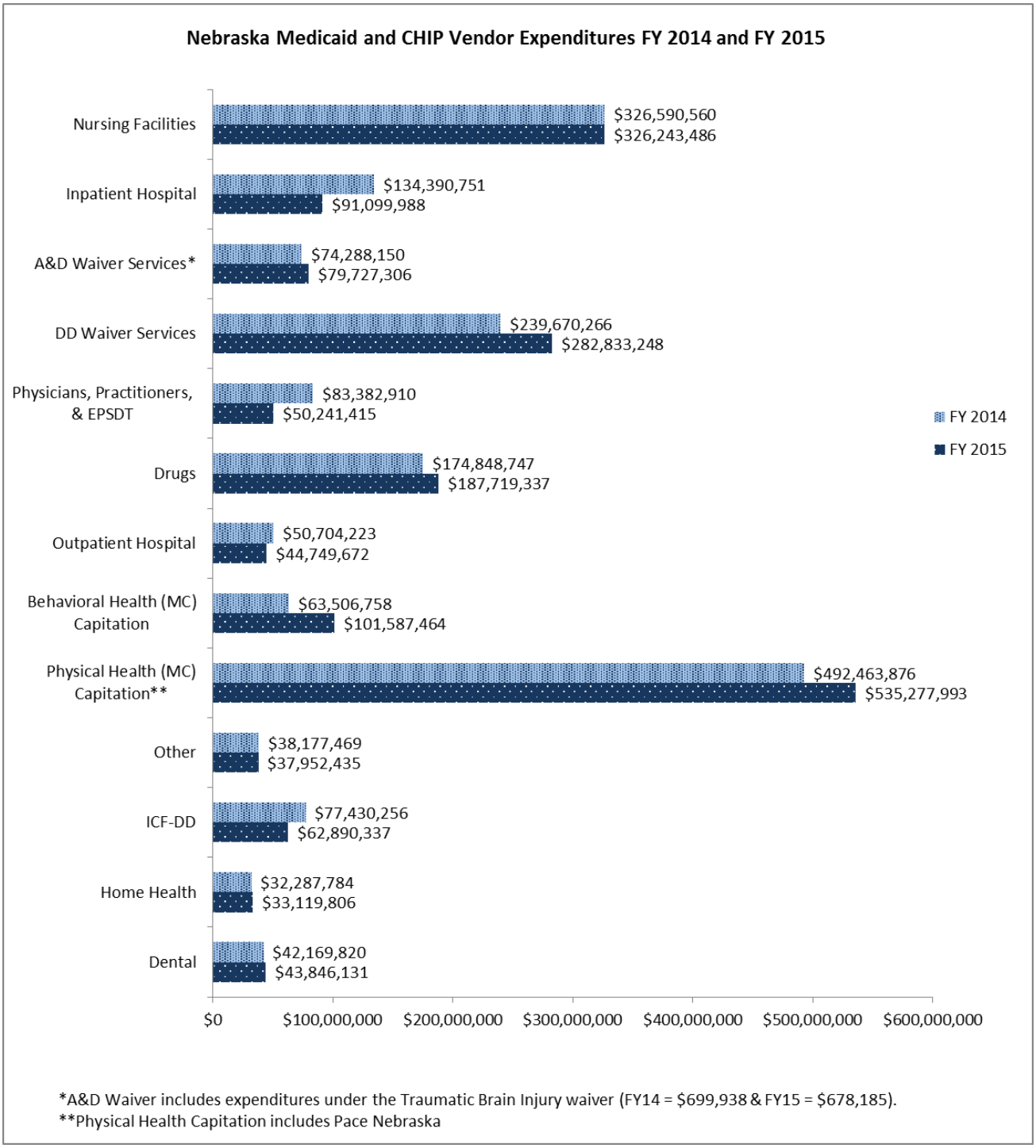


Figure 6

$1,877,288,618	**Vendor Payments**
$42,519,315	Disproportionate Share Hospital/Rate Adjustments
$43,414,909	Medicare Premiums
$5,569,436	Intergovernmental Transfer (IGT)
$65,588,098	Other Payments (Managed Care, Transportation, Federal Insurance Contributions Act taxes, AssistTech, Upper Limit Pmts)
($121,869,610)	Rebates/Refunds
($166,894,123)	General Funds Paid in Other Budget Programs
$51,028,410	Phased Down Contribution
$1,796,645,052	**Net Medicaid and CHIP Expenditures**

Not all Medicaid and CHIP expenditures are captured in Figure 4. Medicaid and CHIP vendor expenditures totaled $1,877,288,618 in SFY 2015. The net program expenditures for this same time period totaled $1,796,645,052. Several of these manual 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 large drug payers, such as insurance companies. In SFY 2015, Medicaid received $106.7 million in drug rebates, an increase of 10.6% compared to the $96.5 million received in SFY 2014.

Disproportionate share hospital (DSH) payments are additional payments to hospitals that serve a high number of Medicaid and uninsured patients. In SFY 2015, Medicaid paid $42,519,315 through the DSH program, a 17.6% decrease compared to $51,614,426 paid in SFY 2014.

Medicaid pays the Medicare Part B premium for clients that are dually eligible for Medicare and Medicaid. In SFY 2015, Medicaid paid $43,414,909 for Medicare premiums, a 1.5% decrease from the $44,076,259 paid in SFY 2014. 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 are estimated at $159.30.

Intergovernmental transfers (IGTs) are payments made to public providers that have 40% or higher Medicaid utilization and whose direct nursing or direct support costs have exceeded the Medicaid maximum allowable rate. In SFY 2015, Medicaid paid $5,569,436 for IGTs, an increase of 33.2% from the $4,182,764 paid in SFY 2014.

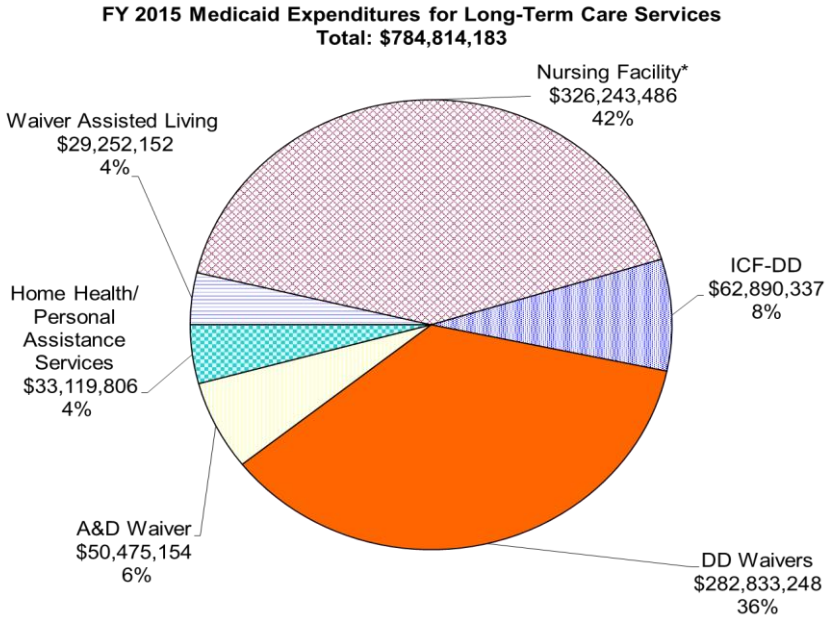
Part D clawback payments are made to CMS to cover the State's share of prescription drugs for persons dually eligible for both Medicare and Medicaid. In SFY 2015, Clawback payments totaled $51,028,410, a 1.4% decrease from the $51,740,416 paid in SFY 2014. The clawback payment

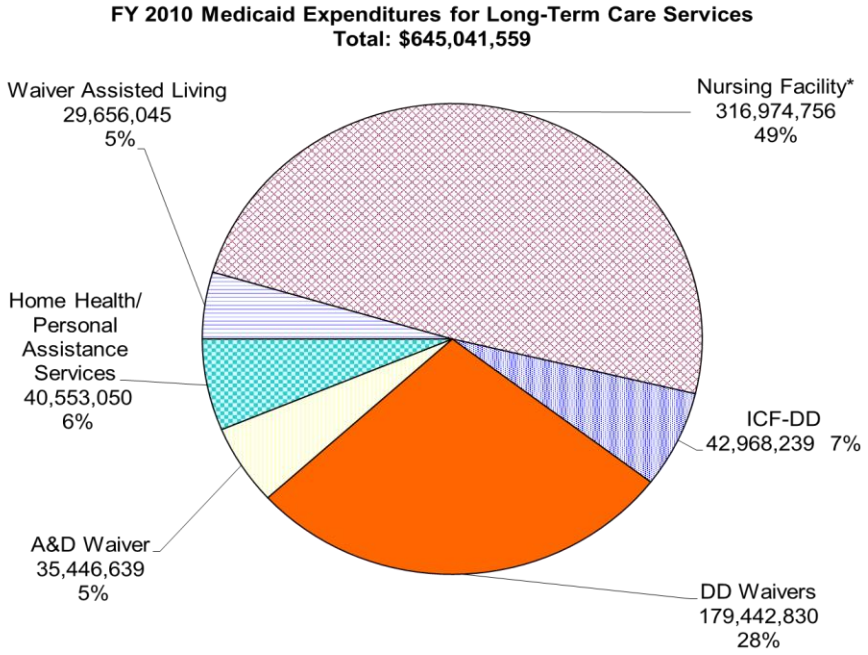
amount per person is based on a complex formula that takes into account the cost of drugs and the FMAP. Nebraska's FMAP has been steadily decreasing since FFY 2011.

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.

Figure 7





*Includes rate increase associated with LB600 implementation.
†A&D Waiver includes expenditures under the Traumatic Brain Injury waiver (FY10 = $505,112 & FY15 = $678,185).

C. PROVIDER REIMBURSEMENT

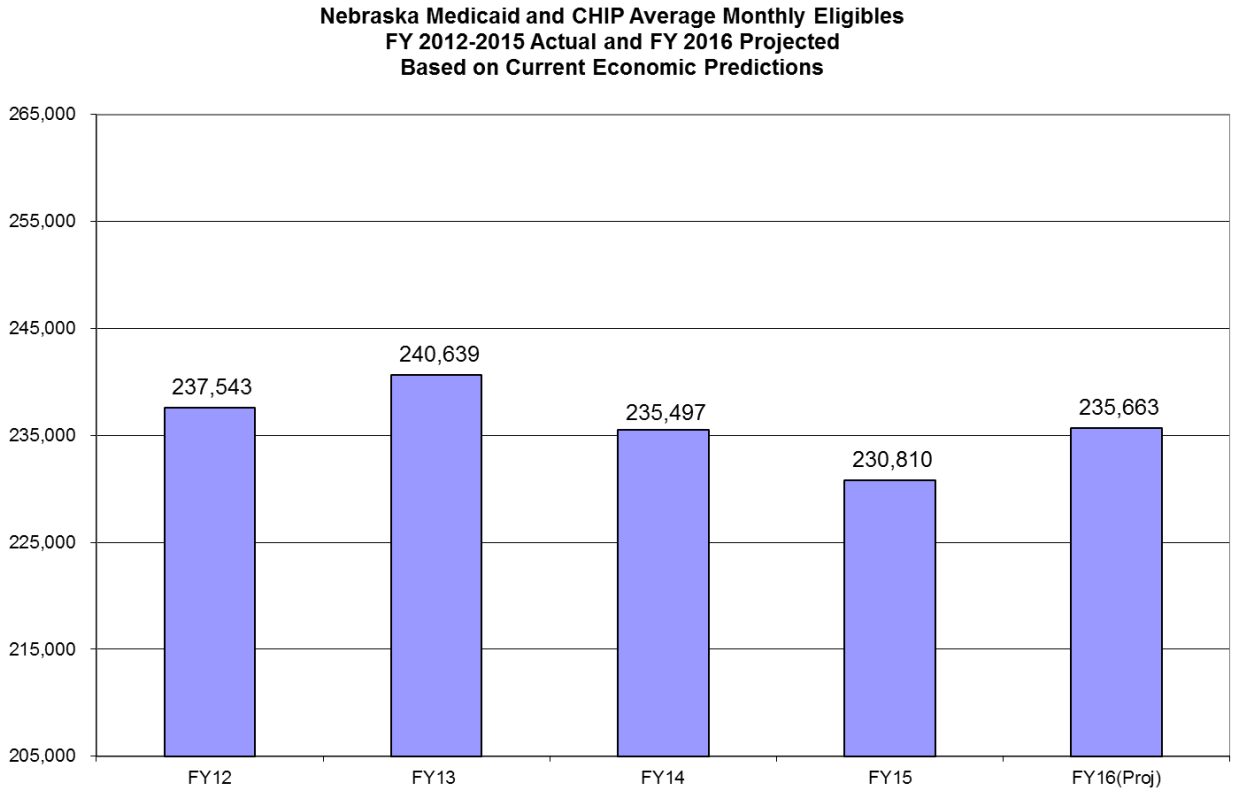
Medicaid purchases health services for clients on a fee-for-service (FFS) basis or, increasingly, by paying premiums to MCOs that coordinate provider networks and provider reimbursements.

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. Federally qualified health centers (FQHCs) are reimbursed on a prospective payment system. 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 many states, budget and enrollment pressures on Medicaid have led to cuts in provider rates. Nebraska Medicaid providers have received rate increases every year from 2005 through 2015. Effective July 1, 2011 rates for all provider types, excepting primary care services, were decreased by 2.5%. Effective July 1, 2012, the rates that were decreased were increased 1.54%. Effective July 1, 2013, Medicaid rates were increased up to 2.25% to a maximum of 100% of Medicare rates as of January 1, 2013. This did not include primary care services which were increased as a result of implementation of the ACA. Effective July 1, 2014, rates were increased by up to 2.25% to a maximum of 100% of Medicare rates as of January 1, 2014. Effective July 1, 2015, the rates were again 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 were increased up to 2.00% to a maximum of 100% of Medicare rates. This rate increase did not include primary care service rates which were increased as a result of implementation of the ACA. FQHCs, RHCs are increased by Medicare economic index (MEI) as required by federal law. Indian Health Services (IHS) rates are established by CMS.

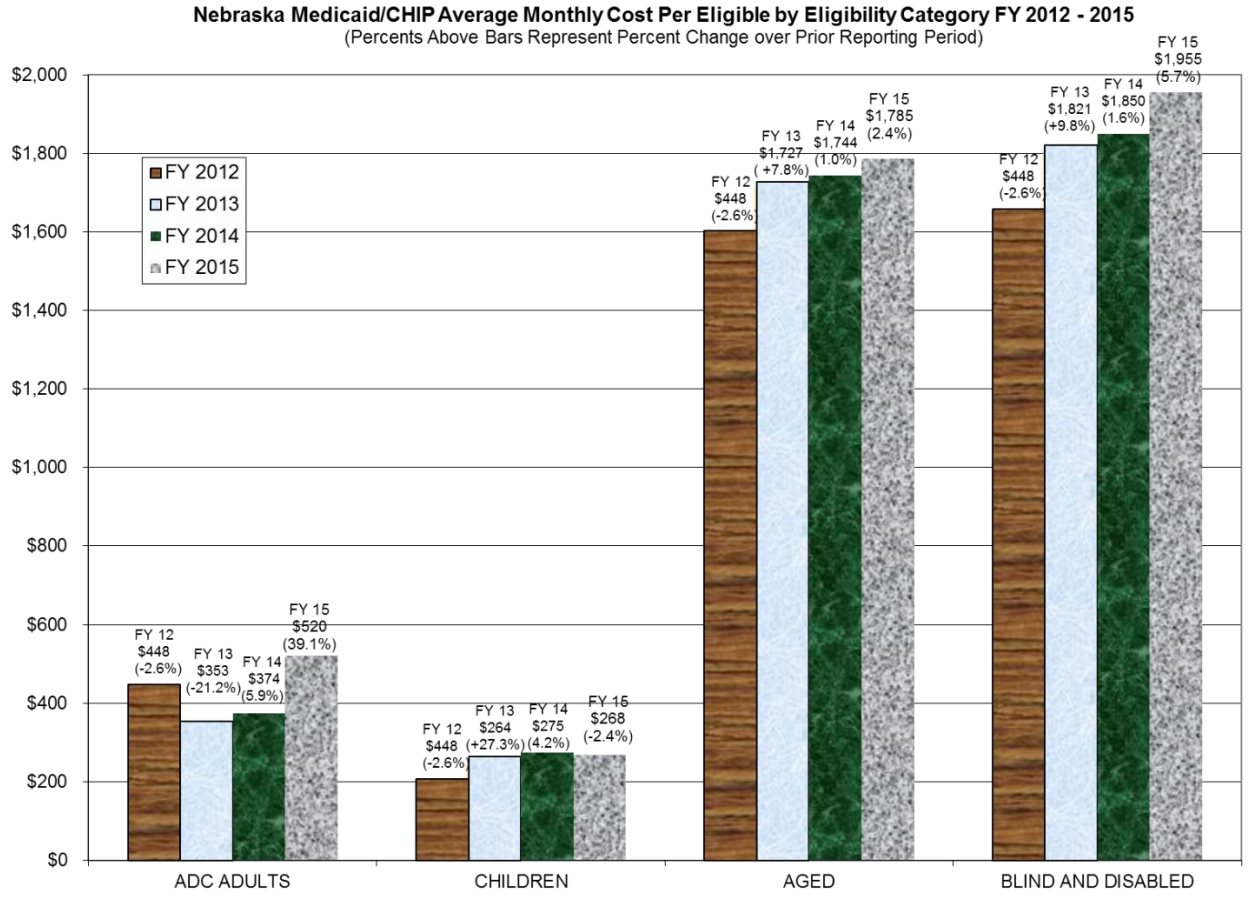
D. PROGRAM TRENDS AND PROJECTIONS

Figure 8



The increase in enrollment from SFY 2011 to SFY 2012 was a modest 0.9%, attributed in part to the statutory expansion of CHIP eligibility to 200% FPL and to the national economy. The number of eligibles increased 1.3% from SFY 2012 to SFY 2013 and then decreased 2.1% from SFY 2013 to SFY 2014. Based on historical trends, the average monthly eligibles in SFY 2016 are expected to increase by 2.1%.

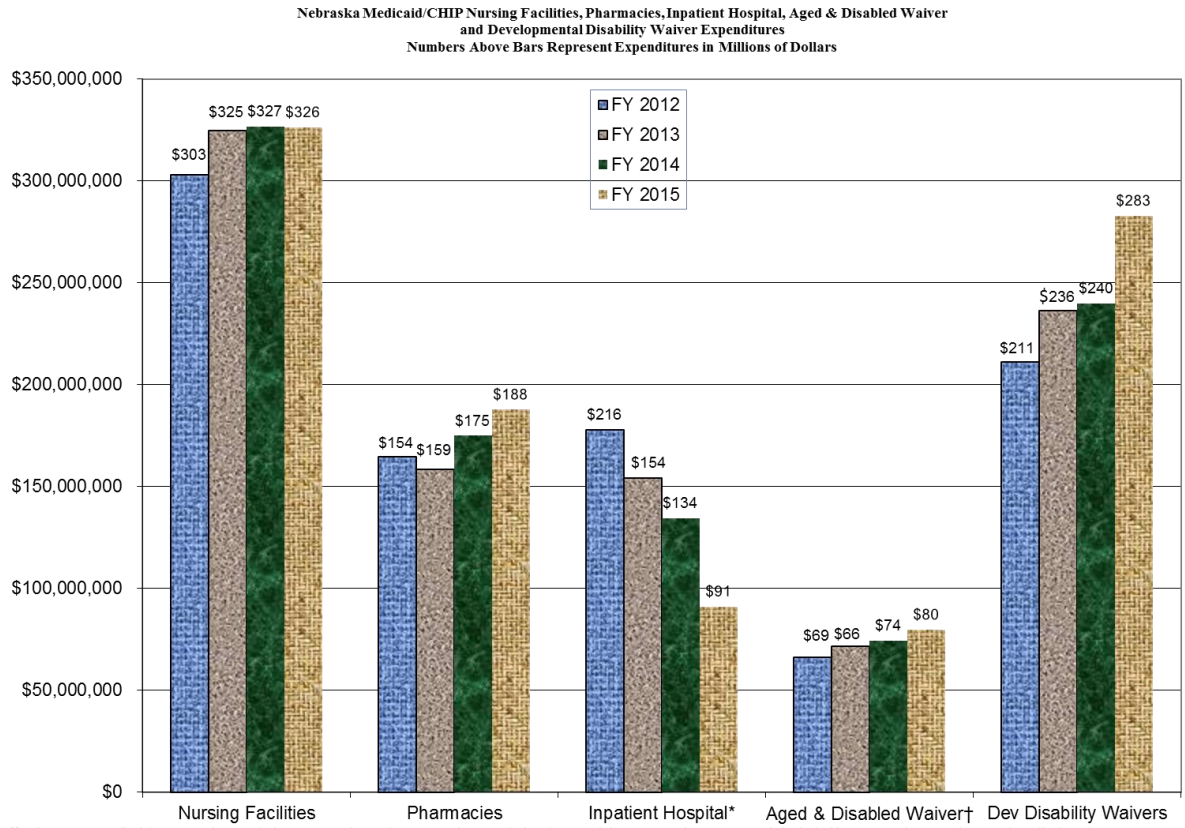
Figure 9



The average monthly cost per eligible (Figure 9) increased 4.7 % overall from SFY 2014 to SFY 2015. The largest cost per eligible increase was in the ADC Adults category, which increased by 39.1%. The Aged category increased by 2.4%. The Children category decreased by 2.4% and the Blind & Disabled category increased by 5.7%. As noted previously, decreases in expenditures in the Adult categories appear to be related, in large part, to the increasing inclusion of those clients in managed care.

The top four vendor expenditure categories in Medicaid and CHIP (excluding managed care capitation payments) are nursing facilities, pharmacies, inpatient hospital, and home and community services. The home and community service category consists of home health, personal assistance services and waiver services, including assisted living. Figure 10 reflects the trends in these categories from SFY 2012 through SFY 2015. The drop in inpatient hospital expenditures reflects inclusion in managed care.

Figure 10



*Effective 8-1-11, Full-Risk Managed expanded to 10 counties and on 7-1-12 it expandedto the remaining 83 counties. Inpt Hosp is included in Managed Care, other services displayed are not.
†A&D Waiver includes expenditures under the Traumatic Brain Injury Waiver (FY12 = $638,782, FY13 = $681,800, FY14 = $699,938, FY15 = $678,185).

E. SFY 2015 INITIATIVES

Highlighted below are some of the major projects during SFY 2015.

Enhanced Provider Enrollment and Screening Requirement

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 December 1, 2015. 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. Implementation of the background checks is mandated by May of 2016.

ICD-10 – International Classification of Diseases Version 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. CMS delayed ICD-10 implementation until October 1, 2015. Because of this delay, providers will not be submitting claims with the ICD-10 codes until after that date. Additional testing and development along with communication and provider outreach activities continue. ICD-10 was implemented on October 1, 2015 without significant complications.

MITA 3.0 -- Medicaid Information and Technical Architecture (MITA)

The Medicaid IT Architecture (MITA) is a CMS initiative to establish national guidelines for technologies and processes that improve program administration for the State Medicaid Enterprise. CMS requires each state to complete a MITA 3.0 State Self-Assessment (SS-A) to obtain enhanced federal funding for its Medicaid program. All technology-related funding requests from the state Medicaid agency to CMS must now reference MITA status and explain how MITA maturity will be enhanced through the funded work. The Division completed the SS-A in December 2014.

Administrative Simplification

All HIPAA covered entities, including providers, clearinghouses and payers, are required to comply with the ACA requirements to implement the Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange® (CORE). The CORE Operating Rules are further standardization of the HIPAA Standard Electronic Transactions version 5010, implemented on January 1, 2012. Planning and implementation of the first two CORE phases began in 2013; these phases affect health plan eligibility (270/271) and health care

claim status (276/277) transactions. This project is known as Medicaid AS-ECS (Administrative Simplification – Eligibility and Claim Status). A RFP was issued to procure a solution to the real-time requirements. Edifecs was awarded the contract in November 2013. The AS-ECS project was implemented on March 9, 2015.

The CORE Operating Rule Phase III affected the Electronic Funds Transfer (EFT) and Health Care Payment and Remittance Advice (ERA or 835) transactions. This project is known as the AS-EFT/ERA (Administrative Simplification – Electronic Fund Transfer and Electronic Remittance Advice). This phase facilitated delivery of the 835, format changes of EFT to national banking standards, and standardized use of reason codes. Edifecs was awarded the contract to extend the enhanced web connectivity to these transactions in December 2014. The AS-EFT/ERA Project was implemented May 1, 2015.

The CORE Operating Rule Phase IV final federal regulations are expected in late 2015.

The Health Plan Identifier (HPID) final federal regulations have not yet been published. The Division of Medicaid and Long-Term Care has applied for and received an HPID for use in Medicaid standard HIPAA transactions when required.

Medicaid Upper Payment Limit

Starting in 2013, CMS required states to submit upper payment limit (UPL) demonstrations on an annual basis. Previously, this information was collected or updated only when a state was proposing an amendment to a reimbursement methodology in its Medicaid state plan. Starting in 2014, and annually thereafter, states are required to submit annual UPL demonstrations for inpatient hospital services, outpatient hospital services, clinics, physician services (for states that reimburse targeted physician supplemental payments), ICF/DD, private residential treatment facilities and institutes for mental diseases. This information must be submitted by the state prior to the start of each SFY. An RFP was issued to solicit proposals for qualified vendors to assist with these new requirements. The contract was awarded to Navigant. Nebraska complied with this requirement by submitting the UPL demonstrations to CMS in June 2015.

Primary Care Services at Medicare Rates

Effective January 1, 2013, Medicaid payment rates for primary care services furnished by certain physicians in CYs 2013 and 2014 cannot be less than the Medicare rates. This minimum payment level applies to specified primary care services furnished by a physician with a specialty designation of family medicine, general internal medicine, or pediatric medicine. The methodology for FFS payments and for managed care capitation rates was approved by CMS. Although the federal rule to pay certain physicians no less than the Medicare rates ends December 2014. The Department continues to reimburse these providers at the Medicare rates. The Department submitted a state plan amendment (NE SPA 15-003) to continue the Enhanced Primary Care Payment Program. The SPA was approved by CMS on June 18, 2015 for effective date of January 1, 2015.

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.

Nebraska Casemix System Web (NCSWeb)

In July 2014, Nebraska Medicaid implemented a live, secure web-based system for a small group nursing home providers. This case mix system allows providers to generate level of care reports as well as weighted days reports. It also enables them to see the status of their resident assessments in terms of timeliness, errors, reimbursement, accurate billing, resident data, and not having their claims rejected. This change eliminates the monthly and yearly mailing of reports to facilities. DHHS collaborated with the nursing facility associations to instruct providers on the use of the system. The use of this system was rolled out statewide in July 2015.

Health Information Exchange (HIE)

The Nebraska Health Information Initiative (NeHII) is the lead health information exchange (HIE) in Nebraska and has the capability to serve any health care provider. The main purpose of an HIE is to exchange laboratory, radiology, medication history, clinical documentation, public health information and other medical data among Nebraska providers and hospitals. Nebraska Medicaid submitted a funding request to CMS on behalf of NeHII in July 2013. This was approved in October 2014, and a contract between NeHII and MLTC was signed. This will allow NeHII to assist Medicaid providers in achieving meaningful use of their electronic health record (EHR) technology, which is one of the qualifications for the EHR Incentive Program. Several of the meaningful use measures relate to the exchange of key medical information.

Electronic Health Record (EHR) Incentive Payment Program

A new computer system was implemented on October 6, 2014 to support the electronic health record (EHR) incentive program. The new system is able to create dashboard reporting and other statistics on the EHR incentive program. It also created a provider portal for submitting and viewing the attestations as well as automating many of the functions performed by EHR incentive program staff. The EHR incentive program has paid over $64 million to Nebraska Medicaid providers since the program launched on May 7, 2012.

Eligibility and Enrollment System

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. WIPRO was awarded the contract for the E&E on March 19, 2014 and the project began on August 28, 2014. First Data was awarded the IV&V contract. Through SFY14 the state and WIPRO solidified a project approach and continued to finalize business requirements. In October 2014 CMS announced the permanent extension of 90/10 enhanced funding for systems. Due to the extended funding opportunity the state and WIPRO have revised the approach and timeline. The updated go-live date is now the first quarter of 2017. The revision will ensure the state is able to fully test and successfully implement the new system.

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' MMISs. 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 and frequency reporting. Implementation and submission of T-MSIS reporting will begin in January 2016.

F. SFY2016 PROJECTS

Many of the SFY 2015 projects detailed above will continue in SFY 2016. In addition, new projects will be implemented.

MMIS Replacement Project

The current MMIS has served the state well for over 35 years, but has become complex 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 will be 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. As more individuals with Medicaid have their healthcare covered through a risk-based MCO, 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 approach that best supports the future Medicaid program is to leverage existing technical infrastructure through a Claims Broker Services arrangement with an MCO. This innovative solution is projected to cost less than a traditional MMIS and also take less time to implement.

Managed Care Enrollment Broker

Nebraska Medicaid is expanding services available from the Managed Care Enrollment Broker. A RFP will be released in early 2016 for these services. The Enrollment Broker contract will provide choice counseling and education to Medicaid members enrolling in a managed care plan. The broker will provide services on an enrollment web portal and will offer a call center to assist m members in plan selection and primary care provider selection and assists members with changing of managed care plans. The Enrollment Broker provides information and counselling regarding the managed care plans and service providers enrolled with Nebraska Medicaid. The information assists members in health care management. The Enrollment Broker will provide real time data exchange with the Medicaid eligibility system and the managed care companies. This allows for immediate communication between parties to better serve the members. The Enrollment Broker is responsible for providing choice counseling services to members, auto-enrolling members if a plan is not selected, capitation payment calculation, and providing information on managed care plans and healthcare providers. The Enrollment Broker services are targeted for implementation September 2016.

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 Fee-For-Service. Contract awards are expected in spring 2016 and this program, Heritage Health, will launch January 1, 2017.

Long-Term Services and Supports (LTSS) 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 LTSS, 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. MLTC will seek input into the design of the current services, and redesign of the LTSS services from a broad group of stakeholders.

III. CONCLUSION

MLTC strives to operate a Medicaid program which addresses the health care needs of eligible low-income Nebraska residents in a cost-effective and deliberately planned manner. While the number of Medicaid-eligible clients has increased in recent years due to economic conditions, the program and policies referenced in this report have moderated the growth of Medicaid expenditures. These policies and initiatives slow the growth of the Medicaid program and further fiscal sustainability by making the program more efficient and cost-effective through careful management of services, better delivery of care, more appropriate services and improved program administration.

The Division looks forward to continuing to work with the Governor, the Legislature, the Medicaid Reform Council, and stakeholders to improve and sustain Medicaid for current and future generations.