NEBRASKA
Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

Jim Pillen, Governor

December 1, 2023

The Honorable Jim Pillen
Governor of Nebraska
PO Box 94848
Lincoln, NE 68509-4848

Mr. Brandon Metzler
Clerk of the Legislature
State Capitol Room 2018
Lincoln, NE 68509

Subject: Nebraska Medicaid Annual Report

Dear Governor Pillen and Mr. Metzler:

On behalf of the Nebraska Medicaid team, I am pleased to present the state fiscal year Medicaid Annual Report in accordance with Neb. Rev. Stat. § 68-908(4).

We are grateful for our partners in the Nebraska Legislature, communities across the state, and the thousands of Medicaid providers across Nebraska who share the Department of Health and Human Services' mission to "Help People Live Better Lives." The Division of Medicaid and Long-Term Care (MLTC) looks forward to doing its part to improve the lives of the state's Medicaid members.

Sincerely,

Kevin Bagley, DHA
Director, Division of Medicaid & Long-Term Care

Attachment

Department of Health and Human Services
Report

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Good Life. Great Mission.

Division of Medicaid & Long-Term Care

Nebraska Medicaid Annual Report

December 2023

Neb. Rev. Stat. § 68-908

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Executive Summary

The Division of Medicaid & Long-Term Care (MLTC), a division of the Nebraska Department of Health and Human Services (DHHS), administers Nebraska's Medicaid program. Each state outlines the eligibility, benefits, provider payments, and service delivery systems of its specific Medicaid program within guidelines set by the federal government.

Medicaid is a significant payer of health services in Nebraska. The program currently represents a roughly $4 billion investment into the health of our communities – particularly for the almost 400,000 Nebraskans who were Medicaid members in the state fiscal year 2023 (SFY23). The program serves low-income children and adults, the aged, and individuals with disabilities. Additionally, approximately 55,000 providers are under contract with Nebraska Medicaid.

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

MLTC has had great success in executing the unwind process. As of October 2023, 48 percent of Medicaid member cases have been reviewed, with 69 percent of those members remaining enrolled. The Department has seen few disenrolled members reapply for Medicaid, meaning Nebraskans are not unnecessarily losing Medicaid coverage.

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

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

MLTC is a steward for stakeholders and taxpayers by facilitating quality health care cost-efficiently. This requires MLTC to evaluate and improve continually:

- Information technology systems and business process models;
- Health services array and delivery models;
- Provider policies and payment methodologies; and
- Beneficiary program eligibility and processes.

In SFY23, there has been continued interest in recent projects the program has implemented. Medicaid Expansion continues to grow, with over 75,000 Nebraskans now enrolled. Additionally, the program continues to bolster the Medical Care Advisory Committee that offers providers, beneficiaries, and their advocates an opportunity to engage and make recommendations to the program.

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

MLTC Organizational Structure

The Division of Medicaid & Long-Term Care includes Medicaid, the Children's Health Insurance Program (CHIP), and the State Unit on Aging (SUA). Medicaid serves low-income children and adults, the aged, and individuals with disabilities, covering 19% of Nebraskans.

MLTC has over 600 full-time employees and collaborates with the Division of Children and Family Services (CFS) for Eligibility Operations.

The Division is structured as follows:

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

- **Eligibility Operations:** Eligibility Operations is responsible for determining eligibility for Medicaid programs.

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

- **Project and Performance Management:** Project and Performance Management drives the implementation of Medicaid's strategic initiatives through the management of MLTC's data and analytics capabilities, IT initiatives, and planning activities.

- **Medical Services, Behavioral Health, and Pharmacy:** Medical Services helps determine the services covered under Nebraska Medicaid and ensures that Medicaid-covered services adhere to a standard of care.

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

- **Communications and Compliance:** Communications and Compliance helps members, stakeholders, and the public understand Nebraska Medicaid and the service it provides to Nebraskans. Additionally, this section is primarily responsible for aligning policies, procedures, guidance documents, and other internal and public-facing information to ensure that the Nebraska Medicaid program complies with relevant state and federal law.

- **State Unit on Aging:** The State Unit on Aging collaborates with public and private service providers to promote a comprehensive and coordinated community-based services system. This system helps members live in a setting of their choice so they can continue to contribute to their community.

Eligibility and Populations Served

Originally enacted in 1965 under Title XIX of the Social Security Act, Medicaid is a public health program that provides coverage for low-income individuals. Nebraska Medicaid, in general, provided coverage for individuals in the following eligibility categories in SFY23:

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

Eligibility factors, such as income and resource guidelines, vary by group. Medicaid enrollment and costs are closely related to the economy. With below-average poverty and unemployment rates (see Table 1 below and Appendix 1), Nebraska's total Medicaid enrollment remained stable at about 12 percent of the state's total population for several years before SFY21. However, average enrollment climbed in the past two years due to the launch of Medicaid expansion and Medicaid cases remaining open when the federal PHE declaration related to COVID-19 was in place (see Appendix 2).

Table 1. Nebraska Poverty Level Compared to National Figures, 2023

Federal Poverty Levels	Nebraska	United States	Percent of Nebraskans	Percent of the Entire US
Under 100% FPL	200,500	40,761,000	10.5%	12.6%
100% to 199% FPL	303,700	51,121,300	15.9%	15.8%
200% to 399% FPL	630,100	96,199,300	32.9%	29.6%
Above 400% FPL	779,400	136,404,400	40.7%	42.0%

Most Nebraska Medicaid beneficiaries (including CHIP children, pregnant people, and parents/caretaker relatives) are subject to modified adjusted gross income (MAGI) budgeting methodology as required by the Affordable Care Act (ACA). It uses federal income tax rules and tax filing status to determine an individual's Medicaid eligibility. This change simplified eligibility groups and aligned them with eligibility for state or federal insurance marketplaces. Other Medicaid eligibility groups in the state, such as those who qualify based on age or disability, are subject to different criteria.

Table 2 provides the 2023 federal poverty levels in annual income. Tables 3 and 4 explain several Nebraska Medicaid programs and their eligibility requirements.

Table 2. 2023 Federal Poverty Level (FPL) Annual Income Guidelines

Household Size	50% FPL	100% FPL	138% FPL	200% FPL
1	$7,290	$14,580	$20,120	$29,160
2	$9,860	$19,720	$27,214	$39,440
3	$12,430	$24,860	$34,307	$49,720
4	$15,000	$30,000	$41,400	$60,000
5	$17,570	$35,140	$48,493	$70,280
6	$20,140	$40,280	$55,586	$80,560
7	$22,710	$45,420	$62,680	$90,840

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

Program	Description	Income Limit
Subsidized Adoption and Guardianship Assistance (SAGA)	Individuals ages 19-21, if subsidized guardianship or adoption agreement was entered into after age 16.	Twenty-three percent (23%) of the federal poverty level (FPL)
Institution for Mental Diseases (IMD)	Individuals in an institution for mental disease ages 19-21.	Fifty-one percent (51%) of the FPL.
Parent/Caretaker Relatives	Parents or caretaker relatives of a dependent child under the age of 19.	Fifty-eight percent (58%) of the FPL
Pregnant Women	Pregnant women Medicaid eligible through a 60-day postpartum period. Beginning January 1, 2024, the 60-day period will extend to 12 months.There is continuous eligibility for a newborn through the first birthday.	194% of the FPL
Newborn to Age One	Children from birth to age one.	162% of the FPL
Children Ages One to Five	Children ages one to five.	145% of the FPL
Children Ages Six to Eighteen	Children ages six through the month of their 19th birthday.	133% of the FPL
Children's Health Insurance Program (CHIP)	CHIP was created in 1997 under Title XXI of the Social Security Act. In Nebraska, CHIP uses the same delivery system, benefits package, and regulations as Medicaid. Eligible children must be uninsured.	213% of the FPL
599 CHIP	This CHIP program covers prenatal and delivery services for the unborn not yet Medicaid eligible.	197% of the FPL

Heritage Health Adult (Medicaid Expansion)	Adults between ages 19 and 64 who meet income, residency, and citizenship requirements and are ineligible for another Medicaid category.	138% of the FPL

Table 4. Nebraska Medicaid Non-MAGI Coverage Groups and Income Eligibility Requirements

Program	Description	Income Limit
Former Foster Care	An individual under twenty-six, was in foster care and receiving Medicaid at age eighteen or nineteen, and ineligible for Medicaid under another program.	No income or resource guidelines; must meet general eligibility requirements (citizenship, residency, etc)
Transitional Medical Assistance (TMA)	12 months of transitional coverage for Parent/caretaker relatives no longer Medicaid eligible due to earned income. In the second 6 months, if income is above 100% FPL, family may pay a premium and become Medicaid eligible.	The first six months are without regard to income. The second 6 months, 185% of the FPL
Aged, Blind, and Disabled	Individuals who are determined blind or disabled by SSA.	100% of the FPL with certain resource limits
Medicare Buy-In	Specified low-income Medicare beneficiaries (SLMB) and qualified individuals for whom the state pays a Medicare Part B Premium.	SLMB = 120% QI = 135% Of the FPL with certain resource limits.
Medically Needy	Individuals with medical needs and exceed income requirements for other Medicaid categories. This category allows individuals to obligate their income above the standard on their medical bills and establish Medicaid eligibility.	Income level is based on a standard of need. For a household size of 2, the income guideline is $392/month.
Medicaid Insurance for Workers with Disabilities	These are individuals with disabilities who are eligible for Medicaid but for their earnings. They are disabled and working but need their Medicaid coverage to enable them to work.	200% of the FPL Between 200% FPL and 250%, they must pay a premium.
Katie Beckett	Are aged 18 or younger with severe disabilities who live with their parent(s), but who would otherwise require hospitalization or institutionalization due to their high level of healthcare needs.	The parent's income is waived under the Tax Equity and Fiscal Responsibility Act (TEFRA.)

Breast and Cervical Cancer	Women who were screened for breast or cervical cancer by the Every Women Matters Program and found in need of care.	Women are below 225% FPL using EWM criteria.
Emergency Medical Services for Aliens	Individuals are ineligible due to citizenship or immigration status and have a condition requiring emergency medical care (including emergency labor and delivery).	Income and resources vary depending on the category of eligibility
Subsidized Adoption	Children under 18 with an adoption assistance agreement in effect or with foster care maintenance payments made under Title IV-E of the Act - A medical review is required for non IV-E.	No income or resource guidelines.
Subsidized Guardianship	Children under 18 for whom kinship guardianship assistance maintenance payments are made under Title IV-E of the Act.	No income or resource guidelines.

The adult category continues to show the most significant change year over year in total number of eligible individuals, growing by 14 percent from SFY22 to SFY23. The Aged, Blind, and Disabled categories saw a slight decrease: a 1 percent decrease for Aged and a 2 percent decrease for Blind & Disabled. Children's enrollment also decreased by 11 percent.

Appendices 4 and 5 compare the cost of different eligibility categories. While the Aged and the Blind & Disabled categories represent 12.8 percent of members, they account for 47 percent of expenditures. In contrast, children account for 42 percent of members but only 18 percent of expenditures. Further cost-per-enrollee details are included in Appendix 4.

Appendix 5 does not account for all Medicaid and CHIP expenditures, partly because some payments and refunds are not specific to a recipient or eligibility category. Examples of transactions not included are drug rebate payments made outside the Medicaid Management Information System (MMIS)[1], and premium payments paid on behalf of persons eligible for Medicare. Beneficiary demographic data is not available for these expenditures. This means some expenditures, particularly in the Aged and the Blind & Disabled categories, are understated.

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

Benefits Package

Federal Medicaid statutes mandate that states provide certain services, while also allowing states the option to provide additional services. The Nebraska Medical Assistance Act (68-901 to 68-975) and the Medicaid State Plan outline the mandatory and optional services available to Medicaid and CHIP recipients in Nebraska. These mandatory and optional services are noted below in Table 5.

Nebraska Medicaid evaluates covered services to ensure that comprehensive healthcare services are provided to Nebraskans as efficiently as possible, aligning with best medical practices. The division collaborates with sister divisions, providers, beneficiaries, managed care partners, and other stakeholders to identify potential service gaps and policy implications.

Table 5. Federal Medicaid Mandatory and Optional Services Covered in Nebraska

Mandatory Services	Optional Services
Certified Pediatric and Family Nurse Practitioner Services	Ambulance Services
	Chiropractic Services
Family Planning Services	Dental Services
Freestanding Birth Center Services (when licensed or otherwise recognized by the state)	Durable Medical Equipment, Orthotics, Prosthetics, and Medical Supplies
	Hearing Aid Services
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT, Health Check)	Hospice Services
	Intermediate Care Facilities for Persons with Intellectual Disabilities (ICF/DD) Services
Home Health Agency Services	
Hospital Services • Inpatient • Outpatient	Mental Health and Substance Abuse Services for Children and Adolescents (aged 0-20)
Laboratory and Radiology (X-ray) Services	Nurse Practitioner Services
Medical Transportation Services	Podiatry Services
Nurse Midwife Services	Prescribed Drugs
Nursing Facility Services	Private-Duty Nursing Services
Physician Services	Adult Psychiatric, Substance Use Disorder, and Medicaid Rehabilitation
Services Provided by Clinics • Rural Health Clinics • Federally Qualified Health Centers (FQHC)	
	Screening Services (Mammograms)
Tobacco Cessation Counseling for Pregnant Women	Services Provided by Clinics • Community Mental Health Centers • Indian Health Service (IHS) Facilities
	Therapies • Physical • Occupational • Speech Pathology • Audiology
	Vision Care Services

Service Delivery

Nebraska covers Medicaid and CHIP services primarily through Heritage Health, a capitated managed care program designed to integrate medical, behavioral, and pharmacy needs. Managed Care Organizations (MCOs) are responsible for managing and providing specific Medicaid-covered services and use population health and care management strategies to manage their member population in quality and cost-conscious manners. Nationally, 41 other states (including the District of Columbia) contract similarly with MCOs to cover Medicaid services using a managed care delivery system.

Nebraskans on Medicaid receive physical health, behavioral health, and pharmacy benefits under Heritage Health. In SFY23, three MCOs provided healthcare services to Medicaid members: Nebraska Total Care, UnitedHealthcare Community Plan, and Healthy Blue Nebraska. Dental services were managed separately by the dental prepaid ambulatory health plan, MCNA.

Beginning in SFY24, three MCOs will provide healthcare services to Medicaid members: Molina Healthcare, Nebraska Total Care, and UnitedHealthcare Community Plan. These MCOs will also be managing dental care; aligning Nebraska's managed care delivery system with national healthcare standards and practices.

An integrated managed care program has the potential to achieve:

- Improved health outcomes;
- Enhanced member satisfaction;
- Enhanced coordination of care and quality of care;
- Reduced rate of costly and avoidable care; and
- Improved fiscal accountability.

When Medicaid members enroll in Heritage Health, MLTC's enrollment broker, Automated Health Systems, assigns them to one of the available plans. New members may select a different plan within 90 days of joining Heritage Health. In addition, the annual open enrollment period is available to all members from November 1 through December 15, and at that time, all members may choose a different plan. Members enrolled with Healthy Blue Nebraska who do not choose a new managed care plan will automatically be enrolled with Molina Healthcare on January 1, 2024.

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

These performance metrics include:

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

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

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

Providers

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

In November 2023, there were 55,453 Medicaid providers, accounting for both in and out-of-state providers. Provider details, including the type of practice and number of in-state and out-of-state providers are noted in Appendix 6.

The Nebraska Medicaid program uses different methodologies to reimburse for Medicaid services via FFS:

- Practitioner, laboratory, and radiology services are reimbursed according to a fee schedule;
- Prescription drugs are reimbursed according to a discounted product cost calculation plus a pharmacy dispensing fee;
- Inpatient hospital services are reimbursed based on a prospective system using either a diagnosis-related group (DRG) or per diem rate;
- Critical access hospitals (CAH) are reimbursed on a per diem based on a reasonable cost of providing services;
- Federally qualified health centers (FQHCs) are reimbursed via the alternative payment methodology;
- Rural health clinics (RHCs) are reimbursed their cost directly or at a prospective rate depending on whether they are independent or provider-based;
- Outpatient hospital reimbursement is based either on a prospective system using Enhanced Ambulatory Patient Groups (EAPGs) or on a percentage of the submitted charges;
- Nursing facilities are reimbursed at a daily rate based on appropriations and relative facility cost, beneficiary level of care, and quality of care;
- Intermediate care facilities for persons with developmental disabilities (ICF/DDs) are reimbursed on a per diem rate based on a cost model;
- HCBSs, including assisted living costs, are reimbursed at reasonable fees as determined by Medicaid;
- Dental services are reimbursed by the dental pre-paid ambulatory health plan (PAHP), a managed care entity for Medicaid managed care members, and via fee-for-service for fee-for-service Medicaid clients.

As specified in the table below, Medicaid rates saw an across-the-board increase of 3 percent in FY 2023-24. In FY 2024-25, rates will remain the same and will see no increase. Dental rates increased by 10 percent in an ongoing effort to maintain comprehensive dental coverage for Nebraskans across the state on Medicaid.

Additionally, rates for behavioral health services increased by 17%, and nursing facilities received a specified appropriation increase of $73.19 for increasing rates and utilization changes.

Each MCO must have an adequate provider network and may negotiate reimbursement rates with providers in its network.

Table 6. Nebraska Medicaid Rate Changes

SFY	Rate Increase
2013	Rates increased to 2.25% to a maximum of 100% of Medicare rates as of January 1, 2013.
2014	Rates increased to 2.25% to a maximum of 100% of Medicare rates as of January 1, 2014.
2015	Rates increased to 2.25% to a maximum of 100% of Medicare rates for behavioral health, nursing facilities, assisted living, and ICF-DD providers. Other Medicaid services rates increased to 2% to a maximum of 100% of Medicare rates.
2016	Rates increased to 2.25% to a maximum of 100% of Medicare rates for behavioral health, nursing facilities, assisted living, and ICF-DD providers. Other Medicaid services rates increased to 2% to a maximum of 100% of Medicare rates.
2017	Rates increased to 2.25% to a maximum of 100% of Medicare rates for behavioral health, nursing facilities, assisted living, and ICF/DD providers. Other Medicaid services rates increased to 2% to a maximum of 100% of Medicare rates.
2018	No rate changes were implemented
2019	No rate changes were implemented
2020	Rates for Medicaid services increased by 2.0%. Rates for Behavioral Health services received an additional 2.0% increase. Nursing Facilities received a specified appropriation increase of $21.25 Million for increasing rates and utilization changes.
2021	Rates for Medicaid services increased by 2.0% Rates for Behavioral Health services received an additional 2.0% increase. Nursing Facilities also received a specified appropriation increase of $14.45 million for increasing rates and utilization changes.
2022	Rates for Medicaid services increased by 2.0% Nursing Facilities also received a specified appropriation increase of $12.28 Million for increasing rates and utilization changes.
2023	Rates for the majority Medicaid services increased by 2.0%. Rates for Dental services increased by 10%. Rates for Behavioral Health services increased by 17%. Nursing Facilities also received a specified appropriation increase of $73.19 Million for increasing rates and utilization changes.

Vendor Expenditures

Federal and state governments finance Medicaid and CHIP jointly, with the federal government matching state spending at a rate known as the Federal Medical Assistance Percentage (FMAP). FMAP is based on each state's per capita income relative to the national average and is highest in poorer states, varying from 52.5 percent to 82.86 percent. Nebraska's FMAP in federal fiscal year (FFY) 2023 was 57.87 percent for Medicaid and 70.51 percent for CHIP. Table 7 shows the FMAP for Medicaid and CHIP for FFY16 through FFY24.

Table 7. Nebraska FMAP Rates

Federal Fiscal Year	Medicaid FMAP	CHIP FMAP
FFY16	51.16%	88.81%
FFY17	51.85%	89.30%
FFY18	52.55%	89.79%
FFY19	52.58%	89.81%
FFY20	54.72%	79.80%
FFY21	56.47%	69.53%
FFY22	57.80%	70.46%
FFY23	57.87%	70.51%
FFY24	58.60%	71.02%

Total SFY23 vendor payments for Medicaid and CHIP expenditures were $4,002,925,090. This includes the cost of drugs, inpatient and outpatient hospital care, payments to physicians and practitioners, and early and periodic screening, diagnostic, and treatment (EPSDT). A&D Waiver includes $267,117,633 of expenditures, a 30.9 percent increase from SFY22. The expenditures include payments to vendors only; no adjustments, refunds, or certain payments for premiums or services paid outside of the Medicaid Payment System (MMIS) or NFOCUS.

Appendix 7 shows the expenditure distribution to vendors arranged by service type.

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

- Drug rebates are reimbursements by pharmaceutical companies to Medicaid and CHIP that reduce individual drug costs to a more competitive or similar price offered to other large drug payers, such as insurance companies. In SFY23, Medicaid received $323.9 million in drug rebates, a 59.8 percent increase from the $202.7 million in rebates received in SFY22.
- Disproportionate share hospital (DSH) payments are additional payments to hospitals serving many Medicaid and uninsured patients. In SFY23, Medicaid paid $104 million through the DSH program, a 673.9 percent increase compared to $13.4 million paid in SFY22;
- Medicaid pays the Medicare Part B premium for beneficiaries that are dually eligible for Medicare and Medicaid. In SFY23, Medicaid paid $77,610,719 for Medicare premiums, a 8.2 percent increase from the $71,706,774 for Medicare premiums paid in SFY22; and

- Medicare Part D Phased-Down state contributions ("clawback") are required monthly payments to CMS for each person dually eligible for Medicare and Medicaid. Funding for this comes entirely from state general funds, and is meant to cover part of the savings to the Medicaid program for prescription drug costs that Medicare pays for dually eligible individuals enrolled in Part D. In SFY23, clawback payments totaled $66,926,324, an 8.9 percent increase from the $61,416,473 paid in SFY23. The clawback payment amount per person is based on a complex formula that takes into account the cost of drugs and the federal matching rate.

As noted in Appendix 7, most of MLTC's expenditures come in the form of capitation payments for managed care. Appendices 8 and 9 note the relative cost of services covered via capitated managed care.

Appendix 10 compares vendor expenditures from SFY22 and SFY23.

Long-Term Care Services

Long-term care (LTC) services support individuals with chronic or ongoing health needs related to age or disability. In SFY23, Medicaid expenditures for LTC services totaled $794,949,381. These services are tailored to multiple levels of beneficiary needs, ranging from limited assistance with activities of daily living to complex nursing interventions. Assistance can be offered in a variety of settings, from an individual's home to small group settings with community support or nursing facilities. Home and community-based care is generally less expensive and offers greater independence for the consumer than facility-based care.

For these reasons, state and federal initiatives encourage the development of care options in the community as an alternative to institutional care. Efforts to promote home and community-based alternatives to facility care are resulting in a gradual rebalancing of LTC expenditures.

Appendix 11 shows the cost of Medicaid expenditures for LTC services.

Definitions of each expenditure category are as follows:

Category	Definition
Nursing Facility	Payment made to nursing facility services for aged and disabled Medicaid-eligible members.
ICF-DD	Payment made to intermediate care facility services for intellectually and developmentally disabled Medicaid-eligible members.
DD Waivers	Payment made for an array of home and community-based services for intellectually and developmentally disabled Medicaid-eligible members; Medicaid offers two waivers for this population.
Home Health/Personal Assistance Services	Payment made for community-based care covered under the Medicaid State Plan to support Medicaid-eligible members living independently in their own home.

A&D Waiver	Payment made for an array of home and community-based services for aged and disabled Medicaid-eligible members to support living independently in their own home.
Waiver Assisted Living	Payment made for the assisted living service within the Aged and Disabled waiver, payment allows members to continue living in the community rather than in a nursing facility. This includes services provided through the TBI waiver.

Highlights and Accomplishments

New Managed Care Contracts

Starting January 1, 2024, the new contracts for Nebraska Medicaid's capitated managed care program will go into effect. Nebraska Medicaid chose Molina Healthcare, Nebraska Total Care, and UnitedHealthcare to provide services to Nebraskans for the next five years. Medicaid continues to work with the newly selected plans on the upcoming transition.

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

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

Community Outreach and Engagement

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

In addition to weekly and monthly communication efforts, Nebraska Medicaid hosted two separate listening tours throughout the spring and fall of 2023. These two tours visited the cities of Lincoln, Omaha, Scottsbluff, O'Neil, Valentine, Chadron, Hastings, Grand Island, Winnebago, Santee, Red Cloud, McCook, Ogallala, Broken Bow, and Beatrice. Multiple virtual listening sessions were offered as well.

The first tour focused on educating members, providers, and community partners on the unwind from the COVID-19 PHE. Resources were provided during these meetings, as well as during additional engagement sessions with communities. The second tour reviewed the upcoming managed care and policy changes for 2024.

Nebraska Medicaid also hosted a Maternal Health Symposium in Columbus on September 27, 2023. The event brought stakeholders from across Nebraska together to discuss the current state of maternal healthcare. The stakeholder group included hospitals representatives, physician groups, universities, local health departments, Medicaid MCOs, and advocacy groups.

Highlights of the event include:

- **Postpartum Coverage:** Effective January 1, 2024, Medicaid coverage will expand from 60 days to 12 months.
    - It is anticipated that this extension will reduce maternal mortality rates and decrease barriers that many mothers face when seeking healthcare services following childbirth.
- **Programs and Initiatives:** Clinical providers and pregnant mothers would find it beneficial to have a central repository that housed information on the programs DHHS offers.
- **Improving Access to Care:** Ideas such as increasing telehealth in rural areas were discussed.

Medical Care Advisory Committee

The Medical Care Advisory Committee (MCAC) continues to see success after being re-established in 2022. The MCAC board is composed of providers, members, and member representatives. During these meetings, committee members discuss the status of Medicaid for Nebraskans and consult representatives from Nebraska Medicaid. During 2023, the committee identified key topics on which they are interested in advocating. The group has established subcommittees to discuss maternal health, dental care, and nursing facility care.

Tribal Health Outreach

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

Medicaid continues to build new informational resources to help assist tribal providers. From presentations on personal assistance services to flyers on non-emergency medical transportation. Web pages developed in 2021 are being expanded to ensure that Tribes based in Nebraska are accurately represented and have access to the resources they need.

Medicaid Expansion

Enrollment in Medicaid Expansion continues to grow, with over 75,000 Nebraskans enrolled as of October 2023. Low-income Nebraskans aged 19-64 can receive comprehensive healthcare coverage. The rollout and implementation of Medicaid Expansion, also known as Heritage Health Adult (HHA), happened during the COVID-19 pandemic. It would not have been possible without the hard work and dedication of DHHS teammates and countless healthcare community workers and application assistors.

Launch of iServe

In October 2023, iServe Nebraska, a new integrated benefit application was released to all Nebraskans and community partners. This presents a new way for Nebraskans to apply for food, utilities, healthcare, and childcare assistance.

Stakeholders across the state have expressed great success using the new application and say it makes the application process faster and easier. With this launch, the local health departments are making additional efforts to certify assistors to help Nebraskans apply for Medicaid.

Home and Community-Based Services

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

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

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

Conclusion

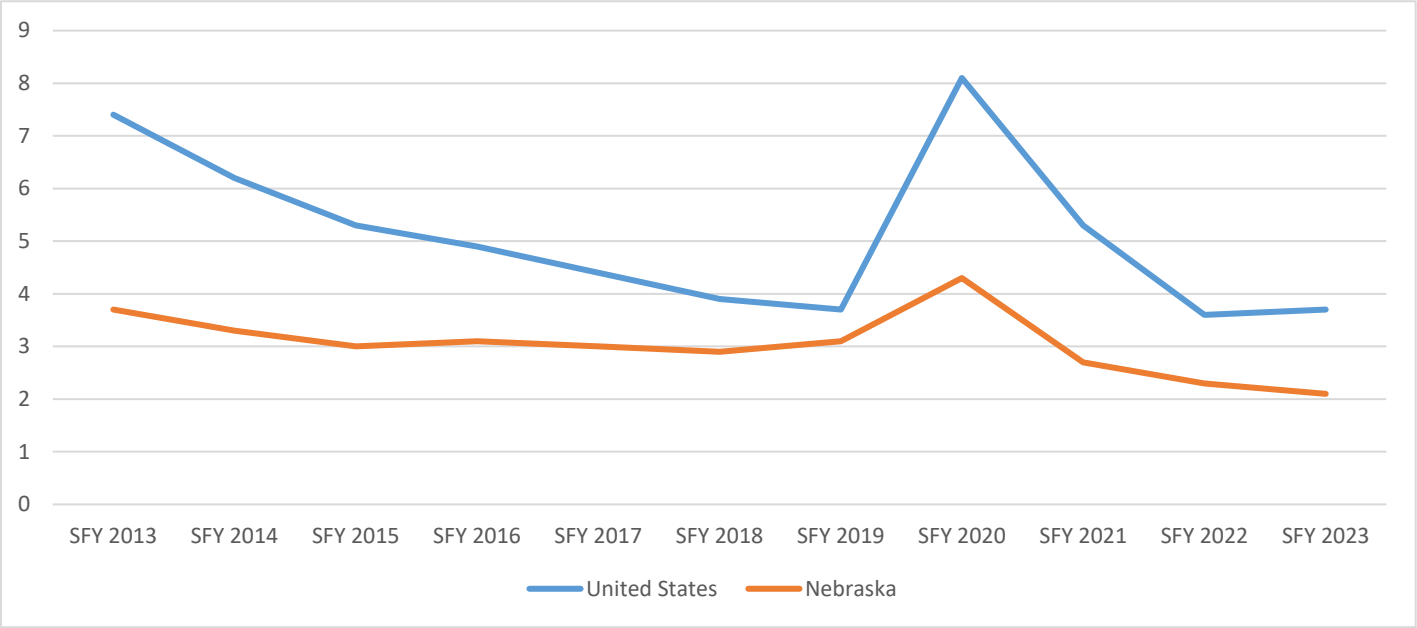
Nebraska Medicaid takes seriously its role in supporting the delivery of quality health care to Nebraskans in need. To meet this commitment to all Medicaid's stakeholders, including beneficiaries, providers, and taxpayers, and focuses on improving all aspects of operations.

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

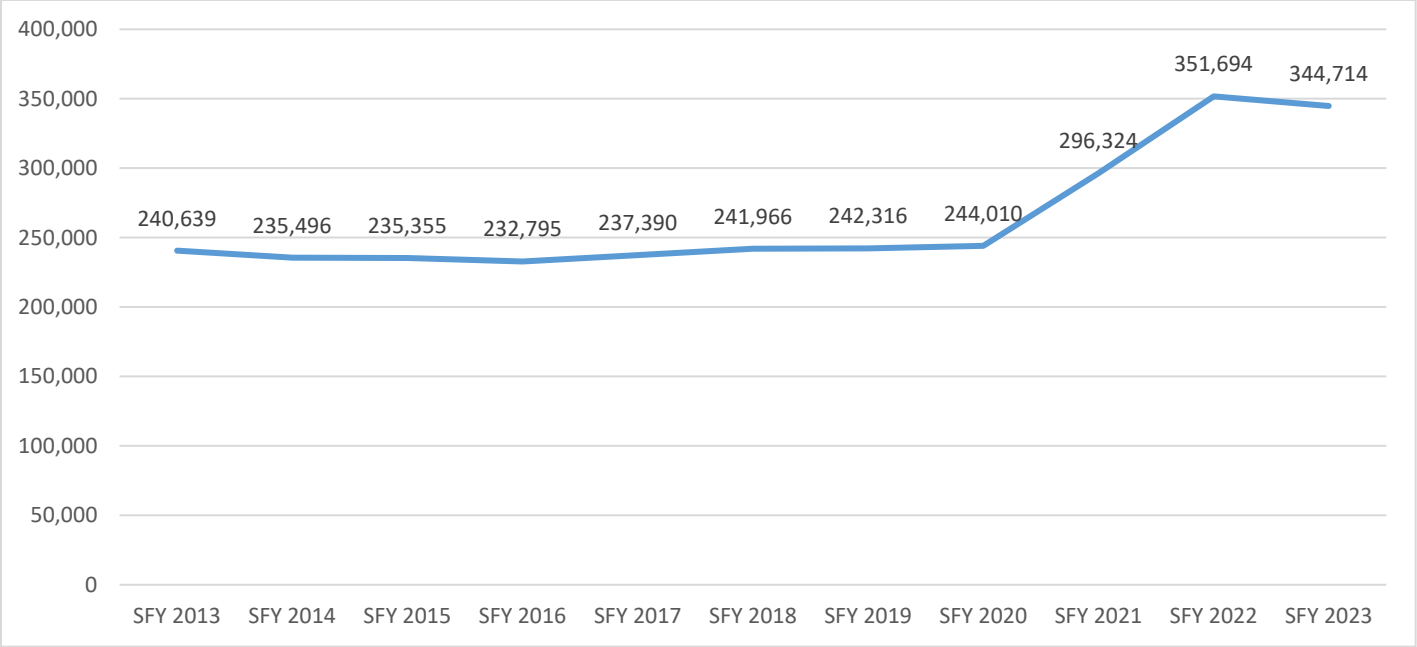
Additionally, there are upcoming challenges that the program will need to overcome. As we continue to complete the redetermination process, the increased workload will impact staff capacity throughout the division. Continued collaboration with community partners and stakeholders will be essential as we complete the unwind process to ensure members do not unnecessarily lose coverage.

Appendix

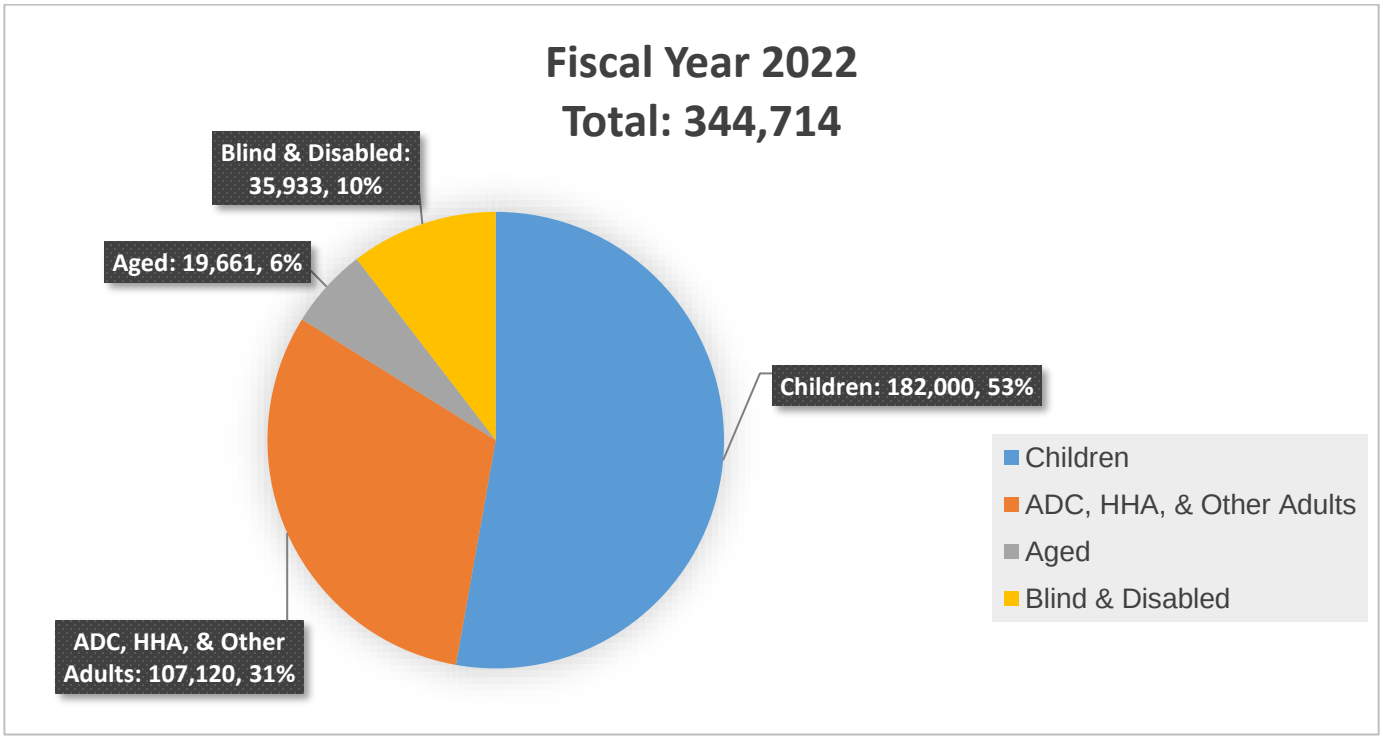
Appendix 1. Average Unemployment Levels by State Fiscal Year (SFY)

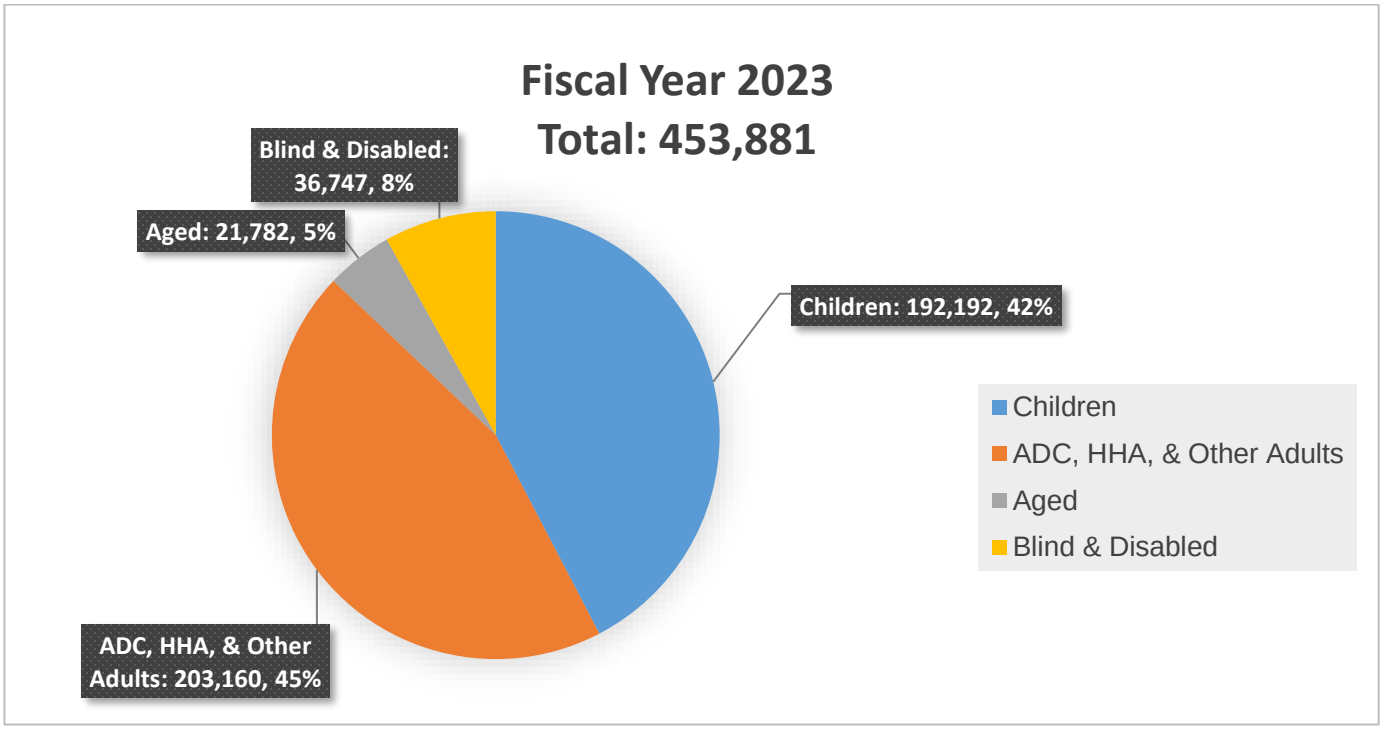


Appendix 2. Average Monthly Nebraska Medicaid Members by State Fiscal Year (SFY)

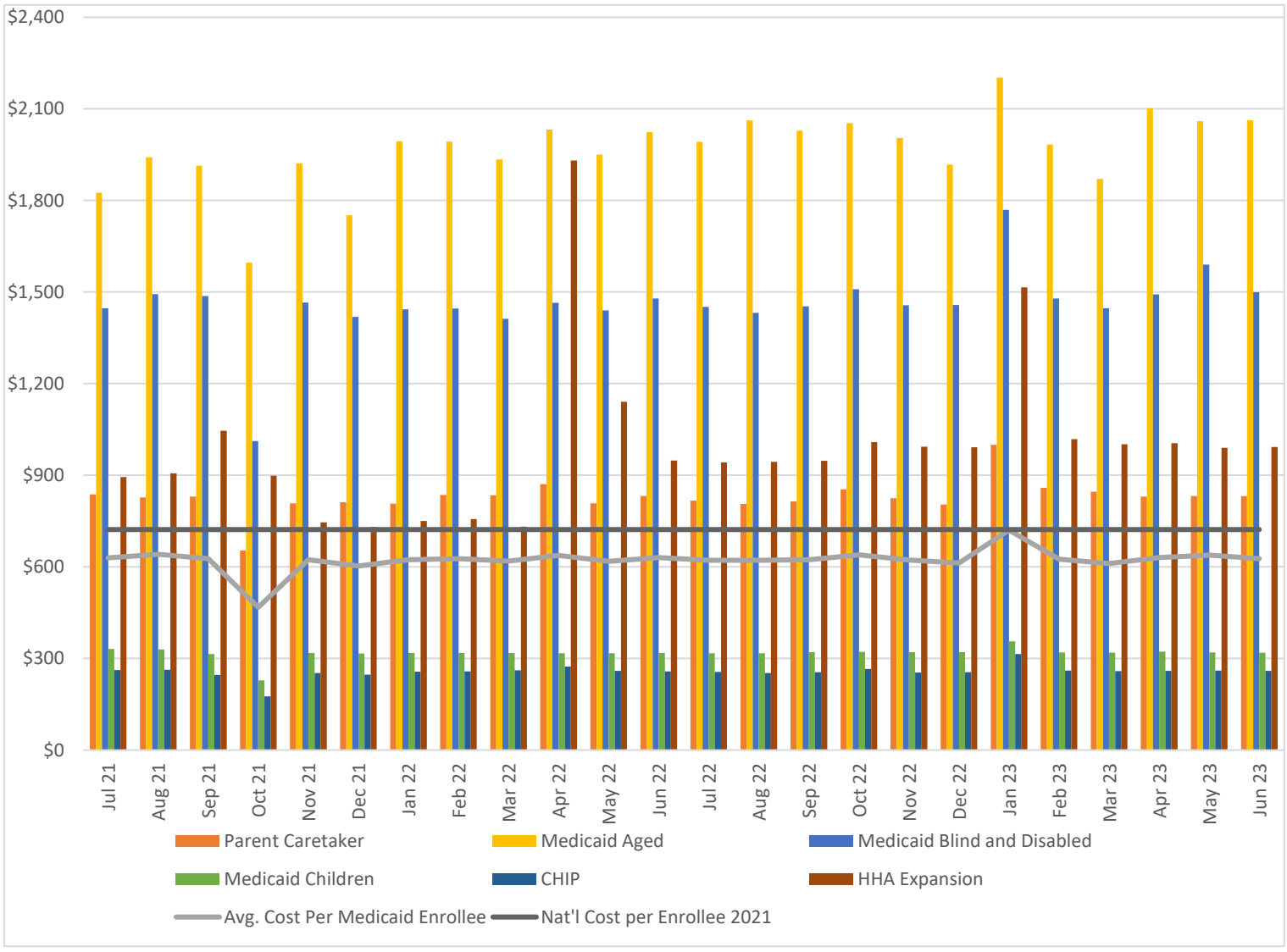


Appendix 3. Average Nebraska Monthly Enrollment for Medicaid and CHIP by Category, SFY22 AND SFY23

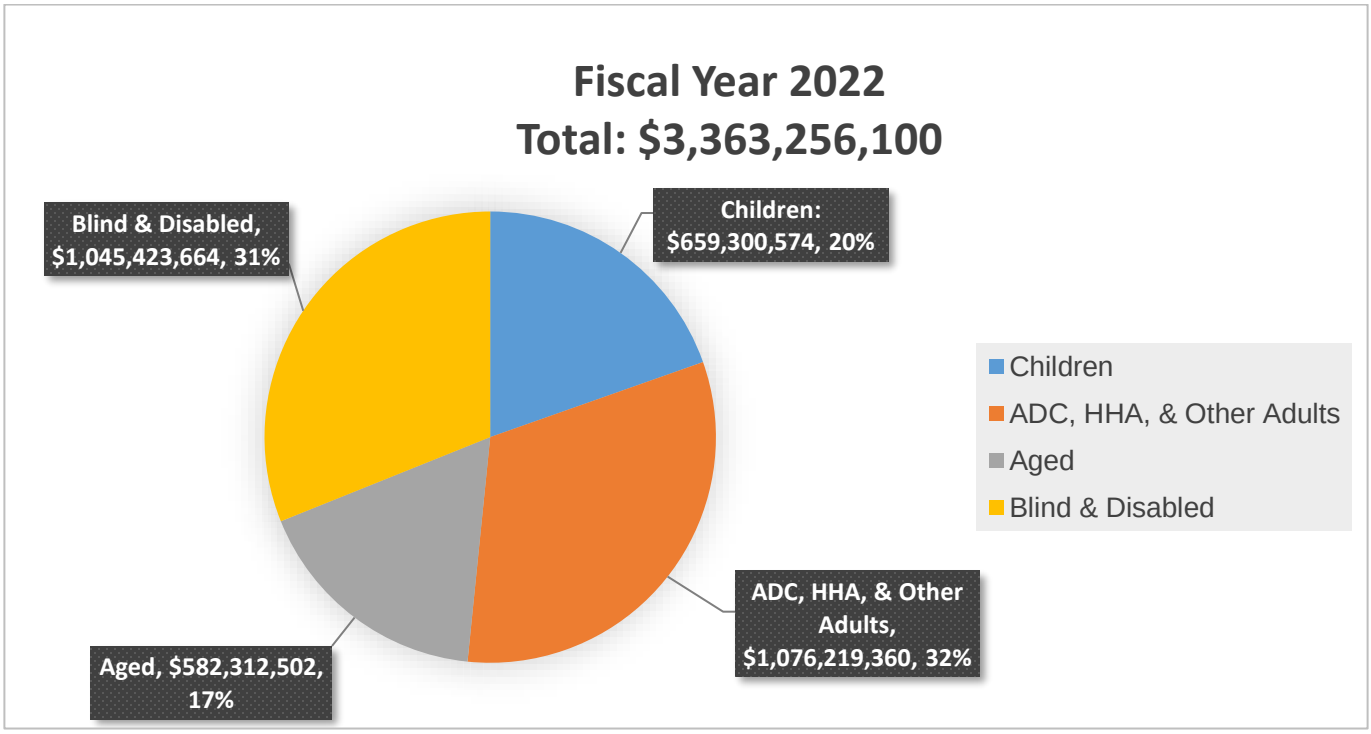


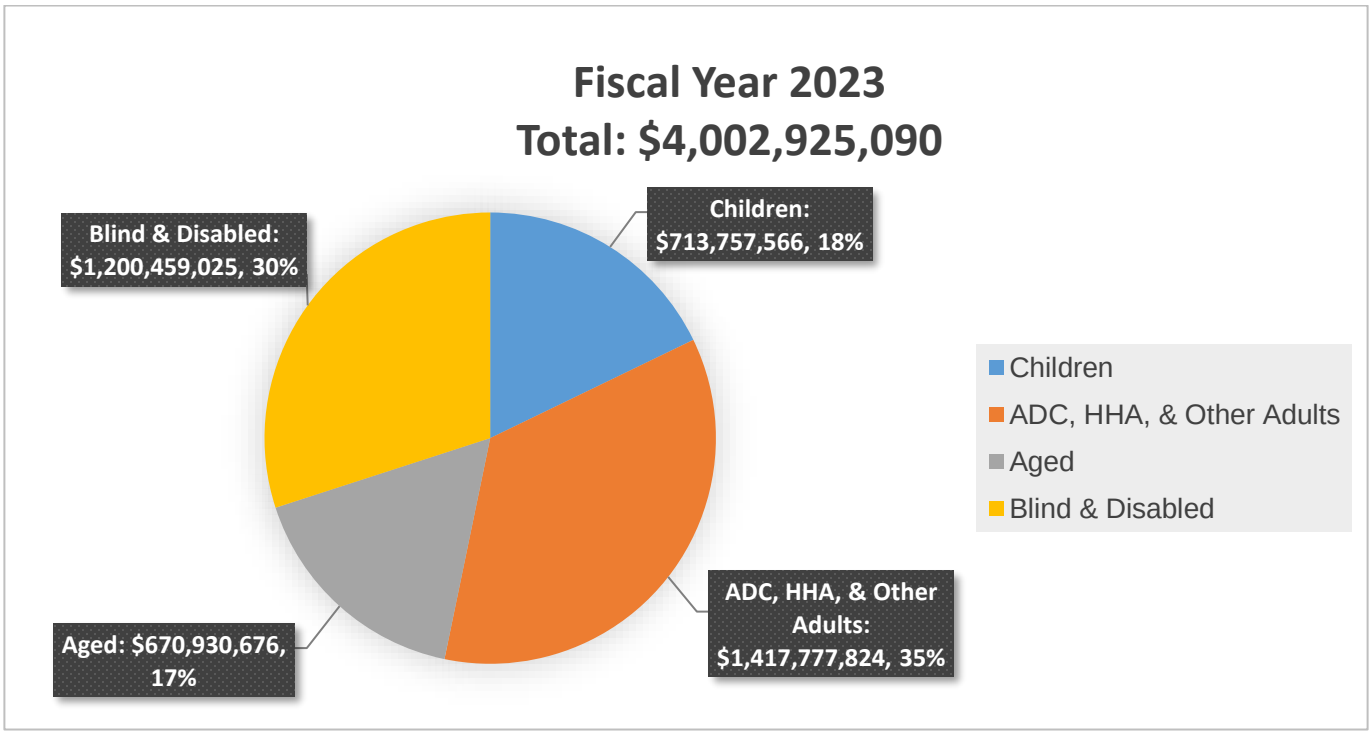


Appendix 4. Nebraska Medicaid Average Cost per Enrollee



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



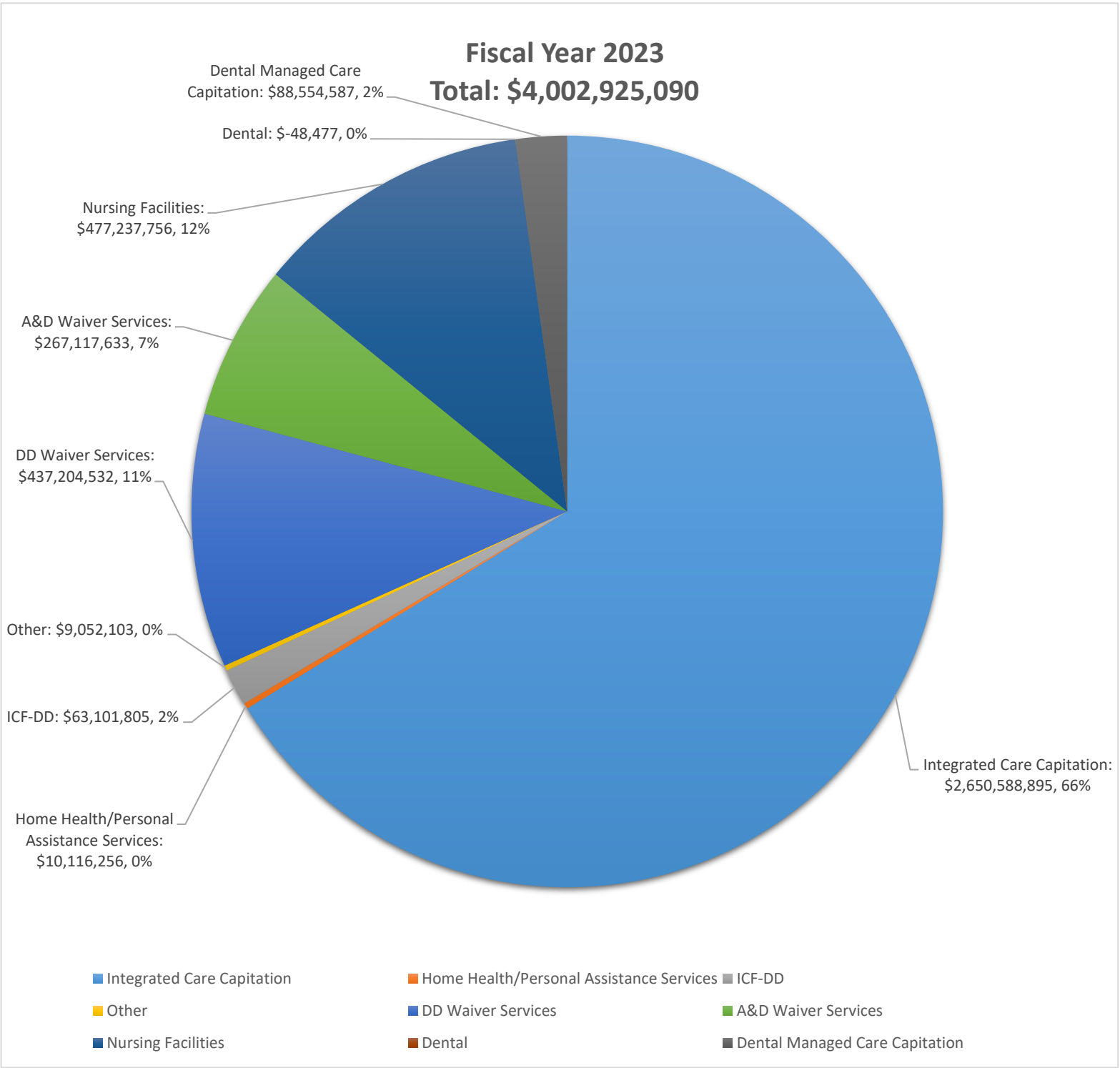


Appendix 6. Nebraska Medicaid Providers by Type

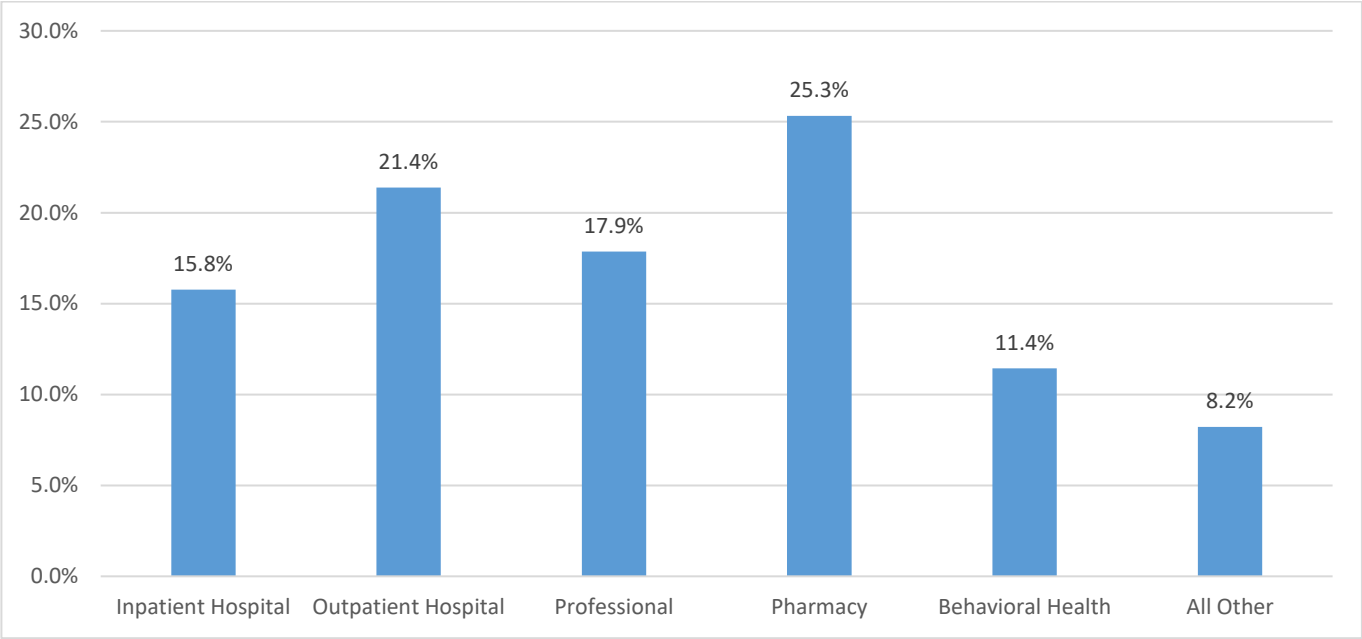
Provider Type Description	Nebraska	Out of State
Adult Day Care (Specialty 79)	1	0
Ambulance (Specialty 59)	304	84
Ambulatory Surgical Centers (ASC)	51	9
Assertive Community Treatment (ACT) MRO Program	3	0
Assisted Living Facility (Specialty 75)	229	0
Case Management	16	0
Clinic (CLNC) (Hospital-based clinic, licensed mental health centers)	302	163
Day Rehabilitation (DAYR) MRO Program	11	0
Day Treatment Provider (DAY)	17	0
Dialysis Centers (Specialty 68)	39	14
Federally Qualified Health Center (FQHC)	64	18
Freestanding Birth Centers	3	0
Home and Community Based Service Providers (HCBS)	4,764	102
Home Health Agency (HHAG)	76	5
Hospice (HSPC)	46	5
Hospice in Nursing Facility (Specialty 82)	686	0
Hospitals (HOSP)	224	612
Indian Health Hospital Clinic (IHSH)	0	5
Intermediate Care Facility (Specialty 88)	11	9
Laboratory (Lab) (Independent)	26	329
Medicaid in Public Schools Direct Care Staff (Specialty 49)	241	6
Medicaid in Public Schools Transportation (Specialty 49)	6	0
Medically Monitored Inpatient Withdrawal (MMIW)	3	0
Multi-Systemic Therapy	0	0
Non-Emergency Medical Transportation (Specialty 94-96)	186	8
Nursing Homes (NH) (Specialty 87)	202	12
Optical Supplier (OPTC)	40	2
Orthopedic Device Supplier (ORTH)	7	10
Opioid Treatment Program (OTP)	3	1
Other Prepaid Health Plan (OPHP)	3	2
Pharmacy (PHCY)	473	282
Professional Clinic (PC)	2,835	757
Professional Resource Family Care	3	1
Psychiatric Residential Treatment Facility	1	27
Qualified Health Maintenance Organization (PHMO)	7	3
Rental and Retail Supplier (RTLR)	135	235
Residential Rehabilitation (REST)	14	2
Rural Health Clinic - Independent (IRHC)	16	11
Rural Health Clinic - Provider Based (PRHC) (Less than 50 beds)	115	30
Rural Health Clinic - Provider Based (RHCP) (Over 50 beds)	5	0
Specialized Add-On Services (in NFs)	0	0
Substance Abuse Treatment Center (SATC)	87	6
Therapeutic Treatment Home (THGH)	1	0
Treatment Crisis Intervention (TCI)	3	0
Tribal 638 Clinic (T638)	13	0

Provider Type Description	Groups		Group Members		Solo Providers	
	In state	Out of state			In state	Out of State
Adult Substance Abuse	44	10				
Anesthesiologist (ANES)	172	69	1552		4	8
Board Certified Associate Behavior Analyst (BCaBA)			8			
Board Certified Behavior Analyst (BCBA)			267			
Community Support (CSW) MRO Program	42	0	272			
Dispensing Physician (MD)			20			
Doctor of Chiropractic Medicine (DC)	331	20	438		133	8
Doctor of Dental Surgery - Dentist (DDS)	278	33	745		238	12
Doctor of Osteopathy (DO)	5	4	1360		5	13
Doctors of Podiatric Medicine (DPM)	71	12	101		14	0
Hearing Aid Dealer (HEAR)	34	5	71		4	1
Licensed Dental Hygienist (LDH)	11	0	48		7	0
Licensed Drug & Alcohol Counselor (LDAC)			122			
Licensed Independent Mental Health Practitioner (LIMHP)	281	8	1580		408	22
Licensed Medical Nutrition Therapist (LMNT)	15	1	85		10	0
Licensed Mental Health Practitioner (LMHP)			775		40	8
Licensed Practical Nurse (LPN)			82		1	
Licensed Psychologist (PHD)	71	3	574		48	0
Mental Health Personal Care Aide (CTAI) / Community Treatment Aid			155			
Nurse Midwife (NW)			99			
Nurse Practitioner (NP)	85	7	4721		75	17
Occupational Therapy Health Services (OTHS)	174	9	664		4	0
Optometrists	248	21	308		39	1
Peer Support Specialist			31			
Personal Care Aide (PCA) in Schools (Specialty 87)			1558			
Pharmacist (PHMS)			28			
Physician Assistant (PA)			2472			
Physicians (MD)	265	264	13802		92	104
PHD Candidate or Intern			6			
Provisional Mental Health Professional / Masters Level Equivalent (MHP)			985		93	0
Provisionally Licensed Drug & Alcohol Counselors (PDAC)			104			
Provisionally Licensed PHD (PPHD)			48		1	0
Psychological Assistant / Associate			1			
Registered Behavioral Technician (RBT)			680			
Registered Nurse (RN)			431		6	
Registered Physical Therapist (RPT)	369	23	1247		11	0
Specially Licensed PHD / Psychology Resident (SPHD)			1			
Speech Therapy Health Service	156	12	1031		13	1

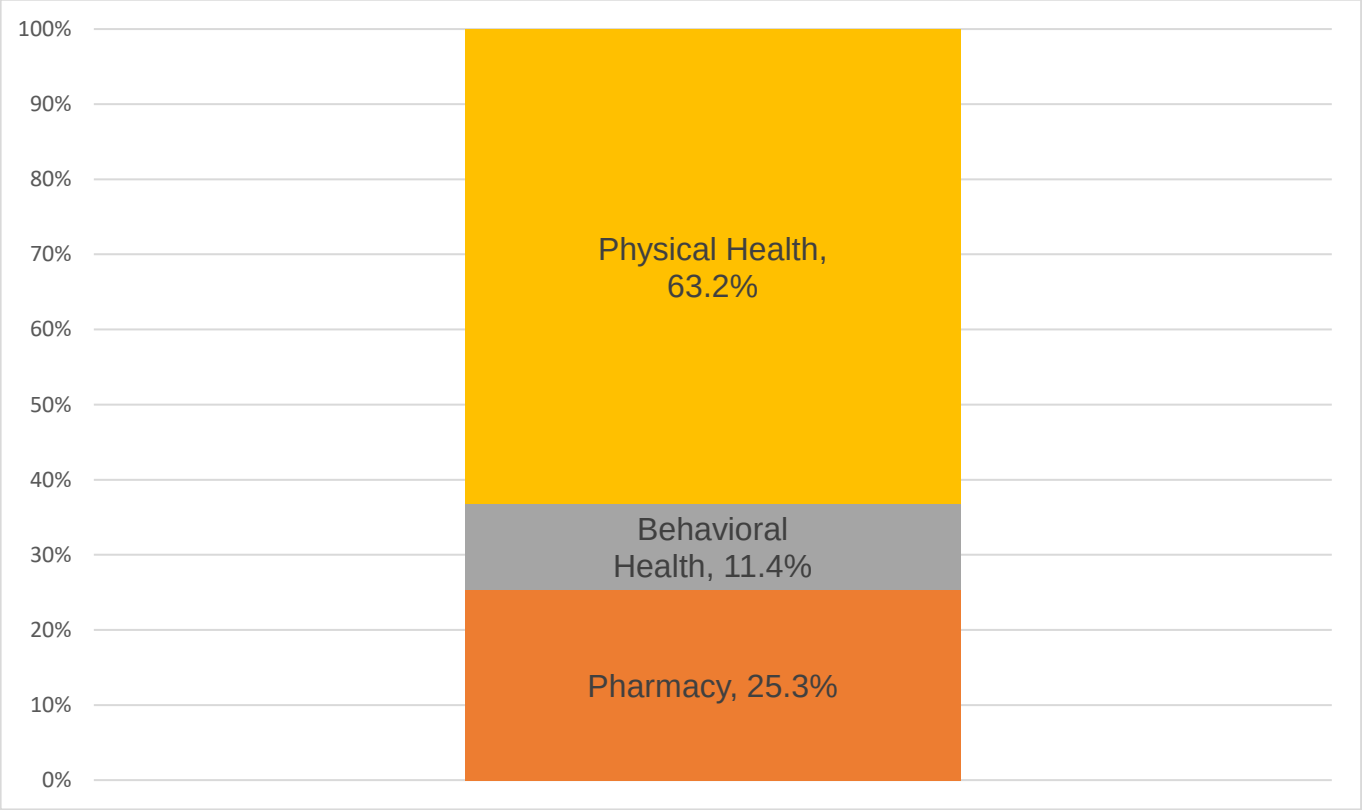
Appendix 7. SFY23 Medicaid and CHIP Expenditure by Service



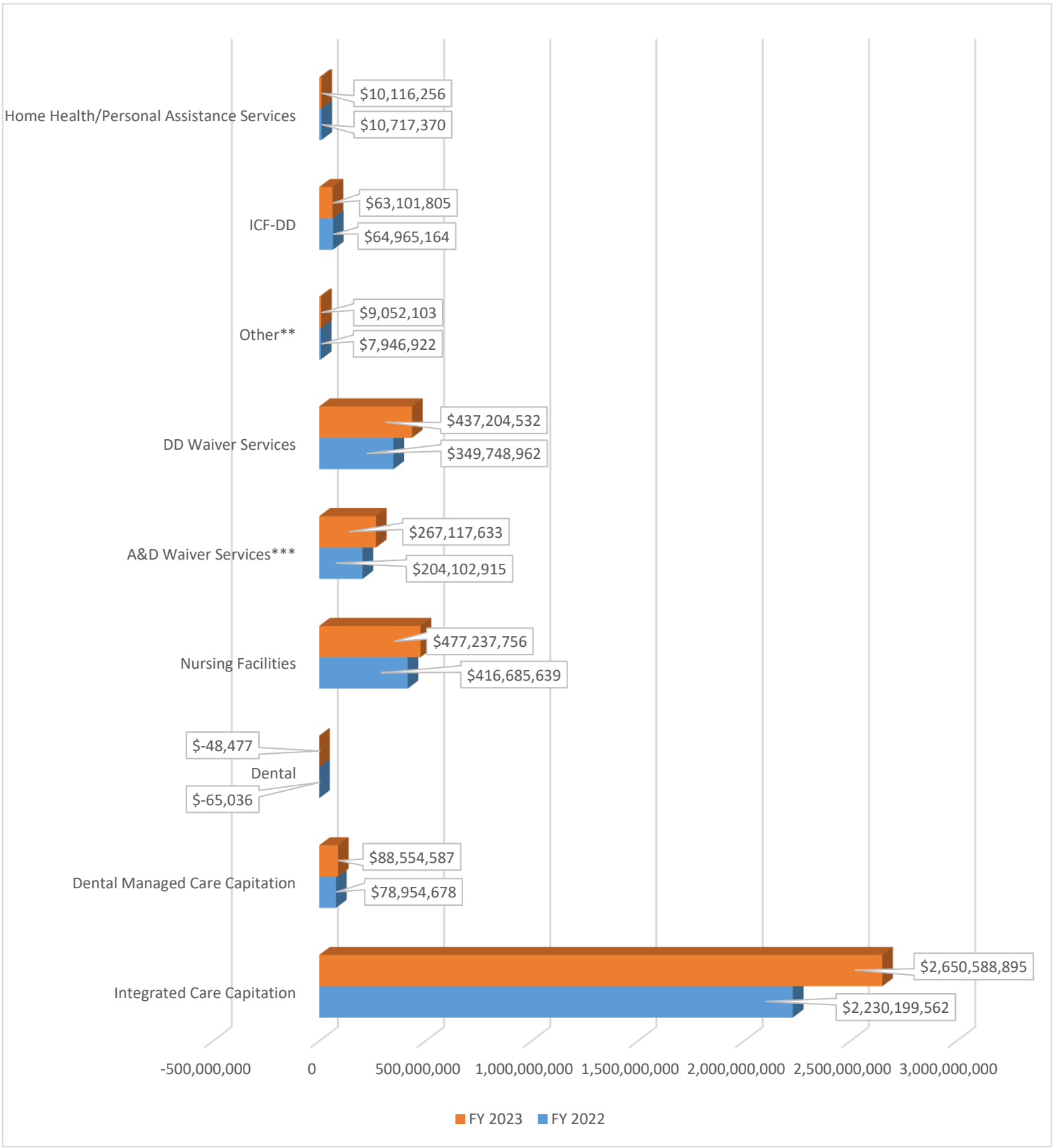
Appendix 8. Percentage of Capitated Health Spend by Service Category



Appendix 9. Heritage Health Medical Services by Relative Cost



Appendix 10. Medicaid and CHIP Expenditures, SFY22 and SFY23



Appendix 11. SFY23 Medicaid Expenditures for Long-Term Care Services