



A Healthy Nebraska:

An Overview of Medicaid in the Cornhusker State

November 2018



POLICY INSTITUTE



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About OpenSky Policy Institute

Our mission is to improve opportunities for every Nebraskan by providing impartial and precise research, analysis, education and leadership.

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Please note, data used in this primer reflect the law as of October 2018 and do not reflect any changes anticipated as a result of the passage of Medicaid expansion on November 6, 2018. The impact of expansion will be explored in subsequent editions of this primer.

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Introduction



Access to quality health care is a key element of “The Good Life” we live in Nebraska because it helps keep our state’s residents working and thriving.

For many Nebraskans, Medicaid and the Children’s Health Insurance Program (CHIP) are essential in getting the care they need. Medicaid and CHIP enable about 225,000 Nebraskans to receive health care coverage with 93 percent of Medicaid and CHIP funding in Nebraska going to children, the elderly and people with disabilities.

Among the many services covered by Medicaid and CHIP are dental care and regular medical checkups for low-income children, quality nursing and end-of-life care for seniors and support services for Nebraskans with developmental disabilities. Medicaid and CHIP enable about 225,000 Nebraskans to receive health care coverage, with 93 percent of Medicaid and CHIP funding in Nebraska going to children, the elderly and people with disabilities. Furthermore, were it not for Medicaid and CHIP, many Nebraska health care professionals would have to cut back on the services they provide and in many cases would not be able to expand their services to help many Nebraskans get the health care they need.

Medicaid and CHIP also play a major role in our state budget and our fiscal debate. Nearly 40 percent of the state general fund budget – or more than \$1.5 billion – supports health and human services with nearly 20 percent – or nearly \$807 million – of the general fund budget being dedicated to Medicaid and CHIP. Medicaid and CHIP are the second largest item in the state’s general fund budget following only state support for K-12 education funding.

This primer is designed to provide a detailed explanation of Medicaid and CHIP funding in Nebraska and to illustrate how this funding interacts with other parts of the state budget as well.

Chapters 1 and 2 describe the Medicaid and CHIP programs and the eligibility requirements. Chapters 3, 4 and 5 examine the services that are provided under Medicaid and CHIP, how the programs are funded and efforts that have been undertaken to improve the programs’ cost effectiveness. Chapter 6 examines some of the other public policy issues that have been linked to Medicaid and CHIP in Nebraska and Chapter 7 provides an overall evaluation of Medicaid and CHIP in Nebraska.

It is our hope that this primer will help policymakers and others gain a deeper understanding of these programs, which in turn will help state leaders formulate policies that truly improve the lives of all Nebraskans.

Chapter 1: What are Medicaid and CHIP?

The Medicaid program was signed into law in 1965 and implemented in Nebraska a year later.

Prior to the development of Medicaid, states received limited payments to provide health care services for individuals and families who received public assistance.¹ In 1960, states began receiving open-ended matching payments from the federal government to pay for the care of low-income seniors, but there were still significant differences among states in the level of services provided to low-income Americans.²

Medicaid vs. Medicare

Medicaid: A joint federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medicare: The federal health insurance program for: people 65 years of age or older; certain younger people with disabilities; and people with End-Stage Renal Disease (permanent kidney failure with dialysis or a transplant, sometimes called ESRD).

(Centers for Medicare & Medicaid Services, Glossary, 2018)

Medicaid was designed to eliminate these disparities among states while expanding federal support for health care services for low-income individuals and families who did not otherwise have access to mainstream healthcare.³ The federal government covers at least half of the program's costs for participating states and sets certain mandates relating to eligibility, coverage and program administration. States are responsible for administration of the program and have some flexibility in tailoring the program to their needs.

Since 1997, the Children's Health Insurance Program (CHIP) has provided health insurance for low-income children whose family income exceeds

the Medicaid eligibility threshold. CHIP is administered by states in accordance with federal requirements. Funding is provided as a block grant, so states get a set amount of federal funding that must be matched with state dollars. It is up to the states to structure their CHIP programs.

Both federal and state governments determine Medicaid policy, as they fund the program jointly. This primer will explore how these entities have intersected to produce Nebraska's Medicaid and CHIP programs. Because these programs have a sizeable impact on Nebraska's state budget, special attention will be given to the program's design and financing and to policy concerns related to state Medicaid spending.

How Medicaid and CHIP Impact Nebraska

- Medicaid and CHIP account for 19.2% of Nebraska's FY 18-19 General Fund appropriations;⁴
- Medicaid enrollees are more likely to receive preventive care, which has long-term, positive effects on health outcomes;⁵
- Medicaid and CHIP enrollment and spending fluctuate with the economy—when economic conditions are good, enrollment falls, and when the economy takes a turn for the worse, Medicaid and CHIP enrollment rise;⁶

- Medicaid and CHIP improve health outcomes for thousands of Nebraskans—over 150,000 children, 22,000 caretakers, 35,000 blind and disabled individuals and 18,000 seniors receive Medicaid or CHIP coverage;⁷
- most individuals enrolled in Medicaid or CHIP are children, the least costly population to cover through these programs;⁸
- on average, one year of a child’s health care coverage through Medicaid or CHIP costs under \$4,000;⁹
- Medicaid and CHIP are flexible-waiver programs that allow the state to tailor the programs to Nebraska’s unique needs;
- nearly 70,000 health care providers across the state offer services to Medicaid and CHIP enrollees.¹⁰

¹ U.S. Department of Health and Human Services (DHHS), Office of the Assistant Secretary for Planning and Evaluation, “Using Medicaid to Support Working Age Adults with Serious Mental Illnesses in the Community: A Handbook,” January 2005, <https://aspe.hhs.gov/report/using-medicaid-support-working-age-adults-serious-mental-illnesses-community-handbook/brief-history-medicaid> (accessed September 13, 2018).

² Id.

³ Id.

⁴ OpenSky analysis of data obtained from the Legislative Fiscal Office.

⁵ Center on Budget and Policy Priorities, “Medicaid Works: Millions Benefit from Effective, Efficient Coverage,” June 2, 2017, <https://www.cbpp.org/research/health/medicaid-works-millions-benefit-from-medicaid-effective-efficient-coverage> (accessed September 18, 2018).

⁶ Congressional Research Service, “Medicaid: The Federal Match Assistance Percentage,” March 2010, <http://www.ncsl.org/documents/health/mafmap.pdf> (accessed September 18, 2018).

⁷ Data received directly from Nebraska Department of Health and Human Services (NE DHHS), November 2017.

⁸ Data received directly from NE DHHS, November 2017.

⁹ Id.

¹⁰ Id.

Chapter 2: Eligibility and Enrollment

Medicaid has limits on who may benefit, what benefits may be offered, and how long those benefits may last. While the federal government mandates some of these limitations, states nonetheless have broad discretion over all three areas and so Medicaid and CHIP programs differ greatly from state to state. This chapter will discuss Medicaid in Nebraska and choices made by the state in structuring the program.

Determining Eligibility

Medicaid is a means-tested program, so most individuals must meet some form of financial requirement before receiving benefits. However, eligibility is more complicated than simply meeting a certain income limit: individuals must also fall into a Medicaid-eligible category, each of which has its own eligibility requirements.

Specifically, states must cover children, the elderly, the blind and disabled, and adult caretakers up to a certain income, which is determined by the Modified Adjusted Gross Income, or MAGI, method.¹¹ Implemented by the Affordable Care Act (ACA), MAGI uses federal tax rules and information to calculate an individual's income, which is then compared to federal poverty standards. This was intended to streamline enrollment processes and ease coordination of eligibility across programs.¹² The MAGI method doesn't have a resource limit, which means it doesn't take into account cash or any property that could be sold for cash, such as a home or vehicle.¹³

Some groups can bypass the MAGI process altogether because their eligibility is tied to their enrollment in another program. This is the case for the elderly and disabled, whose Medicaid eligibility is generally tied to their enrollment in Supplemental Security Income (SSI).¹⁴

Outside of emergency services, Medicaid beneficiaries must also be residents of the state in which they live and be either United States citizens or qualified non-citizens, such as lawful permanent residents.¹⁵

Individuals who don't fall into any of the federal mandatory or optional categories aren't eligible for federal funds. They may, however, be eligible for state funds if their state has chosen to expand coverage beyond the scope of the federal program. States are allowed to expand their coverage to any category of people but won't necessarily receive additional federal funds. Without the promise of federal funds, states are unlikely to expand their coverage too broadly.

The rest of this section will discuss in more detail the specific categories of individuals who are eligible for Medicaid and CHIP in Nebraska. Categories that will become eligible under Medicaid expansion won't be included here until implementation.

Supplemental Security Income (SSI) is a federal income supplement program funded by general tax revenues (not Social Security taxes) that:

- helps aged, blind and disabled people who have little or no income; and
- provides cash to meet basic needs for food, clothing and shelter.

Children

In Nebraska, children under 19 are eligible for Medicaid and CHIP if their family income is below 213% of the Federal Poverty Level (FPL), or \$43,495 for a family of three in 2017.¹⁶ Because coverage under each program is identical, with enrollment depending on age and income, families may not know in which program their children are enrolled. The distinction is important to the state, however, because CHIP has a higher federal reimbursement rate that varies by year and by state.¹⁷ CHIP reimbursements have historically ranged from 65 to 81%, compared to 50 to 73% for children in Medicaid.¹⁸

Children fall under Medicaid if they are 19 or under and have family incomes at or below 133% of the FPL, or \$27,159 for a family of three in 2017.¹⁹ States can expand this coverage by increasing income thresholds or by establishing a separate CHIP program. Nebraska uses a combination of the two (see below for state income thresholds).²⁰

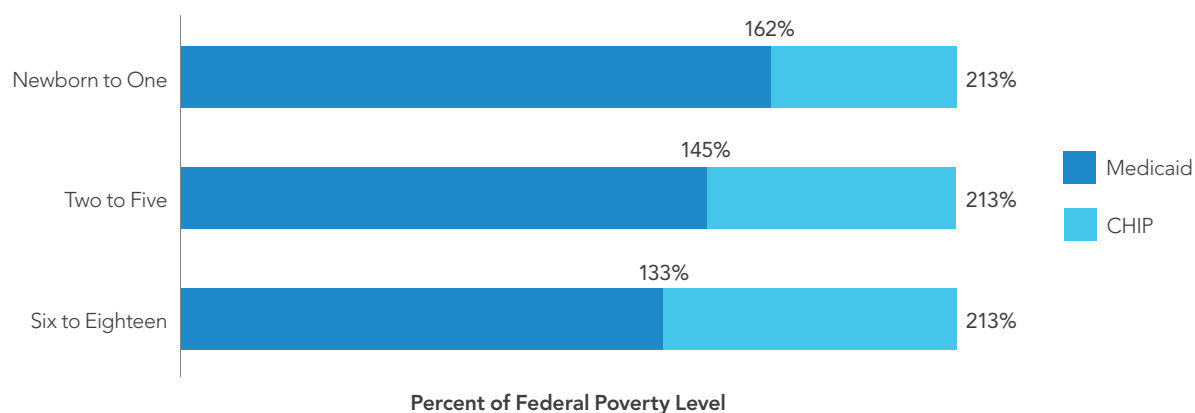
Each program is subject to slightly different rules (see Figure 1 for income limits by age and program).

Medicaid – Children under age one are eligible if their family income is 162% of the FPL or less; children from ages one to five are eligible if their family income is 145% of the FPL or less; children ages six to 18 are eligible if their family income is 133% of the FPL or less.²¹

CHIP Eligibility – Children under age 19 whose family income exceeds the Medicaid income limits for their age group are eligible if their family income is 213% of the FPL or less.²²

Separate CHIP Program – Women who don't meet Medicaid criteria are eligible for coverage of prenatal and delivery services for unborn children if their family income is 197% of the FPL or less.²³

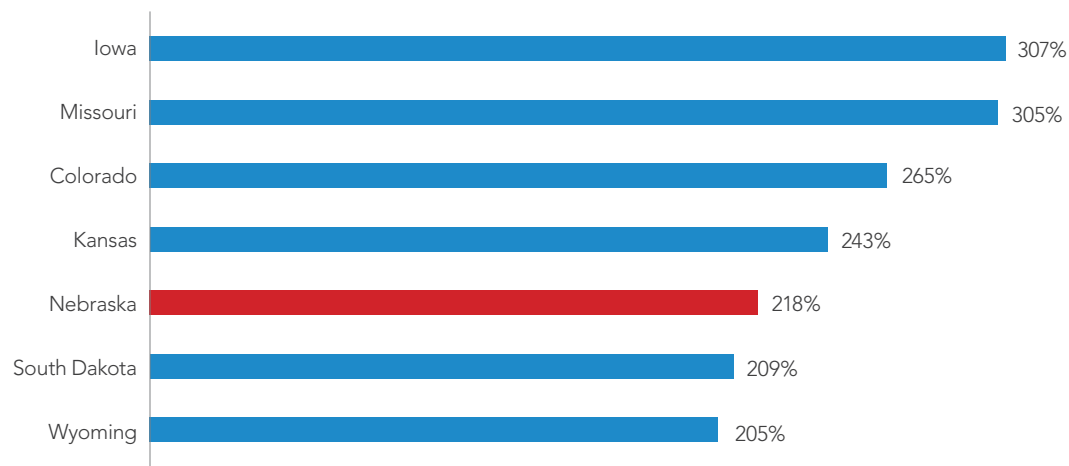
Figure 1: Medicaid and CHIP Income Limits by Child Age



Source: 2017 NE DHHS Report²⁴

As of January 2017, 28 states and the District of Columbia cover children from families with incomes higher than those Nebraska covers.²⁵ Of Nebraska's six neighboring states, only two (South Dakota and Wyoming) have lower income thresholds for covering children through Medicaid and CHIP (as seen in Figure 2); Iowa, Missouri, Colorado and Kansas all cover children through Medicaid and CHIP at higher income levels than Nebraska.²⁶ Nationally, the median upper-income limit for coverage through Medicaid and CHIP is 255% of the FPL.²⁷

Figure 2: Upper Income Limit for Children’s Health Coverage as a Percentage of FPL



Source: Kaiser Family Foundation, January 2017²⁸

Children in foster care can become eligible for Medicaid through the federal Title IV-E Foster Care Program, which helps states fund certain foster care and adoption programs.²⁹ Eligibility, however, is tied to a federal program that hasn’t existed since 1996 and income limits haven’t been adjusted for inflation since then,³⁰ so Nebraska can only receive federal funds if a child is taken into care from a family making less than \$673 a month. Because of this low income threshold, eligibility has been declining. Any Title IV-E eligible children who age out of the foster care system will be eligible for Medicaid coverage up to age 26.³¹

Nebraska doesn’t cover children in state adoption assistance programs who don’t meet Title IV-E standards; instead, those in the child welfare system are eligible for Medicaid based on family incomes or their own income if they’re expected to be in out-of-home placement for more than 90 days.³²

A child 16 or older in a state-subsidized adoption or guardianship will be covered until they’re 21 if they have incomes up to 23% of the FPL, or \$2,774 for an individual in 2017, and meet the requirements of the state’s Bridge to Independence program, which helps transition children out of the foster system and into adulthood.³³ Former wards whose incomes are at or below 51% of the FPL, or \$6,151 for an individual in 2017, are also eligible.³⁴

Children with serious medical needs can receive Medicaid coverage, regardless of income, through what is known as the Katie Beckett program.³⁵ It applies to children who use a ventilator; have a tracheostomy; require excessive amounts of medical supplies, equipment or therapies; or need complex nursing services provided at home. All but one state offers coverage through this or a similar program.³⁶

Individuals with Disabilities

SSI Eligible – Nebraska, like most other states, provides Medicaid services to any individual under 65 who receives SSI and meets the federal definition of “blind” or “disabled.”^{37 38} The federal government considers a person “blind” if their vision can’t be corrected to better than 20/200 in their better eye or if the better eye’s visual field is expected to be 20 degrees or less for over a year.³⁹ A person is “disabled” if, due to physical and/or mental impairments, they can’t expect to

participate in substantial gainful activity for over a year.⁴⁰ While SSI eligibility is limited to those earning up to approximately 73% of the FPL, Nebraska has expanded coverage to those earning up to 100% of the FPL.⁴¹

Workers with Disabilities – Nebraska has expanded coverage for those with disabilities who would be eligible for Medicaid but for their earnings, allowing them to receive Medicaid if their incomes are up to 250% of the FPL.⁴² Disabled workers who earn up to 200% of the FPL or less are eligible and won't have to pay a premium; those who earn between 200% and 250% of the FPL are eligible but will have to pay a premium.⁴³

The Elderly

Individuals 65 and older are eligible for Medicare, the federal health care program for the elderly. However, Medicare, like private insurance, requires significant cost-sharing through co-insurance, co-pays, deductibles⁴⁴ and more – which vary by state and by program – so low-income elderly individuals often still struggle to afford health care. As such, some elderly people may also be eligible for full Medicaid benefits or help with Medicare's cost-sharing provisions.

Fully Dual Eligible – Elderly people who qualify for SSI are also eligible for full Medicaid benefits.⁴⁵ Nebraska has expanded coverage up to 100% of the FPL for those whose resources don't exceed the limits prescribed for SSI eligibility and covers the elderly through Medicaid instead of Medicare.^{46 47}

Medicare Savings Program – Elderly people with incomes too high to qualify for full Medicaid eligibility – more than 100% of the FPL – may still qualify for help with some of the cost-sharing provisions of Medicare through the Medicare Savings Program. Nebraska uses two of four available assistance programs:⁴⁸

Specified Low-income Medicare Beneficiary (SLMB) – This program is available to elderly individuals with incomes between 100% and 120% of the FPL.⁴⁹ Resource limits are \$4,000 per individual and \$6,000 per married couple.⁵⁰ For SLMB individuals, the state must help with premiums for Medicare Part B, which covers medically necessary and preventive services, such as ambulance services, durable medical equipment and mental health services.^{51 52}

Qualifying Individual – This program is available to elderly individuals with incomes between 120% and 135% of the FPL. Offered in Nebraska, it helps qualified individuals with their Medicare Part B premiums.⁵³

Other Adults

Low-Income Caretakers – The federal government requires that caretakers⁵⁴ of children be eligible for Medicaid if they meet the income limits for the Aid to Families with Dependent Children program, as it existed in 1996, which is about 39.5% of the FPL, or \$8,066 for a family of three in 2017.^{55 56} Nebraska has expanded eligibility to incomes up to 63% of the FPL, or \$12,865 for a family of three in 2017, ranking it 37th out of the 50 states plus Washington, D.C. in Medicaid broadness for caretakers.⁵⁷ As such, only 14 states have stricter requirements for caretaker enrollment in Medicaid.

Pregnant Women – States must cover pregnant women with incomes up to 133% of the FPL for up to 60 days after the child's birth.⁵⁸ Nebraska has expanded its coverage to incomes up to 194% of the FPL⁵⁹ and uses a program called 599 CHIP to cover prenatal and delivery services for unborn children of undocumented mothers up to 197% of the FPL.⁶⁰ Nebraska has higher income eligibility thresholds for pregnant women than 19 other states.⁶¹

Other Categories of Eligibility

Transitional Medical Assistance – Caretakers can also access Medicaid for a limited time to help them transition off cash assistance if they lose coverage due to an increase in income.⁶² Eligibility can last six months regardless of income and an additional six months if income is at or below 185% of the FPL.⁶³ Families with incomes at or above 100% of the FPL must pay a premium.⁶⁴

Medically Needy – Nebraska lets some individuals with high medical expenses, including the elderly and disabled, deduct those expenses from their income – effectively spending it down – for the purpose of determining Medicaid eligibility.^{65 66}

Coverage for Specific Ailments and Services – Nebraska has expanded coverage to women with incomes up to 225% of the FPL who are screened through a Centers for Disease Control program and diagnosed with breast or cervical cancer.⁶⁷ Incomes are determined by the screening program's criteria and not MAGI.⁶⁸ States may also cover tuberculosis treatments and family planning services up to certain income levels, although Nebraska does not.⁶⁹

Qualified Non-Citizens – States must provide Medicaid coverage to refugees, persons seeking political asylum and other individuals involved in humanitarian crises upon entrance into the United States.⁷⁰ Nebraska has expanded its Medicaid program to include certain qualified immigrants, such as legal permanent residents, if they otherwise meet eligibility requirements and have been in the United States for at least five years.⁷¹ Some groups of immigrants, including pregnant women and children, are exempt from this waiting period.⁷²

Emergency Services for Immigrants – States must provide emergency medical services for immigrants not eligible for Medicaid if they would have otherwise qualified but for their immigration status.⁷³

Who Enrolls?

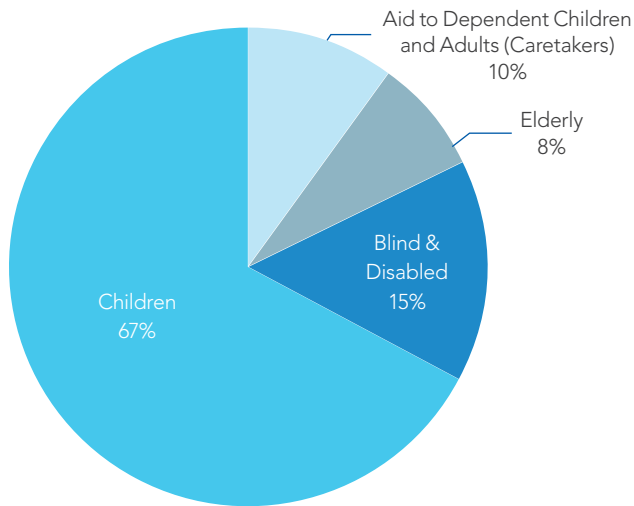
Medicaid and CHIP enrollment in Nebraska averaged 238,855 people a month, or approximately 12.5% of the state's population, from January 2014 through July 2017.^{74 75}

Medicaid enrollment in the state has been stable over the last decade for each of the major populations served as a proportion of total enrollment.

Children and blind and disabled enrollees consistently make up around 65% and 15% of enrollees, respectively. Elderly enrollees averaged around 8% of total enrollees between SFY 2006 and SFY 2016. Caretaker enrollment varies between 9.7% and 13.5% of total enrollees.

Different from a state fiscal year (SFY), which begins on July 1 and ends the following June 30, a federal fiscal year (FFY) begins with the third quarter, or October 1, and ends at the end of the second quarter of the next calendar year, or September 30. Because state and federal fiscal years do not directly line up, this means the percentage reimbursement the state receives from the federal government may not be the same throughout the whole fiscal year.

Figure 3: SFY 2016 NE Enrollees by Group (% of total)

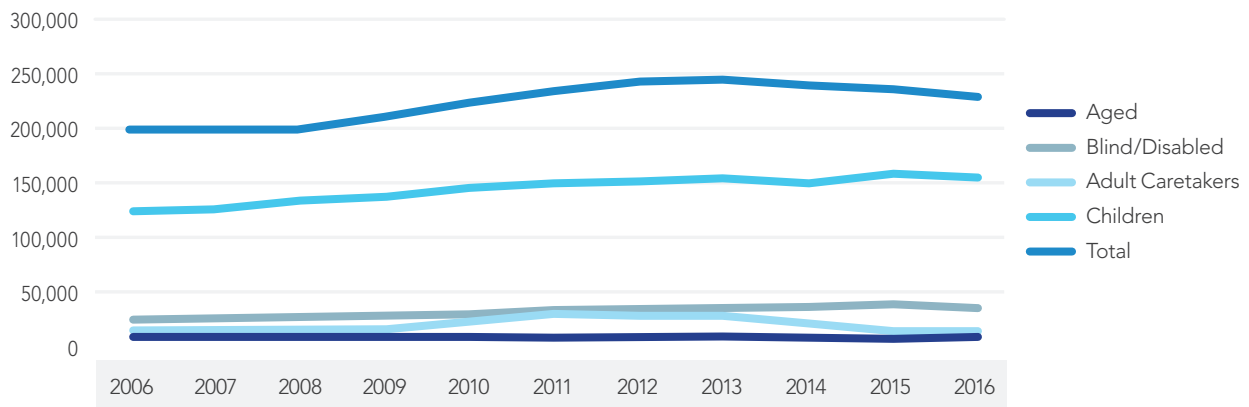


Source: Nebraska Medicaid Reform Annual Report for State Fiscal Year 2015-2016

The chart to the left details the breakdown of enrollment in both Medicaid and CHIP for each of the major Medicaid enrollee populations in SFY 2016. For more specific enrollment breakdowns for SFY 2016 and a comparison of SFYs 2006, 2011 and 2016, see Appendix A.

Figure 4 shows average monthly Medicaid enrollment in Nebraska by each of the major enrollee groups between SFY 2006 and SFY 2016. Total enrollment trends tend to mirror those of child enrollment, as children comprise a majority of Medicaid and CHIP enrollees in the state, and non-disabled, non-senior adult enrollees only qualify if they're both a qualified caretaker and meet income requirements.

Figure 4: SFY 2016 NE Enrollees by Group (% of total)



Source: Data received directly from DHHS, November 2017

CHIP Enrollment

Total annual CHIP enrollment grew from 44,981 in SFY 2006 to 52,852 in SFY 2011 and again to 55,041 in SFY 2016, resulting in an average annual CHIP enrollment of 52,278.⁷⁶

¹¹ Centers for Medicare & Medicaid Services (CMS), "Eligibility," <https://www.medicare.gov/medicaid/eligibility/> (accessed August 17, 2018).

¹² Id.

¹³ Id.

¹⁴ CMS, "Eligibility," <https://www.medicare.gov/medicaid/eligibility/> (accessed August 17, 2018).

¹⁵ Id.

¹⁶ Healthcare.gov, "Federal Poverty Level (FPL)," <https://www.healthcare.gov/glossary/federal-poverty-level-fpl/> (accessed September 18, 2018).

- ¹⁷ Medicaid and CHIP Payment and Access Commission (MACPAC), "CHIP Financing," <https://www.macpac.gov/subtopic/financing/> (accessed August 17, 2018).
- ¹⁸ Id.
- ¹⁹ DHHS, "2017 Poverty Guidelines," <https://aspe.hhs.gov/poverty-guidelines> (accessed August 30, 2018).
- ²⁰ MACPAC, "Federal Requirements and State Options: Eligibility," <https://www.macpac.gov/publication/federal-requirements-and-state-options-elibility/> (accessed August 30, 2018).
- ²¹ NE DHHS, "Nebraska Medicaid Annual Reform Report for State Fiscal Year 2016-2017," December 1, 2017, p. 3-4, <http://dhhs.ne.gov/Reports/Medicaid%20Annual%20Report-2017.pdf> (accessed September 9, 2018)
- ²² Id.
- ²³ Id.
- ²⁴ NE DHHS, "Nebraska Medicaid Annual Reform Report for State Fiscal Year 2016-2017," December 1, 2017, p. 19, <http://dhhs.ne.gov/Reports/Medicaid%20Annual%20Report-2017.pdf> (accessed September 9, 2018).
- ²⁵ Kaiser Family Foundation, "Income Eligibility Limits for Children's Health Coverage as a Percent of the Federal Poverty Level," <http://files.kff.org/attachment/Report-Medicaid-and-CHIP-Eligibility-as-of-Jan-2017-Table-1> (accessed September 13, 2018).
- ²⁶ Id.
- ²⁷ Id.
- ²⁸ Kaiser Family Foundation, "Enrollment, Renewal, and Cost Sharing Policies as of January 2017," <http://files.kff.org/attachment/Report-Medicaid-and-CHIP-Eligibility-as-of-Jan-2017> (accessed September 13, 2018).
- ²⁹ The state hasn't exercised its option to cover children receiving non IV-E state adoption assistance and were previously eligible for Medicaid before adoption. MACPAC, "Federal Requirements and State Options: Eligibility," <https://www.macpac.gov/wp-content/uploads/2017/03/Federal-Requirements-and-State-Options-Eligibility.pdf> (accessed August 30, 2018).
- ³⁰ Nebraska Children's Commission, "Nebraska Child Welfare Financing Primer," p. 9, <http://www.childrens.nebraska.gov/PDFs/Reports/Nebraska%20Child%20Welfare%20Financing%20Primer.pdf> (accessed September 13, 2018).
- ³¹ This provision provides parity for foster children with children who are allowed to stay on their family's health insurance plan up to age 26. MACPAC Fact Sheet, "Federal Requirements and State Options: Eligibility," <https://www.macpac.gov/wp-content/uploads/2017/03/Federal-Requirements-and-State-Options-Eligibility.pdf> (accessed August 30, 2018).
- ³² Nebraska Children's Commission, "Nebraska Child Welfare Financing Primer," p. 9, <http://www.childrens.nebraska.gov/PDFs/Reports/Nebraska%20Child%20Welfare%20Financing%20Primer.pdf> (accessed September 13, 2018).
- ³³ NE DHHS, "Bridge to Independence Program", http://dhhs.ne.gov/children_family_services/BridgeToIndependence/Pages/Program.aspx (accessed September 13, 2018).
- ³⁴ NE DHHS, "Nebraska Medicaid Reform Annual Report for State Fiscal Year 2015-2016", p. 10, <http://dhhs.ne.gov/Reports/Medicaid%20Annual%20Report%20-%202016.pdf> (accessed September 13, 2018).
- ³⁵ NE DHHS, "Home and Community Services, Katie Beckett Program", http://dhhs.ne.gov/Pages/hcs_programs_katie-beckett.aspx (accessed September 13, 2018).
- ³⁶ MACPAC, "Federal Requirements and State Options: Eligibility," <https://www.macpac.gov/wp-content/uploads/2017/03/Federal-Requirements-and-State-Options-Eligibility.pdf> (accessed August 30, 2018).
- ³⁷ Some states, known as 209(b) states, are permitted to use eligibility standards that are more restrictive than SSI in terms of financial limitations or disability. MACPAC, "Medicaid Income Eligibility Levels as a Percentage of the FPL for Non-Aged, Non-Disabled, Non-Pregnant Adults by State," p. 98, <https://www.macpac.gov/publication/medicaid-income-eligibility-levels-as-a-percentage-of-the-federal-poverty-level-for-non-aged-non-disabled-non-pregnant-adults-by-state> (accessed September 13, 2018).
- ³⁸ For a more complete definition, see Social Security Administration (SSA), "Benefits Planner: Disability," <https://www.ssa.gov/planners/disability/dqualify4.html> (accessed September 13, 2018).
- ³⁹ SSA, "If You're Blind Or Have Low Vision—How We Can Help," <https://www.ssa.gov/pubs/EN-05-10052.pdf> (accessed September 13, 2018).
- ⁴⁰ SSA, "Disability Evaluation Under Social Security," <https://www.ssa.gov/disability/professionals/bluebook/general-info.htm> (accessed September 13, 2018).
- ⁴¹ The method for determining countable income for SSI differs significantly from the MAGI method used for determining Medicaid eligibility for other categories of individual. Significant amounts of earned income can be excluded, so an individual's gross income can exceed these limits and still qualify. OASDI and SSI program rates and limits. SSA, "Research, Statistics, & Policy Analysis," https://www.ssa.gov/policy/docs/quickfacts/prog_highlights/index.html (accessed September 13, 2018).
- ⁴² NE DHHS, "Nebraska Medicaid Annual Reform Report for State Fiscal Year 2016-2017," December 1, 2017, p. 3-4, <http://dhhs.ne.gov/Reports/Medicaid%20Annual%20Report-2017.pdf> (accessed September 9, 2018).
- ⁴³ Id.
- ⁴⁴ For specific costs, see CMS, "Medicare 2018 Costs at a Glance," <https://www.medicare.gov/your-medicare-costs/costs-at-a-glance/costs-at-a-glance.html> (accessed August 17, 2018).
- ⁴⁵ MACPAC, "Federal Requirements and State Options: Eligibility," <https://www.macpac.gov/wp-content/uploads/2017/03/Federal-Requirements-and-State-Options-Eligibility.pdf> (accessed August 30, 2018).
- ⁴⁶ Id.

- ⁴⁷ NE DHHS, "Nebraska Medicaid Reform Annual Report for State Fiscal Year 2015-2016," p. 11, <http://dhhs.ne.gov/Reports/Medicaid%20Annual%20Report%20-%202016.pdf> (accessed September 13, 2018).
- ⁴⁸ CMS, "Medicare Savings Program," <https://www.medicare.gov/your-medicare-costs/help-paying-costs/medicare-savings-program/medicare-savings-programs.html#collapse-2614> (accessed September 13, 2018).
- ⁴⁹ MACPAC, "Beneficiaries Dually Eligible for Medicare and Medicaid," p. 5, https://www.macpac.gov/wp-content/uploads/2017/01/Jan17_MedPAC_MACPAC_DualsDataBook.pdf (accessed September 13, 2018).
- ⁵⁰ CMS, "Medicare Savings Program," <https://www.medicare.gov/your-medicare-costs/help-paying-costs/medicare-savings-program/medicare-savings-programs.html#collapse-2614> (accessed September 13, 2018).
- ⁵¹ Id.
- ⁵² CMS, "What Part B Covers," <https://www.medicare.gov/what-medicare-covers/part-b/what-medicare-part-b-covers.html> (accessed September 13, 2018).
- ⁵³ CMS, "Medicare Savings Program," <https://www.medicare.gov/your-medicare-costs/help-paying-costs/medicare-savings-program/medicare-savings-programs.html#collapse-2614> (accessed September 13, 2018).
- ⁵⁴ "Caretaker" is used throughout this report as an all-inclusive category for individuals who are primary caregivers for children.
- ⁵⁵ Nebraska Children's Commission, "Nebraska Child Welfare Financing Primer," p. 11, <http://www.childrens.nebraska.gov/PDFs/Reports/Nebraska%20Child%20Welfare%20Financing%20Primer.pdf> (accessed September 13, 2018).
- ⁵⁶ DHHS, "Poverty Guidelines," <https://aspe.hhs.gov/poverty-guidelines> (accessed September 13, 2018).
- ⁵⁷ Kaiser Family Foundation, "Medicaid Income Eligibility Limits for Adults as a Percent of the Federal Poverty Level," <http://files.kff.org/attachment/Report-Medicaid-and-CHIP-Eligibility-as-of-Jan-2017-Table-5> (accessed September 13, 2018).
- ⁵⁸ MACPAC, "Federal Requirements and State Options: Eligibility," <https://www.macpac.gov/wp-content/uploads/2017/03/Federal-Requirements-and-State-Options-Eligibility.pdf> (accessed August 30, 2018).
- ⁵⁹ NE DHHS, "Nebraska Medicaid Annual Reform Report for State Fiscal Year 2016-2017," December 1, 2017, p. 3-4, <http://dhhs.ne.gov/Reports/Medicaid%20Annual%20Report-2017.pdf> (accessed September 9, 2018).
- ⁶⁰ Id.
- ⁶¹ Kaiser Family Foundation, "Medicaid and CHIP Income Eligibility Limits for Pregnant Women as a Percent of the Federal Poverty Level," <https://www.kff.org/health-reform/state-indicator/medicaid-and-chip-income-eligibility-limits-for-pregnant-women-as-a-percent-of-the-federal-poverty-level/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D> (accessed September 13, 2018).
- ⁶² MACPAC, "Federal Requirements and State Options: Eligibility," <https://www.macpac.gov/wp-content/uploads/2017/03/Federal-Requirements-and-State-Options-Eligibility.pdf> (accessed August 30, 2018).
- ⁶³ NE DHHS, "Nebraska Medicaid Annual Reform Report for State Fiscal Year 2016-2017," December 1, 2017, p. 3-4, <http://dhhs.ne.gov/Reports/Medicaid%20Annual%20Report-2017.pdf> (accessed September 9, 2018).
- ⁶⁴ Id.
- ⁶⁵ MACPAC, "Federal Requirements and State Options: Eligibility," <https://www.macpac.gov/wp-content/uploads/2017/03/Federal-Requirements-and-State-Options-Eligibility.pdf> (accessed August 30, 2018).
- ⁶⁶ NE DHHS, "Nebraska Medicaid Annual Reform Report for State Fiscal Year 2016-2017," December 2017, p. 3-4, <http://dhhs.ne.gov/Reports/Medicaid%20Annual%20Report-2017.pdf> (accessed September 9, 2018).
- ⁶⁷ MACPAC, "Federal Requirements and State Options: Eligibility," <https://www.macpac.gov/wp-content/uploads/2017/03/Federal-Requirements-and-State-Options-Eligibility.pdf> (accessed August 30, 2018).
- ⁶⁸ NE DHHS, "Nebraska Medicaid Annual Reform Report for State Fiscal Year 2016-2017," December 2017, p. 3-4, <http://dhhs.ne.gov/Reports/Medicaid%20Annual%20Report-2017.pdf> (accessed September 9, 2018).
- ⁶⁹ MACPAC, "Federal Requirements and State Options: Eligibility," <https://www.macpac.gov/wp-content/uploads/2017/03/Federal-Requirements-and-State-Options-Eligibility.pdf> (accessed August 30, 2018).
- ⁷⁰ Id.
- ⁷¹ Other qualified immigrants include: victims of trafficking or domestic violence, Haitian and Cuban immigrants, Iraqi and Afghan immigrants granted special immigrant status, certain Amerasian immigrants, immigrants and their families who served on active duty for at least 24 months in the armed forces, certain American Indians born outside of the U.S. and immigrants for whom deportation has been deferred. 477 NAC 5-001.
- ⁷² 477 NAC 5-001.
- ⁷³ MACPAC, "Federal Requirements and State Options: Eligibility," <https://www.macpac.gov/wp-content/uploads/2017/03/Federal-Requirements-and-State-Options-Eligibility.pdf> (accessed August 30, 2018).
- ⁷⁴ Kaiser Family Foundation, "Total Monthly Medicaid and CHIP Enrollment," <https://www.kff.org/health-reform/state-indicator/total-monthly-medicare-and-chip-enrollment/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22nebraska%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22desc%22%7D> (accessed September 13, 2018).
- ⁷⁵ U.S. Census Bureau, "Nebraska Quick Facts," <https://www.census.gov/quickfacts/NE> (accessed September 14, 2018).
- ⁷⁶ Kaiser Family Foundation State Health Facts, "Total Number of Children Ever Enrolled in CHIP Annually," <https://www.kff.org/other/state-indicator/annual-chip-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D> (accessed September 17, 2018).

Chapter 3: Services Provided by Medicaid



The federal government requires all states to cover certain services, while other services are optional.⁷⁷ When implementing its program in 1966, Nebraska chose to cover all services designated as optional by the federal government.⁷⁸ Below is a listing of the various services – both mandatory and optional – that Nebraska Medicaid recipients can use within certain guidelines.

Mandatory Services⁷⁹

- Inpatient and outpatient hospital services
- Laboratory and x-ray services
- Nursing facility services
- Home health services
- Nursing services
- Clinic services
- Physician services⁸⁰
- 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 services for children
- Family planning services (cannot be used for abortion services)

Optional Services

- Prescribed drugs
- Intermediate care facilities for the developmentally disabled
- Home and community-based services for elderly persons and persons with disabilities
- Dental care
- Rehabilitation services
- Personal care
- Durable medical equipment
- Medical transportation services
- Vision-related services
- Speech therapy
- Physical therapy
- Chiropractic services
- Occupational therapy
- Optometric services
- Podiatric services
- Hospice
- Mental health and substance use disorder services
- Hearing screening for newborns and infants
- School-based administrative services

While services must be generally equivalent for all eligible individuals and available statewide, states have broad flexibility in determining both the duration and scope of coverage for most services.⁸¹

Waivers

Medicaid waivers let states forgo some otherwise mandatory Medicaid requirements. This can give states the flexibility to test programs that promote the objectives of Medicaid and CHIP, such as expanding eligibility requirements, providing services not typically covered and experimenting with service delivery systems.⁸² States apply to the federal government to waive general Medicaid program requirements.

Most of Nebraska's waiver programs are designed to provide home-based alternatives to institutional care for those with long-term needs. These Home and Community-Based Services (HCBS), or 1915(c) waivers, are operated by the Department of Health and Human Services' Division of Home and Community Services and include waivers for the elderly and disabled, children with developmental disabilities and their families, those suffering from traumatic brain injuries, adults with intellectual or developmental disabilities who need community support and day services and children and families affected by autism.⁸³

States can operate as many HCBS waiver programs as they want, although each must demonstrate it's at least as cost-effective as institutional treatment, ensure people's health and welfare are protected, "provide adequate and reasonable provider standards" and follow individualized care plans.⁸⁴

Nebraska has also adopted a 1915(b) waiver in order to bypass Medicaid's freedom of choice requirement, which allows enrollees to choose their medical providers, in order to mandate that some enrollees enter a managed care program.⁸⁵ This will be discussed more fully later.

⁷⁷ MACPAC, "Federal Requirements and State Options: Eligibility," <https://www.macpac.gov/wp-content/uploads/2017/03/Federal-Requirements-and-State-Options-Eligibility.pdf> (accessed August 30, 2018).

⁷⁸ MACPAC, "Mandatory and Optional Benefits," <https://www.macpac.gov/subtopic/mandatory-and-optional-benefits/> (accessed September 17, 2018).

⁷⁹ NE DHHS, "Nebraska Medicaid Program, Medicaid Services", http://dhhs.ne.gov/medicaid/Pages/med_medserv.aspx (accessed September 17, 2018).

⁸⁰ Certain physician services aren't covered, such as routine adult physicals, acupuncture, sterilization reversals, sex reassignment surgery, radial keratotomy (corrective eye surgery) and weight control programs. Transplants, cosmetic surgeries, sterilization and hysterectomies and abortions have specific limitations and/or require prior approval. To be covered by Medicaid, abortions must be limited to pregnancies due to rape or incest or pregnancies endangering the life of the mother. They must also be approved in writing by the managed care medical director and the DHHS Medicaid and Long Term Care Medical Director.

⁸¹ States aren't generally allowed to place duration and scope limitations on EPSDT screening for children. MACPAC, "Mandatory and Optional Benefits," <https://www.macpac.gov/subtopic/mandatory-and-optional-benefits/> (accessed September 17, 2018).

⁸² CMS, "Section 1115 Demonstrations," <https://www.medicare.gov/medicaid/section-1115-demo/index.html> (accessed September 17, 2018).

⁸³ Nebraska Medicaid Waiver Disability Services & Waivers, "What Programs Are Available To Assist People With Disabilities in Nebraska?", <http://medicaidwaiver.org/state/nebraska.html> (accessed September 17, 2018).

⁸⁴ CMS, "Home and Community Based Services 1915(c)," <https://www.medicare.gov/medicaid/hcbs/authorities/1915-c/index.html> (accessed September 17, 2018).

⁸⁵ NE DHHS, "Nebraska Medicaid Program, Medicaid Services," http://dhhs.ne.gov/medicaid/Pages/med_medprog.aspx (accessed September 17, 2018).

Chapter 4: Medicaid and CHIP Spending and Financing

Federal-State Funding Partnership

Medicaid is the payer of last resort, so states must ensure that any Medicaid-eligible treatments are billed to all other insurers or providers before Medicaid.⁸⁶

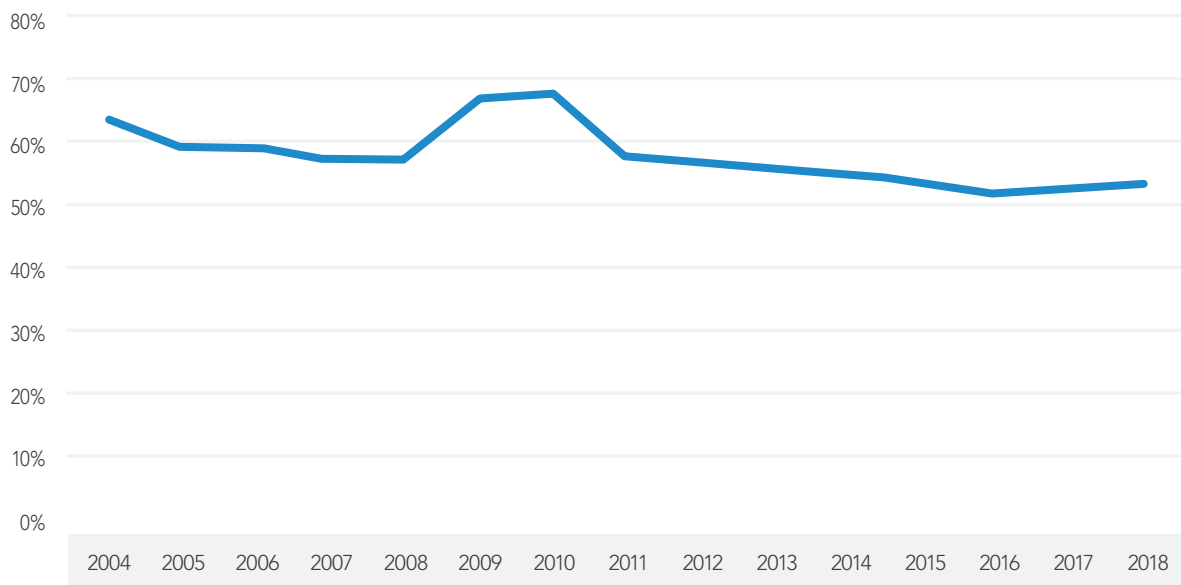
Medicaid is funded through a federal-state partnership in which Nebraska’s Federal Medical Assistance Percentage, or FMAP, determines the federal government’s share of the costs.⁸⁷ For example, Nebraska’s FMAP was 51.85% in Federal Fiscal Year 2017 (FFY 2017), which means the federal government reimbursed the state 51.85% of the costs of most Medicaid beneficiaries’ services during that period, leaving the state responsible for the other 48.15%.⁸⁸

Each state’s FMAP differs based on the state’s economic well-being relative to the national average.⁸⁹ The formula is intended to direct more federal assistance to states experiencing economic difficulties that may struggle to fund higher rates of enrollment from their own revenues.

States with per capita incomes below the national average will have higher FMAPs and pay a lower share of their Medicaid costs. An FMAP must be between 50% and 83% – meaning a state will be reimbursed at least half its costs per Medicaid beneficiary, regardless of its economic situation, although those struggling the most will still pay at least 17%.⁹⁰

Figure 5 shows Nebraska’s FMAP over time. It was raised twice temporarily in the 2000s to help with increased Medicaid enrollment stemming from an economic downturn.⁹¹

Figure 5: Nebraska’s FMAP, Federal Fiscal Years 2004-2018



Source: Kaiser Family Foundation⁹²

Nebraska's FMAP has been only slightly above the minimum FMAP in recent years thanks to a relatively stable economy, moving from 51.85% in FFY 2017 to a projected 52.55% in FFY 2018. The historical average since FFY 2004 has been 57.94%.⁹³

In FFY 2016, Nebraska was reimbursed at a rate lower than 47 other states (51.3%), paying the third highest state share of costs (47.8%).⁹⁴ This was due in part to the state's decision not to expand Medicaid under the Affordable Care Act. The expansion would have been reimbursed at 100% by the federal government through 2016 – a much higher rate than reimbursement determined through the FMAP formula. In 2018, Nebraska elected to expand Medicaid under the Affordable Care Act. This expansion will be reimbursed at 90%, a higher rate than the reimbursement determined through the FMAP formula. Had Nebraska elected to expand Medicaid prior to 2016, this expansion would have been funded at 100%.

The Health Care Cash Fund (HCCF) is another source of funding for Medicaid in the state. Established in 1998, the HCCF was paid for initially by interest earned on the Tobacco Settlement Cash Fund, which consists of any settlement payments or other revenue obtained from state lawsuits against tobacco companies, and the Health Care Trust Fund, which consists of funds obtained through an intergovernmental transfer process by which the state can recapture a part of the federal Medicaid payment to publicly owned nursing homes.⁹⁵ The HCCF funds a program that awards competitive grants for a variety of public health projects and partially funds the General Fund match for CHIP.⁹⁶

Passage of legislation in 2001 changed the sources and beneficiaries of the HCCF, requiring \$50 million be transferred from a combination of the Tobacco Settlement Trust Fund and the Medicaid Intergovernmental Fund at the outset of every fiscal year with the Legislature deciding how much to spend and which health care programs to fund.⁹⁷ The Medicaid Intergovernmental Fund is made up of excess federal funds drawn down for nursing facilities that were reimbursed at a lower rate than the federal rate.⁹⁸ The loophole that allowed states to collect such funds expired in 2005, but the fund still earns interest and had a balance of \$25.9 million as of June 30, 2018.⁹⁹ The Legislature allocated \$62.1 million to the HCCF for SFY 2018.¹⁰⁰

Historical Program Spending

Medicaid spending is driven by utilization and enrollment, so it can't operate from a fixed budget. Accordingly, appropriations are made to Medicaid based on projected costs.

General Fund appropriations for Medicaid grew an average of 5.9% from SFY 1998 to SFY 2019. General Fund appropriations for Medicaid declined in the late 2000s, reaching a low point in 2010. That decline can be attributed to Nebraska's time-limited higher FMAP under the American Recovery and Reinvestment Act (ARRA).¹⁰¹

CHIP uses an enhanced FMAP that's determined generally by increasing the federal share of reimbursement for Medicaid by about 15%.¹⁰² The ACA bumped it up another 23% through the end of FFY 2018,¹⁰³ so Nebraska's enhanced FMAP is 89.79% through mid-2019.¹⁰⁴

State CHIP funding began in 1998 with a one-time transfer of \$25 million from the HCCF.¹⁰⁵ When that funding ran out in SFY 2004, CHIP started to get an annual \$5 million transfer from the HCCF with the remainder coming from the General Fund, which was only \$25,456 the first year.¹⁰⁶

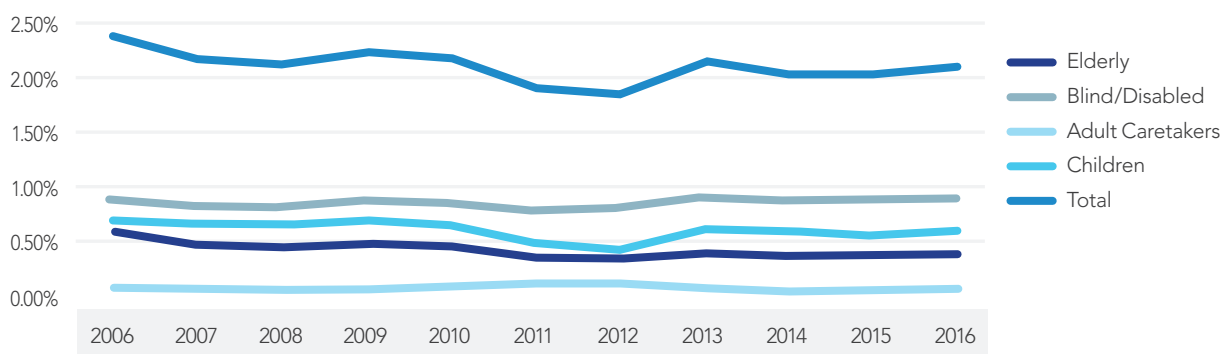
General Fund appropriations for CHIP reached an all-time high in SFY 2015 at \$27,560,027 but then declined after the ACA expanded the federal match rate from 68% to 91%.¹⁰⁷

Program Expenditures Differ From Appropriations

While total appropriations have increased over time, actual expenditures as a fraction of personal income – and thus as a share of the economy – have remained steady.

Figure 6 shows Nebraska's Medicaid expenditures by each of its major enrollee groups from SFY 2006 to SFY 2016. For a table that shows exact figures for SFY 2006, 2011 and 2016, see Appendix B.

Figure 6: Annual Nebraska Medicaid Expenditures by Major Population expressed as a fraction of NE Personal Income, SFY 2006-SFY 2016



Source: Spending data received directly from DHHS, November 2017; Nebraska personal income data are from the Federal Reserve Bank of St. Louis

The Legislative Fiscal Office recommends that appropriations exceed projected expenditures by about one month of funding beyond projected costs to account for unpaid bills due for payment after the end of the fiscal year. Because the program guarantees benefits to those who qualify, it must be funded and any gaps must be filled as they arise. A special session was called in 1992 to address such a gap.

If any appropriations go unspent in a given fiscal year, they will be available for later years and can be used by the Legislature to fund other programs, as happened during the 2016 Legislative session. At the end of SFY 2015, \$138 million of Medicaid appropriations had gone unspent, so \$84 million was recaptured to fill a budget shortfall.

Cost-sharing

Medicaid in Nebraska is funded partially through co-payments and premiums paid by some groups of enrollees, which range from \$1 to \$15 for covered services. Groups including children, pregnant women, inpatients in hospitals and long-term care facilities who spend a majority of their income on medical costs, individuals in alternate care, individuals who receive waiver services, individuals who spend down excess income on medical care and individuals who receive disability assistance are exempt from most, but not necessarily all, out-of-pocket expenses.¹⁰⁸

In SFY 2011, 54,780 enrollees paid \$2,306,048.73 in co-pays, including 7,838 elderly enrollees, 21,826 blind or disabled enrollees, 23,702 adult caretaker enrollees and 1,414 children.¹⁰⁹

In SFY 2016, there were fewer enrollees paying co-pays – 39,321 – but they paid almost as much as those in SFY 2011 at \$2,286,018.50.¹¹⁰ This included 981 elderly enrollees, 7,861 blind or disabled enrollees, 21,952 adult caretaker enrollees and 8,525 children.¹¹¹

Some Medicaid enrollees also pay premiums, with the amount varying year-to-year. In 2006, enrollees paid a total of \$53,590 in premiums, which grew to \$82,590 in 2011 and then declined slightly in 2016 to \$81,922.¹¹² Individual enrollees in Medicaid's Insurance for Workers with Disabilities program paid between \$41 and \$336 a month in 2018, depending on income, and enrollees in the Transitional Medical Assistance program paid between \$30 and \$191 a month in 2018, depending on income and family size.¹¹³

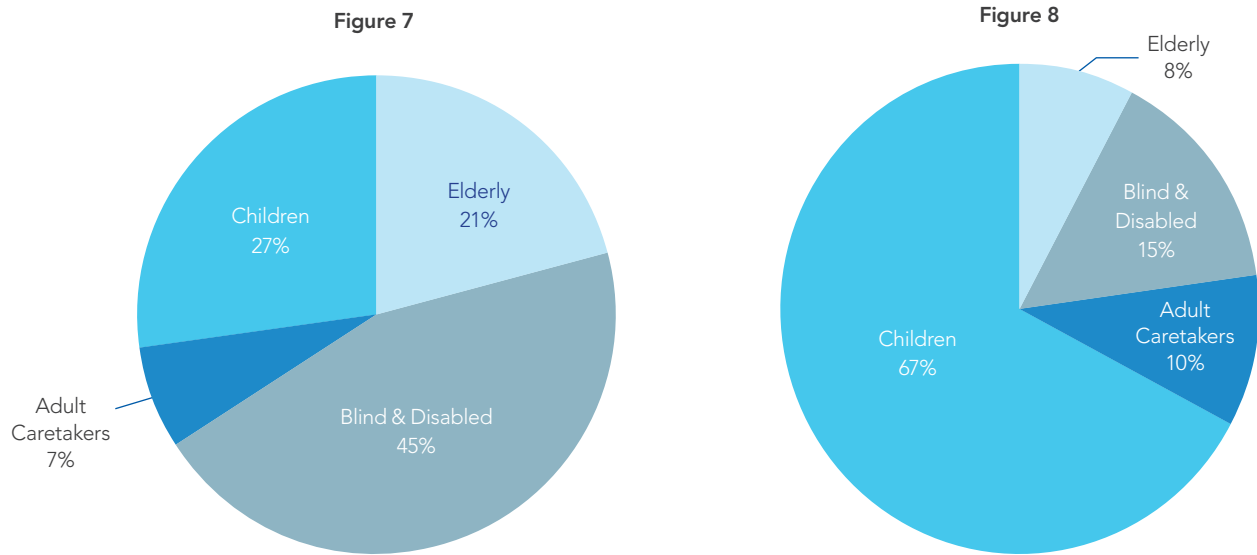
Spending and Enrollment by Enrollee Group

As shown in Figures 7 and 8, children represented 67% of Medicaid enrollees in 2016 but accounted for only 27% of spending. Conversely, blind and disabled enrollees represented 15% of the total but accounted for 45% of spending.

Nebraska has relatively low per capita Medicaid spending levels across all enrollee groups compared to other states. In FFY 2011, the most recent year for which comparable spending data is available, Nebraska spent an average of \$5,777 per enrollee, while the national average was \$6,502.¹¹⁴

Broken down by major eligibility category for FFY 2011, Nebraska had the 10th lowest spending per capita on children, the 13th lowest spending per capita on elderly enrollees, the 24th lowest spending per capita on disabled enrollees and the 22nd lowest spending per capita on adult enrollees.¹¹⁵ The state's per capita spending also grew comparatively slowly from FFY 2000 to FFY 2011: it was 12th lowest nationally for children, 6th lowest for disabled enrollees and 3rd lowest for elderly enrollees.¹¹⁶

Figure 7: SFY 2016 Total Spending by Enrollment Group
Figure 8: SFY 2016 Total Enrollment by Enrollee Group



Source: Data received directly from DHHS, November 2017

Over time, an increasingly large portion of total program spending goes toward managed care categories as NE DHHS shifts enrollees over. Behavioral health managed care capitation payments went from 4.6% to 6.4% of all Medicaid and CHIP vendor payments between SFY 2006 and SFY 2016; similarly, physical health managed care capitation payments went from 5% to 29.2% of all vendor payments in this time frame.¹¹⁷ The growth in managed care use is also responsible for a decline in inpatient hospital expenditures as a percentage of total program spending, according to DHHS.¹¹⁸

Capitation payments are pre-arranged amounts paid either per patient or per capita to healthcare providers for services rendered. Often paid monthly, the rates and schedule are set through agreements between insurers and healthcare providers, which also set out specific services to be provided.

The decline in nursing facility expenditures corresponds with increased spending over time in waiver services, which are used to provide care in less restrictive settings.¹¹⁹ For a detailed breakdown of expenditures by type of service, see Appendix C.

Care for Aging Nebraskans

Long-term care services provide elderly and disabled individuals with support for chronic or ongoing health concerns. These services are an area of focus for state policymakers due to their cost and projections showing an increasingly large population of aging Nebraskans.

Attempts at alleviating costs associated with long-term care date back to 1997, when the state began developing alternatives to nursing home care that would also provide more choice in care.¹²⁰

A state policy shift shortly thereafter required anyone seeking care at a nursing home to be evaluated for care through a less expensive type of provider, such as assisted living, respite care or adult day care.¹²¹ The Legislature designated \$54 million to convert excess nursing home space into assisted living and also harmonized payments for the two lowest acuity levels of nursing home care with the rates paid for assisted living, thereby pushing patients with fewer needs toward non-institutional facilities.¹²²

As a result, spending on nursing facilities fell as a fraction of all long-term care vendor payments from 52% in SFY 2006 to 40% in SFY 2016. For a complete listing of Medicaid expenditures on long-term care services in SFY 2006, SFY 2011 and SFY 2016, see Appendix D.

Miscellaneous Payments

Medicaid pays Medicare Part B premiums for low-income elderly individuals who qualify for both Medicare and Medicaid. The amount paid on those premiums rose 11.8% from SFY 2016 to SFY 2017, going from \$45,768,262 to \$51,885,724.¹²³

Clawback: A means by which money that has already been disbursed is recaptured.

Medicaid also makes Medicare Part D clawback payments to the federal government to cover the state's share of prescription drugs for dually eligible enrollees. Medicaid spending on these payments rose 7.3% from SFY 2015 to SFY 2016, going from \$51,028,410 to \$54,776,185.¹²⁴

Disproportionate share hospitals (DSH) receive Medicaid payments to offset costs they incur treating a relatively large share of Medicaid enrollees and uninsured individuals. Of Nebraska's 99 hospitals, 29% are DSH hospitals.¹²⁵ Of Nebraska's 4,848 hospital beds, 66% are DSH hospital beds.¹²⁶

Federal funding for DSH payments is capped annually per state and per individual hospital.¹²⁷ The hospital-specific limit prevents federal funds from being used for state DSH payments that exceed the cost of treating Medicaid and uninsured patients, less any payments made by or on behalf of those patients.¹²⁸ These payments rose 5.7% from SFY 2015 to SFY 2016, going from \$42,519,315 to \$44,980,223.¹²⁹ They had grown 62.6% from SFY 2006 to SFY 2011, going from \$22,200,000 to \$36,100,000.¹³⁰

Drug rebates aren't costs incurred by Medicaid but are instead payments from drug manufacturers that help offset the state's prescription drugs costs for Medicaid enrollees.¹³¹ The Medicaid Drug Rebate Program (MDRP) involves agreements between Centers for Medicare & Medicaid Services (CMS), state Medicaid agencies and participating drug manufacturers that help offset federal and state costs associated with outpatient prescription drugs dispensed to Medicaid patients.¹³² Between SFY 2006 and SFY 2011, drug rebates to Nebraska Medicaid rose slightly from \$72.2 million to \$73.7 million¹³³ but jumped significantly in SFY 2016 to \$106.9 million.¹³⁴

⁸⁶ CMS, "Deficit Reduction Act Important Facts for State Policymakers," December 11, 2007, <https://www.cms.gov/Regulations-and-Guidance/Legislation/DeficitReductionAct/downloads/tpl.pdf> (accessed September 17, 2018).

⁸⁷ DHHS, "FY 2017 Federal Medical Assistance Percentages," <https://aspe.hhs.gov/basic-report/fy2017-federal-medical-assistance-percentages> (accessed September 17, 2018).

⁸⁸ Id.

⁸⁹ The FMAP formula uses three years of per capita income to account for changes in the economy and compares a state's per capita income to the national average. CMS, "Financing & Reimbursement," <https://www.medicare.gov/medicaid/financing-and-reimbursement/> (accessed September 17, 2018).

- ⁹⁰ MACPAC, "Matching Rates," <https://www.macpac.gov/subtopic/matching-rates/> (accessed September 17, 2018).
- ⁹¹ During the recession of the early 2000s, the federal government held states harmless for the annual decline of FMAP and further increased FMAPs for the last two quarters of 2003 and the first three of 2004. In the Great Recession, as part of the federal stimulus package, the government held states harmless for annual FMAP declines, increased FMAP across the board for all states and gave states experiencing the greatest rises in unemployment a further increase for nine quarters beginning with the first quarter of FFY 2009. It was extended for two more quarters through June 30 of 2011. Peterson, Chris L., "Medicaid: The Federal Match Assistance Percentage (FMAP)," March 25, 2010, <http://www.ncsl.org/documents/health/mafmap.pdf> (accessed October 18, 2018).
- ⁹² Kaiser Family Foundation, "Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier," https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/?activeTab=graph¤tTimeframe=0&startTimeframe=14&sortModel=%7B%22collId%22:%22FY%202004__FMAP%20Percentage%22,%22sort%22:%22asc%22%7D (accessed September 17, 2018).
- ⁹³ Id.
- ⁹⁴ Kaiser Family Foundation, "Federal and State Share of Medicaid Spending," Fiscal Year 2016, <https://www.kff.org/medicaid/state-indicator/federalstate-share-of-spending/?currentTimeframe=0&sortModel=%7B%22collId%22:%22State%22,%22sort%22:%22desc%22%7D> (accessed September 17, 2018).
- ⁹⁵ Nebraska Legislature, "State Government Cash and Revolving Funds," December 2007, http://www.nebraskalegislature.gov/pdf/reports/fiscal/funddescriptions_0108.pdf (accessed September 17, 2018).
- ⁹⁶ Id.
- ⁹⁷ Id.
- ⁹⁸ Nebraska Legislature, "Nebraska Health Cash Fund and Related Funds," <http://nebraskalegislature.gov/pdf/reports/committee/appropriations/LR517HealthCareCashFundReport2016.pdf> (accessed September 17, 2018).
- ⁹⁹ Datta received directly from Legislative Fiscal Office.
- ¹⁰⁰ Id.
- ¹⁰¹ Nebraska Legislature, "State of Nebraska, FY 2009-10 and FY 2010-11 Biennial Budget as Revised During the 2010 Legislative Session," <https://nebraskalegislature.gov/pdf/reports/fiscal/2010budget.pdf> (accessed September 17, 2018).
- ¹⁰² CMS, "CHIP Financing," <https://www.medicare.gov/chip/financing/index.html> (accessed September 17, 2018).
- ¹⁰³ Kaiser Family Foundation, "Enhanced Federal Medical Assistance Percentage (FMAP) for CHIP, FY 2018," <https://www.kff.org/other/state-indicator/enhanced-federal-matching-rate-chip/?currentTimeframe=0&sortModel=%7B%22collId%22:%22Location%22,%22sort%22:%22asc%22%7D> (accessed September 17, 2018).
- ¹⁰⁴ Kaiser Family Foundation, "President Trump's 2018 Budget Proposal Reduces Federal Funding for Coverage of Children in Medicaid and CHIP," May 23, 2017, <http://www.kff.org/medicaid/fact-sheet/presidents-2018-budget-proposal-reduces-federal-funding-for-coverage-of-children-in-medicare-and-chip/> (accessed September 17, 2018).
- ¹⁰⁵ Nebraska Legislature, "State of Nebraska FY2003-04/FY2004-05 Biennial Budget," https://nebraskalegislature.gov/pdf/reports/fiscal/2003budget_0910.pdf (accessed September 17, 2018).
- ¹⁰⁶ Id.
- ¹⁰⁷ Nebraska Legislature, "State of Nebraska FY 2013-14 and FY 2014-15 Biennial Budget," <https://nebraskalegislature.gov/pdf/reports/fiscal/2014budget.pdf> (accessed September 17, 2018).
- ¹⁰⁸ NE DHHS, "Client Copayments," October 15, 2011, http://dhhs.ne.gov/medicaid/Pages/med_medcopay.aspx (accessed September 17, 2018).
- ¹⁰⁹ Data received directly from DHHS, November 2017.
- ¹¹⁰ Id.
- ¹¹¹ Id.
- ¹¹² Data received directly from DHHS, November 2017.
- ¹¹³ NE DHHS, "Income levels/Federal Poverty Levels and Resource Amounts for Medicaid Eligibility," <http://dhhs.ne.gov/medicaid/Documents/Income-levels-federal-poverty-levels.pdf> (accessed August 22, 2018).
- ¹¹⁴ State Health Reform Assistance Network, "Medicaid Capped Funding: Findings and Implications for Nebraska," April 5, 2017, http://www.statenetwork.org/wp-content/uploads/2017/04/NE-Fact-Sheet_rev-4.4.1.7.pdf (accessed September 17, 2018).
- ¹¹⁵ Id.
- ¹¹⁶ Id. No ranking available for growth in spending for adult caretaker enrollees.
- ¹¹⁷ Nebraska Medicaid Annual Reports for 2006 and 2016. See Appendix C for extended source citation.
- ¹¹⁸ NE DHHS, "2011 Medicaid Annual Report," p. 13, <http://dhhs.ne.gov/medicaid/Documents/Medicaid-Annual-Report-2011.pdf> (accessed September 17, 2018).
- ¹¹⁹ Id. at p. 8.
- ¹²⁰ NE DHHS, "Report on Medicaid Reform Activities," August 2005, <http://dhhs.ne.gov/medicaid/Documents/MonthlyReportAugust05.pdf> (accessed September 17, 2018).
- ¹²¹ Id.

- ¹²² Id.
- ¹²³ NE DHHS, "Nebraska Medicaid Annual Reform Report for State Fiscal Year 2016-2017," December 1, 2017, p. 19, <http://dhhs.ne.gov/Reports/Medicaid%20Annual%20Report-2017.pdf> (accessed September 9, 2018).
- ¹²⁴ Id.
- ¹²⁵ MACPAC, "Analyzing Disproportionate Share Hospital Allotments to States," March 2017, <https://www.macpac.gov/wp-content/uploads/2017/03/Analyzing-Disproportionate-Share-Hospital-Allotments-to-States.pdf> (accessed September 17, 2018).
- ¹²⁶ Id.
- ¹²⁷ CMS, "Medicaid Disproportionate Share Hospital Payments," <https://www.medicaid.gov/medicaid/financing-and-reimbursement/dsh/index.html> (accessed September 17, 2018).
- ¹²⁸ Id.
- ¹²⁹ NE DHHS, "Nebraska Medicaid Annual Reform Report for State Fiscal Year 2016-2017," December 1, 2017, p. 19, <http://dhhs.ne.gov/Reports/Medicaid%20Annual%20Report-2017.pdf> (accessed September 9, 2018).
- ¹³⁰ NE DHHS, "Nebraska Medicaid Reform Biennial Report 2006," December 1, 2006, p. 6-7, <http://dhhs.ne.gov/Documents/Biennial-Report-Dec06-Final.pdf> (accessed September 17, 2018).
- ¹³¹ NE DHHS, "Nebraska Medicaid Annual Reform Report for State Fiscal Year 2016-2017," December 1, 2017, p. 19, <http://dhhs.ne.gov/Reports/Medicaid%20Annual%20Report-2017.pdf> (accessed September 9, 2018).
- ¹³² CMS, "Medicaid Drug Rebate Program," <https://www.medicaid.gov/medicaid/prescription-drugs/medicaid-drug-rebate-program/index.html> (accessed September 17, 2018).
- ¹³³ NE DHHS, "Nebraska Medicaid Reform Biennial Report 2006," December 1, 2006, p. 6-7, <http://dhhs.ne.gov/Documents/Biennial-Report-Dec06-Final.pdf> (accessed September 17, 2018).
- ¹³⁴ NE DHHS, "Nebraska Medicaid Annual Reform Report for State Fiscal Year 2016-2017," December 1, 2017, p. 19, <http://dhhs.ne.gov/Reports/Medicaid%20Annual%20Report-2017.pdf> (accessed September 9, 2018).

Chapter 5: Efforts to Improve Cost-effectiveness of Medicaid for the State of Nebraska



Medicaid Reform Council

Nebraska created the Medicaid Reform Advisory Council in 2005 to address concerns over the large number of rural Nebraskans relying on Medicaid coverage and the funding structure’s sustainability, given the high cost of covering the disabled and elderly and projections showing the elderly population increasing 75% between 2005 and 2030.^{135 136}

Made up of Nebraskans in the health care industry, consumer advocates and elected officials chosen by the Governor, the Council met monthly to review Medicaid reform plans in the state and make recommendations to the Governor and Legislature.¹³⁷ Its aims were to control spending growth, ensure flexibility in benefit allocation, set program priorities and create alternatives to Medicaid coverage.¹³⁸

Some policies endorsed by the Council have shaped the current Medicaid program significantly, including implementation of a Preferred Drug List to control prescription drug costs,¹³⁹ expansion of home and community based services¹⁴⁰ and the placement of a majority of enrollees in managed care.¹⁴¹ The Council was repealed in 2017.¹⁴²

Compared to actual spending by major population enrolled in Medicaid in SFY 2016, spending per enrollee adjusted for inflation is less than it was in SFY 2005 for seniors, disabled individuals and children. In SFY 2005, average annual spending per enrollee by major population was \$19,956 for seniors, \$19,788 for disabled individuals, less than \$12,000 for blind individuals, \$4,404 for adult caretakers and \$2,820 for children.¹⁴³ Adjusted for inflation as of 2016, the same amount of spending would be \$24,792.32 for seniors, \$24,583.61 for disabled individuals, less than \$14,908.19 for blind individuals, \$5,471.31 for adult caretakers and \$3,503.42 for children.¹⁴⁴ (See extended cost per enrollee discussion starting on p. 20.)

These figures also show that spending growth during the early 2000s hasn’t continued. Medicaid spending for blind and disabled individuals and children grew from 2000 to 2005¹⁴⁵ but, when adjusted for inflation, decreased from FY 2005 to FY 2016. In the two decades preceding October 2005, average annual growth in Medicaid expenditures was about 11%, according to the Council;¹⁴⁶ however, average annual growth in Medicaid expenditures from SFY 2006 to SFY 2016 was 3.75%.¹⁴⁷

Adoption of Managed Care

Over the past 20 years, Medicaid in Nebraska has transitioned from being administered on a fee-for-service (FFS) basis to a managed care system.¹⁴⁸

In an FFS system, a state department pays Medicaid providers for each covered service provided. Under a managed care system, the state contracts with private companies to manage the provision of those covered services, with Medicaid paying a monthly actuarially-determined amount for each enrollee to cover service and administration costs.¹⁴⁹ The providers are reimbursed by the private company for services provided at a rate determined independently of DHHS.¹⁵⁰

Transitioning from an FFS system to managed care has reduced costs for some states in the long run by encouraging preventive or primary care and managing patients' chronic conditions to prevent costly hospitalizations.¹⁵¹

Nebraska's roll-out of managed care, which involves four private companies,¹⁵² has met with some challenges, including unpaid claims that prompted some providers to reduce the number of Medicaid clients they see or reduce the level of services provided to Medicaid clients.¹⁵³ The managed care companies now meet with the Legislature's Health and Human Services Committee quarterly.

Maximizing Federal Funding for Medicaid

States can maximize federal funds in a number of ways, including through the collection of provider taxes, which are levied evenly on all health care providers in a given category, such as Intermediate Care Facilities for Individuals with Developmental Disabilities (ICF/MR). The Medicaid-related portion of the cost is refunded to the care facilities, and 60% of it is reimbursed by federal funding. Altogether, provider taxes raise \$3.5 million in revenue for Nebraska each year.¹⁵⁴

States can also use certified public expenditures (CPE),¹⁵⁵ which use alternative government funding through a non-Medicaid agency to meet state matching requirements for Medicaid. The non-Medicaid agencies incur a Medicaid-related expense and provide the funds for the required state match. Medicaid then factors the expense into federal claims and transfers the federal matching share to the certifying entity, thereby bypassing state funding for the expense. This has been used to fund items such as city or county owned nursing facilities serving Medicaid residents and Medicaid services provided in public schools.

Nebraska also hasn't implemented a family planning state plan amendment, which would use federal dollars to provide family planning services to low-income adults who don't otherwise qualify for Medicaid.¹⁵⁶ Over half of states have such programs, and studies have shown them to be both cost-effective and to have a positive impact on health.¹⁵⁷

State plan amendments

(SPAs): Much less time intensive than a waiver for states to implement, state plan amendments are made when the changes requested to a state's Medicaid program are allowable by law. No Medicaid requirements are "waived" but approval from the regional office of the Centers for Medicare and Medicaid Services is still required.

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- ¹³⁵State of Nebraska, "Nebraska Medicaid Reform Plan, <http://govdocs.nebraska.gov/epubs/L3790/B057-2005.pdf> (accessed October 1, 2018).
- ¹³⁶Id.
- ¹³⁷Id.
- ¹³⁸ State of Nebraska, "Nebraska Medicaid Reform Plan, <http://govdocs.nebraska.gov/epubs/L3790/B057-2005.pdf> (accessed October 1, 2018).
- ¹³⁹ NE DHHS, "Nebraska Medicaid Reform Annual Report, December 1, 2010," <http://govdocs.nebraska.gov/epubs/H8900/B002-2010.pdf> (accessed September 13, 2018).
- ¹⁴⁰ State of Nebraska, "Nebraska Medicaid Reform Plan, <http://govdocs.nebraska.gov/epubs/L3790/B057-2005.pdf> (accessed October 1, 2018).
- ¹⁴¹ Id.
- ¹⁴² Nebraska Legislature, LB 644 Slip Copy, <https://nebraskalegislature.gov/FloorDocs/105/PDF/Slip/LB644.pdf> (accessed September 17, 2018).
- ¹⁴³ NE Auditor of Public Accounts, "Attestation Report of the Nebraska Health and Human Services System Program 348—Medical Services/Aid July 1, 2004 through June 30, 2005", June 2006, p.1, http://www.auditors.nebraska.gov/APA_Reports/2006/SA25-06132006-July_1_2004_through_June_30_2005_Program_348_Medical_Services_Aid_Attestation_Report_Highlights.pdf (accessed September 25, 2018).
- ¹⁴⁴ OpenSky calculated using CPI with January 2005 as the base year and January 2016 as the end point. Bureau of Labor Statistics, "CPI Inflation Calculator," <https://data.bls.gov/cgi-bin/cpicalc.pl?cost1=2820.00&year1=200501&year2=201601> (accessed September 17, 2018).
- ¹⁴⁵ NE Auditor of Public Accounts, "Attestation Report of the Nebraska Health and Human Services System Program 348—Medical Services/Aid July 1, 2004 through June 30, 2005," June 2006, p.1, http://www.auditors.nebraska.gov/APA_Reports/2006/SA25-06132006-July_1_2004_through_June_30_2005_Program_348_Medical_Services_Aid_Attestation_Report_Highlights.pdf (accessed September 25, 2018).
- ¹⁴⁶ State of Nebraska, "Nebraska Medicaid Reform Plan," <http://govdocs.nebraska.gov/epubs/L3790/B057-2005.pdf> (accessed October 1, 2018).
- ¹⁴⁷ OpenSky calculation based on data received directly from NE DHHS, November 2017.
- ¹⁴⁸ NE DHHS, "Nebraska Medicaid Annual Reform Report for State Fiscal Year 2016-2017," December 1, 2017, p. 19, <http://dhhs.ne.gov/Reports/Medicaid%20Annual%20Report-2017.pdf> (accessed September 9, 2018).
- ¹⁴⁹ Id. at p.8.
- ¹⁵⁰ Id.
- ¹⁵¹ The Commonwealth Fund, "Boom in Managed Care Alters Medicaid's Calculations," August 11, 2014, <http://www.commonwealthfund.org/publications/newsletters/washington-health-policy-in-review/2014/aug/aug-11-2014/boom-in-managedaged-care> (accessed September 17, 2018).
- ¹⁵² NE DHHS, "Nebraska Medicaid Reform Annual Report for State Fiscal Year 2015-2016," p. 17, <http://dhhs.ne.gov/Reports/Medicaid%20Annual%20Report%20-%202016.pdf> (accessed September 17, 2018).
- ¹⁵³ Omaha World-Herald, "One of three companies managing Medicaid in Nebraska faces sanctions for 'serious deficiencies,'" June 28, 2017, http://www.omaha.com/livewellnebraska/consumer/one-of-three-companies-managing-medicare-in-nebraska-faces-sanctions/article_02ddd0c9-7fa0-5b61-8446-4a049a4eed33.html (accessed September 17, 2018).
- ¹⁵⁴ State of Nebraska, "Nebraska Medicaid Reform Plan," <http://govdocs.nebraska.gov/epubs/L3790/B057-2005.pdf> (accessed October 1, 2018).
- ¹⁵⁵ Id.
- ¹⁵⁶ Kaiser Family Foundation, "Medicaid and Family Planning: Background and Implications of the ACA," February 3, 2016, <https://www.kff.org/report-section/medicaid-and-family-planning-medicare-family-planning-policy/> (accessed September 17, 2018).
- ¹⁵⁷ Id.

Chapter 6: Other Policy Issues Related to Medicaid

ACCESSNebraska

ACCESSNebraska is an online portal operated by NE DHHS through which Nebraskans can apply for Medicaid. After a problematic rollout in 2009¹⁵⁸ and a series of failed fixes, a 2014 Special Investigative Committee made a number of recommendations to prevent lapses in coverage caused by long call wait times and missing paperwork.¹⁵⁹

The Committee's first recommendations included updates to the website, which used technology from the early- to mid-1990s, and the hiring of additional staff.¹⁶⁰ By 2015, there were substantial improvements in call wait times, application processing time and employee morale.¹⁶¹ The Committee then recommended continued funding to update ACCESSNebraska's technology, improving staff competence and continued oversight.¹⁶² In 2016, the Committee returned oversight duties to NE DHHS and the Legislature's standing HHS Committee.¹⁶³

As of July 2017, NE DHHS is implementing a plan to maintain and improve ACCESSNebraska's performance, ensuring eligible Nebraskans can access benefits quickly.¹⁶⁴ The agency also is working to implement NTRAC (Nebraska Timely Responsive Accurate Customer Service), a new Medicaid eligibility and enrollment system, in order to comply with federal regulation changes created by the ACA.¹⁶⁵

Provider Reimbursement Rates

Care providers for Nebraska's Medicaid enrollees are reimbursed at different rates depending on the type of provider and changes to those reimbursement rates can impact the state budget greatly.¹⁶⁶ Reimbursement rates have been a challenge for providers, causing some to close or even take out a line of credit in order to keep providing services in instances where payments lagged.¹⁶⁷

Recent History of Provider Rates in Nebraska

SFY 2012—Provider rates increased 1.54%.

SFY 2013 and SFY 2014—Provider rates increased up to 2.25%, capped at 100% of Medicare rates as of January of that year.

SFY 2015, SFY 2016 and SFY 2017—Provider rates increased up to 2.25%, capped at 100% of Medicare rates for behavioral health, nursing homes, assisted living and ICF-DD providers. Other Medicaid provider rates increased up to 2%, capped at 100% of Medicare rates.

SFY 2018 and SFY 2019—Provider rates static.

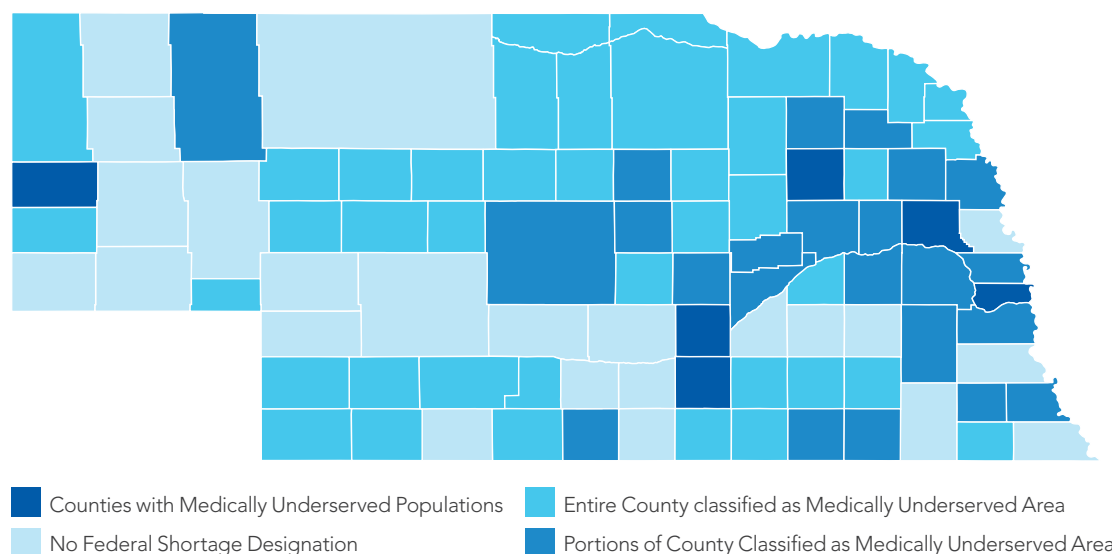
Provider rates were the focus of a major legislative battle in 2017. A 3% reimbursement reduction for physicians, hospitals and durable medical goods was included in the SFY 2018-19 biennial budget,¹⁶⁸ but all other reimbursement rates were left unchanged.¹⁶⁹ The governor, however, vetoed this part of the budget, which resulted in a cut equivalent to reimbursement rates being reduced 3% across the board, NE DHHS later determined it was able to make cuts in other areas to maintain provider rates at their current level.¹⁷⁰

Provider Shortage

Nebraska, like many predominantly rural states,¹⁷¹ is experiencing a shortage of medical professionals in some areas, as shown in Figure 13. See Appendix E for a listing of Nebraska counties' federal shortage designations as of January 9, 2017.

Medically Underserved Areas (MUAs) are geographic areas with a shortage of primary care providers, whereas Medically Underserved Populations (MUPs) are sub-groups of a geographic area's population that face barriers to receiving care based on economic, cultural or linguistic factors.¹⁷²

Figure 9: Federal Primary Care Shortage Status by County



Source: Nebraska Department of Health and Human Services, "Federally Designated Primary Care Medically Underserved Areas/Populations," http://dhhs.ne.gov/publichealth/RuralHealth/Documents/HPSA%20MUA_MUP.pdf (accessed August 27, 2018).¹⁷³

Rural areas are generally where the provider shortage is most pronounced, as those areas have both slightly more poverty (12.2%), on average, than urban areas (11%) and more aging Nebraskans.¹⁷⁴ This population is highly concentrated in rural parts of the state: although Nebraska's 80 rural counties have only 35% of the state population, they contain more than half of adults over the age of 85.¹⁷⁵

DHHS doesn't disclose Medicaid and CHIP enrollment by county, but these statistics point to a greater proportional need for Medicaid and CHIP providers in rural regions of the state. The University of Nebraska Medical Center's Center for Health Policy issued several recommendations in 2018 for sustaining rural access to care. They include expansion of existing programs to incentivize health care professionals to practice in rural areas of the state, increased investment in technologies that support telehealth services, annual reporting on the state's healthcare workforce and regular forecasting of changes to demographics and care needs.¹⁷⁶

Several of Nebraska's counties have seen growth in Medicaid providers between SFY 2011 and SFY 2016 but most have seen a decline. See Appendix F for a listing of counties that have experienced a shift in the number of Medicaid providers from SFY 2011 to SFY 2016 and Appendix G for a listing of provider types that have experienced a shift in number from SFY 2011 to SFY 2016.

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- ¹⁵⁸ Nebraska Legislature, "LR 400, 2014 ACCESSNebraska Special Investigative Committee, Report to the Legislature," December 15, 2014, https://nebraskalegislature.gov/pdf/reports/committee/select_special/lr400_2014/lr400_2014.pdf (accessed September 17, 2018).
- ¹⁵⁹ Id.
- ¹⁶⁰ Id.
- ¹⁶¹ Nebraska Legislature, "LR 33, 2015 ACCESSNebraska Special Investigative Committee, Report to the Legislature," December 15, 2015, https://nebraskalegislature.gov/pdf/reports/committee/select_special/lr400_2014/lr33_2015.pdf (accessed September 17, 2018).
- ¹⁶² Id.
- ¹⁶³ Nebraska Legislature, "LR 418, ACCESSNebraska Oversight Committee, Final Report," December 15, 2016, https://nebraskalegislature.gov/pdf/reports/committee/select_special/lr400_2014/lr418_2016.pdf (accessed September 17, 2018).
- ¹⁶⁴ NE DHHS, "DHHS Business Plan, July 2017-June 2018," July 1, 2017, <http://dhhs.ne.gov/Documents/BusinessPlan.pdf> (accessed September 17, 2018).
- ¹⁶⁵ Id.
- ¹⁶⁶ NE DHHS "Nebraska Medicaid Reform Annual Report for State Fiscal Year 2016-17," December 1, 2017, <http://dhhs.ne.gov/Reports/Medicaid%20Annual%20Report-2017.pdf> (accessed September 13, 2018).
- ¹⁶⁷ Lincoln Journal Star, "More than a decade after mental health reform began in Nebraska, availability of care an issue," June 10, 2018, https://journalstar.com/news/local/more-than-a-decade-after-mental-health-reform-began-in/article_c3f911b2-73ee-508b-9c45-1069e730e9e7.html (accessed September 17, 2018).
- ¹⁶⁸ Nebraska Legislature, "State of Nebraska FY2017-18/FY2018-19 Biennial Budget," August 2017, <http://www.nebraskalegislature.gov/pdf/reports/fiscal/2017budget.pdf> (accessed September 17, 2018).
- ¹⁶⁹ Id.
- ¹⁷⁰ Nebraska Legislature, "State of Nebraska FY2017-18 and FY2018-19 Biennial Budget as Revised in the 2018 Legislative Session," May 2018, <https://nebraskalegislature.gov/pdf/reports/fiscal/2018budget.pdf> (accessed September 17, 2018).
- ¹⁷¹ National Rural Health Association, "About Rural Health Care," <https://www.ruralhealthweb.org/about-nrha/about-rural-health-care> (accessed September 17, 2018).
- ¹⁷² Health Resources & Services Administration, "Medically Underserved Areas and Populations," <https://bhwh.hrsa.gov/shortage-designation/muap> (accessed September 17, 2018).
- ¹⁷³ NE DHHS, "Federal Designated Primary Care Medically Underserved Areas/Populations," http://dhhs.ne.gov/publichealth/RuralHealth/Documents/HPSA%20MUA_MUP.pdf (accessed August 27, 2018).
- ¹⁷⁴ Rural Health Information Hub, "Nebraska State Guide," July 2017, <https://www.ruralhealthinfo.org/states/nebraska> (accessed September 17, 2018).
- ¹⁷⁵ University of Nebraska-Omaha Center for Public Affairs Research, Nebraska State Data Center 28th Annual Data Users Conference, August 16, 2017.
- ¹⁷⁶ Wilson FA, Wehbi NK, Larson J, et al., The Status of the Healthcare Workforce in the State of Nebraska, Omaha, NE: UNMC Center for Health Policy; 2018, <https://www.unmc.edu/familymed/education/ahec/workforce-analysis/status-healthcare-workforce-2018.pdf> (accessed September 17, 2018).

Chapter 7: Evaluation

Given the considerable portion of state and federal budgets that go toward Medicaid and CHIP, it is reasonable to worry about costs growing to an unsustainable level and taking funds from other policy priorities, such as K-12 education. While these concerns warrant close monitoring of health care assistance spending, it is important to note that these programs are working toward the same objectives as many other government financed initiatives.

Medicaid and CHIP support the health of low-income children and, in doing so, they support better outcomes for those children when they grow up. Enrollment in these programs increases the probability that a child will pursue higher education and, therefore, increases future earning potential – goals that are shared by our K-12 education system.¹⁷⁷

Political Controversies

Possible Medicaid Changes at the Federal Level – At the federal level, there have been policy discussions about funding Medicaid through block grants or instituting caps on per capita spending.¹⁷⁸

Proponents say either policy offers states more flexibility to manage their Medicaid programs according to the needs of the state; the drawback, however, is that block grant or per capita amounts are set in advance and can't be adjusted for increased costs.¹⁷⁹ States may, therefore, be faced with covering any cost overruns themselves or cutting services.¹⁸⁰

The use of block grants or per capita spending caps could also result in fewer federal Medicaid dollars going to states, preventing them from responding to rising health costs, enrollment increases due to recession or a public health crisis.

Nebraska's relatively low per capita spending puts the state at heightened risk of becoming locked into low spending levels in the wake of a federal policy shift.¹⁸¹ This could result in more uninsured Nebraskans and disproportionately harm seniors and individuals with disabilities, who account for most of Nebraska's Medicaid spending, if the Legislature doesn't respond by raising additional revenue or making cuts in other areas of the state budget.¹⁸²

Medicaid Expansion – The Medicaid expansion program was introduced by the Affordable Care Act. If a state elects to participate in Medicaid expansion, the pool of individuals eligible for Medicaid increases to include low-income individuals up to 138% of the FPL. Currently, 36 states and the District of Columbia have opted into Medicaid expansion, including three that opted into expansion in November 2018 elections: Nebraska, Idaho and Utah. The federal government paid for all state Medicaid expansion costs for 2014, 2015 and 2016, although the federal reimbursement rate phases down between 2017 and 2020 to reach a 90% reimbursement rate going forward. Nebraska will receive the 90% reimbursement rate for its expansion.

The Legislative Fiscal Office has run estimates based on enrollment beginning in SFY 2020 and anticipates 89,223 new enrollees by SFY 2023 at a cost to the state of \$41,434,116, according to the Legislative Fiscal Office.¹⁸³

Medicaid expansion has benefited participating states in several ways, including reducing uncompensated care costs for providers, lowering health care expenses for low-income families, increasing state revenue while also producing budget savings and improving overall economic growth.

Prenatal Care for Undocumented Immigrants – In 2012, the Nebraska Legislature voted to override the veto of a bill providing access to prenatal care for undocumented immigrants.¹⁸⁴ Nebraska, along with 15 other states, had provided these services through the Medicaid program until a 2010 change at the federal level.¹⁸⁵

Nebraska’s choice to keep providing these services through an alternative state-run program was controversial because many viewed it as a step toward establishing Nebraska as a sanctuary for undocumented immigrants.¹⁸⁶ Leading up to the vote, advocates of preserving access to these services argued that neglecting to do so could result in children of immigrants who become U.S. citizens upon their birth in this country having more health problems and thus being more costly to the state in the long-run.¹⁸⁷ Since 2012, Nebraska has used CHIP funding to run the program that provides prenatal services to undocumented immigrant mothers (see pregnant women section in eligibility chapter).

¹⁷⁷ National Bureau of Economic Research, “Medicaid as an investment in Children,” January 2015, <http://www.nber.org/papers/w20835.pdf> (accessed September 17, 2018).

¹⁷⁸ Families USA, “Block Grants: A Bad Idea for Medicaid,” April 2016, http://familiesusa.org/sites/default/files/product_documents/MCD_Block_Grant_Factsheet.pdf (accessed September 17, 2018).

¹⁷⁹ Id.

¹⁸⁰ Id.

¹⁸¹ State Health Reform Assistance Network, “Medicaid Capped Funding: Findings and Implications for Nebraska,” April 5, 2017, http://www.statenetwork.org/wp-content/uploads/2017/04/NE-Fact-Sheet_rev-4.4.1.7.pdf (accessed September 17, 2018).

¹⁸² Id.

¹⁸³ Legislative Fiscal Office, Tax Rate Review Committee handout, November 15, 2018.

¹⁸⁴ The Christian Science Monitor, “Nebraska approves prenatal care for illegal immigrants,” April 19, 2012, <https://www.csmonitor.com/USA/Society/2012/0419/Nebraska-approves-prenatal-care-for-illegal-immigrants> (accessed September 17, 2018).

¹⁸⁵ Id.

¹⁸⁶ Id.

¹⁸⁷ The Christian Science Monitor, “Nebraska approves prenatal care for illegal immigrants,” April 19, 2012, <https://www.csmonitor.com/USA/Society/2012/0419/Nebraska-approves-prenatal-care-for-illegal-immigrants> (accessed September 17, 2018).

Conclusion



A healthy populace is essential to a thriving state. To succeed in our homes, our workplaces, our schools and our communities, Nebraskans must have access to outstanding health care. But ensuring they have that access is a complicated task for policymakers, who must balance the state's health care needs with other priorities like education and public safety.

Nebraska presently faces many important challenges in terms of providing health care for its residents. For example, in recent years, as state revenues have lagged, lawmakers have had to make difficult decisions affecting funding for needed health services. Those decisions have had consequences for both the Nebraskans receiving the services and those providing them.

Nebraska also faces a shortage of healthcare workers, particularly in rural parts of the state, which means many residents may be going without needed care.

Even greater challenges loom. Our population is aging, which means the need for health care services in Nebraska will increase significantly as more residents move into retirement age. Meanwhile, a decreasing number of working-age Nebraskans will be paying the taxes needed to generate the revenue to pay for this growing demand.

In the face of these challenges, lawmakers are, and will continue to be, confronted with difficult but important questions. Will taxes need to increase to generate revenue to meet the growing demand for health care? Will other changes to the state's revenue system be needed as well, or will vital state services, such as education and public safety, need to be cut so more funding can be redirected to support health care?

Having a firm understanding of how Medicaid is funded in Nebraska and who benefits from these services is essential for state leaders tasked with answering these important questions. Helping policymakers and other state leaders gain that understanding is the focus of this primer. It is our hope that this document will prove to be a powerful tool to forge policies that lead to health and prosperity for all Nebraskans for many years to come.

Appendix A: Medicaid Enrollment by Specific Enrollee Category SFY 2016



Category	Count of Clients - SFY 2016 (Unique Count Throughout Year)
599 CHIP	2,151
Aged	21,770
Blind or Disabled	40,893
CHIP	52,542
Emergency Medical Services for Aliens	150
Former Foster Care	811
Former Ward/IMD	211
Katie Beckett	46
Under One	24,489
Kids 1 to 5	56,266
Kids 6 to 18	93,670
Medicaid Insurance for Workers with Disabilities	122
Medically Needy/Other	2,336
Medicare Buy-In	321
Parent/Caretaker	32,558
Pregnant Women	13,149
Subsidized Adoption/Guardianship Assistance	5,574
Transitional	32,550
Women with Cancer	186

Note: This is a unique count of enrollees by category and not the average monthly rates, as enrollees are often in multiple categories throughout the year. Data received directly from DHHS, November 2017.

Enrollment group	SFY 2006 NE Enrollees (% of total) ¹⁸⁸	SFY 2011 NE Enrollees (% of total) ¹⁸⁹	SFY 2016 NE Enrollees (% of total) ¹⁹⁰
Aid to Dependent Children and Adults (Caretakers)	23,556 (11.7%)	31,723 (13.5%)	22,513 (9.7%)
Elderly	18,370 (9.2%)	17,783 (7.6%)	18,083 (7.8%)
Blind & Disabled	29,682 (14.8%)	34,708 (14.7%)	35,937 (15.4%)
Children	129,062 (64.3%)	151,140 (64.2%)	156,262 (67.1%)

¹⁸⁸ NE DHHS, "Nebraska Medicaid Reform Biennial Report 2006," December 1, 2006, p. 4, <http://dhhs.ne.gov/Documents/Biennial-Report-Dec06-Final.pdf> (accessed September 17, 2018).

¹⁸⁹ NE DHHS, "Nebraska Medicaid Annual Report 2011," p. 4, <http://govdocs.nebraska.gov/epubs/H8900/B002-2011.pdf> (accessed September 17, 2018).

¹⁹⁰ NE DHHS, "Nebraska Medicaid Reform Annual Report for State Fiscal Year 2015-2016," p. 12, <http://dhhs.ne.gov/Reports/Medicaid%20Annual%20Report%20-%202016.pdf> (accessed September 13, 2018).

Appendix B: Nebraska Medicaid Spending by Major Enrollee Population, SFY 2006, 2011 and 2016



Major Medicaid enrollee population	SFY 2006 total spending	SFY 2006 per enrollee spending	SFY 2011 total spending	SFY 2011 per enrollee spending	SFY 2016 total spending	SFY 2016 per enrollee spending
Elderly	\$356,223,258	\$19,392	\$337,748,436	\$18,993	\$406,105,922	\$22,458
Disabled	\$580,589,583	\$19,560	\$664,473,101	\$19,145	\$888,535,550	\$24,725
Adults	\$102,043,747	\$4,332	\$175,196,070	\$5,523	\$140,737,144	\$6,251
Children	\$392,051,029	\$3,038	\$398,429,575	\$2,636	\$531,482,950	\$3,401

Data received directly from DHHS, November 2017

Appendix C: Medicaid and CHIP Expenditures by Type of Service – SFY 2006, SFY 2011, and SFY 2016



Service	Total Spending in SFY 2006 (% of All Vendor Payments) ¹⁹¹	Total Spending in SFY 2011 (% of All Vendor Payments) ¹⁹²	Total Spending in SFY 2016 (% of All Vendor Payments) ¹⁹³
Nursing Facilities	\$296,505,175 (20.7%)	\$299,071,686 (19.0%)	\$327,126,435 (16.6%)
Intermediate Care Facilities for Individuals with Developmental Disabilities	\$60,405,286 (4.2%)	\$20,835,763 (1.3%)	\$72,237,288 (3.7%)
Home Health	\$33,061,309 (2.3%)	\$33,342,386 (2.1%)	\$32,465,765 (1.7%)
Elderly & Disabled Waiver	\$181,023,377 for all ¹⁹⁴ waiver services (12.7%)	\$264,213,708 for all waiver services (16.8%)	\$90,494,809 (4.6%)
Developmental Disabilities Waiver	\$181,023,377 for all waiver services (12.7%)	\$264,213,708 for all waiver services (16.8%)	\$295,921,703 (15.0%)
Physical Health (Managed Care) Capitation	\$71,390,928 (5.0%)	\$214,489,458 (13.6%)	\$572,990,594 (29.2%)
Behavioral Health (Managed Care) Capitation	\$65,586,302 (4.6%)	\$64,372,773 (4.1%)	\$126,495,296 (6.4%)
Drugs	\$201,624,584 (14.1%)	\$154,170,704 (9.8%)	\$183,651,235 (9.3%)
Outpatient Hospital	\$78,042,936 (5.5%)	\$88,482,566 (5.6%)	\$40,905,028 (2.1%)
Inpatient Hospital	\$207,588,587 (14.5%)	\$215,500,169 (13.7%)	\$94,014,893 (4.8%)
Dental	\$33,061,309 (2.3%)	\$38,880,934 (2.5%)	\$45,041,028 (2.3%)
Physicians, Practitioners, & Early and Periodic Screening, Diagnostic, and Treatment	\$136,112,935 (9.5%)	\$125,141,069 (7.9%)	\$47,376,077 (2.4%)
Other	\$66,555,942 (4.7%)	\$57,345,968 (3.6%)	\$38,141,415 (1.9%)
All Vendor Payments	\$1,430,907,617	\$1,575,847,184	\$1,966,861,566

¹⁹¹ NE DHHS, “Nebraska Medicaid Reform Biennial Report 2006,” December 1, 2006, p. 6, <http://dhhs.ne.gov/Documents/Biennial-Report-Dec06-Final.pdf> (accessed September 17, 2018).

¹⁹² NE DHHS, “Nebraska Medicaid Annual Report 2011,” p. 7, <http://govdocs.nebraska.gov/epubs/H8900/B002-2011.pdf> (accessed September 17, 2018).

¹⁹³ NE DHHS, “Nebraska Medicaid Reform Annual Report for State Fiscal Year 2015-2016,” p. 28, <http://dhhs.ne.gov/Reports/Medicaid%20Annual%20Report%20-%202016.pdf> (accessed September 13, 2018).

¹⁹⁴ DHHS tabulated vendor payments with one category for all waiver services in the 2006 and 2011 Annual Medicaid reports, shifting to including the Elderly and Disabled Waiver and the Developmental Disabilities Waiver as distinct categories for this calculation in 2016. A&D and DD Waiver expenditures for 2006 and 2011 are delineated in the Long-Term Care Services expenditures chart in this primer.

Appendix D: Medicaid Expenditures on Long-term Care Services in SFY 2006, SFY 2011, and SFY 2016



Service	Total Spending in SFY 2006 (% of all LTC Vendor Payments) ¹⁹⁵	Total Spending in SFY 2011 (% of all LTC Vendor Payments) ¹⁹⁶	Total Spending in SFY 2016 (% of all LTC Vendor Payments) ¹⁹⁷
Nursing Facility	\$296,505,175 (52%)	\$299,071,686 (49%)	\$327,126,435 (40%)
Intermediate Care Facilities for Individuals with Developmental Disabilities	\$60,405,286 (11%)	\$20,835,763 (3%)	\$72,237,288 (9%)
Developmental Disability Waivers	\$128,025,031 (22%)	\$195,331,272 (32%)	\$295,921,703 (36%)
Elderly & Disabled Waiver	\$27,457,540 (5%)	\$38,691,623 (6%)	\$90,494,809 (7%)
Home Health/Personal Assistance Services	\$33,061,309 (6%)	\$33,342,386 (5%)	\$32,465,765 (4%)
Waiver Assisted Living	\$25,540,808 (4%)	\$30,190,813 (5%)	\$31,030,872 (4%)
All Vendor Payments for LTC	\$570,995,147	\$617,463,543	\$818,246,000

¹⁹⁵ NE DHHS, "Nebraska Medicaid Reform Biennial Report 2006," December 1, 2006, p. 8, <http://dhhs.ne.gov/Documents/Biennial-Report-Dec06-Final.pdf> (accessed September 17, 2018).

¹⁹⁶ NE DHHS, "Nebraska Medicaid Annual Report 2011," p. 9, <http://govdocs.nebraska.gov/epubs/H8900/B002-2011.pdf> (accessed September 17, 2018).

¹⁹⁷ NE DHHS, "Nebraska Medicaid Reform Annual Report for State Fiscal Year 2015-2016," p. 31, <http://dhhs.ne.gov/Reports/Medicaid%20Annual%20Report%20-%202016.pdf> (accessed September 13, 2018).

Appendix E: Federally Designated Primary Care Shortage Areas as of January 9, 2017¹⁹⁸



Federal Primary Care Shortage Status	Counties
No Federal Shortage Designation	Box Butte, Buffalo, Cherry, Cheyenne, Dawes, Dawson, Franklin, Gage, Garden, Hamilton, Kearney, Keith, Kimball, Lincoln, Morrill, Otoe, Perkins, Phelps, Red Willow, Richardson, Seward, Washington, York
Portion of County Classified as Medically Underserved Area	Burt, Butler, Cass, Colfax, Cuming, Custer, Douglas, Harlan, Howard, Jefferson, Johnson, Lancaster, Merrick, Nance, Nemaha, Pierce, Platte, Sarpy, Saunders, Sheridan, Thayer, Valley, Wayne
Entire County Classified as Medically Underserved Area	Antelope, Arthur, Banner, Blaine, Boone, Boyd, Brown, Cedar, Chase, Clay, Dakota, Deuel, Dixon, Dundy, Fillmore, Frontier, Furnas, Garfield, Gosper, Grant, Greeley, Hayes, Hitchcock, Holt, Hooker, Keya Paha, Knox, Logan, Loup, McPherson, Nuckolls, Pawnee, Polk, Rock, Saline, Sherman, Sioux, Stanton, Thomas, Thurston, Webster, Wheeler
Counties with Medically Underserved Populations	Adams, Dodge, Hall, Madison, Sarpy, Scotts Bluff

¹⁹⁸ NE DHHS, "Federally Designated Primary Care Medically Underserved Areas/Populations," January 9, 2017, http://dhhs.ne.gov/publichealth/RuralHealth/Documents/HPSA%20MUA_MUP.pdf (accessed September 17, 2018).

Appendix F: Nebraska Counties Growth Trend in Medicaid Providers SFY 2011-SFY 2016



Counties

Medicaid providers in SFY 2016 exceeded Medicaid providers in SFY 2011	Antelope, Blaine, Box Butte, Boyd, Chase, Cherry, Cheyenne, Cuming, Dixon, Garden, Garfield, Grant, Holt, Jefferson, Keith, Keya Paha, McPherson, Nance, Nemaha, Nuckolls, Otoe, Perkins, Pierce, Sarpy, Sheridan, Wheeler
Medicaid providers in SFY 2011 exceeded Medicaid providers in SFY 2016	Adams, Arthur, Banner, Boone, Brown, Buffalo, Burt, Butler, Cass, Cedar, Clay, Colfax, Custer, Dakota, Dawes, Dawson, Deuel, Dodge, Douglas, Dundy, Fillmore, Franklin, Frontier, Furnas, Gage, Greeley, Hall, Hamilton, Harlan, Hayes, Hitchcock, Hooker, Howard, Johnson, Kearney, Kimball, Knox, Lancaster, Lincoln, Loup, Madison, Merrick, Morrill, Pawnee, Phelps, Platte, Polk, Red Willow, Richardson, Rock, Saline, Saunders, Scotts Bluff, Seward, Sherman, Sioux, Stanton, Thayer, Thomas, Thurston, Valley, Washington, Wayne, Webster, York

Source: Data received directly from DHHS, November 2017

Appendix G: Growth trend in Nebraska's Medicaid Providers by Provider Type SFY 2011-SFY 2016



Provider Type

Medicaid Provider Type Experienced Growth Between 2011 and 2016

Community Support MRO Program, Day Rehabilitation MRO Program, Dispensing Physician, Dentist, Chiropractor, Podiatrist, Osteopath, Federally Qualified Health Center, Free Standing Birth Center, Hospice, Indian Health Hospital Clinic, Lab, Dental Hygienist, Drug and Alcohol Counselor, Licensed Independent Mental Health Practitioner, Licensed Medical Nutrition Therapist, Licensed Psychologist, Mental Health Home Health Care Provider, Mental Health Personal Care Aide, Mental Health Professional, Nurse Midwife, Nurse Practitioner, Nursing Homes, Optometrists, Orthopedic Device Supplier, Other Prepaid Health Plan, Pharmacist, Pharmacy, Physician Assistant, Physicians, Professional Clinic, Professional Resource Family Care, Provisionally Licensed Drug & Alcohol Counselors, Provisionally Licensed PHD-PPHD, Psychiatric Residential Treatment Facility, Qualified Health Maintenance Organization, Registered Physical Therapist, NOFCUS Providers, Rural Health Clinic-Provider Based (Fewer than 50 Beds), Psychology Resident, Tribal 638 Clinic

Medicaid Provider Type Experienced Decline in numbers Between 2011 and 2016

Adult Substance Abuse Provider, Ambulatory Surgical Center, Anesthesiologist, Assertive Community Treatment MRO Program, Clinic, Day Treatment Provider, Hearing Aid Dealer, Home Health Agency, Hospitals, Licensed Mental Health Practitioner, Licensed Practical Nurse, Occupational Therapy Health Services, Optical Supplier, Registered Nurse, Rental and Retail Supplier, Residential Treatment Center, Rural Health Clinic-Independent, Rural Health Clinic-Provider Based (More than 50 Beds), Speech Therapy Health Service, Substance Abuse Treatment Center, Therapeutic Group Home, Transportation, Treatment Foster Care

Source: Data received directly from DHHS, November 2017

OpenSky Policy Institute: Clear Thinking for a Stronger Nebraska



OpenSky’s mission is to improve opportunities for every Nebraskan by providing impartial and precise research, analysis, education, and leadership.

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David Spinar resides in Lincoln where he has been a financial advisor for RBC Wealth Management since 2009.

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Kathy Campbell resides in Lincoln, where, from 2009 to 2017, she represented District 25 in the Nebraska Legislature. While in the Unicameral, she served as chair of the Health and Human Services Committee and led a review of child welfare reform. Prior to her Legislative tenure, Kathy held a variety of professional and service positions in the Lincoln area including serving as executive vice president of the CEDARS Home for Children Foundation.

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Jerry Bexten resides in Omaha where he has served as the Director of Education Initiatives at the Sherwood Foundation since 2006. Previously, Jerry worked in OPS schools for 33 years.

Mary Bills-Strand resides in Lincoln and has more than three decades of experience in real estate sales and management, including having served as Executive Vice-President for Woods Bros. Realty.

Dr. John Harms resides in Scottsbluff. After a 30-year career as president of Western Nebraska Community College, Dr. Harms retired in 2006 ahead of an eight-year term in the Nebraska Legislature.

Maja Viklands Harris resides in Lincoln, where she is a director of the Hormel Harris Foundation. Maja has over ten years of experience serving on city boards, including her current role as a Lincoln-Lancaster County Planning Commissioner.

Dr. Joel Johnson resides in Kearney and is an active community volunteer. From 2002-2008, Dr. Johnson served as a Senator in the Nebraska Legislature, and held the position of Chairman of the Health and Human Services Committee during his tenure.

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Annette Smith resides in Omaha where she is an active fundraiser and community volunteer. Along with serving on OpenSky's board, Annette also is the President of the Board of Directors for the Boys and Girls Club of the Midlands and she holds several other service positions as well.

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