OVERVIEW OF THE MEDICAID PROGRAM IN NEBRASKA

INTRODUCTION

Congress created the Medicaid Program in1965. This joint partnership between the federal government and the states was part of the President Johnson's Great Society initiatives. The program was established as a safety net for medical care for low-income persons meeting certain eligibility requirements. The State Children's Health Insurance Program (SCHIP) was created in 1998. This federal program extends medical coverage to children in low-income families who are not covered by health insurance. The Affordable Care Act passed in 2010 created the Medicaid Expansion category. Nebraska added Medicaid Expansion in 2018 through and initiative petition ballot amendment.

MEDICAID/SCHIP OVERVIEW

The federal statutory basis is in Title XIX of the Social Security Act. At the federal level the program is administered by the Centers for Medicare and Medicaid Services (CMS). The Department of Health and Human Services is the designated state Medicaid agency.

All 50 states offer Medicaid programs, although participation is not required. States agreeing to participate are required to meet certain minimum requirements regarding covered services and categories of eligibility in order to obtain federal financial participation. Beyond the minimum mandated coverage, states are allowed to design and administer their own programs within a patchwork of complex federal guidelines.

In addition to providing the majority of the funding, the federal government places limits and controls on state programs. All states which participate must comply with mandated coverages. The federal government also allows for expansion of services and populations under optional coverages spelled out in the law and rules and regulations. Federal rules and regulations can be exempted with the approval of the Centers for Medicare and Medicaid under a waiver process.

The Medicaid Program is the payer of last resort. Any insurance coverage or third-party payment source must be assigned to the state at the time of application.

Financing

In FY2023, Medicaid aid appropriation is $3,302,544,258 ($991,653,018 GF, $42,117,244 CF and $2,268,773,906. The Developmental Disabilities Services appropriation contains the General Fund match for Medicaid of $174,638,509. The Children's Health Insurance Program aid appropriation is

$129,753,757 ($26,433,262 GF and $7,085,700 CF and $96,234,795 FF). These are direct service costs and costs for the managed care contracts. State administrative costs for eligibility determination, management, data processing and waiver administration are not included.

The federal Medicaid match rate referred to as the FMAP. The FMAP is adjusted every year and is based on a three-year rolling average of the state's per capital personal income compared to the national average. The FMAP can range from 50% to 83%. Nebraska's regular match in the last 40 years has ranged from the lower 50s to upper 60s. Currently the state is receiving an enhanced match of 6.2%. This due to the federal Public Health Emergency (PHE). Congress is providing the additional funding to assist states through the pandemic. The enhanced match is in effect until the last quarter of the federal PHE. The current projection is that the PHE will end at the end of September 2022. The current FMAP with the enhanced rate is 64% and will revert to the regular match of roughly 57.8% when the PHE ends.

The State Children's Health Insurance Program (SCHIP) is matched at 70% of the state's regular Medicaid match rate up to a capped amount. Expenditures above the cap are matched at the Medicaid rate. The SCHIP match in FFY 2023 is 70.51%. Medicaid Expansion has a 90% federal match. The SCHIP and expansion match rates were not included in the PHE enhanced match.

SCHIP and Medicaid Expansion operate seamlessly as an extension of the Medicaid program; using the same delivery system, benefit package, and regulations as Medicaid.

ELIGIBILITY

Medicaid

Medicaid recipients must be citizens, legal permanent residents or other qualified aliens. Illegal immigrants are required to be covered for emergency assistance, if other Medicaid qualifications are met.

Medicaid is a means-tested program, meaning that an individual's or a family's income and/or resources must be sufficiently low to qualify. Modified adjusted gross income (MAGI) is used for eligibility determination, except for those qualifying as aged or disabled. Individuals qualifying due to age (65 or older) or disability have an asset test in addition to an income test.

Children's Health Insurance

Nebraska's SCHIP provides health care coverage for qualifying uninsured children through age 18, if they live in a household with income above the Medicaid eligibility threshold, but at or below 213% of the federal poverty level (FPL).

The state implemented an additional CHIP category in 2012. The program provides coverage for the unborn children of pregnant women who are otherwise ineligible for coverage under Medicaid for prenatal care and pregnancy-related services connected to the health of the unborn child.

Medicaid Expansion

Effective October 1, 2020, citizens and permanent residents aged 19-64 whose income is below 138% of the PPL and who are not already eligible for Medicaid qualify for Medicaid Expansion.

In the last completed state fiscal year, FY 2021, the average monthly number of individuals enrolled in Medicaid and SCHIP combined was 327,698. Children make up 37% of all Medicaid eligibles, but only 22% of the total costs. By contrast, individuals with disabilities are 11% of the number of eligibles, but more than one-third of total costs at 37%.. Enrollment by categorical eligibility and the associated costs are shown below:

			Cost	
FY 2021	**Eligibles**	**%**	**by Eligibility Category**	**%**
Aged	20,235	6%	568,119,431	19%
Blind and Disabled	36,933	11%	1,095,807,600	37%
Medicaid children	141,335	43%	636,613,586	22%
ADC parents and caretakers	46,263	14%	581,293,217	20%
Medicaid Expansion adults	46,298	14%	40,244,042	1%
SCHIP Children	36,634	11%	15,140,520	1%
TOTAL	327,698	100%	2,937,218,396	100%

SERVICES

The federal government imposes requirements on the states regarding the services provided under the Medicaid Program. States are required to cover specific services commonly referred to as “mandatory” services. States could also elect to cover additional services from an array identified by Centers for Medicare and Medicaid and receive a federal match. These services are labeled “optional” services. States are also allowed to expand services beyond the identified array to encompass non-medical health related services through a waiver process.

Federal law requires specific services to be provided and allows a broad range of allowable services beyond those that are mandatory. All services, except for certain screening services must be medically necessary. The services are as follows:

Mandatory Services	Optional Services
Inpatient and outpatient hospital	Prescribed drugs
Lab and radiology	Intermediate care facilities for the mentally retarded (ICF-DD)
Nursing facility	Home and community-based services for the aged and persons with disabilities
Early and periodic screening services for children (EPSDT)	Mental health and substance abuse treatment
Family planning	Dental
Physician services	Rehabilitation
Home health	Personal care
Nurse midwife	Durable medical equipment
Nurse practitioner	Speech, physical and occupational therapies
Medical supplies	Optometric services
Federally Qualified Health Centers (FQHCs)	Eyeglasses
Transportation to medical services	Podiatric
Tobacco cessation counseling for pregnant women	Hospice
Pregnancy-related services	Hearing screenings for newborns and infants
	Chiropractic services
	Case management
	School-based administrative expenses

The cost by service category is listed in the following chart:

Service Category	FY 2021
Medical managed care	1,822,985,748
Dental managed care	63,752,062
Nursing facilities	394,528,336
Aged and disabled waiver services	180,280,160
DD waiver services	368,142,223
Intermediate Care Facility -- DD (ICF - DD)	73,562,341
Home Health	12,898,585
Other	21,119,811
Dental	50,851
Total	2,937,320,117

Home and Community-Based Waivers

Non-medical, health-related services are offered through home-and-community-based waivers. In 1981 Congress passed legislation which allowed states to apply for special waivers. Home-and-community-based waivers allow states to offer a coordinated set of services to individuals to either avoid institutionalization or return to the community, if in an institution. Examples of the type of services which may be provided under a waiver but not under the regular Medicaid Program are respite care and habilitation services.

States select the target populations to include under home-and-community-based waivers. These populations can include the aged, the disabled, the developmentally disabled, the chronic mentally ill or any other population identified as likely to require extended hospital or nursing home care. States may also limit the number of individuals served under a waiver.

Home-and-community-based waiver services are required to be either budget neutral or reduce costs. States have to show that per capita expenditures for waiver services do not exceed the average per capita payments that would have been spent by Medicaid for those individuals, if they had been in a nursing facility or an ICF-MR. Nebraska has seven approved Medicaid home-and-community-based waivers: 1) three developmental disability waivers for adults; 2) a developmental disability waiver for children who also have other disabilities; 3) an aged and disabled waiver for elderly persons, adults and children with disabilities; 4) a waiver for children served by the Early Intervention Program and 5) a traumatic brain injury waiver.

These waivers allow Medicaid funding to be used to purchase services that are not considered “medical”. Depending on the waiver, services available include: adult day care, assisted living, assistive technology, extra care for children with disabilities, chore, home-delivered meals, home modifications respite and service coordination.

Payment Structure

Physical health, behavioral health, pharmacy, and dental services are paid through managed care capitation payments. The department pays a monthly per-member/per month payment for each enrolled clients to managed care organizations that administer the services in the benefit package. Other services are paid on a fee-for-service basis where medical providers bill the department directly for each service rendered, which include long-term care services and service for certain individuals who are exempt from managed care.

FUTURE ISSUES

Public Health Emergency Unwind

The Families First Coronavirus Response Act provided for an enhanced Medicaid match of 6.2% through the end of the quarter in which the Public Health Emergency ends. The PHE has been extended multiple times and is projected to end July 15, 2022. Based on this end date, the enhanced FMAP would be discontinued at the end September.

A condition of receiving the enhanced FMAP is that enrollees cannot be disenrolled until after the end of the PHE and the cases are redetermined. During the redetermination period the FMAP drops to the normal percentage match, so the higher number of enrollees through the 14-month allowable period for redetermination will not be paid with the enhanced match. An additional $21.5 million in cash funds provided through the deficit based on an assumed end date of June 2022. Those funds will be carried over into the next fiscal year.

Family Support Waiver for Children with Developmental Disabilities

LB 376 which passed in the 2022 Session requires the department to apply for a three-year family support waiver for children with developmental disabilities. The waiver if approved will provide ten thousand dollars per child for support services. Families can self-direct services. The number of participants is also capped at 850 children. Only the child's income and resources would be counted towards eligibility.