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Department of Health & Human Services



*Division of Medicaid and Long-Term Care*

## **Nebraska Medicaid Annual Report**

**December 1, 2011**

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

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

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

**I. Introduction**

The Nebraska Department of Health and Human Services (DHHS) is pleased to submit this Annual Report in compliance with Neb. Rev. Stat. § 68-908(4) requiring DHHS to prepare an annual summary and analysis of the medical assistance program for legislative and public review.

A draft of this Annual Report has been provided to the Medicaid Reform Council to receive public comment and recommendation as required by law.

Medicaid is a joint federal-state program that pays for a broad range of medically necessary health care and long-term care services for eligible low-income populations. DHHS administers the program through the Division of Medicaid and Long-Term Care in partnership with the federal Centers for Medicare and Medicaid Services (CMS).

In 2005, the Nebraska Legislature mandated “fundamental reform” of the state’s Medicaid program, and one year later, the Medical Assistance Act (Neb. Rev. Stat. § 68-901 to 68-949) was adopted, continuing the reform efforts. The specific legislative findings set forth in Neb. Rev. Stat. § 68-904 provide the rationale for reform. The Legislature found that Medicaid alone cannot meet all of the health care needs of all low-income Nebraska residents. Secondly, the Legislature found that the State cannot sustain a rate of growth in Medicaid expenditures that exceeds General Fund revenue. Finally, the Legislature mandated the Medicaid program establish policies that effectively moderate the growth of expenditures while addressing the needs of eligible recipients. This Annual Report summarizes the policies and programs established by DHHS during the last year to address the foregoing concerns.

The policies implemented by DHHS over the years have yielded tangible results, making the Medicaid program more efficient and saving taxpayer significant resources. Because DHHS implemented policies moderating the growth of expenditures, Nebraska is in better financial shape than many other states. That being said, the reality is that the economy is recovering from a protracted recession. The Medicaid program in Nebraska is dealing with an increase in the number of eligible recipients. General Fund revenues have decreased. Additionally, the Medicaid program must comply with a number of new federal mandates, many of which are unfunded and represent a significant burden for DHHS. In short, the legislative findings set forth in § 68-904 are every bit as relevant today as when they were enacted in 2006.

This Annual Report fulfills DHHS’s statutory obligation to provide a summary that includes, but is not limited to, a description of eligible recipients, covered services, provider reimbursement, program trends and projections, program budget and expenditures, the status of implementation of the Medicaid Reform Plan, and recommendations for program changes.

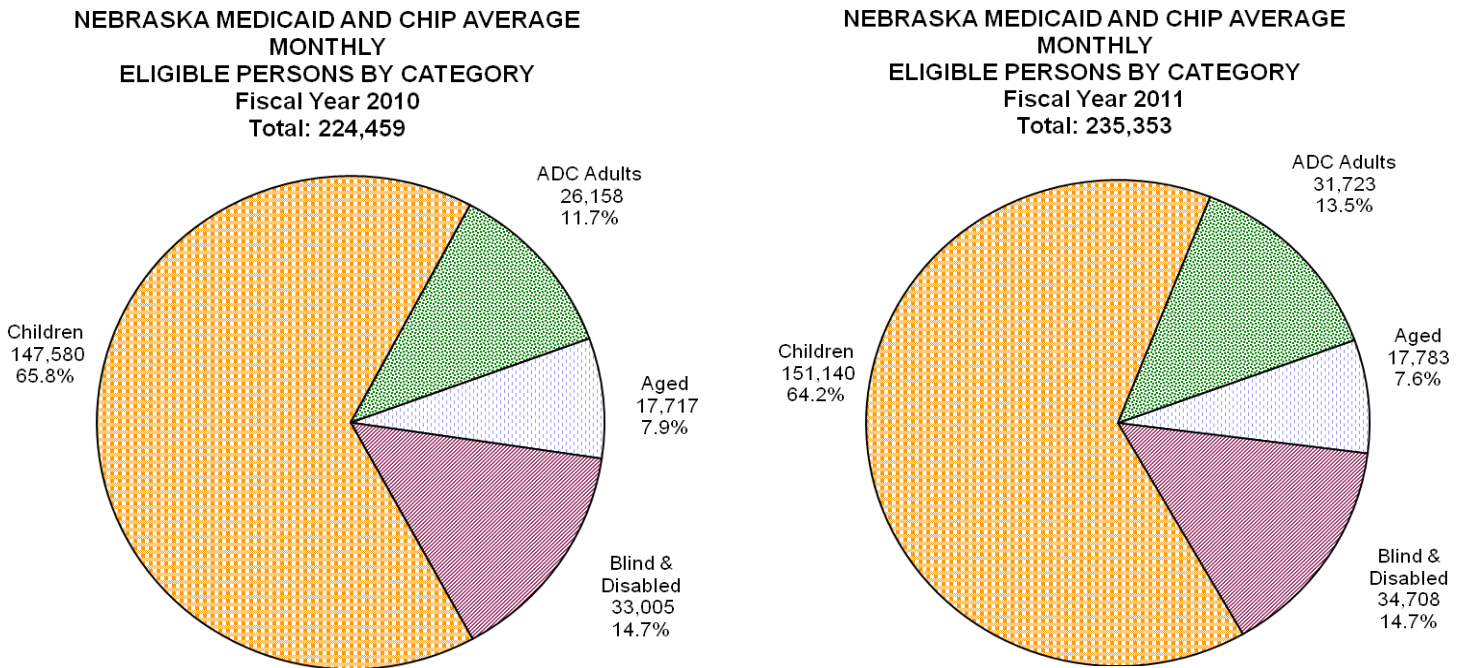
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## II. Discussion

### A. Eligible Recipients

Nebraska Medicaid provides coverage for the following eligibility categories: Children, Aid to Dependent Children (ADC) Adults, Aged, and Blind and Disabled. Figure 1 compares client eligibility by category for State Fiscal Years (SFY) 2010 and 2011.

Figure 1



The total increase in average monthly eligibles from SFY 2010 to SFY 2011 was 4.9%. The largest percentage increase was in the ADC Adults category, which grew 21.3%. Average monthly eligibles in the Blind and Disabled category grew by 5.2%, while the Children increased by 2.4%, and eligibles in the Aged category increased by 0.4%. (Figure 1)

A significant increase in Medicaid eligibility began in the latter half of SFY 2009 and has continued into SFY 2010. This is likely the result of the economic downturn. Assuming continued pressure on Medicaid caseloads due to weak economic conditions, eligibility is projected to increase 4.2% in SFY 2012.

**Figure 2**

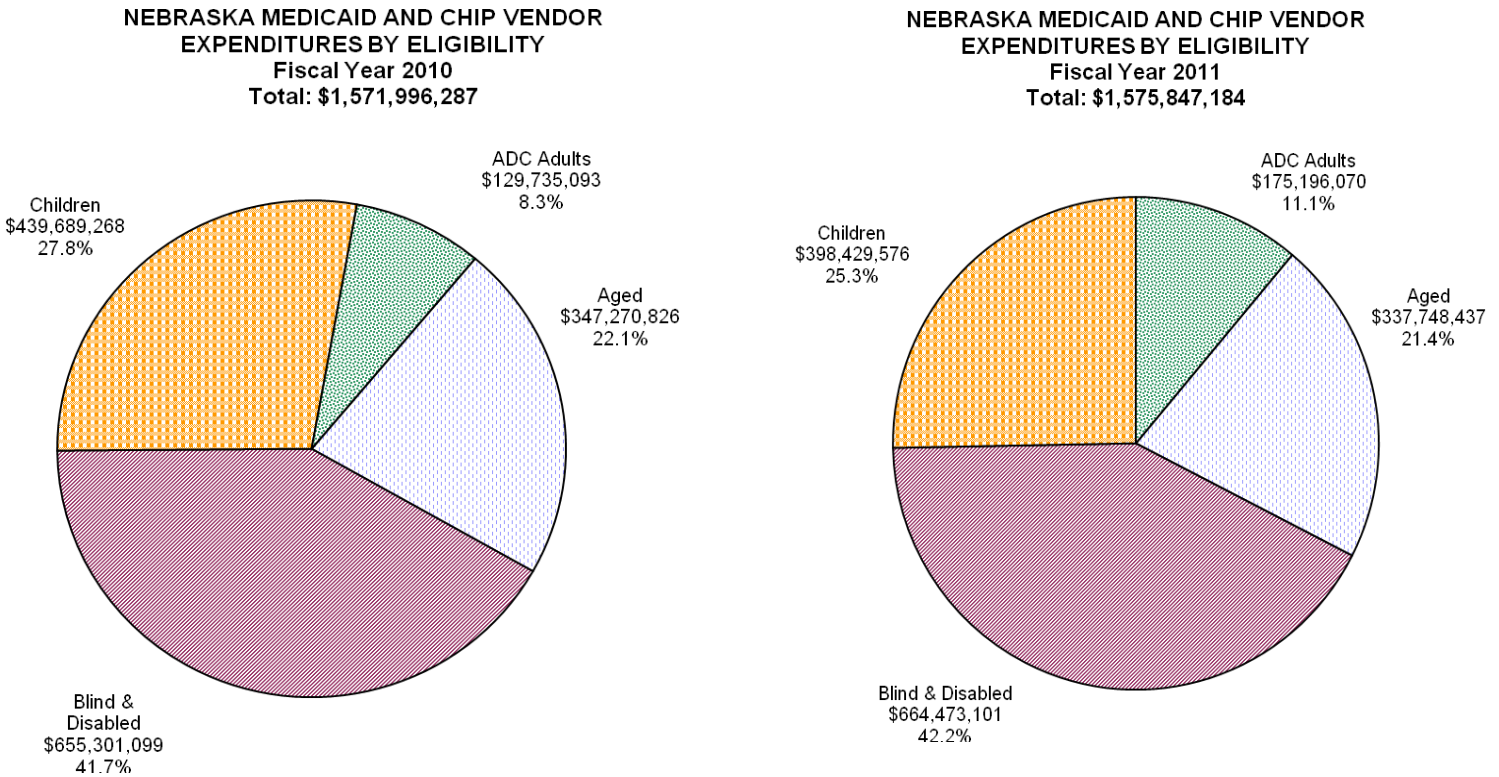


Figure 2 compares vendor expenditures by eligibility category for SFYs 2010 and 2011. The graphic does not account for all Medicaid expenditures, in part because some payments and refunds are not specific to a recipient or eligibility category. Examples of transactions not shown are drug rebates, payments made outside the claims processing systems, and premium payments paid on behalf of persons eligible for Medicare. (See detail on page 7)

Total Medicaid vendor expenditures experienced an increase of 0.2% from SFY 2010 to SFY 2011. The largest increase in expenditures was in the Aid to Dependent (ADC) Adult category, which increased by 35.0% from SFY 2010 to SFY 2011. Blind & Disabled expenditures were the second fastest growing category, increasing by 1.4% from SFY 2010 to SFY 2011, followed by Aged, which decreased at 2.7%. Expenditures for Children decreased by 9.4%.

The average monthly cost per eligible decreased 4.4% from SFY 2010 to SFY 2011. The largest cost per eligible increase was in the ADC Adults category, which increased by 11.3%. Blind and Disabled increased by 1.4%. Medicaid expenditures per eligible decreased by 2.7% for Aged and by 9.4% for Children.

The large increases in ADC Adults category was due to a change in how pregnant women are categorized. Prior to April 2010, expenses for pregnant women were characterized as expenses for children because, contrary to federal law, the eligible client was not considered to be the

pregnant woman. A corresponding reduction was found in the Children category now that the eligibility has been corrected.

**B. Covered Services**

Federal Medicaid statutes mandate states to provide certain services and allow states the option of providing a choice of others. The Nebraska Medical Assistance Act delineates the mandatory and optional services offered in Nebraska.

**Federal Medicaid Mandatory and Optional Services Covered in Nebraska**

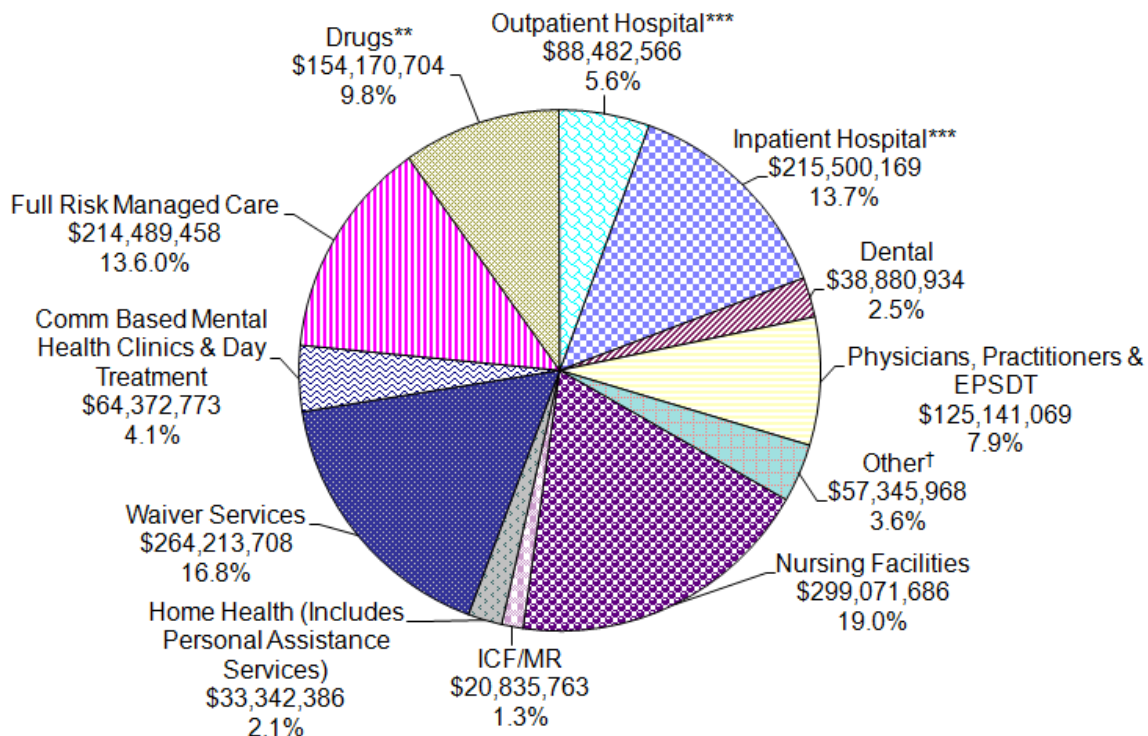
**(Neb. Rev. Stat. § 68-911)**

<b>Mandatory Services</b>	<b>Nebraska Optional Services</b>
<ul style="list-style-type: none"> <li>• Inpatient and outpatient hospital services</li> <li>• Laboratory and x-ray services</li> <li>• Nursing facility services</li> <li>• Home health services</li> <li>• Nursing services</li> <li>• Clinic services</li> <li>• Physician services</li> <li>• Medical and surgical services of a dentist</li> <li>• Nurse practitioner services</li> <li>• Nurse midwife services</li> <li>• Pregnancy-related services</li> <li>• Medical supplies</li> <li>• Early and periodic screening and diagnosis treatment (EPSDT) services for children</li> </ul>	<ul style="list-style-type: none"> <li>• Prescribed drugs</li> <li>• Intermediate care facilities for the mentally retarded (ICF/MR)</li> <li>• Home and community-based services for aged persons and persons with disabilities</li> <li>• Dental services</li> <li>• Rehabilitation services</li> <li>• Personal care services</li> <li>• Durable medical equipment</li> <li>• Medical transportation services</li> <li>• Vision-related services</li> <li>• Speech therapy services</li> <li>• Physical therapy services</li> <li>• Chiropractic services</li> <li>• Occupational therapy services</li> <li>• Optometric services</li> <li>• Podiatric services</li> <li>• Hospice services</li> <li>• Mental health and substance abuse services</li> <li>• Hearing screening services for newborn and infant children</li> <li>• School-based administrative services</li> </ul>

## Expenditures

Medicaid expenditures to vendors in SFY 2011 totaled \$1,575,847,184. Figure 3 shows the services by vendor type. It does not include drug rebates, payments made outside the claims processing systems, or premium payments made on behalf of Medicare eligibles.

**Figure 3**  
**NEBRASKA MEDICAID AND CHIP VENDOR EXPENDITURES\* BY SERVICE**  
**FISCAL YEAR 2011**  
**Total Vendor Payments \$1,575,847,184**



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

\*\* \$73.7 million in offsetting drug rebates is not reflected in the drug expenditures of \$154,170,704

\*\*\* DSH payments of \$36.1 million are not reflected in Inpatient or Outpatient Hospital Expenditures

† Includes Speech/ Physical Therapy, Medical/Optical Supplies, Ambulance, and Lab/Radiology

### **\$1,575,847,184 Vendor Payments**

\$45,638,700	Disproportionate Share Hospital/Rate Adjustments
\$47,134,300	Medicare Premiums
\$ 4,573,772	Intergovernmental Transfer (IGT)
\$52,488,921	Other Payments (Managed Care, Transportation, Federal Insurance Contributions Act taxes, AssistTech, Upper Limit Pmts)
(\$81,205,580)	Rebates/Refunds
(\$89,494,683)	General Funds Paid in Other Budget Programs
\$34,960,645	Phased Down Contribution
\$1,589,943,259	Net Medicaid Expenditures

Total vendor payments increased \$3,850,897, or 0.2%, from SFY 2010 to SFY 2011. From SFY 2010 to 2011 vendor expenditures for Managed Care Capitation Services showed significant increases due to the implementation of full-risk managed care in ten counties. Prior to SFY 2011, full-risk managed care was only offered in a three county service area. In SFY 2011, DHHS expanded full-risk managed care into ten counties and added an additional full-risk health plan. (Table 1)

**Table 1**  
**Nebraska Medicaid and CHIP Vendor Expenditures**

	FY 2010		FY 2011		FY 2010 to FY 2011		
	Expenditures	% of Total	Expenditures	% of Total	Increase	% Increase	
Nursing Facilities	\$316,974,756	20.5%	\$299,071,686	19.0%	-\$17,903,070	-5.6%	
Inpatient Hospital Waiver Services (DD Waivers, Assisted Living)	\$234,601,172	14.9%	\$215,500,169	13.7%	-\$19,101,003	-8.1%	**
Physicians, Practitioners & EPSDT	\$244,545,513	13.9%	\$264,213,708	16.8%	\$19,668,194	8.0%	
Drugs	\$161,968,760	10.3%	\$125,141,069	7.9%	-\$36,827,691	-22.7%	**
Outpatient Hospital	\$150,724,210	10.1%	\$154,170,704	9.8%	\$3,446,494	2.3%	
Managed Care Capitation	\$114,122,090	5.9%	\$88,482,566	5.6%	-\$25,639,524	-22.5%	**
Other	\$94,901,326	5.9%	\$214,489,458	13.6%	\$119,588,132	126.0%	
Comm Based Mental Health Clinics & Day Treatment	\$66,681,571	4.6%	\$57,345,968	3.6%	-\$9,335,603	-14.0%	**
ICF-MR	\$65,418,622	4.5%	\$64,372,773	4.1%	-\$1,045,849	-1.6%	
Home Health	\$42,968,239	4.5%	\$20,835,763	1.3%	-\$22,132,476	-51.5%	*
Dental	\$40,553,050	2.6%	\$33,342,386	2.1%	-\$7,210,664	-17.8%	**
Dental	\$38,536,977	2.3%	\$38,880,934	2.5%	\$343,957	0.9%	
<b>Total</b>	<b>\$1,571,996,287</b>	<b>100%</b>	<b>\$1,575,847,184</b>	<b>100.0%</b>	<b>\$3,850,897</b>	<b>0.2%</b>	

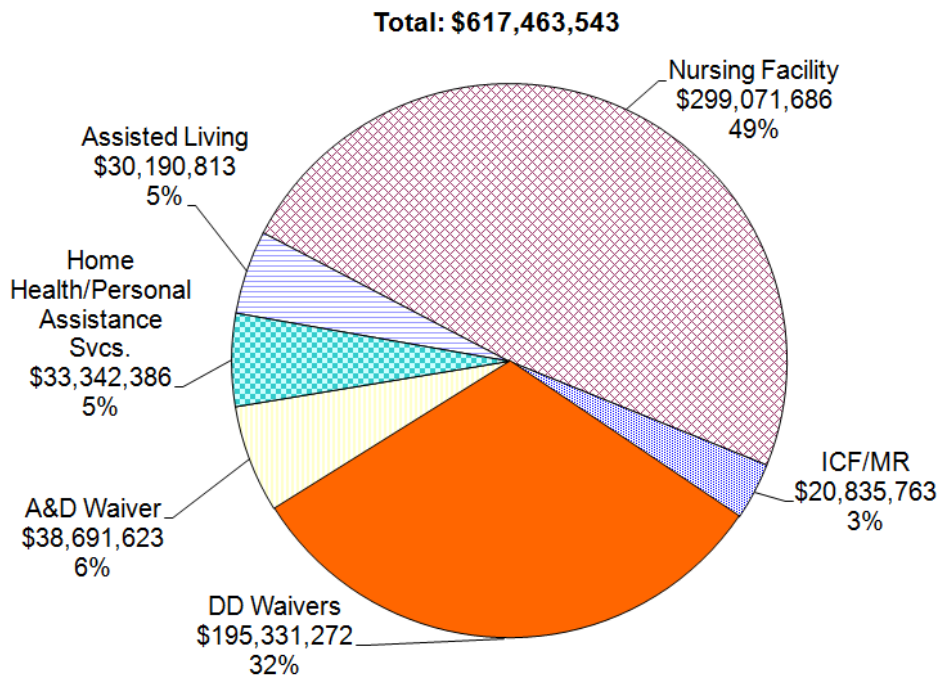
\*reduction caused by decertification of Beatrice State Developmental Center (BSDC)

\*\* reduction due in part to transition to full-risk managed care

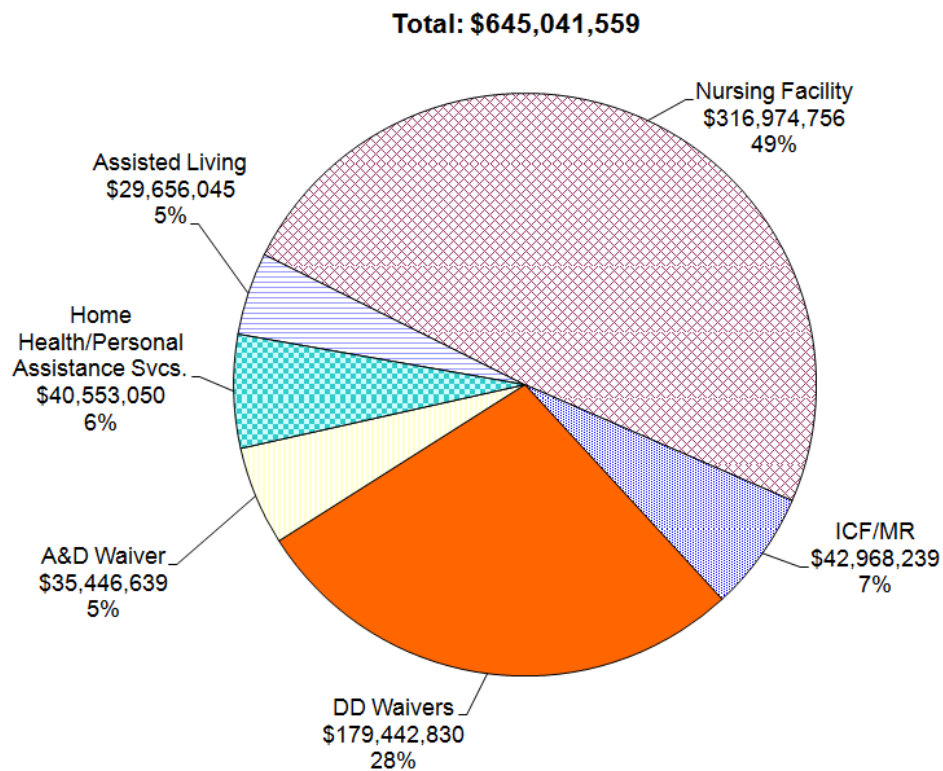
### Long-Term Care Services

Efforts to encourage home and community-based alternatives to facility-based care are resulting in a gradual rebalancing of long-term care expenditures. Comparison of Fiscal Year 2011 spending with Fiscal Year 2010 spending shows a decline in the percentage of dollars directed to institutional providers (nursing facilities and ICF/MR) and a corresponding increase in the proportion of spending for services in less restrictive settings. (Figure 4) Institutional payments declined from 56% of total long-term care expenditures in 2010 to 52% in 2011. Home and Community payments increased from 44% of total long-term care expenditures in 2010 to 48% in 2011.

**Figure 4**  
**SFY 2011 Medicaid Expenditures for Long-Term Care Services**



**SFY 2010 Medicaid Expenditures for Long Term-Care Services**



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### C. Provider Reimbursement

DHHS uses different methodologies to reimburse Medicaid services. Practitioner, laboratory, and radiology services are reimbursed according to a fee schedule. Prescription drugs are reimbursed according to a discounted product cost calculation plus a pharmacy dispensing fee. Inpatient Hospital services are reimbursed based on a prospective system using either a diagnosis related group or per diem rate. Critical Access Hospitals are reimbursed a per diem based on reasonable cost of providing the service. Federally Qualified Health Centers are reimbursed on a prospective payment system. Rural Health Clinics are reimbursed cost or a prospective rate depending on whether they are independent or provider based. Outpatient Hospital reimbursement is based on a percentage of the submitted charges. Nursing Facilities are reimbursed a daily rate based on facility cost and client level of care. Intermediate Care Facilities for the Mentally Retarded (ICF/MRs) are reimbursed a per diem rate based on a cost model. Home and Community-Based Waiver Services, including Assisted Living, are reimbursed at reasonable fees as determined by DHHS.

Table 2 below shows a recent history of provider rate changes by provider type.

**Table 2**

<b>Year-to-Year Average Medicaid Provider Rate Increases</b>	<b>SFY 2005</b>	<b>SFY 2006</b>	<b>SFY 2007</b>	<b>SFY 2008</b>	<b>SFY 2009</b>	<b>SFY 2010</b>	<b>SFY 2011</b>
<b>Hospitals</b>	3.80%	2.00%	2.00%	1.95%	1.90%	1.50%	0.50%
<b>Practitioners</b>	2.00%	2.00%	2.00%	1.40%	1.40%	1.50%	0.50%
<b>Nursing Facilities</b>	2.00%	6.00%	3.50%	2.50%	2.50%	1.50%	1.50%
<b>Assisted Living</b>	3.00%	2.00%	2.00%	2.00%	2.00%	1.50%	0.50%
<b>Non-public ICF-MRs</b>	3.00%	2.00%	2.00%	2.50%	2.50%	1.50%	0.50%

For Medicaid recipients participating in at-risk managed care, Medicaid pays a monthly capitation payment to the Managed Care Organization (MCO) based on actuarially determined cost of services and administration per enrollee. Providers are reimbursed by the MCO for services delivered to MCO clients. The MCO independently determines reimbursement methodology and rates for participating providers. As shown in Figure 3, at-risk managed care constitutes approximately \$214 million or 13.6% of vendor expenditures.

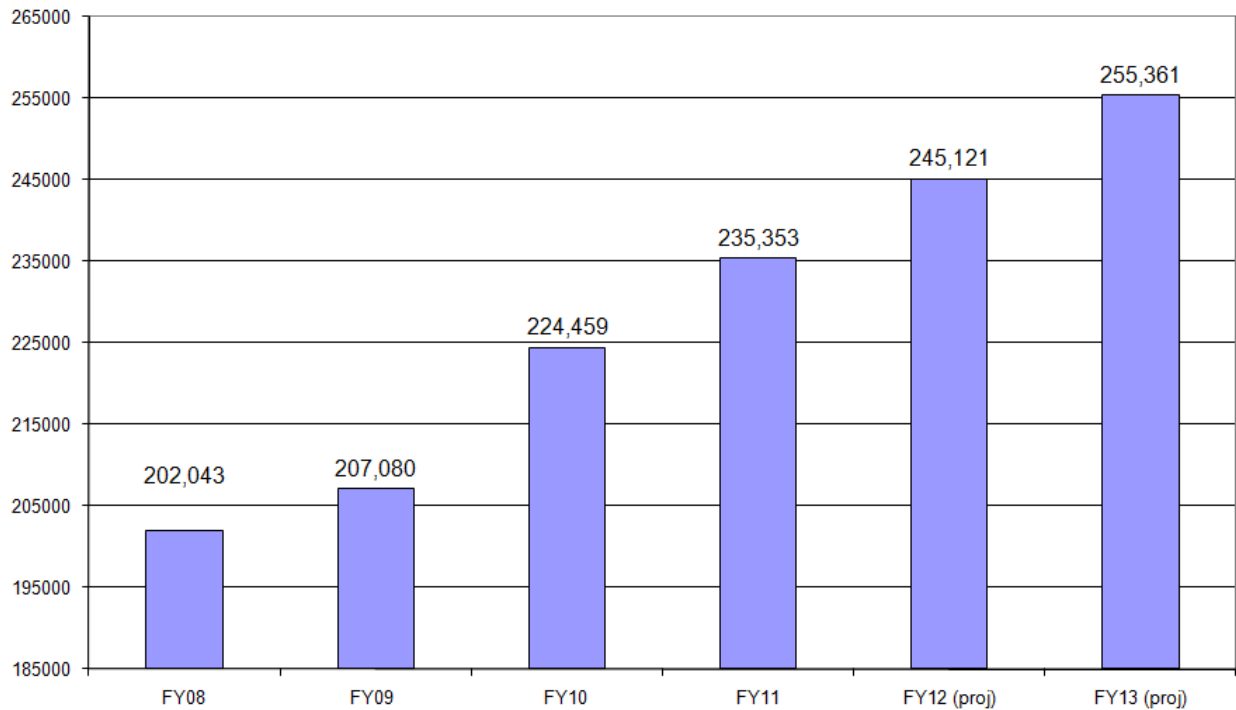
### D. Program Trends and Projections

Growth in Medicaid eligibility, which had been moderate from SFY 2006 through SFY 2008, experienced a significant increase in the latter half of SFY 2009 that continued until the first half of SFY 2010. Assuming continued pressure on Medicaid caseloads due to weak economic conditions and factoring in the statutory expansion of Children's Health Insurance Program (CHIP) eligibility to 200% FPL in LB 603, eligibility is projected to increase 4.2% in SFY 2012.

As shown in Figure 1, the average monthly number of eligibles in SFY 2011 was 235,353. Figure 6 tracks the growth of average monthly eligibles by fiscal year. In June 2011, there were 236,589 persons eligible for Medicaid, an increase of 8,107 persons (3.5% increase) over the same month in 2010.

**FIGURE 6**

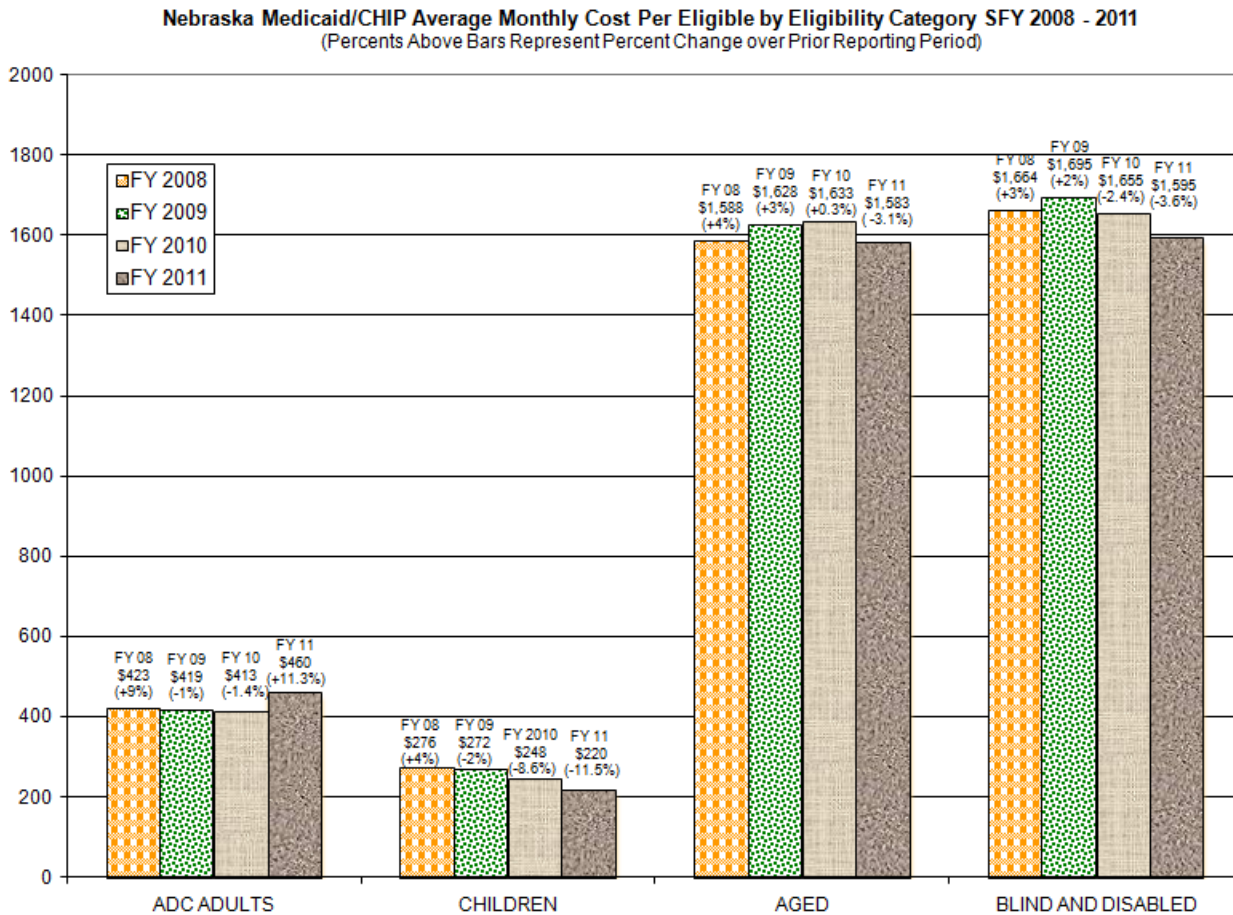
**Nebraska Medicaid and CHIP Average Monthly Eligibles  
SFY 2008-2011 Actual and SFY 2012-2013 Projected  
Based on Current Economic Predictions\***



\*This does not include changes resulting from implementation of federal Health Reform

Equally important to the fiscal sustainability of Medicaid is the trend in cost per Medicaid eligible person. The trends in average cost per category are shown in Figure 7.

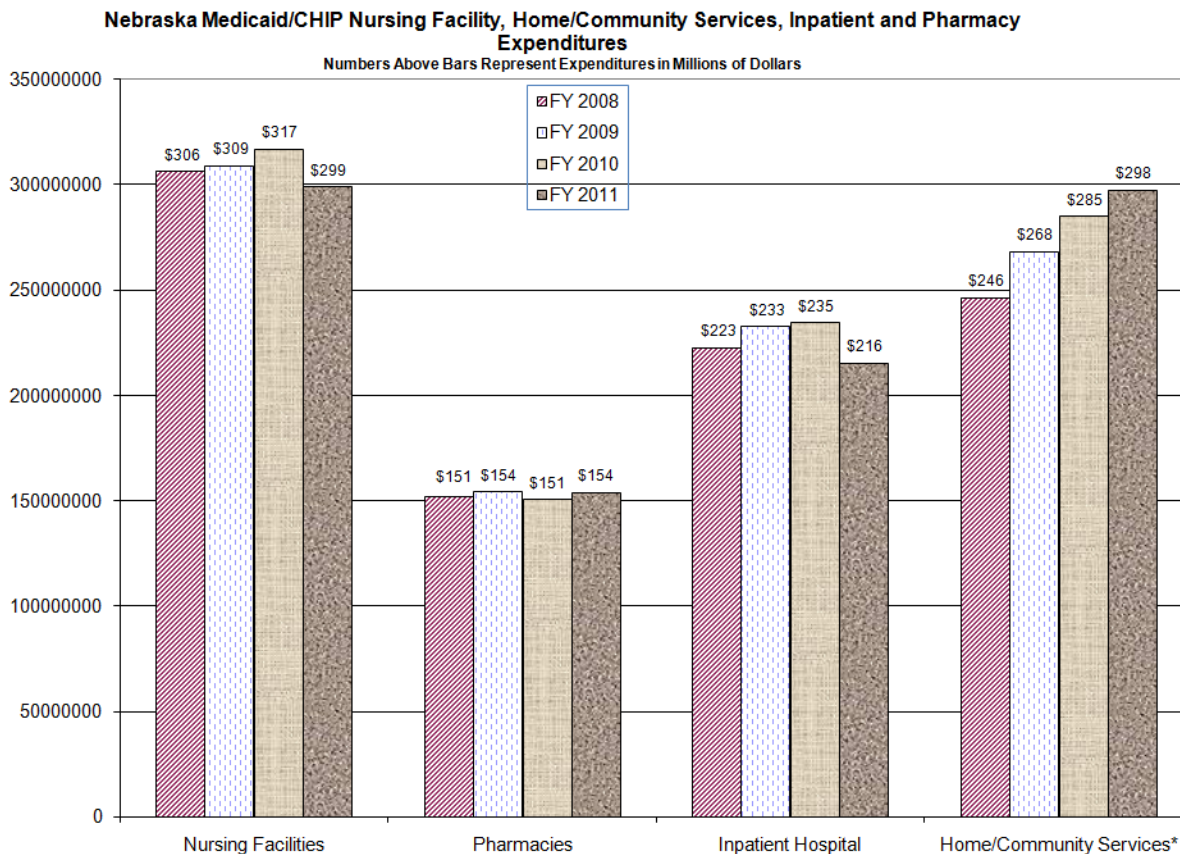
**Figure 7**



These trends are based on vendor payments. The majority of persons in the Aged and the Blind and Disabled categories now have their drug costs paid by Medicare. As mentioned above in Section A, the increase in average monthly cost per eligible for ADC Adults was due to a change in how pregnant women are categorized. A corresponding reduction is seen in the Children category.

The top four vendor expenditure categories in Medicaid are nursing facilities, pharmacies, home and community services, and inpatient hospitals. The home and community service category consists of home health, personal assistance services and waiver services, including assisted living. Figure 8 reflects the trends.

**Figure 8**



\*Includes HCBS Waiver Services, Home Health Services, and Personal Care Aide Services

Spending for nursing facility services decreased in SFY 2011 and declined as a percentage of the overall Medicaid program. Home and community services continue to grow both in terms of dollars and as a percentage of the Medicaid program as more care and services are delivered outside of traditional institutional settings. Expenditures for inpatient hospital services declined in SFY 2011, probably as a result of expanded managed care.

### **E. Program Budget and Expenditures**

The legislature enacted LB 374, the mainline appropriations bill of the 2011 legislative session continuing funding for Medicaid for SFY 2012 and 2013. The Medicaid appropriation included a rate decrease of 2.5% per year for most provider categories as well as an adjustment in the state and federal funding split to reflect the expiration of enhanced Federal Medical Assistance Percentage (FMAP) funding available to DHHS because of the federal American Recovery and Reinvestment Act (ARRA). Enhanced federal funding ended June 30, 2011.

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## **F. SFY 2011 Initiatives**

This report highlights some of the major projects the Division has been engaged in during SFY 2011:

### **1. Managed Care Expansion**

In August 2010, DHHS expanded the physical health managed care program into seven additional counties with the procurement of two Managed Care Organization (MCO) health plans. The MCOs that were awarded the contracts were United Healthcare/Share Advantage and Coventry. With the award of the two contracts, full-risk managed care is now offered to over 100,000 Medicaid recipients in Cass, Dodge, Douglas, Gage, Lancaster, Otoe, Sarpy, Saunders, Seward, and Washington counties. Full-risk managed care is a health care delivery system where MCOs are contracted to operate a health plan that authorizes, arranges, provides, and pays for the delivery of services in the Basic Benefits package to enrolled clients. Managed care offers an opportunity to assure access to a primary care physician, emphasizes preventive care, and encourages the appropriate utilization of services in the most cost-effective settings. With the implementation of the two MCO contracts, the Primary Care Case Management model of managed care was discontinued.

### **2. Transportation Broker**

Effective May 2011, DHHS implemented a transportation broker program for non-emergency medical transportation for Medicaid recipients. The broker is responsible for reviewing each request for service to assure it is an allowable trip according to Medicaid regulations. The broker also recruits and enrolls transportation providers into the Medicaid system. All potential households received brochures by mail notifying them of the change.

### **3. Medicaid EHR Incentive Program**

DHHS submitted a State Medicaid Health Information Technology (SMHP) plan for CMS approval in order to implement the Medicaid Electronic Health Record (EHR) Incentive Program. This program will provide federal payments to eligible Medicaid professionals and hospitals for their efforts to adopt, implement, upgrade, and subsequently use EHR technology in a meaningful manner.

### **4. Institution for Mental Disease (IMD) Compliance**

An IMD is a hospital, nursing facility or other institution of more than 16 beds that has over 50% of its residents with a mental health diagnosis. An IMD primarily engages in providing diagnosis, treatment or care of persons with mental disease, including medical attention, nursing care and related services. Medicaid recipients who reside in an IMD are not eligible for Medicaid benefits unless the IMD is a Psychiatric Residential Treatment Facility and the Medicaid recipient is under 21 years of age, or is 65 years of age or older. DHHS submitted a State Plan Amendment, drafted new children's mental health regulations, implemented new rates in compliance with the new rate methodology and has compliance plans for all children's residential providers in Nebraska that describes their intention to come into compliance with the federal IMD regulations by July 2012 as required by CMS.

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In July 2011, CMS raised the IMD rule in regard to the provision of adult services. DHHS has been working with consumers and providers to arrive at a plan that ensures compliance with federal requirements.

### **5. Durable Medical Equipment**

With the input of physicians, other medical professionals, and durable medical equipment providers, DHHS clarified coverage criteria and maximum monthly limits on selected products. Effective October 2010, monthly maximum units were established for non-sterile gloves and incontinence products. Beginning December 2010, Medicaid rents only hospital grade breast pumps when the mother or newborn has a medical condition that prevents the baby from receiving all nutrition from breastfeeding. Medicaid reimburses for breast pumps when there is a medical necessity, and not for convenience.

### **6. Legal Permanent Residents**

Effective July 1, 2010, Medicaid and CHIP began covering children and pregnant women who are lawfully residing in the United States and who were previously not eligible due to the 5-year bar. These populations were previously covered with only General Funds.

### **7. Version 5010 of Medicaid Standard Electronic Transactions**

Effective January 2012, the Medicaid Management Information System (MMIS) will implement the latest mandated version of HIPAA electronic transactions. At the same time, the MMIS will become fully National Provider Identifier (NPI) compliant. This project has required all providers to validate all current enrollment information and provide NPI, taxonomy and nine-digit zip codes.

### **8. Electronic Billing**

DHHS continues to encourage providers to take advantage of the benefits of electronic claim submission, and DHHS initiated an awareness campaign to remind providers of the benefits of electronic claim submission. Providers using the DHHS-generated paper turnaround document (TAD) for Medicaid billing were provided with targeted education and support efforts, encouraging them to move to electronic billing. Beginning in May 2011, these providers were also able to bill Medicaid using standard paper claims, and notified that generation of TADs would cease as of November 2011. DHHS is working with the provider associations to offer additional training opportunities to support this transition.

### **9. National Correct Coding Initiative (NCCI)**

The NCCI is a set of claim edits designed by CMS to prevent improper payment when incorrect procedure code combinations are reported as well as for medically unlikely units of service. DHHS will implement NCCI in the MMIS prior to November 2011. Claims for services on or after October 1, 2010, received on or after April 1, 2011, are subject to NCCI editing.

### **10. Enhanced Provider Participation Requirements**

DHHS is implementing a number of new federally mandated provider participation requirements. These included screening provider enrollment using three levels of screening

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protocols as mandated by federal law to assist in determining the risk of fraud, waste and abuse; suspending payments to providers when DHHS determines that there is a credible allegation of Medicaid fraud; terminating (or not enrolling) a provider who was terminated by another state's Medicaid program or by Medicare and; prohibiting Medicaid payments to entities outside the United States.

### **11. Program of All-Inclusive Care for the Elderly (PACE)**

One organization has taken steps to become a PACE provider in Nebraska and has indicated it will submit a PACE application to CMS in the fall of 2011. Following submission of the application, another 15 to 18 months will be required to launch an operational PACE program. In the meantime, DHHS has developed a proposed Medicaid payment rate to which the provider organization has agreed. Final steps in the process include executing a program agreement between CMS, DHHS, and the PACE organization and a thorough provider Readiness Review. The service area will be metro Omaha.

### **12. Behavioral Pharmacy Management Program**

The Behavioral Pharmacy Management (BPM) program shares the latest prescribing best practices for mental health drugs with Nebraska prescribers and, in turn, shapes the prescribing practices in Nebraska to more closely align with national evidence-based guidelines. The BPM evaluates behavioral health pharmacy claims and identifies prescribing patterns that are inconsistent with national, evidence-based guidelines. DHHS operates the program with assistance from the Nebraska Medical Association (NMA) and an independent vendor that contracts directly with state Medicaid agencies or other third party payers. Beginning July 2010, DHHS mailed educational materials to the top 100 prescribers who deviate from national prescribing guidelines, informing them when their patients failed to fill prescriptions in a timely fashion. BPM completed monthly mailings alternating between adult and child/adolescent populations through March 2011.

From the mailings, the program contacted thirty-three prescribers that were outside the evidence-based guidelines and offered a peer consult with a psychiatrist from NMA. Out of those thirty-three prescribers, sixteen peer consults were completed and seventeen attempts at contact were unsuccessful. Currently, Mercer, an independent third party, is analyzing the prescribing data and the findings will be available in late 2011.

### **13. Medical Home Project**

DHHS implemented the Medicaid Patient-Center Medical Home Pilot in February 2011, one year earlier than required in legislation. DHHS selected two practices to participate in the pilot: Kearney Clinic, Kearney (20 providers) and Plum Creek Medical Group, Lexington (10 providers). The average number of Medicaid clients in the pilot is 7,120. The practices receive a per-member-per-month (PMPM) payment with an option to meet advanced medical home standards and receive an additional reimbursement incentive. DHHS provides comprehensive technical assistance to transform into a medical home as well as funding for care coordination activities. The program will evaluate the pilot for improved health care access, improved health outcomes for patients, Medicaid cost containment, patient satisfaction, and provider satisfaction.

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## **G. SFY 2012 Projects**

This report highlights some of the major projects the Division will be working on this fiscal year:

### **1. At-Risk Managed Care for Physical Health (Budget Bill)**

DHHS will expand the physical health managed care program statewide effective July 1, 2012. This will affect all counties not already served by physical health managed care. Counties currently involved in physical health managed care are Cass, Dodge, Douglas, Gage, Lancaster, Otoe, Sarpy, Saunders, Seward, and Washington.

### **2. Client Copayments (LB 468)**

Additional client copayments will be required to include inpatient hospital admissions, durable medical equipment with payment greater than \$50, mental health substance abuse service visits, and brand name drugs. This change will be effective in October 2011. DHHS will submit a SPA to CMS prior to October 2011.

### **3. Nursing Facility Provider Tax (LB 600)**

DHHS is working together with providers to develop and implement a nursing facility provider tax in compliance with LB600. DHHS will use tax funds collected from licensed nursing facilities to leverage federal funds to pay enhanced Medicaid rates for nursing facility services. DHHS estimates that if approved by the CMS, Medicaid payment to nursing facilities for State Fiscal Year 2012 will increase by approximately \$19,000,000.

### **4. At-Risk Managed Care for Behavioral Health**

DHHS will move to an at-risk mental health and substance abuse managed care program statewide. The specific effective date in 2012/2013 will depend on the outcome of a corrective action plan submitted by the state to CMS in September, 2011. This at-risk managed care program is intended to include all services currently covered on the 2011 Fee Schedule under "Mental Health and Substance Abuse Services."

### **5. Durable Medical Equipment in Nursing Facilities**

DHHS received notice from CMS in May 2011 to submit a corrective action plan for payment of medical equipment and supplies for clients residing in nursing homes or ICF/MRs. In July 2011, DHHS submitted a plan for the transition of payment from Durable Medical Equipment (DME) providers to the facilities for these items. DHHS will develop new reimbursement methodology to comply with federal requirements. DHHS notified both DME providers and the facilities of these federal requirements, and DHHS will continue to communicate with these providers throughout the transition process.

### **6. ICD-10**

ICD-10 (International Classification of Diseases, 10<sup>th</sup> Revision) is a diagnostic coding system implemented by the World Health Organization (WHO) in 1992 to replace ICD-9, the coding system in use today. Almost every country in the world, except the United States, has already

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converted to ICD-10. DHHS must implement ICD-10 by October 1, 2013. This transition will require system and business changes throughout the health care industry. DHHS is currently in the planning stages for its own ICD-10 implementation and will begin outreach to providers and industry partners in the year ahead.

### **7. Payment Adjustment for Hospital Acquired Conditions**

Effective July 2011, federal legislation directs Medicaid to implement provisions for non-payment for any amounts expended for providing medical assistance for health care acquired conditions. This includes payment for conditions that are a result of avoidable inpatient hospital complications and medical errors that are identifiable, preventable, and serious in their consequences to patients. This means that Medicaid will identify as a hospital acquired condition (HAC), those secondary diagnosis codes that were not present on hospital admission. DHHS will submit a state plan to CMS prior to October 2011.

## **III. Conclusion**

DHHS continues to address the health care needs of eligible low-income Nebraska residents. The numbers of individuals that are Medicaid eligible have increased due to current economic conditions. At the same time, the programs and policies referenced in this Annual Report effectively moderate the growth of medical assistance expenditures. The policies outlined in this report slow the growth of the Medicaid program and further fiscal sustainability by making the program more efficient and cost effective through better management of services, better delivery of care, more appropriate services, and improved administration of the program.

The Department of Health and Human Services, Division of Medicaid and Long-Term Care looks forward to continuing to work with the Governor, the Legislature, and the Medicaid Reform Council to improve Medicaid for current and future generations.