A Healthy Nebraska

An Overview of Medicaid in the Cornhusker State

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Table of Contents

Introduction

Access to quality health care is a key element of "The Good Life" we live in Nebraska, as 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. As of August 2023, Medicaid and CHIP enabled 388,603 Nebraskans to receive health care coverage (CMS, 2023). Medicaid expansion, discussed in Chapter 4, provided health care coverage to an additional 72,000 individuals in its first two years (Foote, 2022).

Among the many services covered by Medicaid and CHIP are medical checkups and routine dental care for low-income children, quality nursing and end-of-life care for seniors and support services for Nebraskans with developmental disabilities. Medicaid and CHIP allow health care professionals in the state to provide and expand their services to Nebraskans seeking the care they need.

Medicaid and CHIP also play a major role in our state budget and fiscal debate. Nearly 40% of the state General Fund budget – or more than $1.9 billion – supports health and human services with nearly 20% – over $1 billion – 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 (Fiscal Office, 2023).

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.

Chapters 1 through 3 describe the Medicaid and CHIP programs and their eligibility requirements, the services provided by each and how the programs are funded. Chapter 4 discusses recent developments, including Medicaid expansion and changes to the program during the COVID-19 public health emergency. Chapter 5 addresses additional policy issues related to the administration of Nebraska's Medicaid and CHIP system.

It's 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 (Provost, 2000). In 1960, states began receiving open-ended matching payments from the federal government to pay for the care of low-income seniors, but significant differences persisted among states in the level of services provided to low-income Americans (Moore, 2005).

Medicaid was designed to eliminate these disparities among states while expanding federal support for health care services for low-income individuals and families that did not otherwise have access to mainstream health care (Rowland, 2000). The federal government covers at least half of the program's costs for states and sets certain requirements 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.

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).

(CMS, Glossary, n.d.)

Since 1997, 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 and 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 sizable 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 accounted for about one-fifth of Nebraska's FY23 General Fund appropriations (Fiscal Office, 2023)
- Medicaid enrollees access health care at similar rates to privately insured people and at a much higher rate than uninsured people (Paradise, 2017)
- Medicaid and CHIP help thousands of Nebraskans — providing health care coverage for 182,000 children, about 36,000 blind and disabled individuals and nearly 20,000 seniors (DHHS, Medicaid Report, 2022)
- More than 107,000 adults age 19-64 (including those who qualify under Medicaid expansion) received Medicaid coverage in recent years (DHHS, Medicaid Report, 2022)
- Most individuals enrolled in Medicaid or CHIP are children, the least costly population to cover through these programs (DHHS, Medicaid Report, 2022)
- Nearly 55,000 health care providers across the state offer services to Medicaid and CHIP enrollees (DHHS, Medicaid Report, 2022)

Chapter 2: Eligibility and Enrollment

Medicaid has limits on who may participate, 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, 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 (Musumeci, 2014). Implemented by the Affordable Care Act, MAGI applies 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. The MAGI method doesn't have a financial 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 (CMS, Income Eligibility, n.d.).

Some groups, known as "Non-MAGI" in the regulations, 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) (Rupp, 2016).

Outside of emergency services, Medicaid beneficiaries must also be residents of the state in which they live and be either United States citizens or meet certain immigration status requirements (MACPAC, 2017). States must provide Medicaid coverage to refugees, those seeking political asylum and other individuals involved in humanitarian crises once they enter the United States (MACPAC, 2017). Nebraska also covers certain qualified immigrants, such as legal permanent residents, if they otherwise meet eligibility requirements and have been in the U.S. for at least five years. Some groups of immigrants, including pregnant women and children, are exempt from this waiting period (DHHS, Eligibility, n.d.).

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

Children

In Nebraska, children under 19 are eligible for Medicaid or CHIP if their family income is below 213% of the Federal Poverty Level (FPL), or $63,900 for a family of four in 2023 (DHHS, Income Levels, 2023). Because coverage under each program is identical, with enrollment generally dependent on age and income, families may not know in which program – Medicaid or CHIP – 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. CHIP reimbursements have historically ranged from 65% to 81%, compared to 50% to 73% for children in Medicaid (MACPAC, CHIP, n.d.).

Children are eligible for Medicaid if they are 19 or under and have family incomes at or below 133% of FPL, or $39,900 for a family of four in 2023 (DHHS, Eligibility, n.d.). States can expand this coverage by increasing income thresholds or by establishing a separate CHIP program. Nebraska uses a combination of the two (NASHP, 2019).

Each program is subject to slightly different rules.

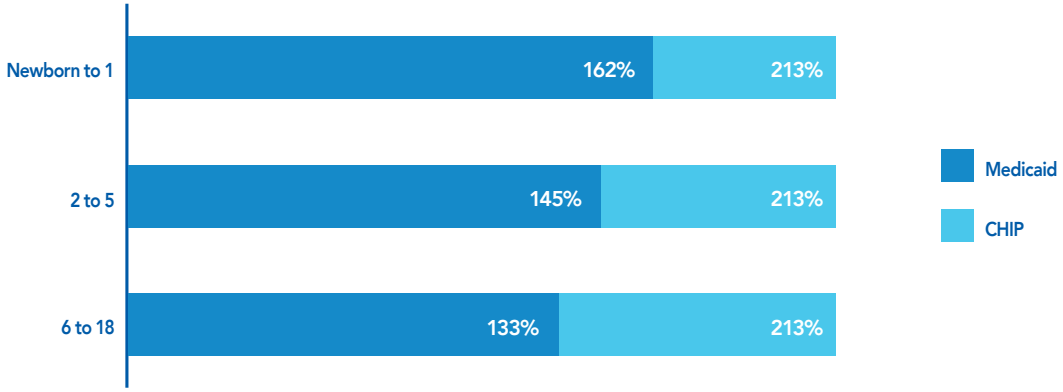
Medicaid – Newborns – if they are born to a Medicaid-eligible pregnant woman at the time of birth – can receive Medicaid up to one year postpartum (DHHS, Title 477, n.d.). Children under age 1 are eligible in Nebraska if their family income is 162% of FPL or less; Children from ages 1 to 5 are eligible if their family income is 145% of FPL or less; children ages 6 to 18 are eligible if their family income is 133% of FPL or less. (DHHS, Eligibility, n.d.).

CHIP – Children under age 19 whose family income exceeds the Medicaid income limits for their age group are eligible for CHIP in Nebraska if their family income is 213% of FPL or less (DHHS, Eligibility, n.d.) and they aren't covered by creditable health insurance (DHHS, Title 477, n.d.).

Separate CHIP Program (599 CHIP) – Women and their unborn children who don't otherwise meet any Medicaid eligibility criteria are eligible for coverage of prenatal and delivery services if their family income is 197% of FPL or less (DHHS, Eligibility, n.d.).

As of 2022, 28 states and the District of Columbia cover children from families with incomes higher than those Nebraska covers (Moreno, 2022).

Figure 1: Medicaid and CHIP Income Limits by Child Age



Source: DHHS, Eligibility, n.d.

Children in foster care can become eligible for Medicaid through the federal Title IV-E Foster Care Program (NACAC, n.d.). Eligibility, however, is tied to a federal program that was ended in 1996 and income limits haven't been adjusted since then, so Nebraska can only receive federal funds for care provided if a child is taken into care from a family making less than $673 a month (KFF, 2019). Because of this low income threshold, eligibility has been declining. Those in the child welfare system who are not eligible for Title IV-E may still be eligible for Medicaid based on their own income if they're expected to be in out-of-home placement for more than 90 days (NACAC, n.d.). In addition, any youth who is in foster care at age 18, 19 or 21 and receiving Medicaid when they "aged out" should be eligible for Medicaid coverage up to age 26 regardless of income (MACPAC, 2017).

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

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" (DHHS, Title 477, n.d.). 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. 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 (SSA, n.d.). While SSI eligibility is limited to those earning up to approximately 73% of FPL, Nebraska has expanded coverage to those earning up to 100% of FPL (Musumeci, 2019).

Workers with Disabilities – Nebraska covers 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 FPL. Disabled workers who earn up to 200% of FPL don't have to pay a premium (DHHS, Disabilities, n.d.).

Seniors

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

Fully Dual Eligible – Seniors who qualify for SSI are also eligible for full Medicaid benefits. Nebraska provides coverage for those with incomes up to 100% of FPL if their resources don't exceed the limits prescribed for SSI eligibility and covers seniors through Medicaid instead of Medicare (MACPAC, 2023).

Medicare Savings Program – Seniors with incomes too high to qualify for full Medicaid eligibility – more than 100% of 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 (CMS, Medicare Savings, n.d.):

> *Specified Low-income Medicare Beneficiary (SLMB)* – This program is available to seniors with incomes between 100% and 120% of FPL (MACPAC, 2017). Resource limits are $4,000 per individual and $6,000 per married couple (CMS, Part B, n.d.). 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 (CMS, Part B, n.d.).
>
> *Qualifying Individual* – This program is available to seniors with incomes between 120% and 135% of FPL and helps qualified individuals with their Medicare Part B premiums (CMS, Part B, n.d.).

Other Adults

Low-Wage Adults – Discussed later, Nebraska implemented Medicaid expansion in 2020 to cover all adults aged 19 to 64 with incomes below 133% of FPL, or $39,900 for a family of four in 2023 (DHHS, Eligibility, n.d.).

Pregnant Women – Federal law requires state Medicaid programs to cover eligible women during pregnancy and for 60 days postpartum. Prior to April 2022, states could use their own funding or a section 1115 waiver to extend coverage for up to 12 months postpartum, but beginning in April 2022, states had the option to make this extension and receive federal funding through a state plan amendment (KFF, Postpartum, 2023). The Nebraska Legislature voted to extend coverage to six months during the 2023 legislative session (LB 227, 2023). Guidance from the Pillen administration subsequently clarified that Nebraska's state plan will be amended to extend coverage to 12 months beginning January 1, 2024 (Stoddard, Moms, 2023).

> ***State Plan Amendments (SPA)**: An agreement between a state and the federal Centers for Medicare and Medicaid Services (CMS) that outlines how that state administers its Medicaid and CHIP program. In order for any change to be implemented, the state must submit a SPA to CMS for review and approval.*

Other Categories of Eligibility

Transitional Medical Assistance – Caretakers of incapacitated individuals can also access Medicaid for a limited time if they lose coverage due to an increase in income. Eligibility can last six months regardless of income and an additional six months if income is at or below 185% of FPL. Some families with incomes at or above 100% of FPL may have to pay a premium (DHHS, 2016).

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 (MACPAC, 2017).

Coverage for Specific Ailments and Services – Nebraska has expanded coverage to women with incomes up to 225% of FPL who are screened through a Centers for Disease Control and Prevention program and diagnosed with breast or cervical cancer (MACPAC, 2017). Incomes are determined by the screening program's criteria and not MAGI (DHHS, 2016). States may also cover family planning services up to certain income levels, although Nebraska does not (MACPAC, 2017).

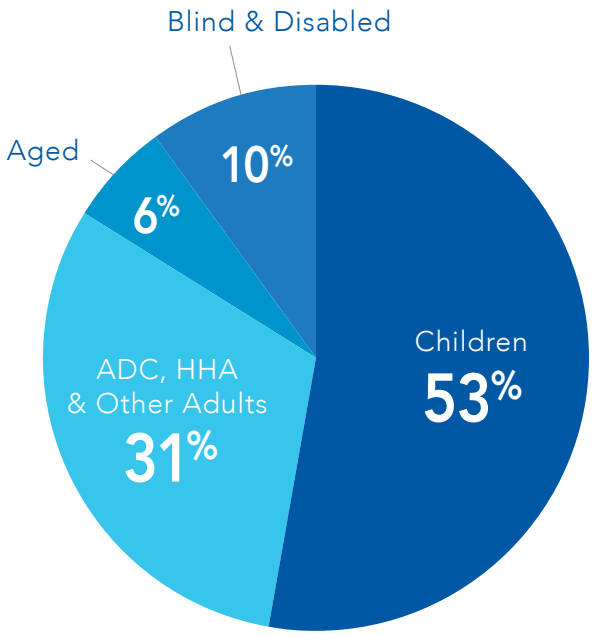
Emergency Medical Services Assistance – States must cover emergency medical services for certain individuals if they would have otherwise qualified but for their immigration status (MACPAC, 2017).

Who Enrolls?

Medicaid and CHIP enrollment in Nebraska averaged 344,714 people a month, or approximately 18% of the state's population, from July 2021 through June 2022 (DHHS, Medicaid Report, 2022).

Figure 2 details the breakdown of enrollment in both Medicaid and CHIP for each of the major enrollee populations in FY22, which ran from July 1, 2021 to June 30, 2022 (DHHS, Medicaid Report, 2022).

Figure 2: Nebraska Medicaid and CHIP Enrollees by Group (FY22)



* ADC - Aid to Dependent Children (representing caretakers covered by Medicaid), HHA - Heritage Health Adult (adults covered by Medicaid expansion)

Source: DHHS, Medicaid Report, 2022

Chapter 3: Spending and Financing

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 (MACPAC, Other Payers, n.d.).

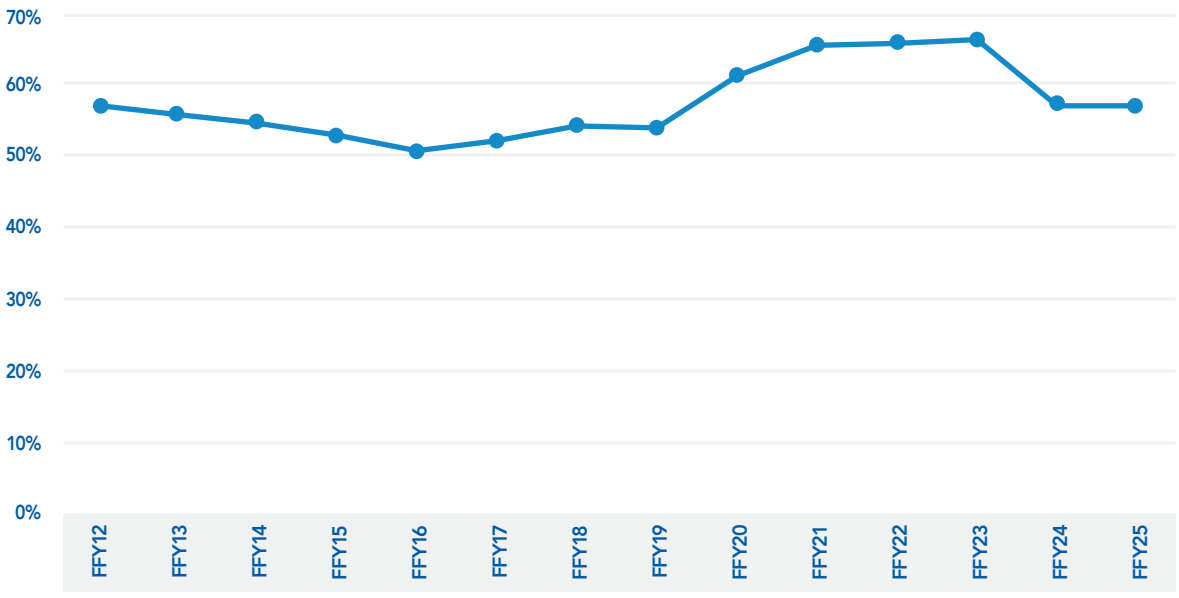
Federal-State Funding Partnership

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. Nebraska's FMAP will be 58.6% in Federal FY24 beginning October 1, 2023, which means the federal government will reimburse the state 58.6% of the costs of most Medicaid beneficiaries. As such, the state will receive $1.42 from the federal government for every $1 it spends on Medicaid (KFF, FMAP, n.d.).

Each state's FMAP differs based on its economic well-being relative to a national average. 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 from state funds. An FMAP must be between 50% and 83% – meaning a state will be reimbursed at least half its costs per Medicaid beneficiary (MACPAC, Matching Rates, n.d.). Figure 3 shows Nebraska's FMAP over time. The federal government provided an emergency 6.2% increase to the FMAP from 2020 to 2023 in all states to help with increased Medicaid enrollment and costs during the COVID-19 pandemic (KFF, FMAP, n.d.).

Figure 3: Nebraska's Federal Medical Assistance Percentage (FMAP)



Note: This figure contains the enhanced FMAP added due to the public health emergency
Source: KFF, FMAP, n.d.

State Funding

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

State funds largely come from appropriations made by the Legislature out of the General Fund. Appropriations to Nebraska's Medicaid program grew an average of 6.5% annually from State FY10 to State FY23, according to an OpenSky analysis of the state's biennial budgets.

CHIP uses an enhanced FMAP that's determined by increasing the federal share of reimbursement for Medicaid by approximately 15% (CMS, CHIP, n.d.). In Federal FY24, the enhanced FMAP for CHIP in Nebraska will be 71.02% (KFF, Enhanced FMAP, n.d.).

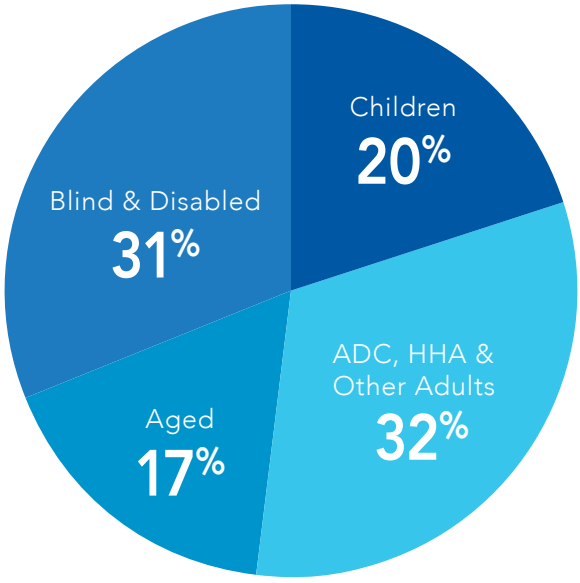
State CHIP funding began in 1998 with a one-time transfer of $25 million from the Health Care Cash Fund. The Health Care Cash Fund was established in 1998 using interest earned on the Tobacco Settlement Cash Fund, which consists of any settlement payments or other revenue obtained from state lawsuits against tobacco companies, and the Health Care Trust Fund, which consists of funds obtained by recapturing a portion of federal Medicaid dollars going to publicly owned nursing homes (Fiscal Office, 2003).

When CHIP's initial $25 million was spent down in FY04, the program began to receive an annual $5 million transfer from the Health Care Cash Fund, with additional state obligations coming from the General Fund (Fiscal Office, 2003).

Spending and Enrollment by Enrollee Group

Children represented 53% of Medicaid and CHIP enrollees in State FY22 but accounted for 20% of spending, as shown in Figure 4. Conversely, blind and disabled enrollees represented 10% of the total but accounted for 31% of spending (DHHS, Medicaid Report, 2022).

Figure 4: Nebraska Medicaid and CHIP Spending by Enrollee Group (FY22)



* ADC - Aid to Dependent Children (representing caretakers covered by Medicaid), HHA - Heritage Health Adult (adults covered by Medicaid expansion)

Source: DHHS, Medicaid Report, 2022

In 2019, the most recent year for which there is disaggregated data, Nebraska ranked 20th among all states in spending per enrollee across all enrollment groups; however its rankings swing among the groups (KFF, Enrollee Spending, n.d.).

Table 1: Nebraska's Per Capita Spending by Enrollee Group (2019)

ENROLLMENT GROUP	STATE RANKING (MOST TO LEAST)
Aged (65 and over)	9th
Blind and disabled	34th
Adults (19-64)	12th
Children (up to 18)	15th

Source: KFF, Enrollee Spending, n.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 in Nebraska rose about 16% from State FY21 to State FY22, going from $62 million to nearly $72 million (DHHS, Medicaid Report, 2022).

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 increased 8% from State FY21 to State FY22, increasing to about $61 million from $57 million (DHHS, Medicaid Report, 2022).

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

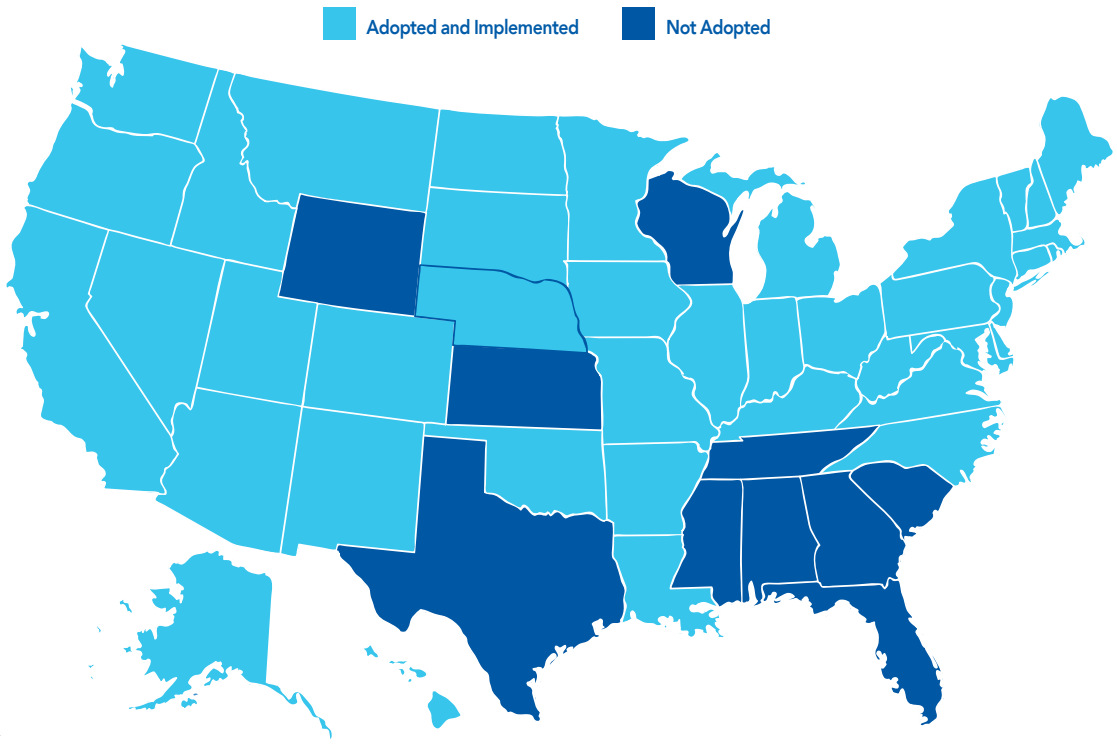
Chapter 4: Recent Developments

Nebraska's Medicaid program has undergone a number of significant policy changes in recent years, including voter-approved Medicaid expansion, the COVID-19 public health emergency that paused eligibility reviews and the resumption of those reviews in 2023.

Medicaid Expansion

The Affordable Care Act of 2010 allowed states to voluntarily expand Medicaid to adults ages 18 to 64 with incomes at or below 138% of FPL, which is $41,400 for a family of four or $20,120 for a single individual in 2023. Medicaid has also included an enhanced FMAP for expanded populations to provide a financial incentive for states to expand their Medicaid programs. To date, 40 states, including Nebraska, have adopted and implemented this policy (KFF, Expansion, 2023).

Figure 5: State Action on Medicaid Expansion



Source: KFF, Expansion, 2023

In Nebraska, at least half a dozen bills to expand Medicaid were introduced in the Legislature without success between 2013 and 2017. In 2018, Medicaid expansion went before voters through a ballot initiative, and 53% of Nebraska voters approved it (Health Insurance Organization, n.d.).

Expansion, however, was not implemented by the Nebraska Department of Health and Human Services (DHHS) until 2020 as policymakers sought a waiver to impose work requirements on the newly eligible population and create a tiered benefit structure to support compliance (Health Insurance Organization, n.d.). These requirements were only in place for one year as the federal CMS instructed DHHS in Nebraska to remove them in August 2021. All eligible adults in Nebraska could be enrolled with full coverage starting in October 2021 (KFF, Waiver, 2023). As of August 2022, 72,000 additional individuals had received coverage as a result of Medicaid expansion (Foote, 2022).

Public Health Emergency

Beginning in January 2020, the United States faced an unprecedented public health challenge with the advent of the COVID-19 pandemic. As a result, states of emergency were called on both the state and federal level early in 2020 (NASHP, 2023). The federal declaration expanded both Medicaid eligibility and the range of services covered to protect Americans from the risks of COVID-19. During the public health emergency, Nebraska expanded covered services (such as telehealth services) and made provider requirements more flexible (DHHS, Emergency, n.d.).

The 2020 Families First Coronavirus Response Act provided funding for states to receive an increased FMAP that would enable them to maintain continuous coverage of Medicaid participants during the public health emergency (Williams, 2023). Nebraska's FMAP increased from 52.58% in Federal FY19 to 60.92% in Federal FY20 (KFF, FMAP, n.d.). This increased federal funding ensured that Medicaid participants would not be disenrolled during the pandemic. Between Federal FY20 and Federal FY22, average monthly enrollment in Medicaid and CHIP in Nebraska grew from 243,000 to nearly 345,000 (DHHS, Medicaid Report, 2020 & 2022).

> ***Continuous Coverage**: During the public health emergency, states could opt to provide ongoing, uninterrupted Medicaid services, meaning enrollees didn't have to recertify their coverage every year (CMS, 2021).*

Unwinding

"Unwinding" refers to states going back to conducting annual eligibility reviews for Medicaid participants. Continuous coverage was initially set to end with the close of the public health emergency, but a Congressional spending bill in 2022 unlinked the two and ended the continuous coverage requirement on March 31, 2023. The public health emergency was lifted on May 11, 2023 (CBPP, 2023).

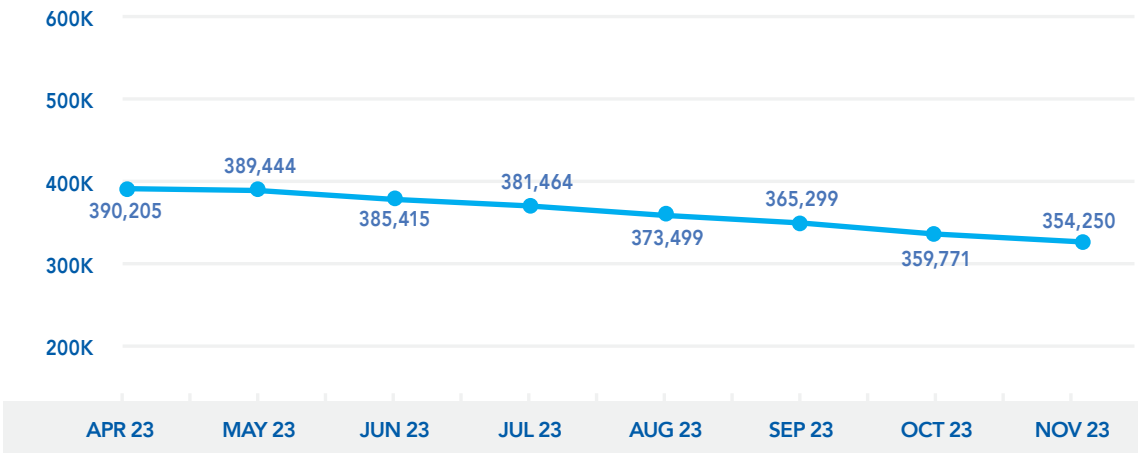
Guidance from the CMS gives states 12 months to conduct reviews and renew eligibility for Medicaid participants, with substantial latitude for states in how they conduct those reviews (CBPP, 2023). Nebraska began to reevaluate enrollees' eligibility in March 2023 (DHHS, Unwind Resources, 2023).

As part of the unwinding, the 6.2% FMAP increase the state received during the public health emergency will be reduced incrementally through the end of 2023, decreasing to 5% on April 1, 2.5% on July 1 and 1.5% on October 1, before expiring on January 1, 2024 (DHHS, Maintenance of Eligibility, 2023).

The unwinding process will continue into 2024, and DHHS estimates 40,000 to 80,000 current Medicaid participants in Nebraska will no longer be eligible for Medicaid once it's completed (DHHS, Maintenance of Eligibility, 2023). Medicaid enrollment declined from 390,205 participants in April 2023 to 354,250 participants in November 2023 (DHHS, Unwind Dashboard, 2023).

Individuals found to no longer be eligible for Medicaid due to changes in life circumstances, income or employment changes may be eligible to seek health coverage through the federal marketplace established under the Affordable Care Act. A significant challenge of the unwinding process is that DHHS in Nebraska, along with Medicaid agencies in other states, must establish or reestablish contact with Medicaid participants who may not have interacted with that agency for more than two years, leading to individuals being disenrolled due to administrative concerns rather than changes in eligibility (CBPP, 2023).

Figure 6: Nebraska's Medicaid Enrollment during Unwinding



Source: DHHS, Unwind Dashboard, 2023

Chapter 5: Other Related Policy Issues

A considerable portion of the state budget goes toward funding Medicaid and CHIP, and policy decisions at the state level have implications not only on state spending but also for health care providers and those Nebraskans receiving those services.

Adoption of Managed Care

Over the past couple of decades, Medicaid in Nebraska has transitioned from being administered on a fee-for-service basis to a managed care system. Across the country, 40 other states operate their Medicaid systems in a similar manner (Hinton, 2023).

In a fee-for-service system, states pay Medicaid providers for each covered service provided (MACPAC, Provider payment, n.d.). Under a managed care system, the state contracts with private insurance companies to manage the provision of most covered services, with Medicaid paying a monthly amount for each enrollee to cover service and administration costs (DHHS, 2017). Managed care programs are intended to increase budget predictability and aim to reduce long-term costs by encouraging preventive care and managing patients' chronic conditions to prevent costly hospitalizations (Hinton, 2023).

In 1997, the Managed Care Patient Protection Act established requirements for insurance carriers offering managed care plans in Nebraska and health care providers. The state expanded services provided under managed care statewide in 2012 and established Heritage Health, the integrated managed care program for Medicaid in Nebraska, in 2015 (DHHS, History, 2022).

Under Heritage Health, Nebraska DHHS awards contracts to private managed care providers through a procurement process. Beginning in 2024, Nebraska Total Care, United Healthcare and Molina Healthcare will be responsible for managing physical and behavioral health care, pharmacy services and dental benefits for Medicaid patients. Each contract is worth up to $4.25 billion over five years (Stoddard, Contract, 2023).

One of the current managed care providers, Community Care Plan of Nebraska, filed suit after the new contracts were announced, alleging Nebraska Total Care should have been disqualified for not disclosing state investigations into overcharging for prescription benefits. Centene, the parent company of Nebraska Total Care, paid nearly $1 billion nationally to settle concerns, including a $29.3 million settlement with the state of Nebraska in 2021 (Stoddard, Contract, 2023).

Provider Reimbursement Rates

The private managed care administrators negotiate reimbursement rates with providers in their respective networks. Additionally, care providers for Nebraska Medicaid enrollees are reimbursed at different rates for certain services (DHHS, Medicaid Report, 2022).

For health care providers, rising health care costs linked to inflation and workforce shortages have put pressure on provider rates. Medicaid reimbursement rates have failed to keep up with hospital costs in Nebraska, rising only 6.1% over two years compared to a 27.4% increase in accrued hospital costs (Connell, 2023).

Increasing Medicaid reimbursement rates not only helps existing Medicaid providers but encourages additional providers to accept Medicaid, expanding health care access in Nebraska (NBER, 2019).

Any changes to these reimbursement rates impact the state budget. In 2023, the Legislature approved Medicaid provider rate increases of 3% in FY24 and 2% in FY25. However, the governor vetoed the FY25 increase (Center For Rural Affairs, 2023).

Table 2: Recent History of Provider Rates in Nebraska

FY12	Provider rates increased 1.54%
FY13 & FY14	Provider rates increased up to 2.25%, capped at 100% of Medicare rates
FY15, FY16 & FY17	Provider rates increased up to 2.25%, capped at 100% of Medicare rates for some services. Other Medicaid provider rates increased up to 2%, capped at 100% of Medicare rates
FY18 & FY19	No changes
FY20 & FY21	Provider rates increased by 2%, with an additional 2% increase for Behavioral Health services. Nursing facilities received an additional appropriation of $21.25 million in FY20 and $14.45 million in FY21
FY22	Provider rates increased by 2%. Nursing facilities received an additional appropriation of $12.28 million

Source: DHHS, Medicaid Report, 2020 & 2022

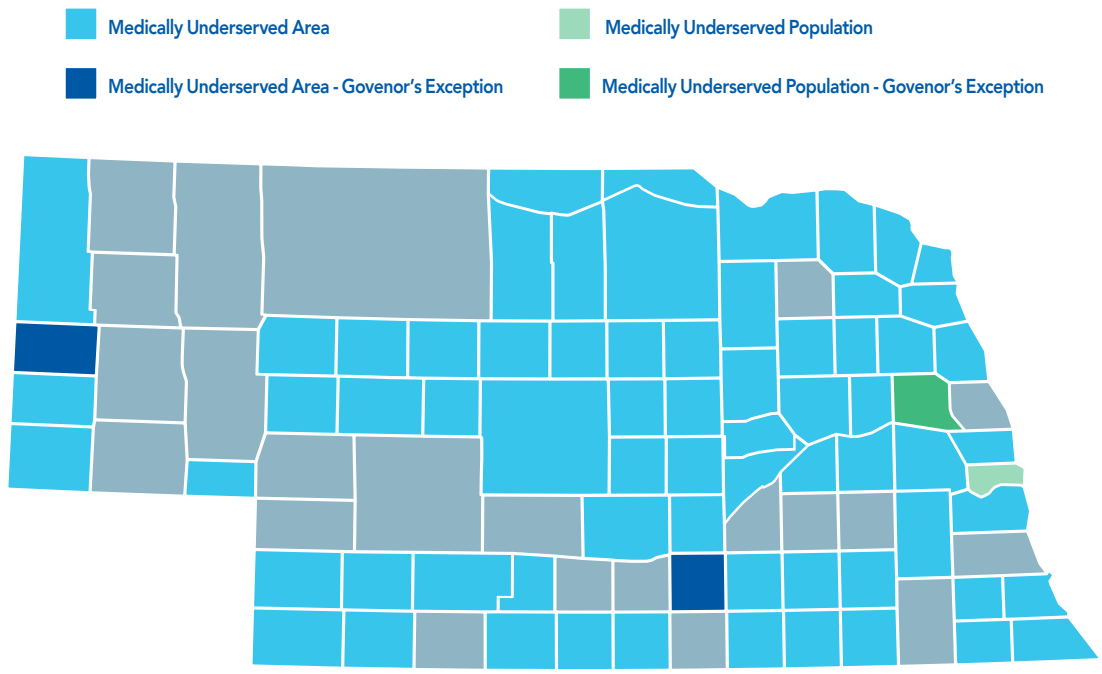
Access to Care Issues

Nebraska, like other rural states, is experiencing a shortage of health care professionals, and some residents of the state face barriers to accessing timely and affordable care (UNMC, 2020).

Medically Underserved Areas (MUAs) are geographic areas with a shortage of primary care services designated as having too few primary care providers and levels of high infant mortality, high poverty and more older residents. Nearly three-fourths of Nebraska is considered a Medically Underserved Area as of September 2023, according to the Health Resources & Services Administration (HRSA).

Medically Underserved Populations (MUPs) are sub-groups of a geographic area's population that struggle to access care based on economic, cultural or linguistic factors. Those with a "governor's exception" are acknowledged as a known area for low service provision or lack of available resources to attain services (HRSA, n.d.).

Figure 7: Federal Primary Care Shortage Designation by County



Source: OpenSky analysis of Health Resources & Services Administration data

Rural areas of Nebraska are generally where the provider shortage is most pronounced, as those areas have both slightly more poverty (10.7%), on average, than urban areas (9.0%) and more seniors (Rural Health Information Hub, 2023).

Nebraska 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 Center for Health Policy at the University of Nebraska Medical Center has issued several recommendations for sustaining rural access to care. They include expanding existing programs to incentivize health care professionals to practice in rural areas of the state, increasing investment in technologies that support telehealth services, annual reporting on the state's health care workforce and regular forecasting changes to demographics and care needs (UNMC, 2020).

In 2023, five to seven rural hospitals in Nebraska were operating at a deficit and struggling to remain open amid double-digit percentage increases in costs of labor and supplies (Stoddard, Rural Care, 2023).

Conclusion

A flourishing state relies on the well-being of its people. Nebraskans need access to excellent health care in order to maintain strong homes, workplaces, schools and communities. But ensuring they have access to affordable, quality care is a complex challenge for policymakers, who must balance the state's health care needs with other priorities like education and public safety.

Medicaid in Nebraska has undergone a number of changes in recent years, including significant increases in enrollment and expenditures. Voter-approved expansion enabled a new demographic to become eligible for benefits, improving access to care for tens of thousands of Nebraskans. With eligibility reviews suspended through spring 2023, enrollment grew steadily through the COVID-19 public health emergency.

Challenges loom, however, as inflationary factors and a prolonged shortage of health care workers, particularly in rural areas of Nebraska, threaten the availability of needed care for many residents. Will state revenues be able to keep up with a growing demand for health care and investments in health care services? If not, what vital state services will need to be cut so more funding can be redirected to 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, and 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. Ensuring everyone in the state can access the health care they need to work, raise families and enjoy retirement commands resources but is also the heartbeat to a thriving state.

Appendix

Services Covered Under Medicaid in Nebraska

The federal government requires states to cover certain services, while other services are optional (MACPAC, 2017). When implementing its program in 1966, Nebraska chose to cover all services designated as optional by the federal government (MACPAC, Benefits, n.d.).

The following table shows various services available to Nebraska Medicaid recipients within certain guidelines.

Table: Services Provided by Medicaid

MANDATORY SERVICES	OPTIONAL SERVICES
Inpatient and outpatient hospital services	Prescribed drugs
Laboratory and x-ray services	Intermediate care facilities for the disabled (ICF/DD)
Nursing facility services	Home and community based services (HCBS)
Home health services	Dental services
Nursing services	Rehabilitation services
Clinic services	Personal care services
Physician services	Durable medical equipment
Medical and surgical services of a dentist	Medical transportation services
Nurse practitioner services	Vision-related services
Nurse midwife services	Speech therapy services
Pregnancy-related services	Physical therapy services
Medical supplies	Chiropractic services
Mental health and substance abuse services	Occupational therapy services
Early and periodic screening and diagnostic treatment (EPSDT) for children	Optometric services
	Podiatric services
	Hospice services
	Hearing screening services for newborn and infant children
	School-based administrative expenses

Source: DHHS, Medicaid Report, 2022

Waivers

Medicaid waivers allow states to 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, while providing services not typically covered and experimenting with service delivery systems. States apply to the federal government to waive Medicaid program requirements (MACPAC, Waivers, n.d.).

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, or 1915(c) waivers, are administered by Nebraska DHHS (DHHS, HCBS Waiver, 2023).

To qualify for federal funding, a Home and Community Based Services program 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 (DHHS, HCBS Waiver, 2023).

Home and Community Based Services include waivers for seniors and the disabled, children with a developmental disability and their families, those suffering from traumatic brain injuries, adults with intellectual or developmental disabilities who need community support and day services, and children with autism and their families (DHHS, HCBS Waiver, 2023).

Section 1115 waivers, which are connected to the Social Security Act, allow the federal Department of Health and Human Services to approve experimental or pilot programs (CMS, Eligibility, n.d.). Beginning in 2020, Nebraska used this waiver to expand coverage to include residential substance abuse treatment beyond 15 days, as well as opioid and medically monitored drug withdrawal treatments (DHHS, Substance Use, 2022).

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