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DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

Public Notice of Nebraska Medicaid Section 1115 Heritage Health Adult Expansion Demonstration

Improving Health Outcomes and Encouraging Life Successes for Adult Medicaid Beneficiaries.

October 25, 2019

In November 2018, Nebraska voters approved Initiative 427, electing the federal option to provide Medicaid coverage to otherwise ineligible adults up to 138% of the federal poverty level under the Patient Protection and Affordable Care Act (ACA). The Nebraska Department of Health and Human Services Division of Medicaid and Long-Term Care (MLTC) administers the Nebraska Medicaid program and is responsible for the implementation of this adult Medicaid expansion project.

MLTC is providing a public notice of its intent to: (1) request, on or before December 20, 2019, approval of a Section 1115 demonstration project from the Centers for Medicare & Medicaid Services that will implement Medicaid expansion through a program that will be known as "Heritage Health Adult"; (2) hold public hearings to receive comments on the Section 1115 demonstration application.

This Section 1115 demonstration project will:

- Implement Medicaid expansion through a tiered benefit package designed to improve health outcomes and encourage life successes using wellness initiatives, personal responsibility requirements, and community engagement activities. This program will be known as "Heritage Health Adult" ("HHA");
- Encourage timely enrollment and promote increased continuity of care through waiver of retroactive eligibility for most adult Medicaid enrollees in Nebraska; and
- Through a future amendment to the demonstration, facilitate and encourage more widespread enrollment in private health insurance.
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MLTC seeks public comment and input on its proposed demonstration project application.

1 PROGRAM DESCRIPTION

Under the proposed demonstration application, the HHA beneficiaries will be enrolled in managed care plans through MLTC's existing Heritage Health program. Unlike existing Medicaid-eligible individuals, HHA adults will have a tiered benefit system through which all eligible HHA beneficiaries will receive either the "Basic" benefits

package or the “Prime” benefits package. The Basic benefits package includes comprehensive medical, behavioral health, and prescription drug coverage. The Prime benefits package is the Basic package plus vision, dental, and over-the-counter medication. All beneficiaries newly eligible for Medicaid under the HHA program will receive the Basic benefits package for the initial six-month benefit tier period.

HHA beneficiaries will receive the Prime benefits package if:

- They are medically frail; or
- They are age 19 or 20; or
- They are a pregnant woman eligible under expansion; or
- They engage in wellness initiatives and personal responsibility activities and, beginning in Demonstration Year (DY) 2, they participate in certain community engagement activities.

HHA beneficiaries who do not engage in these activities will not lose eligibility for HHA, but will be enrolled in the Basic benefits package. After a beneficiary’s initial six month benefit tier period, the beneficiary will be evaluated for Prime benefits assignment during subsequent six month benefit tier reviews.

The draft application also requests waiver authority to waive retroactive coverage requirements for newly enrolled individuals, with the exception of pregnant women; children age 0-18; beneficiaries dually-enrolled in Medicare and Medicaid; and recipients who are residing in a nursing facility. To allow for consistency with the commercial market and federal Marketplace policies, coverage and benefits will begin on the first day of the application month.

MLTC proposes that the demonstration operate statewide for five years, from October 1, 2020 through September 30, 2025.

2 GOALS AND OBJECTIVES

The goals of the HHA Demonstration are as follows:

- Goal #1: Improve the health of the HHA population through beneficiary engagement
- Goal #2: Improve HHA beneficiaries’ patient self-management through beneficiary engagement
- Goal #3: Reduce inappropriate or unnecessary costs in the HHA population through beneficiary engagement
- Goal #4: Improve the provider and beneficiary experience of care through beneficiary engagement

MLTC will work with an outside evaluator to develop a plan to evaluate the following hypotheses:

Hypothesis	Method	Measure
HHA beneficiary engagement in the wellness initiatives will improve health outcomes	Correlation between health outcome data and wellness initiatives	• ED Utilization • AHV • Inpatient rates • HEDIS metrics • State and national survey data
HHA beneficiaries participating in community engagement activities will have higher average income compared to non-participating beneficiaries	Correlation between average financial income and community engagement activities	• Beneficiary financial data • Labor hours • Job seeking hours • Volunteer hours

		• Education hours • CD program
HHA beneficiaries participating in community engagement activities have a higher percentage of ceasing Medicaid compared to those non participating beneficiaries	Compare participating and non-participating beneficiary groups remaining or ceasing Medicaid	• HHA enrollment data • Enrollee survey data • State and national survey data • Labor hours • Job seeking hours • Volunteer hours • Education hours • CD program
HHA beneficiaries participating in community engagement activities will have improved health outcomes, compared to non-participating beneficiaries	Correlation between health outcome data and community engagement initiatives	• ED Utilization • AHV • Inpatient rates • HEDIS metrics • State and national survey data
Waiving retroactive eligibility for certain adult groups will improve enrollment continuity	Medicaid enrollment data	• HHA enrollment data • Retroactive eligibility data • Presumptive eligibility data • State and national survey data
Waiving retroactive eligibility for certain adult groups will increase enrollment of eligible people when they are healthy relative to those eligible people who have the option of retroactive eligibility	Correlation between health outcome data and retroactive eligibility status	• HHA enrollment data • Retroactive eligibility data
Health outcomes will be better for those subject to retroactive eligibility waivers compared to other Medicaid beneficiaries who have access to retroactive eligibility	Correlation between health outcome data and retroactive eligibility status	• Claim and Utilization Data
Elimination of retroactive coverage eligibility will not have adverse financial impacts on consumers	Correlation between average financial status and retroactive eligibility status	• Beneficiary financial data • State and national survey data • HHA enrollment data

3 ELIGIBILITY

The proposed demonstration would impact the ACA adult expansion group as described in 42 CFR 435.119 and other adult Medicaid beneficiaries with the exception of pregnant women, those dually-eligible for Medicare and Medicaid, and individuals residing in a nursing facility.

- Adult expansion beneficiaries will be subject to 1) the tiered benefits structure based on participation with beneficiary engagement activities; and 2) the retroactive Medicaid enrollment limit.
- Non-expansion adult beneficiaries not otherwise exempted will be subject to the retroactive Medicaid enrollment limit.

3.1 Projected Demonstration Enrollment

Table 1 presents estimated member month and average beneficiary counts for the non-expansion adults subject to the retroactive Medicaid enrollment limit and adult expansion group subject to the retroactive and benefit tier demonstrations proposals.

Table 1 -- Estimated Expansion Adult and Non-Expansion Adult Groups

	Demonstration Year (DY)				
	DY1 (10/1/2020 to 9/30/2021)	**DY2 (10/1/2021 to 9/30/2022)**	**DY3 (10/1/2022 to 9/30/2023)**	**DY4 (10/1/2023 to 9/30/2024)**	**DY5 (10/1/2024 to 9/30/2025)**
Non-Expansion Group					
Total Member Months	491,572	496,487	501,452	506,467	511,532
Average Number of Beneficiaries	64,396	65,040	65,691	66,347	67,011
Expansion Adult Group					
Total Member Months	484,634	760,177	832,990	841,325	849,745
Average Number of Beneficiaries	58,250	84,172	84,762	85,355	85,952

4 BENEFITS AND COST-SHARING

4.1 Description of Basic and Prime Benefits

In accordance with Section 1902(i)(26) of the Social Security Act and 42 C.F.R. § 440.305, the benefits provided to most individuals eligible in the expansion adult group will be through Alternative Benefit Plans. Both the Basic benefits package and the Prime benefits package will meet federal Alternative Benefit Plan (ABP) requirements, which will be implemented through a State Plan Amendment (SPA). MLTC does not propose to provide benefits or services different from those described in the State Plan, as specified in the ABP SPA, in respect to the amounts, duration or scope of those benefits or services.

The *Nebraska Basic Alternative Benefit Plan* will provide benefits equivalent to the current state plan with the exception of dental services, vision services, and over-the-counter medications. The *Nebraska Prime Alternative Benefit Plan* will provide benefits equivalent to the current state plan, including dental services, vision services, and over-the-counter medications.

Non-exempt adult expansion beneficiaries will be assigned to the Prime benefits package or the Basic benefits package based on their participation with the beneficiary engagement activities. Beneficiaries who do not engage in these activities will not lose eligibility for Medicaid, but will be enrolled in the Basic benefits package. After a beneficiary's initial six month benefit tier period, the beneficiary will be evaluated for Prime benefits assignment during subsequent six month benefit tier reviews.

4.2 Cost Sharing

The demonstration waiver does not propose to change Nebraska's cost-sharing requirements or exemptions. Cost sharing for the populations impacted in this application will be the same as those in the current state plan.

5 BENEFICIARY ENGAGEMENT REQUIREMENTS

To be eligible for Prime benefits, a non-exempt adult expansion beneficiary must participate in wellness initiatives, personal responsibility activities and, beginning in DY2, community engagement activities. Non-participation will not impact the beneficiary's Medicaid eligibility, only the benefit tier. MLTC believes this approach to balancing the need for coverage of medical, behavioral health, and pharmacy services with incentivizing participation leads to improved health outcomes and life successes, promotes the goals of the Quadruple Aim, and aligns with the federal intent of the Medicaid program.

5.1 Wellness Initiatives

For DY1, MLTC has identified a combination of health-focused activities MLTC believes will help members more actively engage in the management of their health and provide opportunities for beneficiaries, providers, and the Heritage Health managed care plans to proactively identify health concerns and ensure that the beneficiary is receiving the right combination of services in the most appropriate and cost effective setting.

A beneficiary must complete three wellness activities to be eligible for Prime benefits: (1) actively participate in case and care management; (2) attend an annual health visit; and (3) select a primary care provider.

5.1.1 Case and Care Management

Heritage Health managed care plans are responsible for providing Case and Care Management services to Heritage Health beneficiaries including those newly eligible under the HHA program.

HHA beneficiaries will be expected to actively participate in Case and Care Management as a condition of receiving the Prime benefits package. Specifically, beneficiaries will complete a health risk screening and social determinants of health assessment upon enrollment and then annually. Beneficiaries will also be required to fill medication prescriptions routinely and have clinical labs drawn that were ordered by their provider. DY1 criteria for active participation in Case and Care Management is included in Table 2 – HHA Beneficiary Active Case and Care Management Activities.

Table 2 – HHA Beneficiary Active Case and Care Management Activities

Beneficiary Activity	Activity Description
Health Risk Screening and Social Determinants of Health Assessment	HHA beneficiary must complete a health risk screening (HRS) and social determinants of health (SDoH) assessment.
Case and/or Care Management Participation	HHA beneficiary must fill medications routinely and have clinical labs drawn as ordered by their provider.

5.1.2 Annual Health Visit

MLTC will require HHA beneficiaries to attend a qualifying annual health visit as a condition of receiving the Prime benefits package.

Annual health visits are defined as an annual appointment with the beneficiary's Primary Care Provider (PCP) for a comprehensive assessment and screening of health status. The PCP annual health visit may be substituted for a

visit with a Specialist for an updated assessment of current diagnoses that the beneficiary is receiving ongoing care or treatment for.

Satisfying the annual health visit requirement requires a beneficiary to attend a qualifying health visit in the 12 months preceding the beneficiary's benefit tier review date, which will be 60 days prior to the end of the current benefit tier period.

5.1.3 Primary Care Provider (PCP) Selection

An important initial component of beneficiary care engagement is selecting a PCP. To the extent possible, MLTC encourages beneficiaries to affirmatively choose their PCP. In the event a beneficiary does not affirmatively select a PCP at the time of Medicaid eligibility approval and health plan enrollment, MLTC works with the beneficiary's Heritage Health plan and the state's contracted enrollment broker to assign a PCP to the beneficiary.

5.2 Personal Responsibility Activities

Under the demonstration, an individual's qualification for Prime benefits is also dependent on participation in certain personal responsibility activities. Specifically, to receive Prime benefits, a beneficiary must: (1) not miss three or more scheduled medical appointments in a six month period; (2) maintain commercial coverage, if such coverage is available to the beneficiary; (3) timely notify the State of any changes in status that may impact the beneficiary's eligibility for Medicaid benefits or benefit tier.

5.2.1 Attending Appointments

Nebraska Medicaid proposes that HHA beneficiaries who do not attend three or more scheduled appointments in the six month benefit period preceding the current benefit period will be assigned to the Basic benefits package for the subsequent two 6-month benefit periods.

5.2.2 Maintaining Commercial Coverage

MLTC proposes that HHA beneficiaries who voluntarily discontinue employer-sponsored health coverage up to 90 days prior to Medicaid application or who voluntarily cancel coverage after obtaining Medicaid enrollment will be assigned to the Basic benefits package for the subsequent two 6-month benefit periods.

5.2.3 Timely Change Notification

To further incentivize timely beneficiary communication, MLTC proposes that if a beneficiary does not notify Medicaid within 10 days of a change in status (by phone, online, email, fax, or written notification), the beneficiary will be assigned to the Basic benefits package for the subsequent two 6-month benefit periods.

5.3 Community Engagement

Beginning in DY2, MLTC is proposing that in order to be eligible for the Prime benefits package, non-exempt beneficiaries in the Medicaid expansion group must engage in approved community activities. In alignment with CMS recommendations, qualifying community engagement activities as well as exemptions from these requirements have been aligned with comparable SNAP[1] and TANF[2] requirements to the extent possible. Qualifying community engagement activities are outlined in Table 3 – Qualifying Community Engagement Activities. Exemptions from community engagement requirements are detailed in Table 4 – Community Engagement Exemptions.

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[1] Nebraska SNAP exemption regulations are located in 475 NAC 3-001.04. Available at: https://sos.nebraska.gov/rules-and-regs/regsearch/Rules/Health_and_Human_Services_System/Title-475/Chapter-3.pdf

[2] Nebraska TANF exemption regulations are located in 468 NAC 2-020. Available at: https://sos.nebraska.gov/rules-and-regs/regsearch/Rules/Health_and_Human_Services_System/Title-468/Chapter-2.pdf

During the initial six month benefit tier period after the community engagement provision is in effect, the beneficiary must meet the community engagement requirements in four out of six months. For subsequent benefit tier periods, the beneficiary must meet the requirement in each of the six months preceding the beneficiary's benefit tier review date which will be 60 days prior to the end of the current benefit tier period.

Table 3 – Qualifying Community Engagement Activities

Qualifying Activities *Weekly/Monthly Hour Requirements are noted when applicable.*
Currently employed or self-employed and working at least 80 hours per month. *Can be combined with other approved activities to meet the 80 hours per month requirement*.
Participating in volunteer activities with a public charity for at least 80 hours per month. *Can be combined with other approved activities to meet the 80 hours per month requirement.*
Enrolled at least half time in any accredited college, university, trade school, post-secondary training program, refugee employment program, and other agency approved educational opportunities. *Students enrolled in a qualifying program less than half time can combine education and training hours with other approved activities to meet the 80 hours per month requirement.*
A caregiver in the home for individuals who are: - A parent, caretaker relative, guardian, or conservator of a dependent child; [3] or - A parent, caretaker relative, guardian, or conservator responsible for the care of an elderly or disabled relative.
Relative, Kinship or Licensed Foster parent
Participation in the SNAP Employment and Training (E&T) program or otherwise meeting SNAP ABAWD requirements.
Participation in the TANF/AFDC Employment First (EF) program.
Participation in SNAP and TANF recognized job search activity for at least 20 hours per week. *Can be combined with other approved activities to meet the 80 hours per month requirement.*

Table 4 – Community Engagement Exemptions

Exemptions
Individuals who are determined Medically Frail.
Individuals with a serious mental illness or chronic substance use disorder.
Individuals participating in a substance use disorder or mental health treatment program.
Individuals receiving unemployment compensation (IUC), or who have applied for IUC and are fulfilling weekly work search requirement while in the waiting period.
American Indian / Alaska Native (AI/AN) individuals enrolled in a federally recognized tribe.
Individuals who are experiencing chronic homelessness.
Individuals who are pregnant or in the post-partum period.
High School students of any age who are attending at least half time.
Individuals age 60 and older.
Individuals residing in an area that has been granted a federal ABAWD waiver due to insufficient jobs to provide employment.

[3] Nebraska Medicaid currently defines Parent/Caretaker Relative in 477 NAC 1. Available at: https://sos.nebraska.gov/rules-and-regs/regsearch/Rules/Health_and_Human_Services_System/Title-477/Chapter-01.pdf

Exemptions
Victims of domestic violence, when participation would make it harder to escape, penalize the individual, or put them at further risk of domestic violence.

6 DELIVERY SYSTEM

HHA beneficiaries will receive integrated medical, behavioral health, and pharmacy benefits through the Heritage Health managed care program. Beneficiaries who meet the criteria for the Prime benefits package will receive vision and OTC benefits through their Heritage Health plan and dental benefits through the dental prepaid ambulatory health program (PAHP).

Beneficiaries receiving personal assistant services (PAS) and long term services and supports (LTSS) will receive these services through the fee-for-service delivery system with no deviation from the current Nebraska Medicaid FFS authorization or reimbursement methodologies. Beneficiaries who choose to participate in the Program of All-Inclusive Care for the Elderly (PACE) program will receive the same benefits provided to all current PACE participants. PACE services will continue to be reimbursed using the current PACE reimbursement system and methodology.

7 DEMONSTRATION FINANCING AND BUDGET NEUTRALITY

This section presents MLTC's approach for budget neutrality supporting this 1115 demonstration application. MLTC proposes a per capita budget neutrality model for the populations covered under the demonstration.

Federal policy requires that section 1115 demonstration applications be budget neutral to the federal government. This means that an 1115 demonstration cannot cost the federal government more than what would have otherwise been spent absent the 1115 demonstration. The particulars of budget neutrality, including methodologies, are subject to negotiation between MLTC and CMS.

Table 5 includes preliminary beneficiary enrollment by member month and expenditure projections for the waiver proposals.

Table 5 – Waiver Proposal Estimated Enrollment and Expenditures

	Demonstration Year (DY)				
	DY1 (10/1/2020 to 9/30/2021)	DY2 (10/1/2021 to 9/30/2022)	DY3 (10/1/2022 to 9/30/2023)	DY4 (10/1/2023 to 9/30/2024)	DY5 (10/1/2024 to 9/30/2025)
Non-Expansion Adult Group					
Total Member Months	491,572	496,487	501,452	506,467	511,532
Aggregate Expenditures (*Total Computable*)	$741,449,729	$788,226,433	$838,000,186	$890,965,458	$947,329,465
Adult Expansion Group					
Total Member Months	484,634	760,177	832,990	841,325	849,745

Aggregate Expenditures (*Total Computable)*	$466,896,759	$736,120,906	$833,850,645	$884,720,889	$938,704,651

8 LIST OF PROPOSED WAIVERS AND EXPENDITURE AUTHORITIES

Under section 1115 authority, the State of Nebraska is requesting the following federal requirements be waived to allow the implementation of the HHA expansion demonstration.

- §1902(a)(10)(B) Amount, duration, and scope of services: To the extent necessary to permit the State to offer tiered benefits based on enrollee completion of wellness initiatives, personal responsibility activities, and, beginning in DY2, community engagement.

- §1902(a)(34) Retroactive benefits: To permit the State not to provide retroactive coverage to non-pregnant, non-dual eligible, non-institutionalized adult beneficiaries.

The State is not requesting any expenditure authorities.

9 PUBLIC HEARINGS AND COMMENTS

The public is invited to review and comment on the State's demonstration request.

The full draft can be found at http://dhhs.ne.gov/Pages/Heritage-Health-Adult-Demonstration.aspx. Paper copies of the full public notice document, and a draft of the amendment application, can be picked up during regular business hours at the Department of Health and Human Services, 301 Centennial Mall South, Lincoln, Nebraska 68509

Comments will be accepted 30 days from the publication of this notice. The comment period ends November 26, 2019. Comments may be sent to:

Department of Health and Human Services
Nebraska Medicaid
ATTN: HHA Waiver
301 Centennial Mall South
P.O. Box 95026
Lincoln, Nebraska 68509-5026

Comments may also be sent by email to DHHS.HHAWaiver@Nebraska.gov.

Public hearings are scheduled at the following times/locations:

Meeting Date (Agenda)	Time	Location	Call-in Information
Tuesday, October 29, 2019	7 pm - 8:30 pm MDT	Board Room, Scottsbluff High School 313 E 27th St, Scottsbluff NE 69361	(844) 588-2804 Meeting ID: 704387476
Wednesday, October 30, 2019	6:45 pm - 8:15 pm CDT	South Platte Room, Kearney Public Library 2020 1st Ave, Kearney NE 68847	(844) 588-2804 Meeting ID: 985819573
Thursday, November 7, 2019	6 pm - 7:30 pm CST	Meeting Room A, Norfolk Public Library 308 W Prospect Ave, Norfolk, NE 68701	--
Tuesday, November 12, 2019	7 pm - 8:30 pm CST	Room 132, UNO College of Public Affairs and Community Service 6320 Maverick Plaza, Omaha, NE 68182	(888) 820-1398 Attendee code: 7300221

Please note: Spoken comments will be accepted over the phone at the Kearney meeting on October 30. For the other meetings with call-in information, the phone line will be open as listen-only for callers. We would encourage those calling into the Scottsbluff or Omaha meetings to submit written comments.

After the State reviews comments submitted during this state public comment period, it will submit a revised application to CMS. Interested parties will also have opportunity to officially comment during the federal public comment period after CMS finds the application and public notice requirements met.