Nebraska Medicaid
Section 1115 Heritage Health Adult Expansion Demonstration

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

December XX, 2019

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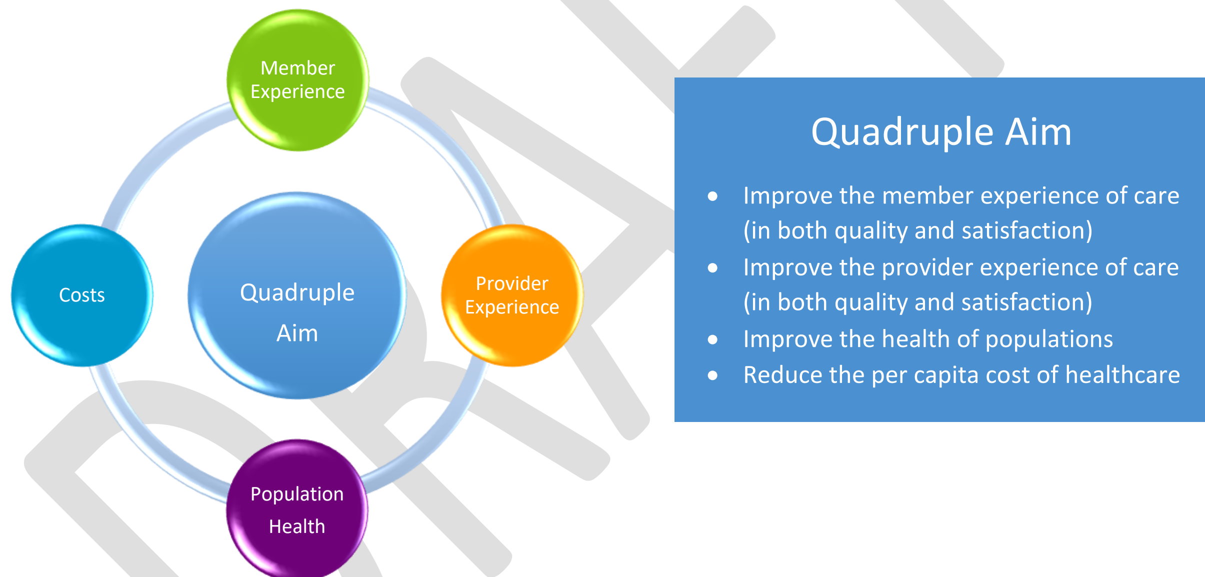
1 PROGRAM DESCRIPTION

The Nebraska Medicaid program provides coverage to approximately 240,000 Nebraskans with expenditures totaling $2,117,730,000 for calendar year 2018.

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 provisions of 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 the adult Medicaid expansion project.

MLTC's goals for the Nebraska Medicaid program are rooted in the concept of the Quadruple Aim. The Quadruple Aim represents a rigorous and innovative approach to fulfilling the mission of Medicaid to furnish medical assistance to disadvantaged and vulnerable individuals through improving population health, enhancing the beneficiary and provider experience, and ensuring the long-term financial viability of the Medicaid program.



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Using the Quadruple Aim as a guide, MLTC proposes a Section 1115 demonstration project that will:

1. Implement Medicaid expansion through a tiered benefit package designed to improve health outcomes and encourage life successes using wellness initiatives, community engagement activities, and personal responsibility activities. This program will be known as "Heritage Health Adult" ("HHA"), and it will impact only individuals eligible through the ACA's expansion eligibility group under Section 1902(a)(10)(A)(i)(VIII) and 42 CFR 435.119. Under the tiered benefit system, all eligible HHA beneficiaries will receive at least a comprehensive "Basic" benefits package. These beneficiaries will be eligible for the "Prime" benefits package – which is the Basic package plus vision, dental, and over-the-counter medication – if they engage in wellness initiatives, complete personal responsibility activities and, beginning on the second year of demonstration, comply with community

engagement requirements. These initiatives and requirements are further described in Section 1.1 – Program Design.

2. Encourage timely enrollment and promote increased continuity of care through a waiver of retroactive eligibility. This feature of the state demonstration will apply to all Medicaid beneficiaries in Nebraska, 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.
3. Through a future amendment to the demonstration, facilitate and encourage more widespread enrollment in private health insurance.

MLTC is committed to robust monitoring and evaluation to determine the goals of the demonstration, the objectives of the Quadruple Aim, and federal intent of the Medicaid program are being met.

1.1 Program Design

The HHA beneficiaries will be enrolled in managed care plans through MLTC's existing Heritage Health program. Unlike existing Medicaid eligibility categories, HHA adults will have a tiered benefit system providing a health coverage foundation for all HHA beneficiaries while incentivizing wellness and life successes.

Under the tiered benefit system, 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.[1]

HHA beneficiaries will receive the Prime benefits package only 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, including but not limited to, employment, actively participating in job-seeking activities through the State of Nebraska, satisfactorily attending a post-secondary school or apprenticeship, or actively engaging in volunteer activity for a public charity.

As described in more detail in Sections 4.1 through 4.1.3, to comply with the wellness initiative requirements, a non-exempt beneficiary must actively participate in case and care management; attend an annual health visit; and choose a primary care provider. To comply with the personal responsibility requirements, a non-exempt beneficiary must avoid missing three or more scheduled provider appointments in a benefit period; maintain employer-sponsored health coverage if it is available to him or her; and timely notify the State of any change in status that will impact the beneficiary's Medicaid eligibility or benefit tier. To comply with the community engagement requirements, a non-exempt beneficiary must participate in one of the qualifying activities described in Section 4.3.

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[1] This will include the Adult Hospital Presumptive Eligibility Group (42 CFR 435.1103)

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.

1.2 Demonstration Goals, Hypotheses and Evaluation

The goals of the HHA Demonstration are to provide medical assistance through design features that advance the objectives of the Quadruple Aim:

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

MLTC will work with an independent entity to develop a robust evaluation plan and methodology for 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

1.3 Demonstration Area

The demonstration will operate statewide.

1.4 Demonstration Timeframe

MLTC is requesting a five year demonstration approval effective October 1, 2020 with the initial demonstration period ending on September 30, 2025. As detailed in the Section 4.3 - Community Engagement, MLTC proposes to implement the community engagement provisions of the demonstration in DY2.

2 DEMONSTRATION ELIGIBILITY

The eligibility groups impacted by the demonstration are as follows:

Table 1 – Impacted Eligibility Groups

Eligibility Group	Social Security Act and CFR Citations	Income Level	Demonstration Component
Heritage Health Adult (HHA) Expansion Group	1902(a)(10)(A)(i)(VIII) 42 CFR 435.119	0-133% FPL plus %5 disregard	Tiered benefits Retroactive eligibility waiver
Parents and Caretaker Relatives	1902(a)(10)(A)(i)(I) 42 CFR 435.110	0-58% FPL	Retroactive eligibility waiver
Aged, Blind, and Disabled Medicaid		0-100% FPL	Retroactive eligibility waiver
Transitional Medical Assistance	408(a)(11)(A) 1902(a)(52) 1902(e)(1)(B) 1925 1931(c)(2)	0-185% FPL	Retroactive eligibility waiver
Former Foster Care Children	42 CFR 435.150 1902(a)(10)(A)(i)(IX)	No Income Test	Retroactive eligibility waiver
Medically Needy Parents and Caretaker Relatives	42 CFR 435.310	(MNIL)	Retroactive eligibility waiver

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Eligibility Group	Social Security Act and CFR Citations	Income Level	Demonstration Component
Medically Needy Aged, Blind, and Disabled	42 CFR 435.320-324	(MNIL)	Retroactive eligibility waiver
Extended Medicaid due to Spousal Support Collections	408(a)(11)(B) 1931 (c)(1) 42 CFR 435.115	0-185% FPL	Retroactive eligibility waiver
Individuals Receiving SSI	1902(a)(10)(A)(i)(II)(aa) 42 CFR 435.120	Categorically Eligible	Retroactive eligibility waiver
Individuals Who Would be Eligible for SSI/SSP but for OASDI COLA increases since April, 1977	42 CFR 435.135	Categorically Eligible	Retroactive eligibility waiver
Disabled Widows and Widowers Ineligible for SSI due to Early Receipt of Social Security	1634(d) 42 CFR 435.138	Categorically Eligible	Retroactive eligibility waiver
Working Disabled under 1619(b)	1619(b) 1902(a)(10)(A)(i)(II)(bb) 1905(q)	Categorically Eligible	Retroactive eligibility waiver
Disabled Adult Children	1634(c)	Categorically Eligible	Retroactive eligibility waiver
Individuals under age 21 who are not mandatorily eligible and who have income at or below a standard established by the State	1902(a)(10)(A)(ii)(I) 1902(a)(10)(A)(ii)(IV) 42 CFR 435.222	0-23% FPL 0-51% FPL	Retroactive eligibility waiver
Certain Individuals Needing Treatment for Breast or Cervical Cancer	1902(a)(10)(A)(ii)(XVIII) 1902(aa) 42 CFR 435.213	0-225% FPL	Retroactive eligibility waiver
Individuals Receiving Home and Community Based Services under Institutional Rules	1902(a)(10)(A)(ii)(VI) 42 CFR 435.217	Not Applicable	Retroactive eligibility waiver
Optional State Supplement Recipients - 209(b) States, and SSI Criteria States without 1616 Agreements	1902(a)(10)(A)(ii)(XI) 42 CFR 435.234	Not Applicable	Retroactive eligibility waiver

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Eligibility Group	Social Security Act and CFR Citations	Income Level	Demonstration Component
Individuals participating in a PACE Program under Institutional Rules	1934	Not Applicable	Retroactive eligibility waiver
Poverty Level Aged or Disabled	1902(a)(10)(A)(ii)(X) 1902(m)(1)	0-100% FPL	Retroactive eligibility waiver
Work Incentives Eligibility Group	1902(a)(10)(A)(ii)(XIII)	0-250% FPL	Retroactive eligibility waiver

2.1 Eligibility Methods and Standards

Medicaid eligibility for the HHA program will be determined using modified adjusted gross income (MAGI) and redetermined annually in accordance with 42 CFR 435.119.

The only change to eligibility in the demonstration is that MLTC is requesting 1115 demonstration 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.

2.2 Enrollment Limits

MLTC is not proposing enrollment limits for the HHA expansion program.

2.3 Projected Demonstration Enrollment and Enrollment Impact

Table 2 presents estimated member month and average beneficiary counts for the non-expansion adult and adult expansion group covered by the demonstrations proposals. Table 3 includes estimated member month counts by Prime and Basic benefit tier for the adult expansion group based on benefit tier criteria detailed in Section 4 – Beneficiary Engagement Requirements.[2] Table 4 presents estimated member month and average beneficiary counts for the non-expansion adult and adult expansion group that will be impacted by the elimination of retroactive eligibility proposals outlined in Section 2.1 – Eligibility Methods and Standards. These estimates are preliminary and subject to change as MLTC continues to refine enrollment projections.

Table 2 -- 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

[2] Due to the potential for a beneficiary to move between benefit packages within the demonstration year, projecting average beneficiary counts for the full demonstration year would not accurately convey the impact of the beneficiary engagement requirements. MLTC included total member months to provide a more accurate impact projection.

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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	58,249	84,172	84,762	85,355	85,952

Table 3 -- Estimated Member Months for Basic and Prime Benefits Expansion Adult Group[3]

	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)**
Basic Benefit Plan					
Total Member Months	252,863	243,265	268,741	271,430	274,146
Prime Benefit Plan					
Total Member Months	231,771	516,913	564,249	569,896	575,599

Table 4 -- Estimated Retroactive Eligibility Demonstration Proposal Impact for Non-Expansion Adult Group

	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	23,321	23,554	23,790	24,027	24,268
Average Number of Beneficiaries	13,936	14,075	14,216	14,358	14,502
Expansion Adult Group					
Total Member Months	25,507	40,009	43,842	44,280	44,723
Average Number of Beneficiaries	15,242	23,908	26,198	26,460	26,725

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3 DEMONSTRATION BENEFITS

In accordance with Section 1902(i)(26) of the Social Security Act and 42 C.F.R. § 440.305, the benefits provided to individuals eligible in the expansion adult group will be through one of two Alternative Benefit Plans, except for those who are medically frail under Section 1937(a)(2).[4]

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[3] The member months between DY1 and DY2 are impacted by the ramp-up of enrollment estimates during DY1, populations exempt from community engagement, wellness initiatives, and other personal responsibility activities. All non-exempt beneficiaries will receive the Basic alternative benefit plan for the first six months of enrollment. A beneficiary may receive the Prime alternative benefit plan if they participate in the wellness initiatives, personal responsibility activities, and for Demonstration Year 2 and beyond, the proposed community engagement activities.

[4] In accordance with this waiver application, MLTC will submit a State Plan Amendment to implement the identified ABPs as MLTC seeks to offer different benefit packages to individuals in the adult expansion group. MLTC

The two Alternative Benefit Plans reflect a two-tiered benefit structure:

1) The first plan, *Nebraska Basic Alternative Benefit Plan,* provides benefits equivalent to the current state plan with the exception of dental services, vision services, and over-the-counter medications. The Basic benefits package covers all state plan services, except for dental services, vision services, or over-the-counter medications.
2) The second plan, *Nebraska Prime Alternative Benefit Plan*, will provide benefits equivalent to the current state plan including dental services, vision services, and over-the-counter medications. The Prime benefits package covers all state plan services.

Table 5 outlines the Basic and Prime benefits that will be available to expansion adults under the demonstration. The Basic and Prime benefits meet minimum essential health benefit requirements and reflect the same amount, duration or scope as benefits described in the current State Plan. In accordance with this demonstration, MLTC will submit a State Plan Amendment to implement the identified ABPs.

Table 5 - Nebraska Prime and Basic Alternative Benefit Plans

		Benefit Package	
Benefit	**Reference**	**Basic**	**Prime**
Ambulatory Patient Services			
Outpatient Hospital Services	Mandatory 1905(a)(2)	●	●
Physicians' Services	Mandatory 1905(a)(5)	●	●
Clinic Services	Optional 1905(a)(9)	●	●
Hospice Care	Optional 1905(a)(18)	●	●
Home Health Services	Mandatory for certain individuals 1905(a)(7)	●	●
Other Practitioner Services	Optional 1905(a)(6)	●	●
Chiropractic Services	Optional 1905(a)(6)	●	●
Emergency Services			
Emergency Hospital Services	Optional 1905(a)(29), 42 CFR 440.170(d)	●	●
Transportation Services: Emergency	Optional 1905(a)(29), 42 CFR 440.170(d), Required as an administrative function 42 CFR 431.53	●	●
Hospitalization			
Inpatient Hospital Services	Mandatory 1905(a)(1)	●	●
Maternity and Newborn Care			
Physicians' Services-Maternity	Mandatory 1905(a)(5)	●	●
Nurse-Midwife Services	Mandatory 1905(a)(17)	●	●
Inpatient Hospital Services-Maternity	Mandatory 1905(a)(1)	●	●
Outpatient Hospital Services-Maternity	Mandatory 1905(a)(2)	●	●
Freestanding Birth Center Services	Optional 1905(a)(28)	●	●
Other Practitioners Services-Maternity	Optional 1905(a)(6)	●	●
Extended Services for Pregnant Women	Optional 1902(a)(5)	●	●

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elects to use the Secretary-Approved standard and will be aligned with the benefits offered in the selected plan when providing coverage to the adult group population in the MLTC's Alternative Benefit Plans (ABP). The alternative benefit plan coverage provided to beneficiaries is a Benchmark Benefit Package as described at 45 CFR 156.100(a) and is the largest plan by enrollment of the three largest small group insurance products in the state's small group market. The plan name is BCBS of Nebraska: Blue Pride Plus Option 102 Gold. A high level summary of the services covered under the Prime and Basic benefits ABPs is provided in Table 5 – Nebraska Prime and Basic Alternative Benefit Plans, including benefits that may differ from the State Plan.

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Benefit	Reference	Benefit Package	
		Basic	Prime
Tobacco Cessation-Maternity	Mandatory 1905(a)(4)	●	●
Home Health Services-Maternity	Mandatory for certain individuals 1905(a)(7)	●	●
Mental Health and Substance Abuse Disorder Services Including Behavioral Health Treatment			
Outpatient Hospital Services: MH/SUD	Mandatory 1905(a)(2)	●	●
Inpatient Hospital Services: MH/SUD	Mandatory 1905(a)(1)	●	●
Physicians' Services: MH/SUD	Mandatory 1905(a)(5)	●	●
Rehabilitation Services: MH/SUD	Optional 1905(a)(13)	●	●
Clinic Services: MH/SUD	Optional 1905(a)(9)	●	●
Other Practitioner Services: MH/SUD	Optional 1905(a)(6)	●	●
Home Health Services: MH/SUD	Mandatory for certain individuals 1905(a)(7)	●	●
Prescription Drugs			
Prescribed Drugs	Optional 1905(a)(12)	●	●
Rehabilitative and Habilitative Services and Devices			
Home Health Services: PT, OT, ST, & Audiology	Optional-1905(a)(7), 1902(a)(10)(D), 42 CFR 440.70	●	●
Physical Therapy and related services: PT	Optional 1905(a)(11)	●	●
Physical Therapy and related services: OT	Optional 1905(a)(11)	●	●
Short-Term Nursing Facility Services	Optional 1905(a)(14), Optional 1905(a)(29), 42 CFR 440.170(d)	●	●
Home Health Services: Medical Supplies, Equipment,	Mandatory for certain individuals-1905(a)(7)	●	●
Prosthetic Devices	Optional 1905(a)(12)	●	●
Services for individuals with speech, hearing, & language disorders	Optional 1905(a)(11)	●	●
Physical therapy and related services: ST	Optional 1905(a)(11)	●	●
Laboratory services			
Laboratory and X-ray Services	Mandatory 1905(a)(3)	●	●
Preventive and wellness services and chronic disease management			
Nutrition Services	Optional 1905(a)(13)	●	●
Other Diagnostic, Screening, Preventative, and Rehabilitative Services	Optional 1905(a)(13)	●	●
Pediatric services including oral and vision care			
Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services	Mandatory 1905(a)(4)	**Not Covered**[5]	●
Other 1937 Covered Benefits that are not Essential Health Benefits			
Family Planning Services and Supplies	Mandatory 1905(a)(4)	●	●
Rural Health Clinic Services	Mandatory 1905(a)(2)	●	●
Federally Qualified Health Center (FQHC)	Mandatory 1905(a)(2)	●	●
Certified Pediatric & Family Nurse Practitioner Services	Mandatory 1905(a)(21)	●	●
Podiatrists' Services	Optional 1905(a)(6)	●	●
Case Management	Optional 1905(a)(19)/1915(g), 1905(a)(25)	●	●
Inpatient Psychiatric Services under Age 21	Optional 1905(a)(16)	●	●
Telehealth	Optional 1905(a)(29)	●	●
Non-Emergency Transportation	Optional 1905(a)(29)	●	●
Respiratory Care Services	Optional 1905(a)(20)	●	●
Abortion Services	42 USC 457.475	●	●
Critical Care Hospital	Optional 1905(a)(29)	●	●

[5] Beneficiaries age 19 and 20 in the adult expansion group will be assigned to the Prime benefits package which includes EPSDT coverage.

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		Benefit Package	
Benefit	**Reference**	**Basic**	**Prime**
Intermediate Care Facility Services	Optional 1905(a)(15)	●	●
PACE Services	Optional 1905(a)(26)	●	●
Long-Term Nursing Facility Services	Mandatory 1905(a)(4)	●	●
1915(c) HCBS Waivers	Optional 1915(i)	●	●
Personal Assistance Services	Optional 1905(a)(24) / 42 CFR 440.170	●	●
Private Duty Nursing Services	Optional 1905(a)(8)	●	●
Medically-Monitored Inpatient Withdrawal Management[6]	Optional 1905(a)(13)	●	●
Opioid Treatment Program[6]	Optional 1905(a)(13)	●	●
Optometrists' Services	Optional 1905(a)(6)	**Not Covered**	●
Dental Services	Optional 1905(a)(10)	**Not Covered**	●
Dentures	Optional 1905(a)(12)	**Not Covered**	●
Eyeglasses	Optional 1905(a)(12)	**Not Covered**	●
Over-the-Counter Medications	Optional 1927(k)(4)	**Not Covered**	●

As indicated in the services chart above, MLTC intends to offer Long-Term Services and Supports (LTSS) to all qualifying individuals eligible in the expansion population, in addition to the Basic or Prime benefits. The services provided will be the same as those offered to all Medicaid participants in the current State Plan and waivers.

4 BENEFICIARY ENGAGEMENT REQUIREMENTS

To be eligible for Prime benefits, an HHA beneficiary over age 20 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. Table 6 includes estimated member month counts for the projected impact of the wellness initiatives and community engagement activities on Prime and Basic benefit tier determinations for the adult expansion group based on benefit tier criteria detailed in this section.

Table 6 – Estimated Impact of Beneficiary Engagement for the Adult Expansion Group by Member Month

	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)**
Basic Benefit Plan – Adult Expansion Group					
Non-Exempt Beneficiaries ***Do not meet community engagement requirements***	0	77,140	84,979	85,829	86,688
Non-Exempt Beneficiaries	252,863	166,124	183,762	185,601	187,458

[6] Will be added as a covered service under the Medicaid State Plan with an anticipated effective date of January 1, 2020 assuming CMS approval of the State Plan Amendment (SPA).

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Do not meet wellness initiatives					
Total	**252,863**	**243,265**	**268,741**	**271,430**	**274,146**
Prime Benefit Plan – Adult Expansion Group					
Exempt Beneficiaries ***Classified as Medically Frail or between 19-20 years old***	95,614	129,289	135,472	136,828	138,197
Non-Exempt Beneficiaries ***Meet community engagement and wellness initiatives.***	136,157	387,624	428,777	433,068	437,402
Total	**231,771**	**516,913**	**564,249**	**569,896**	**575,599**

4.1 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.

4.1.1 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.

Case Management and Care Management are relationship-based and person-centered. Case and Care Management are intended to improve health outcomes, promote wellness, and empower the beneficiary to participate in the management of their own care. Case and Care Management plans use evidence-based guidelines and best practice standards to achieve high quality and cost-effective outcomes.

Over the course of the demonstration, MLTC will use a combination of existing collaborative processes which include, for example, Performance Improvement Projects (PIPs), along with contract incentives to encourage Heritage Health managed care plans to achieve MLTC's Case and Care Management goals and outcomes for the HHA population.

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

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their provider. DY1 criteria for active participation in Case and Care Management is included in Table 7 – HHA Beneficiary Active Case and Care Management Activities.

Table 7 – 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.

4.1.2 Annual Health Visit

In order to support the early identification of serious health conditions and better ensure the delivery of care in the most appropriate and cost effective setting, MLTC requires HHA beneficiaries 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. PCPs are defined as doctors of medicine (MD), doctors of osteopathic medicine (DO), nurse practitioners (NP), or physician assistants (PA) working within general practice, family practice, internal medicine, pediatrics, or OB/GYN. 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. This time period may include up to 8 months prior to a beneficiary's Medicaid enrollment. Beneficiaries will be allowed to provide documentation of a qualifying annual health visit prior to Medicaid enrollment which may include an explanation of benefits (EOB), qualified doctor's medical document, or other documentation.

4.1.3 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. Whether a beneficiary affirmatively selects a PCP or is assigned one, MLTC will ensure the beneficiary has a designated PCP.

4.2 Personal Responsibility Activities

Under the demonstration, an individual's qualification for Prime benefits is also dependent on participation in personal responsibility activities, which are designed to advance the goals of the Quadruple Aim and federal intent of the Medicaid program. 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 or benefit tier.

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4.2.1 Attending Appointments

Appointment attendance or reasonable notice of a cancellation is an important component in ensuring that MLTC is improving the Medicaid provider experience. 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. After the second 6-month period, the beneficiary may once again be assessed for participation in the Prime benefit package.

4.2.2 Maintaining Commercial Coverage

An important factor in ensuring the long-term financial viability of the Medicaid program is to ensure that, consistent with federal regulations, Medicaid remain the payer of last resort. 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. After the second 6-month period, the beneficiary may once again be assessed for participation in the Prime benefits package.

4.2.3 Timely Change Notification

CMS has provided recent guidance[7] emphasizing the importance of ensuring Medicaid eligibility determinations are rigorous and accurate. Proactive notification by a beneficiary regarding a change in status that impacts the individual's Medicaid eligibility (e.g., change in income) or benefit tier determination is vital to ensuring the integrity of the Medicaid program. 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. After the second 6-month period, the beneficiary may once again be assessed for participation in the Prime benefit package. MLTC will use current processes and electronic data sources (e.g. state wage index) to ensure information is reported timely.

4.3 Community Engagement

MLTC is proposing to empower individual life successes through positive community engagement. Beginning in DY2, 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[8] and TANF[9] requirements to the extent possible. Qualifying community engagement activities are outlined in Table 8 – Qualifying Community Engagement Activities. Exemptions from community engagement requirements are detailed in Table 9 – Community Engagement Exemptions.

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[7] CMCS Information Bulletin. Oversight of State Medicaid Claiming and Program Integrity Expectations. June 20, 2019. Available at: https://www.medicaid.gov/federal-policy-guidance/downloads/cib062019.pdf

[8] 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

[9] 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 8 – 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; [10] 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 9 – 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.
Victims of domestic violence, when participation would make it harder to escape, penalize the individual, or put them at further risk of domestic violence.

[10] 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

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4.4 Good Cause

In instances in which a beneficiary is assigned to the Basic benefits package based on nonparticipation in a beneficiary engagement activity, the beneficiary will have the opportunity to appeal that determination based on providing a “Good Cause” explanation. Good cause appeals will be assessed on case by case basis. An example of a good cause explanation could be the failure of a non-emergency transportation provider to transport the beneficiary to an appointment within the scheduled window.

5 COST SHARING REQUIREMENTS

The demonstration 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. Individuals determined eligible in a group subject under this wavier, will be allowed the same exemptions and subject to the same nominal copayment and cost sharing obligations of all Nebraska Medicaid participants.

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). The Heritage Health managed care program and dental PAHP are full-risk arrangements for which Nebraska Medicaid makes monthly capitation payments for each beneficiary. The Heritage Health managed care program and dental PAHP are authorized under Nebraska Medicaid’s 1915(b) waiver authority.

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.

6.1 Managed Care Contracting and Procurement

- MLTC will utilize currently contracted Heritage Health managed care plans to provide benefits to the HHA population. MLTC’s current Dental PAHP will administer benefits for HHA beneficiaries that qualify for dental coverage. At this time, the state does not anticipate conducting a procurement prior the implementation of the demonstration. MLTC will amend current contracts and conduct readiness reviews with the managed care plans prior to implementation of HHA.
- Current managed care contracts will expire during the course of the five-year demonstration and re-procurement activities will be conducted accordingly.
- On March 27, 2019, two of Nebraska Medicaid’s contracted Heritage Health plans WellCare and Centene announced that they will merge with an anticipated closing date of calendar year Q1 2020. The outcome of this merger may impact MLTC’s decision process in regards to the timing and structure of future managed care procurements.

6.2 Premium Assistance for Employer Sponsored Coverage.

Nebraska currently operates a federally-approved voluntary employer sponsored insurance (ESI) and individual market premium assistance program under its State Plan. In DY1, HHA beneficiaries will be allowed to voluntarily participate in the current premium assistance program provided the individual meets the standard Health Insurance Premium Payment (HIPP) program participation criteria including the cost effectiveness calculation. For DY2, the State will submit an amendment to the demonstration to include the newly eligible adult group in a mandatory premium assistance program and will also be seeking to mandate program participation for all Medicaid participants when cost-effective.

Individuals enrolled in employer-sponsored coverage will still be enrolled in a Heritage Health Plan and will receive wrap-around benefits for any benefit not provided through the commercial insurance.

7 IMPLEMENTATION OF DEMONSTRATION

Assuming timely federal approval of the demonstration, applications for the HHA expansion population will begin on August 1, 2020 for coverage effective October 1, 2020 under Nebraska's targeted timeline. The HHA program will be implemented on a statewide basis for all demonstration provisions. The wellness initiatives and the personal responsibility activities, described in Section 4.1 and Section 4.2 respectively, will apply in DY 1, but community engagement participation described in Section 4.3 will not go into effect until DY2. As detailed in Section 6.2, MLTC intends to submit an amendment to the demonstration to mandate HIPP participation for all Medicaid beneficiaries to be implemented in DY2. The waiver for retroactive Medicaid will begin effective October 1, 2020.

A proposed implementation timeframe is included below:

Table 10 -- Implementation Timeframe

Milestone	Timeframe
Issue public notice of demonstration	To be determined
Accept comments on demonstration	To be determined
Conduct tribal consultation	To be determined
Submit demonstration application to CMS	December 15, 2019
CMS demonstration approval	To be determined
Begin receiving applications for Medicaid expansion	August 1, 2020
Medicaid expansion coverage becomes effective	October 1, 2020
Waiver of retro-active eligibility becomes effective	October 1, 2020
Wellness initiatives	October 1, 2020
Personal responsibility activities	October 1, 2020
Community engagement participation	October 1, 2021
Mandatory HIPP participation – contingent on submission and approval of an amendment to the demonstration	October 1, 2021

7.1 Notification and Enrollment of HHA Demonstration Participants

When a Medicaid determination has been made for an individual eligible for HHA, Nebraska will send a notice to the individual containing the basis of the eligibility determination, effective date of coverage, information on the level of services available to the individual, regulations that support the law, and appeal rights.

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Applications for the HHA program will begin to be accepted on August 1, 2020, for a coverage effective date of October 1, 2020, through the following process:

i. An application is submitted by an individual seeking a Medicaid determination via phone, online, by mail, or in-person or the individual is being transitioned from an existing category by the State.
ii. A Medicaid eligibility determination will be made by Nebraska Medicaid in the State's eligibility and enrollment system.
iii. The individual is auto-enrolled in one of the three MCOs based on a pre-determined algorithm and the individual has 90 days from initial MCO assignment to select a different MCO.
iv. Individuals found Medically Frail or who qualify for Prime benefits will be enrolled in the Dental PAHP.
v. The MCO sends out a welcome packet and information regarding the plan to the individual.

7.2 Enrollment Initiatives

MLTC, in partnership with other DHHS divisions, is undertaking several initiatives to expedite the enrollment of Medicaid eligible individuals including adults newly eligible under the HHA program. These initiatives include coordination with hospitals, FQHCs, tribal organizations, and other providers and stakeholders to expand the presumptive eligibility process and, on a targeted basis, to embed DHHS eligibility staff within those entities to directly facilitate the Medicaid application process. These efforts will include providing individuals education on the opportunity for beneficiaries to earn the Prime benefits package through participation in wellness initiatives and community engagement activities.

8 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 11 includes preliminary enrollee and expenditure projections for the waiver proposals as described in Section 2 – Demonstration Eligibility and Section 3 – Demonstration Benefits. Revised financing and budget neutrality forms will be included in the final application submission after MLTC has received public input on the demonstration application proposal.

Table 11 -- 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					

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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

9 LIST OF PROPOSED WAIVERS AND EXPENDITURE AUTHORITIES

9.1 Relevant Authorities Outside of this Demonstration

The Medicaid expansion population will be subject to several waivers outside of this demonstration. Specifically:

- MLTC's current 1915(b) waiver authority expires on June 30, 2020. MLTC's renewal request for its current Section 1915(b) waiver – which expires on June 30, 2020 – will seek to add the HHA expansion population to the list of eligibility groups authorized to receive services through the Heritage Health managed care program and Dental PAHP.
- MLTC will submit an amendment the state's current 1915(c) waivers to add the HHA expansion population as an additional eligibility group.
- MLTC will submit an amendment to the state's current section 1115 SUD demonstration to add the HHA expansion population as an additional eligibility group.

9.2 Requested 1115 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 beneficiary completion of wellness initiatives 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.

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