NEBRASKA

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DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

December 12, 2019

Angela D. Garner, MPH, Director
Division of System Reform Demonstrations
State Demonstrations Group
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-25-26
Baltimore, MD 21244-1850

Dear Ms. Garner:

I hereby submit for CMS's review and approval Nebraska's 1115 demonstration waiver related to adult expansion.

In November 2018, Nebraska's voters passed Initiative 427, which extended Medicaid coverage to eligible able-bodied adults ages 19-64 who earn up to 138 percent of the federal poverty level. Learning from other states' experiences and creating an innovative approach that is best for Nebraska, we are proposing to utilize this 1115 waiver to launch the Heritage Health Adult (HHA) expansion program.

HHA will include two benefit tiers – Basic and Prime. Most beneficiaries will begin with the robust package of services available in the Basic benefits package. By completing certain wellness, personal responsibility, and community engagement activities, beneficiaries can earn additional, Prime benefits – which consist of dental, vision, and over-the-counter medications. Unlike other states, everyone who meets underlying eligibility criteria will receive at least the robust Basic benefits package.

The structure of HHA will improve population health, patients' self-management of their own care, patient and provider experiences of care, and reduce the per-capita costs of healthcare. Our waiver also seeks to waive retroactive Medicaid coverage for certain Medicaid populations in an effort to promote early and continuous enrollment, improve health outcomes, and reduce the per-capita costs of healthcare.

We thank you for your assistance throughout this process. If you have any questions, please contact Nate Watson, JD and Cert Legis Prac, Deputy Director for Policy and Regulations, at nate.watson@nebraska.gov or by phone at (402) 471-0300.

Sincerely,

[redacted]

Matthew A. Van Patton, DHA, Director
Division of Medicaid & Long-Term Care
Nebraska Department of Health & Human Services

MVP/dp

NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

Nebraska Medicaid
Section 1115 Heritage Health Adult Expansion Demonstration

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

December 12, 2019

Contents

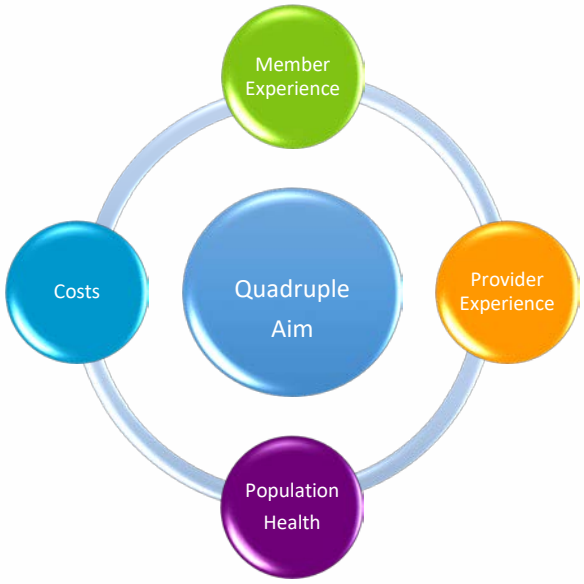
1 PROGRAM DESCRIPTION

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.



Quadruple Aim

- Improve the member experience of care (in both quality and satisfaction)
- Improve the provider experience of care (in both quality and satisfaction)
- Improve the health of populations
- Reduce the per capita cost of healthcare

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

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

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.

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

Hypothesis	Method	Measure
		• 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
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

Eligibility Group	Social Security Act and CFR Citations	Income Level	Demonstration Component
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
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	491,568	496,484	501,449	506,463	511,528
Average Number of Beneficiaries	64,396	65,040	65,690	66,347	67,010
Expansion Adult Group					
Total Member Months	472,751	735,727	824,626	832,877	841,212
Average Number of Beneficiaries	52,382	75,556	78,912	79,701	80,499

[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.

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	260,441	242,350	271,882	274,602	277,350
Prime Benefit Plan					
Total Member Months	212,310	493,377	552,744	558,275	563,862

Table 4 -- Estimated Retroactive Eligibility Demonstration Proposal Impact for Non-Expansion Adult Group and 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	23,789	24,027	24,268
Average Number of Beneficiaries	13,936	14,075	14,216	14,358	14,501
Expansion Adult Group					
Total Member Months	24,882	38,722	43,401	43,836	44,274
Average Number of Beneficiaries	14,868	23,139	25,935	26,195	26,457

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]

[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 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

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 illustrates the mandatory and optional Medicaid benefits included in the Basic and Prime benefit packages available to expansion adults under the demonstration. Mandatory benefits are those that States are required to provide under federal law; optional benefits are those that federal law does *not* require States to cover (they are elective for States to provide). Both the Basic and Prime benefits include all mandatory services and many optional services, and both the Basic and the Prime benefits meet minimum essential health benefit requirements. 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)	•	•

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.

		Benefit Package	
Benefit	**Reference**	**Basic**	**Prime**
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)	●	●
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)	●	●

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

		Benefit Package	
Benefit	**Reference**	**Basic**	**Prime**
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)	●	●
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 activities, 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.

[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).

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	72,966	81,555	82,371	83,195
Non-Exempt Beneficiaries ***Do not meet wellness initiatives or personal responsibility activities***	260,441	169,384	190,327	192,232	194,155
Total	**260,441**	**242,350**	**271,882**	**274,602**	**277,350**
Prime Benefit Plan – Adult Expansion Group					
Exempt Beneficiaries ***Classified as Medically Frail or between 19-20 years old***	72,072	98,149	108,647	109,734	110,832
Non-Exempt Beneficiaries ***Meet personal responsibility, community engagement, and wellness initiatives.***	140,238	395,229	444,097	448,541	453,029
Total	**212,310**	**493,377**	**552,744**	**558,275**	**563,862**

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. 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.

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.

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 within the first six months of the twelve month period preceding the benefit tier review date will be assigned to the Basic benefits package for the subsequent two 6-month benefit periods. At the time of the benefit tier review during the second 6-month period, the beneficiary may once again be assessed for participation in the Prime benefits package.

For the initial benefit tier redetermination during the beneficiary's initial benefit tier period, MLTC will not review for instances of missed appointments. For the beneficiary's second benefit tier redetermination during the second benefit tier period, MLTC will review for instances of missed appointments during the first four months of the ten month period prior to the beneficiary's benefit tier review date. For subsequent benefit tier reviews, MLTC will review for instances of missed appointments within the first six months of the twelve month period preceding the beneficiary's benefit tier review date.

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. At the time of the benefit tier review during 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. At the time of the benefit tier review during 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.

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.

[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

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

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	October 25, 2019
Accept comments on demonstration	October 25 - November 26, 2019
Conduct tribal consultation	October 25 - November 26, 2019
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.

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

8.1 Background

The five-year demonstration is proposed to start October 1, 2020 and end September 30, 2025. Table 11 illustrates the demonstration years for the budget neutrality calculations described in this section.

Table 11 -- Five-Year Demonstration Years

Demonstration Year (DY)				
DY1	**DY2**	**DY3**	**DY4**	**DY5**
10/1/2020 - 9/30/2021	10/1/2021 - 9/30/2022	10/1/2022 - 9/30/2023	10/1/2023 - 9/30/2024	10/1/2024 - 9/30/2025

Separate "Without Waiver" and "With Waiver" projections of expenditures and enrollment are included within the budget neutrality projections. The 1115 waiver authorities requested in this demonstration application include excluding retro-active enrollment and limiting the benefit package for certain Heritage Health Adult (HHA) individuals. Since the authorities requested are not expenditure authority, the "Without Waiver" and "With Waiver" projections have been developed as estimates and should not be viewed as binding PMPM limits.

For purposes of budget neutrality, a separate approach has been taken for adults who are currently eligible for Medicaid in Nebraska and impacted by the 1115 demonstration, and those adults who will be newly eligible effective October 1, 2020 under Heritage Health Adult. The budget neutrality projections for the currently eligible adults is based on the PMPMs underlying the 5-year historical base, including the implied 5-year average trend. The process for currently eligible adults is described in detail in the following section.

Currently Eligible Adults

Historical Data:

The 5-year historical base for the currently eligible adults subject to the 1115 demonstration was developed based on Calendar Year (CY) 2014 – 2018 experience. The currently eligible adult population excludes all children and includes adult Medicaid beneficiaries with the exception of pregnant women, those dually-eligible for Medicare and Medicaid, and individuals residing in a nursing facility.

The historical base includes data from the following sources:

1. Fee-for-service (FFS) for 2014 – 2018
2. Physical Health and Behavioral Health capitation rates for 2014 – 2016, as applicable
3. Heritage Health capitation rates for 2017 – 2018, as applicable
4. Dental Benefit Management capitation rates for 10/1/2017 – 12/31/2018, as applicable

The capitation rates above are reflective of the full capitation rate, including any applicable amounts for the Health Insurance Providers' Fee (HIPF) and the University of Nebraska Medical Center (UNMC) physician pass-through (which the State is currently in the process of seeking approval for conversion to a directed payment via 42 CFR 438.6(c)). Also consistent with the development of capitation rates, all expenditures are gross of any state-collected pharmacy rebates, meaning that the reduction to overall expenditures due to these rebates has not been included in these amounts.

The historical experience has been aggregated into two Medicaid Eligibility Groups (MEGs), Aid to the Aged, Blind, and Disabled (AABD) and Family (FAM):

The AABD MEG is comprised of members who fall into any of the following Heritage Health rating cohorts: AABD 00-20 M&F, AABD 21+ M&F, AABD 21+ - WWC (Women with Cancer), or Non-Dual Waiver. The FAM MEG is comprised of members who fall into one of the following Heritage Health rating categories: Family 06-20 M, Family 06-20 F, or Family 21+ M&F.

Consistent with the design of the 1115 demonstration, populations underlying the experience included in the 5-year historical base development reflect only members age 19+ and who are assigned to one of the rating cohorts underlying the AABD and FAM MEGs as noted above. In the development of the 5-year historical base and subsequent demonstration year projections, maternity supplemental payments are not included for the currently eligible adults, due to the exemption of pregnant women from the 1115 demonstration.

Historical Trend Evaluation:

The 5-year historical base was compiled and reviewed to develop an observed 5-year historical trend. The PMPM trends observed for the AABD MEG is 5.7% annualized trend, and 3.9% for the FAM MEG. For budget neutrality, the trend used must be the lesser of the historical trend or the President's Budget trend. Upon review of the "2017 Actuarial Report on the Financial Outlook for Medicaid[11]", the President's Budget trend of 5.1% for Disabled populations is less than the historical 5.7% annualized trend. Therefore, the 5.1% President's Budget trend has been used. The historical 3.9% trend for the FAM MEG is less than the 5.2% Adults population President's Budget trend, and therefore the 3.9% historical trend is used for budget neutrality purposes. These trends are applied to the most recent base year, CY2018 or Base Year 5 (BY5), for purposes of projecting to each of the DYs.

For purposes of enrollment growth projections, a 1% annual enrollment growth trend was used in budget neutrality projections. This is comparable to the average annual non-aged enrollment growth noted within the "2017 Actuarial Report on the Financial Outlook for Medicaid."

Prospective Adjustments:

A prospective adjustment to the historical base was necessary to reflect the State's change to the design of its maternity supplemental payment within the Heritage Health program. Prior to January 1, 2019 all costs for a member incurred within the maternity window (defined as 5 months pre-delivery and 2 months post-delivery) were included within the supplemental maternity payment. Effective January 1, 2019, the supplemental payment rate was adjusted so that only the expenditures incurred within the duration of the delivery event (e.g. costs incurred between the admit and discharge date of the hospital stay in which the delivery occurred), are captured within the maternity supplemental payment. Effective

[11] "2017 Actuarial Report on the Financial Outlook for Medicaid." Department of Health & Human Services. Available at cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/MedicaidReport2017.pdf

January 1, 2019, the pre- and post-delivery costs were shifted into the standard capitation rate for the rating cohort (e.g. Family 21+ M&F capitation rate) in which the individual resides. Although this adjustment resulted in a budget-neutral funding change in aggregate, the maternity supplemental payment was reduced due to the removal of the pre- and post-delivery costs, and the capitation rates for applicable rating cohorts were increased due to the inclusion of the pre- and post-delivery costs. Table 12 illustrates the expenditures included within the maternity supplemental payment and the non-maternity capitation rates, pre- and post-January 2019:

Table 12 -- Maternity-Related Expenditures Pre- and Post-January 2019

Maternity Supplemental Payment			**Non-Maternity Capitation Rates**		
Pre-January 2019		**Post-January 2019**	**Pre-January 2019**		**Post-January 2019**
5 Months Pre-Delivery			Non-Delivery Expenditures		Non-Delivery Expenditures
+					+
Delivery Event		Delivery Event			5 Months Pre-Delivery
+					+
2 Months Post-Delivery					2 Months Post-Delivery
=		=	=		=
Maternity Supplemental Payment	≥	**Maternity Supplemental Payment**	**Capitation Rate**	≤	**Capitation Rate**

Since this change happens entirely after BY 5, it is necessary to adjust the BY experience so it can be comparable to the payments that will be made in the Demonstration Years. In the development of the 5-year historical base and subsequent demonstration year projections, the supplemental payments are not included for the currently eligible adults, due to the exemption of pregnant women from the 1115 demonstration. As a result, the change described above is not budget-neutral in the context of the populations and expenditures included within the 1115 demonstration but is budget neutral in the context of the Nebraska Medicaid program. Given that the entire 5-year base reflects experience prior to the change in the maternity supplemental payment described above, an adjustment was made to the base to reflect the impact of this change. Table 13 below shows the impact of this adjustment for each of the MEGs:

Table 13 -- Prospective Adjustment Impact

	Prospective Adjustment
MEG	**PMPM Impact**
AABD	0.2%
FAM	16.2%

Without Waiver:

The Without Waiver projections for the currently eligible adults reflect projections of the BY to each of the DYs after adjusting for the impact of the maternity supplemental payment change noted in the 'Prospective Adjustments' section. Table 14 illustrates the annualized PMPM and membership trend for each MEG and DY:

Table 14 -- Without Waiver Trend

	Annualized PMPM Trend (Without Waiver)				
MEG	**Base to DY1**	**DY1 to DY2**	**DY2 to DY3**	**DY3 to DY4**	**DY4 to DY5**
AABD	5.1%	5.1%	5.1%	5.1%	5.1%
FAM	3.9%	3.9%	3.9%	3.9%	3.9%

	Annualized Enrollment Trend (Without Waiver)				
MEG	**Base to DY1**	**DY1 to DY2**	**DY2 to DY3**	**DY3 to DY4**	**DY4 to DY5**
AABD	1.0%	1.0%	1.0%	1.0%	1.0%
FAM	1.0%	1.0%	1.0%	1.0%	1.0%

With Waiver:

The With Waiver projections for the currently eligible adults reflect projections from the BY to each of the DYs after adjusting for the impact of the maternity supplemental payment change noted in the 'Prospective Adjustments' section and the estimated impact of removing retro-active enrollment. Based on a comparison of the base year PMPMs with retro enrollment included and the PMPMs after removing retro expenditures and member months, an adjustment was developed to estimate the impact of removing retro via the 1115 demonstration. Table 15 illustrates the impact of the removal of retro enrollment to the base year member months and to the base year PMPMs, respectively:

Table 15 -- Retro Adjustment Impact

	Retro Adjustment Base Year Impact	
MEG	**MMs % Impact**	**PMPM % Impact**
AABD	-2.4%	-1.1%
FAM	-5.7%	2.9%

It is not anticipated that the removal of retro-active enrollment will have a material impact on future enrollment and PMPM growth compared with the current policy. As a result, once the base year was adjusted for the impact of retro, the same PMPM and enrollment trends used for the Without Waiver projections were applied to the With Waiver projections and illustrated in Table 16:

Table 16 -- With Waiver Trend

	Annualized PMPM Trend (With Waiver)				
MEG	**Base to DY1**	**DY1 to DY2**	**DY2 to DY3**	**DY3 to DY4**	**DY4 to DY5**
AABD	5.1%	5.1%	5.1%	5.1%	5.1%
FAM	3.9%	3.9%	3.9%	3.9%	3.9%

	Annualized Enrollment Trend (With Waiver)				
MEG	**Base to DY1**	**DY1 to DY2**	**DY2 to DY3**	**DY3 to DY4**	**DY4 to DY5**
AABD	1.0%	1.0%	1.0%	1.0%	1.0%
FAM	1.0%	1.0%	1.0%	1.0%	1.0%

The overall With Waiver and Without Waiver projections are displayed in Appendix I.

Newly Eligible Expansion Adults

The newly eligible adults reflect those adults eligible for Medicaid under Medicaid Expansion, via the Heritage Health Adult (HHA) program. Heritage Health Adult Expansion is considered “Hypothetical” for purposes of budget neutrality.

Without Waiver:

The Without Waiver projections for the HHA Expansion beneficiaries have been developed under the basis that without the demonstration, all members would be eligible for retro-active eligibility periods and would be eligible for the full state plan benefit offering. In order to develop the Without Waiver estimates for the HHA Expansion population, the first step was to identify expected volume of enrollees. This estimate was based on a review of 2017 American Community Survey (ACS) data. This data was reviewed for all Nebraska residents age 19-64 with income at or below 138% of the Federal Poverty Level (FPL) who are either uninsured, insured via direct purchase, or insured via an employer-sponsored plan. Using this data as a starting point, expected take-up assumptions were developed to convert the ACS data to an expected HHA Expansion enrollment volume and form the basis for this population. Total

member month estimates by DY are illustrated in Table 17 below. Note that the growth in enrollment in this population is higher for the first two years, as it is expected that the population will continue to ramp in through DY2:

Table 17 -- Without Waiver Expansion Enrollment Estimates

	HHA Expansion Member Month Estimates (Without Waiver)				
MEG	**DY1**	**DY2**	**DY3**	**DY4**	**DY5**
HHA	497,632	774,450	868,027	876,713	885,486

PMPMs for this population were projected based on assumptions regarding the expected acuity of the HHA population relative to the currently enrolled Family and Disabled adults, including expectations that a higher proportion of older and Medically Frail individuals would enroll during the initial two years of expansion. The expenditures underlying the projections include estimated capitation rates that would be paid to the Heritage Health MCOs, including payments for maternity supplemental payments related to deliveries that could occur while a member is categorized as Heritage Health Adult. The expenditures also include estimated capitation rates that would be paid to the Dental Benefit Manager; the Heritage Health and Dental expenditures are inclusive of estimates related to the HIPF and the 438.6 (c) directed payment for which the State is currently seeking approval and would be applicable for UNMC providers. Additionally, the projections include expenditures that would fall within the State's FFS system, such as medical claims related to long-term support services (LTSS).

With Waiver:

The development of the With Waiver enrollment and expenditure estimates accounts for the impact of excluding retro-active enrollment periods, in addition to an estimated impact to expenditures as a result of some beneficiaries receiving Basic benefits rather than Prime/State plan benefits (differences in Basic and Prime/State plan benefits is outlined in further detail below).

The estimated impact of excluding retro-active enrollment was derived based on a review of the overall member month and PMPM impact for the currently eligible adult populations. Table 18 below illustrates the estimated impact of excluding retro-active enrollment on total HHA Expansion member months and PMPMs:

Table 18 -- Expansion Retro Adjustment Impact

	HHA Expansion Retro Adjustment Impact (With Waiver)				
% Impact	**DY1**	**DY2**	**DY3**	**DY4**	**DY5**
MMs	-5.0%	-5.0%	-5.0%	-5.0%	-5.0%
PMPM	0.4%	0.6%	0.7%	0.7%	0.7%

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

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

The Prime benefits mirror the current State Plan; therefore, an adjustment was applied to the With Waiver estimates to reflect the impact of beneficiaries eligible for the Basic benefit package not receiving vision, dental, or OTC drugs. Based on a review of the anticipated portion of members who are automatically enrolled in Prime, as well as those who are anticipated to meet the community engagement, wellness initiatives, and personal responsibility activities, an estimated enrollment mix of Prime vs. Basic member months has been estimated in Table 19 below:

Table 19 -- Prime vs. Basic Enrollment Estimates

	Expansion Prime vs. Basic Estimated Enrollment Mix (With Waiver)				
Benefit Package	**DY1**	**DY2**	**DY3**	**DY4**	**DY5**
Prime	45%	67%	67%	67%	67%
Basic	55%	33%	33%	33%	33%

As a result of Basic beneficiaries not receiving vision, dental, or OTC medication, it is anticipated that a modest reduction to overall HHA PMPMs will ensue. Table 20 illustrates the estimated PMPM impact of certain members not being eligible for Prime benefits:

Table 20 -- Prime vs. Basic PMPM Impact Estimates

	Expansion Prime/Basic PMPM Impact (With Waiver)				
% Impact	**DY1**	**DY2**	**DY3**	**DY4**	**DY5**
PMPM	-1.53%	-0.83%	-0.83%	-0.83%	-0.83%

The overall budget neutrality estimates, inclusive of each demonstration year and corresponding trends for enrollment and expenditure growth by year, are displayed in Appendix I.

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.

Appendix I – Budget Neutrality Tables

Appendix I contains tables illustrating the 5-year historical base, along with the With Waiver and Without Waiver projections for each demonstration year for all populations subject to the 1115 waiver.

Appendix I.A Historical Caseload, PMPM, and Trend - Total Expenditures

	CY 2014 (BY1) 1/14-12/14	CY 2015 (BY2) 1/15-12/15	CY 2016 (BY3) 1/16-12/16	CY 2017 (BY4) 1/17-12/17	CY 2018 (BY5) 1/18-12/18	5 Year Total CY 2014 – CY 2018
MEG 01 - AABD						
TOTAL EXPENDITURES						
Eligible Member Months	179,372	176,559	178,197	179,379	182,351	895,857
Cost per Eligible	$2,101.42	$2,268.96	$2,257.30	$2,498.26	$2,624.06	$2,351.29
Expenditures	$376,935,161	$400,604,361	$402,243,549	$448,135,300	$478,500,010	$2,106,418,381
TREND RATES			Annual Change			5-Year Average
Eligible Member Months		-1.6%	0.9%	0.7%	1.7%	0.4%
Cost per Eligible		8.0%	-0.5%	10.7%	5.0%	5.7%
Expenditures		6.3%	0.4%	11.4%	6.8%	6.1%
					President's Budget Trend - Disabled	**5.1%**

	CY 2014 (BY1) 1/14-12/14	CY 2015 (BY2) 1/15-12/15	CY 2016 (BY3) 1/16-12/16	CY 2017 (BY4) 1/17-12/17	CY 2018 (BY5) 1/18-12/18	5 Year Total CY 2014 – CY 2018
MEG 02 - FAM						
TOTAL EXPENDITURES						
Eligible Member Months	299,972	283,023	305,893	318,942	318,640	1,526,470
Cost per Eligible	$391.45	$403.37	$433.68	$444.64	$456.46	$426.81
Expenditures	$117,424,390	$114,162,909	$132,659,063	$141,815,848	$145,445,347	$651,507,556
TREND RATES			Annual Change			5-Year Average
Eligible Member Months		-5.7%	8.1%	4.3%	-0.1%	1.5%
Cost per Eligible		3.0%	7.5%	2.5%	2.7%	3.9%
Expenditures		-2.8%	16.2%	6.9%	2.6%	5.5%
					President's Budget Trend - Adults	**5.2%**

	CY 2014 (BY1) 1/14-12/14	CY 2015 (BY2) 1/15-12/15	CY 2016 (BY3) 1/16-12/16	CY 2017 (BY4) 1/17-12/17	CY 2018 (BY5) 1/18-12/18	5 Year Total CY 2014 – CY 2018
All Included Populations						
TOTAL EXPENDITURES						
Eligible Member Months	479,344	459,581	484,090	498,321	500,991	2,422,327
Cost per Eligible	$1,031.33	$1,120.08	$1,104.97	$1,183.88	$1,245.42	$1,138.54
Expenditures	$494,359,551	$514,767,270	$534,902,612	$589,951,148	$623,945,357	$2,757,925,937
TREND RATES			Annual Change			5-Year Average
Eligible Member Months		-4.1%	5.3%	2.9%	0.5%	1.1%
Cost per Eligible		8.6%	-1.3%	7.1%	5.2%	4.8%
Expenditures		4.1%	3.9%	10.3%	5.8%	6.0%
					President's Budget Trend	**5.1%**

Appendix I.B Historical Caseload, PMPM, and Trend - Federal Only

	CY 2014 (BY1) 1/14-12/14	CY 2015 (BY2) 1/15-12/15	CY 2016 (BY3) 1/16-12/16	CY 2017 (BY4) 1/17-12/17	CY 2018 (BY5) 1/18-12/18	5 Year Total CY 2014 – CY 2018
MEG 01 - AABD						
TOTAL EXPENDITURES						
Eligible Member Months	179,372	176,559	178,197	179,379	182,351	895,857
Cost per Eligible	$1,142.59	$1,196.71	$1,158.73	$1,299.72	$1,379.14	$1,236.08
Expenditures	$204,949,070	$211,288,755	$206,481,670	$233,142,390	$251,487,643	$1,107,349,528
TREND RATES			Annual Change			5-Year Average
Eligible Member Months		-1.6%	0.9%	0.7%	1.7%	0.4%
Cost per Eligible		4.7%	-3.2%	12.2%	6.1%	4.8%
Expenditures		3.1%	-2.3%	12.9%	7.9%	5.2%
					President's Budget Trend - Disabled	**5.1%**

	CY 2014 (BY1) 1/14-12/14	CY 2015 (BY2) 1/15-12/15	CY 2016 (BY3) 1/16-12/16	CY 2017 (BY4) 1/17-12/17	CY 2018 (BY5) 1/18-12/18	5 Year Total CY 2014 – CY 2018
MEG 02 - FAM						
TOTAL EXPENDITURES						
Eligible Member Months	299,972	283,023	305,893	318,942	318,640	1,526,470
Cost per Eligible	$212.84	$212.75	$222.62	$231.33	$239.90	$224.29
Expenditures	$63,846,576	$60,212,372	$68,097,213	$73,779,695	$76,442,438	$342,378,295
TREND RATES			Annual Change			5-Year Average
Eligible Member Months		-5.7%	8.1%	4.3%	-0.1%	1.5%
Cost per Eligible		0.0%	4.6%	3.9%	3.7%	3.0%
Expenditures		-5.7%	13.1%	8.3%	3.6%	4.6%
					President's Budget Trend - Adults	**5.2%**

	CY 2014 (BY1) 1/14-12/14	CY 2015 (BY2) 1/15-12/15	CY 2016 (BY3) 1/16-12/16	CY 2017 (BY4) 1/17-12/17	CY 2018 (BY5) 1/18-12/18	5 Year Total CY 2014 – CY 2018
All Included Populations						
TOTAL EXPENDITURES						
Eligible Member Months	479,344	459,581	484,090	498,321	500,991	2,422,327
Cost per Eligible	$560.76	$590.76	$567.21	$615.91	$654.56	$598.49
Expenditures	$268,795,647	$271,501,127	$274,578,883	$306,922,084	$327,930,081	$1,449,727,823
TREND RATES			Annual Change			5-Year Average
Eligible Member Months		-4.1%	5.3%	2.9%	0.5%	1.1%
Cost per Eligible		5.3%	-4.0%	8.6%	6.3%	3.9%
Expenditures		1.0%	1.1%	11.8%	6.8%	5.1%
					President's Budget Trend	**5.1%**

Appendix I.C Without Waiver Projections - Total Expenditures

Medicaid Eligibility Group	Annual Trend Rate (DY1 to DY2)	Annual Trend Rate (DY2 to DY3)	Annual Trend Rate (DY3 to DY5)	FFY 2021 (DY1) 10/20-9/21	FFY 2022 (DY2) 10/21-9/22	FFY 2023 (DY3) 10/22-9/23	FFY 2024 (DY4) 10/23-9/24	FFY 2025 (DY5) 10/24-9/25	5 Year Total DY1 - DY5
AABD									
Eligible Member Months	1.0%	1.0%	1.0%	187,410	189,284	191,177	193,088	195,019	
Without Waiver Cost per Eligible	5.1%	5.1%	5.1%	$3,014.06	$3,167.78	$3,329.34	$3,499.14	$3,677.60	
Without Waiver Expenditures	6.2%	6.2%	6.2%	$564,863,903	$599,609,238	$636,491,817	$675,643,136	$717,202,698	$3,193,810,792
FAM									
Eligible Member Months	1.0%	1.0%	1.0%	327,479	330,754	334,062	337,402	340,776	
Without Waiver Cost per Eligible	3.9%	3.9%	3.9%	$589.81	$612.93	$636.96	$661.93	$687.88	
Without Waiver Expenditures	5.0%	5.0%	5.0%	$193,150,661	$202,729,206	$212,784,003	$223,336,781	$234,413,298	$1,066,413,948
All Included Populations									
Eligible Member Months	1.0%	1.0%	1.0%	514,889	520,038	525,238	530,491	535,796	
Without Waiver Cost per Eligible	4.8%	4.8%	4.8%	$1,472.19	$1,542.85	$1,616.93	$1,694.62	$1,776.08	
Without Waiver Expenditures	5.8%	5.9%	5.9%	$758,014,563	$802,338,444	$849,275,820	$898,979,917	$951,615,996	$4,260,224,740
Hypothetical Groups									
HHA									
Eligible Member Months	55.6%	12.1%	1.0%	497,632	774,450	868,027	876,713	885,486	
Without Waiver Cost per Eligible	-1.3%	3.7%	5.1%	$1,005.81	$992.57	$1,029.12	$1,081.68	$1,136.92	
Without Waiver Expenditures	53.6%	16.2%	6.2%	$500,523,220	$768,693,244	$893,307,395	$948,324,420	$1,006,729,835	$4,117,578,114
Without Waiver Total Expenditures	**24.8%**	**10.9%**	**6.0%**	**$1,258,537,783**	**$1,571,031,688**	**$1,742,583,215**	**$1,847,304,337**	**$1,958,345,831**	**$8,377,802,854**

Appendix I.D Without Waiver Projections - Federal Only

Medicaid Eligibility Group	Annual Trend Rate (DY1 to DY2)	(DY2 to DY3)	(DY3 to DY5)	FFY 2021 (DY1) 10/20-9/21	FFY 2022 (DY2) 10/21-9/22	FFY 2023 (DY3) 10/22-9/23	FFY 2024 (DY4) 10/23-9/24	FFY 2025 (DY5) 10/24-9/25	5 Year Total DY1 - DY5
AABD									
Eligible Member Months	1.0%	1.0%	1.0%	187,410	189,284	191,177	193,088	195,019	
Without Waiver Cost per Eligible	5.1%	5.1%	5.1%	$1,649.90	$1,734.04	$1,822.48	$1,915.43	$2,013.12	
Without Waiver Expenditures	6.2%	6.2%	6.2%	$309,206,500	$328,226,097	$348,415,621	$369,847,053	$392,596,757	$1,748,292,027
FAM									
Eligible Member Months	1.0%	1.0%	1.0%	327,479	330,754	334,062	337,402	340,776	
Without Waiver Cost per Eligible	3.9%	3.9%	3.9%	$322.86	$335.52	$348.67	$362.34	$376.55	
Without Waiver Expenditures	5.0%	5.0%	5.0%	$105,730,672	$110,973,967	$116,477,963	$122,254,554	$128,317,839	$583,754,995
All Included Populations									
Eligible Member Months	1.0%	1.0%	1.0%	514,889	520,038	525,238	530,491	535,796	
Without Waiver Cost per Eligible	4.8%	4.8%	4.8%	$805.88	$844.55	$885.11	$927.63	$972.23	
Without Waiver Expenditures	5.8%	5.9%	5.9%	$414,937,172	$439,200,064	$464,893,584	$492,101,607	$520,914,596	$2,332,047,023
Hypothetical Groups									
HHA									
Eligible Member Months	55.6%	12.1%	1.0%	497,632	774,450	868,027	876,713	885,486	
Without Waiver Cost per Eligible	-1.3%	3.7%	5.1%	$905.23	$893.31	$926.21	$973.51	$1,023.23	
Without Waiver Expenditures	53.6%	16.2%	6.2%	$450,470,898	$691,823,920	$803,976,655	$853,491,978	$906,056,851	$3,705,820,302
Without Waiver Total Expenditures	**30.7%**	**12.2%**	**6.0%**	**$865,408,070**	**$1,131,023,984**	**$1,268,870,239**	**$1,345,593,585**	**$1,426,971,447**	**$6,037,867,325**

Appendix I.E With Waiver Projections - Total Expenditures

Medicaid Eligibility Group	Annual Trend Rate (DY1 to DY2)	(DY2 to DY3)	(DY3 to DY5)	FFY 2021 (DY1) 10/20-9/21	FFY 2022 (DY2) 10/21-9/22	FFY 2023 (DY3) 10/22-9/23	FFY 2024 (DY4) 10/23-9/24	FFY 2025 (DY5) 10/24-9/25	5 Year Total DY1 - DY5
AABD									
Eligible Member Months	1.0%	1.0%	1.0%	182,848	184,677	186,523	188,389	190,272	
With Waiver Cost per Eligible	5.1%	5.1%	5.1%	$2,982.02	$3,134.10	$3,293.94	$3,461.93	$3,638.49	
With Waiver Expenditures	6.2%	6.2%	6.2%	$545,256,562	$578,794,736	$614,396,568	$652,187,924	$692,304,302	$3,082,940,091
FAM									
Eligible Member Months	1.0%	1.0%	1.0%	308,720	311,808	314,926	318,075	321,256	
With Waiver Cost per Eligible	3.9%	3.9%	3.9%	$607.15	$630.95	$655.68	$681.38	$708.09	
With Waiver Expenditures	5.0%	5.0%	5.0%	$187,439,565	$196,734,980	$206,490,441	$216,729,870	$227,477,907	$1,034,872,764
All Included Populations									
Eligible Member Months	1.0%	1.0%	1.0%	491,568	496,484	501,449	506,463	511,528	
With Waiver Cost per Eligible	4.8%	4.8%	4.8%	$1,490.53	$1,562.04	$1,637.03	$1,715.66	$1,798.11	
With Waiver Expenditures	5.8%	5.8%	5.9%	$732,696,127	$775,529,716	$820,887,009	$868,917,794	$919,782,209	$4,117,812,855
Hypothetical Groups									
HHA									
Eligible Member Months	55.6%	12.1%	1.0%	472,751	735,727	824,626	832,877	841,212	
With Waiver Cost per Eligible	-0.4%	3.7%	5.1%	$994.25	$990.67	$1,027.43	$1,079.90	$1,135.05	
With Waiver Expenditures	55.1%	16.2%	6.2%	$470,031,941	$728,859,780	$847,244,428	$899,424,525	$954,818,290	$3,900,378,964
With Waiver Total Expenditures	**25.1%**	**10.9%**	**6.0%**	**$1,202,728,069**	**$1,504,389,496**	**$1,668,131,437**	**$1,768,342,319**	**$1,874,600,499**	**$8,018,191,819**

Appendix I.F With Waiver Projections - Federal Only

Medicaid Eligibility Group	Annual Trend Rate (DY1 to DY2)	Annual Trend Rate (DY2 to DY3)	Annual Trend Rate (DY3 to DY5)	FFY 2021 (DY1) 10/20-9/21	FFY 2022 (DY2) 10/21-9/22	FFY 2023 (DY3) 10/22-9/23	FFY 2024 (DY4) 10/23-9/24	FFY 2025 (DY5) 10/24-9/25	5 Year Total DY1 - DY5
AABD									
Eligible Member Months	1.0%	1.0%	1.0%	182,848	184,677	186,523	188,389	190,272	
With Waiver Cost per Eligible	5.1%	5.1%	5.1%	$1,632.36	$1,715.61	$1,803.10	$1,895.06	$1,991.71	
With Waiver Expenditures	6.2%	6.2%	6.2%	$298,473,442	$316,832,238	$336,320,681	$357,007,669	$378,967,375	$1,687,601,406
FAM									
Eligible Member Months	1.0%	1.0%	1.0%	308,720	311,808	314,926	318,075	321,256	
With Waiver Cost per Eligible	3.9%	3.9%	3.9%	$332.35	$345.38	$358.92	$372.99	$387.61	
With Waiver Expenditures	5.0%	5.0%	5.0%	$102,604,418	$107,692,728	$113,032,868	$118,637,931	$124,521,406	$566,489,351
All Included Populations									
Eligible Member Months	1.0%	1.0%	1.0%	491,568	496,484	501,449	506,463	511,528	
With Waiver Cost per Eligible	4.8%	4.8%	4.8%	$815.91	$855.06	$896.11	$939.15	$984.28	
With Waiver Expenditures	5.8%	5.8%	5.9%	$401,077,860	$424,524,967	$449,353,549	$475,645,600	$503,488,781	$2,254,090,757
Hypothetical Groups									
HHA									
Eligible Member Months	55.6%	12.1%	1.0%	472,751	735,727	824,626	832,877	841,212	
With Waiver Cost per Eligible	-0.4%	3.7%	5.1%	$894.82	$891.60	$924.69	$971.91	$1,021.55	
With Waiver Expenditures	55.1%	16.2%	6.2%	$423,028,747	$655,973,802	$762,519,985	$809,482,072	$859,336,461	$3,510,341,067
With Waiver Total Expenditures	**31.1%**	**12.2%**	**6.0%**	**$824,106,607**	**$1,080,498,768**	**$1,211,873,534**	**$1,285,127,673**	**$1,362,825,242**	**$5,764,431,824**

Appendix II – Public Notice and Tribal Consultation

1. Public Notice Process

In accordance with the requirements set forth at 42 C.F.R. § 431.408, Nebraska's Department of Health and Human Services, Division of Medicaid and Long-Term Care (MLTC), has provided the public with an opportunity to review and comment on this demonstration application. The following describes the actions taken by MLTC to ensure compliance with the public notice process described in Section 431.408.

On October 25, 2019, MLTC posted the full public notice for the 1115 demonstration application, as well as the draft demonstration application, itself, on MLTC's dedicated Heritage Health Adult (HHA) Demonstration web page: http://dhhs.ne.gov/Pages/Heritage-Health-Adult-Demonstration.aspx. This webpage was shared with MLTC's stakeholder listserv. A copy of this message is included as Attachment 1. In compliance with Section 431.408(a), this public notice included a comprehensive description of the demonstration application with a sufficient level of detail to ensure meaningful input from the public; the locations where copies of the demonstration were available for public review and comment; the postal and e-mail addresses where written comments could be sent by the public and the 30-day time period in which comments would be accepted; and, the location, date, and time of the four (4) public hearings convened to solicit public input on the demonstration. A copy of the full public notice is included as Attachment 2.

On October 25, 2019, in compliance with Section 431.408(a)(2), MLTC published an abbreviated public notice on the State's Medicaid Public Notices webpage in accordance with the Nebraska Administrative Procedure Act: http://dhhs.ne.gov/Pages/Medicaid-Public-Notices.aspx. MLTC also published the abbreviated public notice in the *Lincoln Journal-Star*. A copy of the abbreviated public notice is included as Attachment 3. A copy of the abbreviated notice published in the *Lincoln Journal-Star* is included as Attachment 4.

Public comments on the demonstration application were accepted from October 25, 2019 to November 26, 2019.

The public was invited to submit written comments electronically at DHHS.HHAWaiver@Nebraska.gov or via mail to the following address:

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

MLTC held four public hearings where an overview of the 1115 demonstration application was presented and public comments were accepted.

Hearing 1: Tuesday, October 29, 2019
Time: 7:00 – 8:30 pm Mountain
Location: Board Room, Scottsbluff High School, 313 E 27th St., Scottsbluff, NE 69361
Conference Line: 844-588-2804
Passcode: 704387476
Approximate number of attendees: 15

Hearing 2: Wednesday, October 30, 2019
Time: 6:45 – 8:15 pm Central
Location: South Platte Room, Kearney Public Library, 2020 1st Ave., Kearney, NE 68847
Conference Line: 844-588-2804
Passcode: 985819573
Approximate number of attendees: 30

Hearing 3: Thursday, November 7, 2019
Time: 6:00 – 7:30 pm Central
Location: Meeting Room A, Norfolk Public Library, 308 W Prospect Ave., Norfolk, NE 68701
Approximate number of attendees: 14

Hearing 4: Tuesday, November 12, 2019
Time: 7:00 – 8:30 pm Central
Location: Room 132, UNO College of Public Affairs and Community Service, 6320 Maverick Plaza, Omaha, NE 68182
Conference Line: 844-588-2804
Passcode: 7300221
Approximate number of attendees: 58

Printed copies of the demonstration application and public notice were made available at each public hearing. Three of the four public hearings included toll-free teleconference numbers. Details for the public hearings were posted on the dedicated demonstration webpage, in the full public notice, itself, and on the Nebraska State Government's public meeting calendar, a copy of which is included in Attachment 5. A copy of the presentation given at all of the public meetings is included as Attachment 6. Copies of each meeting's agenda are included as Attachment 7. Copies of the sign-in sheets from each meeting are included as Attachment 8.

2. Summary of Public Comments

MLTC received approximately 430 written comments from individuals, legal advocates, health care providers, and social service providers during the comment period. Copies of written comments and an example of an email comment are included as Attachment 9. MLTC also received a number of verbal comments at its public hearings. We are pleased with the high level of public engagement with these proposals and appreciate the thoughtful input and feedback provided in the written comments and at the public hearings. In response to these comments, MLTC has made changes to the draft application to clarify its intent and refine certain details of the proposal. MLTC has removed the requirement for beneficiaries to complete clinical labs ordered by their provider. Upon further consideration, MLTC does not believe adherence to this requirement can be equitably monitored for all beneficiaries subject to the wellness, personal responsibility, and community engagement activities under this proposal. Based on public comments received regarding the ability of beneficiaries to effectively participate with the beneficiary engagement activities, MLTC has further clarified the lookback period for attending appointments. Originally, the application proposed that MLTC would look for three instances of missed appointments within the beneficiary's preceding 6-month benefit tier review period. As outlined in Section 4.2.1, MLTC has revised the lookback period for attending appointments to include the first six months of the 12-month period preceding the benefit tier review date. This approach to the lookback better aligns with the structure of lookback periods for other beneficiary engagement activities such the Annual Health Visit. MLTC believe this change will improve the ability of beneficiaries to effectively participate in beneficiary engagement activities. A summary of the comments and responses is included as Attachment 10.

3. Tribal Consultation

On October 10, 2019, MLTC electronically sent a tribal pre-notice document of the 1115 demonstration application to representatives and constituents of the State's federally recognized tribal organizations. A copy of the tribal pre-notice document is included as Attachment 11. MLTC also met with tribal representatives on October 10, 2019, at 1:00 pm, at the Ponca Tribe of Nebraska Headquarters, 1701 E Street, Lincoln, NE. At the meeting print copies of the tribal pre-notice were made available and MLTC gave a presentation about the HHA program and demonstration application. A copy of the presentation is included as Attachment 12.

On October 25, 2019, MLTC electronically sent a formal tribal notice document of the 1115 demonstration application to representatives and constituents of the State's federally recognized tribal organizations. A copy of the formal tribal notice document is included as Attachment 13.

Comments on the demonstration application from the tribal organizations were accepted from October 10, 2019 to November 26, 2019.

The State received no written comments from tribal organizations.

Attachment 1

From: Preston, Drew
To: "DHHS-mltcstakeholder@listserv.nebraska.gov"
Subject: Section 1115 Waiver for Medicaid Expansion
Date: Friday, October 25, 2019 10:28:00 AM

Good morning,

Today, the Department of Health and Human Services, Division of Medicaid and Long-Term Care released its draft application for a section 1115 demonstration waiver for Medicaid expansion. This waiver will allow the State to build the Heritage Health Adult expansion program.

For more information, including a copy of the waiver application draft, the public notice, and details on our public hearings for the waiver, please visit http://dhhs.ne.gov/pages/Heritage-Health-Adult-Demonstration.aspx.

NEBRASKA
Good Life. Great Mission.
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.
-

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.

[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.

Attachment 2

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.

Attachment 3

NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES PUBLIC NOTICE

Posted: October 25, 2019

Section 1115 Heritage Health Adult Expansion Demonstration

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

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 this abbreviated 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" ("HHA"); (2) hold public hearings to receive comments on the Section 1115 demonstration application.

Summary of HHA Program Features

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 benefits package plus vision, dental, and over-the-counter medication. Both benefit packages will be provided through the State's current managed care entities.

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
- Beginning in Demonstration Year (DY) 1, they engage in the wellness initiatives and personal responsibility activities. Beginning in DY2, HHS beneficiaries must also participate in community engagement activities, including but not limited to, employment, job-seeking activities, and educational activities. HHA beneficiaries who do not engage in these activities will be assigned to the Basic benefits package.

In addition to the tiered benefit structure, MLTC will encourage timely enrollment and promote increased continuity of care through a waiver of retroactive eligibility for HHA and most other adult Medicaid beneficiaries, with the exception of pregnant women, individuals dually-eligible for Medicare and Medicaid, and individuals in nursing facilities.

Attachment 3

In addition to the tiered benefit structure, MLTC will encourage timely enrollment and promote increased continuity of care through a waiver of retroactive eligibility for HHA and most other adult Medicaid beneficiaries, with the exception of pregnant women, individuals dually-eligible for Medicare and Medicaid, and individuals in nursing facilities.

Finally, MLTC plans to facilitate and encourage more widespread enrollment in private health insurance through a future amendment to the demonstration.

Public Meetings and Comment

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

A full public notice statement describing the demonstration application in more detail can be found at the following link: Full Public Notice. A draft of the demonstration application itself can be found on the Heritage Health Adult Demonstration webpage. 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.

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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.

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Attachment 4

*** Proof of Publication ***

State of Nebraska)
Lancaster County) SS.

NE DEPT OF HEALTH & HUMAN SERVICES

P.O. BOX 95026
LINCOLN NE 68509

ORDER NUMBER 877358

The undersigned, being first duly sworn, deposes and says that she/he is a Clerk of the Lincoln Journal Star, legal newspaper printed, published and having a general circulation in the County of Lancaster and State of Nebraska, and that the attached printed notice was published in said newspaper

one successive times(s) the first insertion having been on October 25, 2019 and thereafter on

_____, 20_____ and that said newspaper is the legal newspaper under the statues of the State of Nebraska.

Mary Wintsman

Section: Class Legals
Category: 0099 LEGALS
PUBLISHED ON: 10/25/2019

TOTAL AD COST:	89.88
FILED ON:	10/25/2019

The above facts are within my personal knowledge and are further verified by my personal inspection of each notice in each of said issues.

Subscribed in my presence and sworn to before me on

Oct 25, 2019

U K Boone Notary Public

GENERAL NOTARY - State of Nebraska
UVA K. BOONE
My Comm. Exp. January 31, 2021

Attachment 4

*** Proof of Publication ***

ABBREVIATED PUBLIC NOTICE

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

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HHA beneficiaries will receive the Prime benefits package if:

They are medically frail; or

Age 19 or 20; or

Pregnant Women eligible under expansion; or

Beginning in Demonstration Year (DY) 1, they engage in the wellness initiatives and personal responsibility activities. Beginning in DY2, HHS beneficiaries must also participate in community engagement activities, including but not limited to, employment, job-seeking activities, and educational activities. HHA beneficiaries who do not engage in these activities will be assigned to the Basic benefits package.

In addition to the tiered benefit structure, MLTC will encourage timely enrollment and promote increased continuity of care through a waiver of retroactive eligibility for HHA and most other Medicaid enrollees, with the exception of pregnant women, individuals dually-eligible for Medicare and Medicaid, and individuals in nursing facilities.

Finally, MLTC plans to facilitate and encourage more widespread enrollment in private health insurance through a future amendment to the demonstration.

Public Meetings and Comment

The public is invited to review and comment on the State's demonstration request. A full public notice statement describing the demonstration application in more detail can be found at at http://dhhs.ne.gov/Pages/Heritage-Health-Adult-Demonstration.aspx, and a draft of the demonstration application itself will be found at http://dhhs.ne.gov/Pages/Heritage-Health-Adult-Demonstration.aspx. Appointments may be made to view a hard copy of the full public notice document and a draft of the amendment application by calling 402-471-9718. Appointments may be made during regular business hours, Monday through Friday. Appointments to view the documents will take place at the Nebraska State Office Building, 301 Centennial Mall South, Lincoln NE.

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

Attachment 4

*** Proof of Publication ***

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 Email: DHHS.HHA-Waiver@Nebraska.gov

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Wednesday, October 30, 2019 6:45 pm - 8:15 pm CDT South Platte Room Kearney Public Library 2020 1st Ave, Kearney, NE 68847 Room Capacity 100

Thursday, November 7, 2019 6 pm - 7:30 pm CST Meeting Room A Norfolk Public Library 308 W Prospect Ave, Norfolk, NE 68701 Room Capacity 100

Tuesday, November 12, 2019 7 pm - 8:30 pm CST Room 132 UNO College of Public Affairs & Community Service University of Nebraska Omaha 6320 Maverick Plaza, Omaha, NE 68182 room Capacity 110

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.

877358 1t Oct 25

Attachment 5

Date	Time	Activity	Agency	Location
Tue 10/29/2019	7:00 PM MST	Public Hearing	Department of Health & Human Services : Department of Health & Human Services : Division of Medicaid and long term care	Board Room, Scottsbluff High School 313 E 27th St, Scottsbluff, NE 69361
Wed 10/30/2019	6:45 PM Central	Public Hearing	Department of Health & Human Services : Department of Health & Human Services : Division of Medicaid and long term care	South Platte Room, Kearney Public Library 2020 1st Ave, Kearney, NE 68847
Thu 11/07/2019	6:00 PM Central	Public Hearing	Department of Health & Human Services : Department of Health & Human Services : Division of Medicaid and long term care	Meeting Room A, Norfolk Public Library 308 W Prospect Ave, Norfolk, NE 68701
Tue 11/12/2019	7:00 PM Central	Public Hearing	Department of Health & Human Services : Department of Health & Human Services : Division of Medicaid and long term care	Room 132, UNO College of Public Affairs and Community Service 6320 Maverick Plaza, Omaha, NE 68182

HERITAGE HEALTH ADULT EXPANSION

Nebraska's Section 1115 Demonstration Application

Nathan R. Watson, JD

Deputy Director for Policy and Regulations

Nebraska Division of Medicaid and Long-Term Care

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Medicaid Expansion

HERITAGE HEALTH ADULT EXPANSION

- Initiative 427: Nebraska voters elected 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 the adult Medicaid expansion project

- “Heritage Health Adult” will be the program through which Initiative 427 is implemented

- Heritage Health Adult beneficiaries will be enrolled in managed care plans operated by Nebraska's existing Heritage Health program

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Attachment 6

Who is covered by the expansion?

HERITAGE HEALTH ADULT EXPANSION

Individuals under 138% of the federal poverty level who are not otherwise eligible for Medicaid

Family Size	138% of the federal poverty level
1	$16,753
2	$22,715
3	$28,676
4	$34,638
5	$40,600
6	$46,561

*Figures reflect 2019 federal poverty levels

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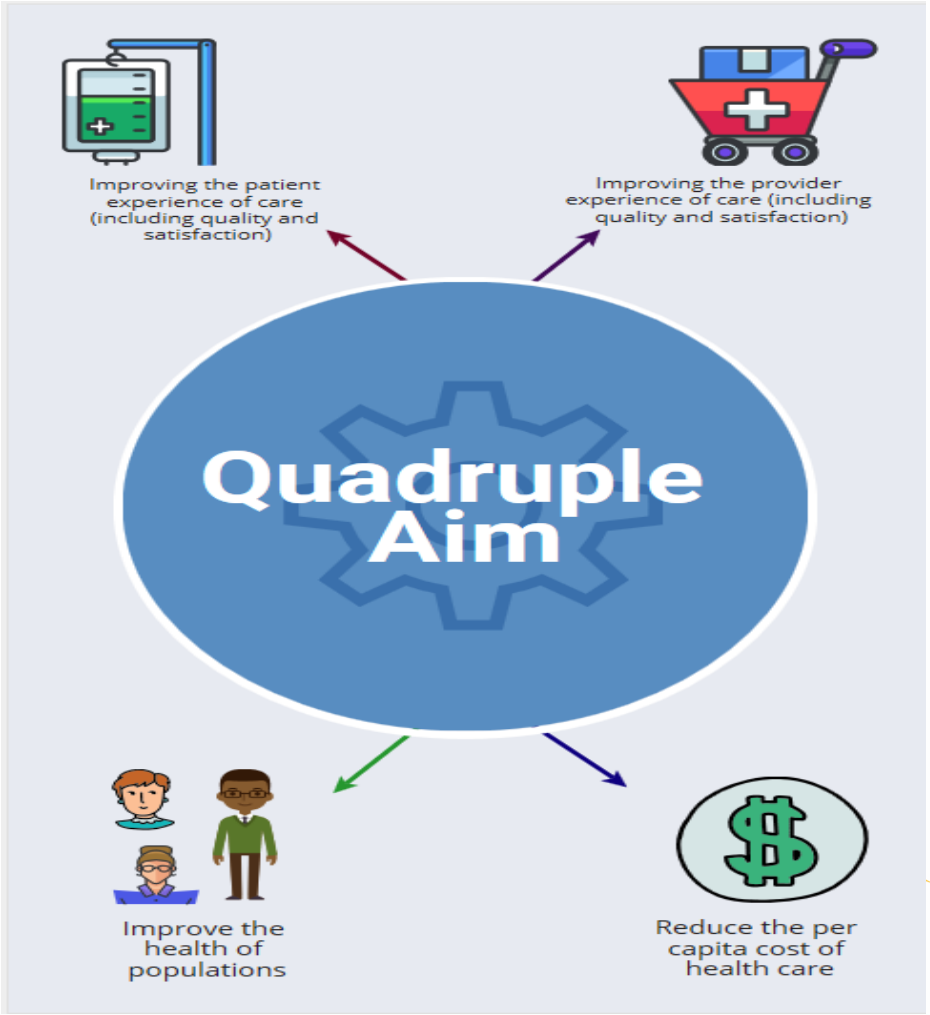
Attachment 6

Heritage Health Adult expansion: Goals

MLTC's goals for the Nebraska Medicaid program are rooted in the concept of the Quadruple Aim.

Using the Quadruple Aim as a guide, MLTC proposes a Heritage Health Adult program that will:

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



How does the Heritage Health Adult expansion accomplish these goals?

HERITAGE HEALTH ADULT EXPANSION

- The Heritage Health Adult program has innovative features designed to improve health through beneficiary engagement in:
  - Wellness initiatives;
  - Personal responsibility activities; and
  - Community engagement.
- These features require federal approval through a section 1115 demonstration waiver
- When does Nebraska intend to submit the expansion waiver to the federal government for review?
  - December 2019
- When will the Heritage Health Adult expansion program be implemented?
  - October 1, 2020

Tiered Benefit System

Attachment 6

HERITAGE HEALTH ADULT EXPANSION

- The Heritage Health Adult program proposes a tiered benefit system
  - Under the tiered benefit system, all eligible beneficiaries will receive either the “Basic” benefits package or the “Prime” benefits package.
- All beneficiaries newly eligible for Medicaid under the Heritage Health Adult program will receive the Basic benefits package for the initial six month benefit tier period.
  - Benefit tiers will be reviewed every six months.
- Beneficiaries will receive the Prime benefits package if:
  - They are medically frail; or
  - They are age 19 or 20; or
  - They engage in wellness initiatives and personal responsibility activities, and beginning in Demonstration Year (DY) 2, they participate in community engagement activities.

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Basic and Prime Benefit Tier Services

HERITAGE HEALTH ADULT EXPANSION

Basic Benefit Tier Services

- Ambulatory
- Emergency
- Hospitalization
- Maternity and Newborn
- Mental Health and Substance Use Disorder Services, including Behavioral Health
- Prescription Drugs
- Rehabilitative & Habilitative Services and devices
- Laboratory Services
- Preventive, wellness, and chronic disease management
- Other services such as: long-term care, non-emergency medical transportation, durable medical equipment

Prime Benefit Tier Services

- All services included in the Basic Tier; plus:
- Dental
- Dentures
- Optometrist
- Eyeglasses
- Over the counter medication
- Pediatric services including oral and vision care (EPSDT services for 19 and 20 year olds)

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What does “medically frail” mean?

HERITAGE HEALTH ADULT EXPANSION

- “Medically frail” is determined based on complex health needs
- States that expand Medicaid are required to have a process for identifying medically frail beneficiaries
- Federal rules define “medically frail” as an individual with special medical needs and must include at least the following:
  - Individuals with disabling mental disorders,
  - Individuals with chronic substance use disorders,
  - Individuals with serious and complex medical conditions,
  - Individuals with a physical, intellectual or developmental disability

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Attachment 6

Beneficiary Engagement

HERITAGE HEALTH ADULT EXPANSION

What are Wellness Initiatives?

- Actively participate in case and care management with the managed care organizations;
- Attend an annual health visit; and
- Select a Primary Care Provider.

What are Personal Responsibility activities?

- Not miss three or more scheduled medical or dental appointments;
- Maintain commercial health coverage; and
- Notify MLTC, timely, of changes which impact eligibility such as changes in income or residency.

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Why is Nebraska adding wellness and personal responsibility requirements?

HERITAGE HEALTH ADULT EXPANSION

- 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.

Non-participation will not impact the beneficiary's Medicaid eligibility, only the benefit tier.

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What is Community Engagement?

MLTC is proposing to empower individual life successes through positive community engagement.

These activities may include:

- Employed or self-employed,
- Volunteer activities,
- Enrolled in college, university, trade school, training program,
- Caregiver of dependent child or elderly or disabled relative,
- SNAP Employment and Training program,
- TANF/AFDC Employment First program, or
- SNAP and TANF recognized job search activities.

Community Engagement Exceptions

Exemptions from these requirements may include:

- Medically frail,
- 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,
- Victims of domestic violence, when participation would make it harder to escape, penalize the individual, or put them at further risk of domestic violence,
- Residing in an area that has been granted a federal ABAWD waiver due to insufficient jobs,
- Individuals experiencing chronic homelessness,
- Pregnant or in a post-partum period,
- In high-school at least half time, or
- Age 60 or older.

Is this like other states' work requirements?

HERITAGE HEALTH ADULT EXPANSION

In short, No.

- Other states are terminating Medicaid enrollment if a beneficiary is unable to satisfy work requirements.
- Nebraska will not drop individuals from Medicaid if they are unable to meet all of the requirements.
- Participating in community engagement only affect access to the additional services available through the Prime package.

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Attachment 6

Additional Demonstration Waiver Request

HERITAGE HEALTH ADULT EXPANSION

In addition to the Heritage Health Adult expansion program, Nebraska is requesting additional approval to eliminate “retroactive” Medicaid coverage.

- This will mean coverage and benefits will begin on the first day of the application month.
- Exceptions to the elimination of retroactive coverage include:
  - Pregnant women,
  - Children ages 0 to 18 years old,
  - Beneficiaries enrolled in both Medicare and Medicaid, and
  - Nursing facility residents

Changing retroactive eligibility will promote

- Early and continuous coverage
- Enrollment of eligible people at the time when care and case management can assist
- Consistency with commercial and federal markets

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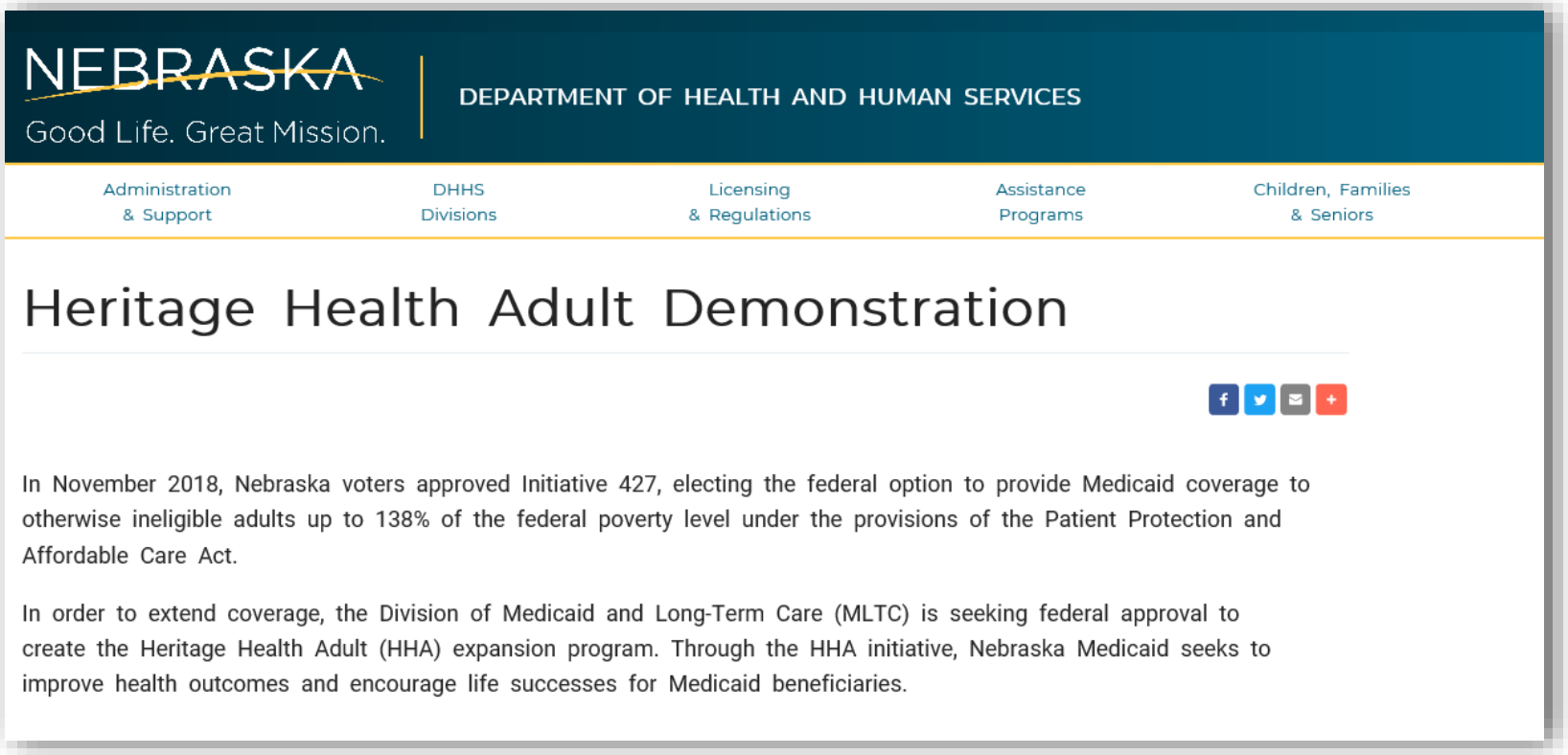
Attachment 6

Waiver Application Webpage

- Additional information about the demonstration program, including the proposed waiver application, the full public notice, additional public hearings, and the public input process, can be found on the DHHS website at:



- http://dhhs.ne.gov/Pages/Heritage-Health-Adult-Demonstration.aspx

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Public Feedback

MLTC would like to hear from stakeholders on:

- Demonstration program goals
- Evaluation criteria
- How the demonstration program impacts you as a provider/patient/advocate
- Any other aspect of the demonstration program

Public Comments

In accordance with federal law, MLTC is allowing 30 calendar days for public review and comment.

- Comments must be submitted to the department by November 26, 2019.
- Comments and questions about the proposed demonstration application can be submitted:
  - By email to: DHHS.HHAWaiver@Nebraska.gov
  - By mail to: Department of Health and Human Services
    Nebraska Medicaid
    ATTN: HHA Waiver
    301 Centennial Mall South
    P.O. Box 95026
    Lincoln, Nebraska 68509-5026

Attachment 6

CMS Submission & Review Process

HERITAGE HEALTH ADULT EXPANSION

State Public Comment Period

Oct. 25 – Nov. 26, 2019

→

Application Submission to CMS

December 2019

→

Federal Public Comment Period

Dec. – Jan. 2020

↓

CMS Application Review

Dec. 2019 - TBD

→

Demonstration Implementation

10-1-2020

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HERITAGE HEALTH ADULT EXPANSION

Thank You

@NEDHHS NebraskaDHHS @NEDHHS

dhhs.ne.gov

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DEPT. OF HEALTH AND HUMAN SERVICES Division of Medicaid and Long-Term Care

HERITAGE HEALTH
ADULT EXPANSION

Section 1115 Medicaid Expansion Waiver
Public Hearing Agenda

Meeting Date / Time	Tuesday, October 29, 2019; 7:00pm – 8:30pm
Meeting Location	Board Room Scottsbluff High School 313 E 27th St Scottsbluff NE 69361
Conference Line	(844) 588-2804 Meeting ID: 704387476

Agenda:

Topics	Facilitator
Welcome	Nate Watson
1115 Demonstration Waiver for Medicaid Expansion	Nate Watson
Public Comment on Waiver	Drew Preston

More Information:

1115 Waiver Website	http://dhhs.ne.gov/Pages/Heritage-Health-Adult-Demonstration.aspx
Public Comment Information	Public Comment Period Deadline: November 26, 2019 Email: DHHS.HHAWaiver@Nebraska.gov Mail: Department of Health and Human Services Division of Medicaid and Long-Term Care ATTN: HHA Waiver 301 Centennial Mall South P.O. Box 95026 Lincoln, Nebraska 68509-5026
	Printed copies of the waiver application will be available at this meeting.

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DEPT. OF HEALTH AND HUMAN SERVICES Division of Medicaid and Long-Term Care

HERITAGE HEALTH
ADULT EXPANSION

Section 1115 Medicaid Expansion Waiver
Public Hearing Agenda

Meeting Date / Time	**Wednesday, October 30, 2019; 6:45pm – 8:15pm**
Meeting Location	South Platte Room Kearney Public Library 2020 1st Ave Kearney, NE 68847
Conference Line	(844) 588-2804 Meeting ID: 985819573

Agenda:

Topics	Facilitator
Welcome	Nate Watson
1115 Demonstration Waiver for Medicaid Expansion	Nate Watson
Public Comment on Waiver	Drew Preston

More Information:

1115 Waiver Website	**http://dhhs.ne.gov/Pages/Heritage-Health-Adult-Demonstration.aspx**
Public Comment Information	Public Comment Period Deadline: November 26, 2019 Email: DHHS.HHAWaiver@Nebraska.gov Mail: Department of Health and Human Services Division of Medicaid and Long-Term Care ATTN: HHA Waiver 301 Centennial Mall South P.O. Box 95026 Lincoln, Nebraska 68509-5026
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NEBRASKA
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DEPT. OF HEALTH AND HUMAN SERVICES Division of Medicaid and Long-Term Care

HERITAGE HEALTH ADULT EXPANSION

Section 1115 Medicaid Expansion Waiver
Public Hearing Agenda

Meeting Date / Time	**Thursday, November 7, 2019; 6:00pm – 7:30pm**
Meeting Location	Meeting Room A Norfolk Public Library 308 W Prospect Ave Norfolk, NE 68701

Agenda:

Topics	Facilitator
Welcome	Nate Watson
1115 Demonstration Waiver for Medicaid Expansion	Nate Watson
Public Comment on Waiver	Drew Preston

More Information:

1115 Waiver Website	**http://dhhs.ne.gov/Pages/Heritage-Health-Adult-Demonstration.aspx**
Public Comment Information	Public Comment Period Deadline: November 26, 2019 Email: DHHS.HHAWaiver@Nebraska.gov Mail: Department of Health and Human Services Division of Medicaid and Long-Term Care ATTN: HHA Waiver 301 Centennial Mall South P.O. Box 95026 Lincoln, Nebraska 68509-5026
	Printed copies of the waiver application will be available at this meeting.

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES Division of Medicaid and Long-Term Care

HERITAGE HEALTH
ADULT EXPANSION

Section 1115 Medicaid Expansion Waiver
Public Hearing Agenda

Meeting Date / Time	Tuesday, November 12, 2019; 7:00pm – 8:30pm
Meeting Location	Room 132 UNO College of Public Affairs and Community Service 6320 Maverick Plaza Omaha, NE 68182
Conference Line	(888) 820-1398 Attendee code: 7300221

Agenda:

Topics	Facilitator
Welcome	Nate Watson
1115 Demonstration Waiver for Medicaid Expansion	Nate Watson
Public Comment on Waiver	Drew Preston

More Information:

1115 Waiver Website	http://dhhs.ne.gov/Pages/Heritage-Health-Adult-Demonstration.aspx
Public Comment Information	Public Comment Period Deadline: November 26, 2019 Email: DHHS.HHAWaiver@Nebraska.gov Mail: Department of Health and Human Services Division of Medicaid and Long-Term Care ATTN: HHA Waiver 301 Centennial Mall South P.O. Box 95026 Lincoln, Nebraska 68509-5026
	Printed copies of the waiver application will be available at this meeting.

Andy Gartner
[redacted]

October 18th, 2019

Division of Medicaid and Long-Term Care
Nebraska Department of Health and Human Services
301 Centennial Mall South
Lincoln, NE 68509

To Whom it May Concern,

As a resident of Hastings, NE, I am writing to express my disapproval of the Section 1115 Demonstration Waiver submitted by the Department, and the proposed Heritage Health Adult Program. Based on my review of the concept paper published by the Department in August of 2019, the proposed plan includes several elements that I strongly believe are not in the best interests of Nebraskans, including:

- A tiered benefit model, which withholds critical health services such as dental and vision care from low-income Nebraskans.
  - Lack of dental care can lead to poor nutrition, infection, heart disease, and even death. Dental care is NOT a luxury and should be considered an essential health service.
  - Lack of vision care can contribute to unnecessary burdens with transportation, job seeking, and even activities of daily living (ADLs). Serious vision problems may remain undiagnosed and untreated, and may progress to blindness or systemic health problems. Vision care is NOT a luxury and should be considered an essential health service.
- Work and community engagement requirements, which will result in an increased administrative and financial burden on the state of Nebraska.
  - Determining eligibility for "Prime Coverage" will require additional time and resources, all of which costs Nebraskans money.
  - Requirements such as these have been litigated and "struck down" in other states, including KY, AK, and NH. The proposed plan may open DHHS up to similar litigation and cost Nebraskans financially due to wasted time and resources, as well as legal fees.

- A delay in the expansion process, which has already impeded low-income Nebraskans from accessing care that they desperately need, and cost Nebraska financially in terms of Federal matching dollars.
    - The proposed plan is so complex that implementation has been delayed until October of 2020 - nearly two years after Nebraskans voted to expand the program. The cost to Nebraskans who would qualify for Medicaid under the expanded program cannot be quantified. These are real people, real Nebraskans, who are still waiting for health care.
    - The Federal matching rate for expansion started at 100% from 2014-2016, and drops every year until 2020. The rate for 2019 is 93%, and beginning in 2020 it will be 90%. This cost can be quantified and is unjustifiable.

The proposed plan is neither fiscally nor ethically defensible. This is clearly an attempt to knee-cap policy implementation and I will not stand for Nebraskans not having access to healthcare just because Pete Ricketts doesn't like a policy. As a Nebraskan, I implore the Department to do what is truly best for our state: to move forward with a simple, streamlined, cost-effective program expansion and do away with the proposed two-tiered plan and increased eligibility requirements. Now is the time to change course.

Sincerely,

Andy Gartner, Social Work student

Hastings

Adam Jacobs
[redacted]

October 23rd, 2019

Division of Medicaid and Long-Term Care
Nebraska Department of Health and Human Services
301 Centennial Mall South
Lincoln, NE 68509

To Whom it May Concern,

As a resident of Hastings, NE, I am writing to express my disapproval of the Section 1115 Demonstration Waiver submitted by the Department, and the proposed Heritage Health Adult Program. Based on my review of the concept paper published by the Department in August of 2019, the proposed plan includes several elements that I strongly believe are not in the best interests of Nebraskans, including:

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Sincerely,

Adam Jacobs

Hastings, NE

Lanae Hall
[redacted]

October 25th, 2019

Division of Medicaid and Long-Term Care
Nebraska Department of Health and Human Services
301 Centennial Mall South
Lincoln, NE 68509

To Whom it May Concern,

As a resident of Hastings, NE, I am writing to express my disapproval of the Section 1115 Demonstration Waiver submitted by the Department, and the proposed Heritage Health Adult Program. Based on my review of the concept paper published by the Department in August of 2019, the proposed plan includes several elements that I strongly believe are not in the best interests of Nebraskans, including:

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Sincerely,

Lanae Hall, PLMHP

Hastings, NE

Jean Stinnette
[redacted]

October 28th, 2019

Division of Medicaid and Long-Term Care
Nebraska Department of Health and Human Services
301 Centennial Mall South
Lincoln, NE 68509

To Whom it May Concern,

As a resident of __Inland_, NE, I am writing to express my disapproval of the Section 1115 Demonstration Waiver submitted by the Department, and the proposed Heritage Health Adult Program. Based on my review of the concept paper published by the Department in August of 2019, the proposed plan includes several elements that I strongly believe are not in the best interests of Nebraskans, including:

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Sincerely,

Jean Stinnette

[redacted]

October 28, 2019

Department of Health and Human Services
Nebraska Medicaid
ATTN: HHA Waiver
301 Centennial Mall South
P.O. Box 95026
Lincoln, NE 68509-5026
Via Email at DHHS.HHAWaiver@Nebraska.gov

To whom it may concern,

ACLU
AMERICAN CIVIL LIBERTIES UNION FOUNDATION
Nebraska

134 S. 13th St. #1010
Lincoln, NE 68508
(402) 476-8091
aclunebraska.org

For over 50 years in Nebraska, the ACLU has worked in courts, legislatures, and communities to protect the constitutional and individual rights of all people. With a nationwide network of offices and millions of members and supporters, we take up the toughest civil liberties fights. Beyond one person, party, or side — we the people dare to create a more perfect union.

The ACLU of Nebraska has supported Medicaid expansion efforts in the Nebraska Legislature and was proud to be a part of the successful citizen initiative which mandated such in November 2018. As such, we ask that our testimony be included in the official rulemaking record regarding the proposed Section 1115 waiver.

We support Medicaid expansion for three primary reasons as critical civil rights and civil liberties issues grounded in our disability rights, reproductive justice and smart justice decarceration work.

The ACLU strives for an America free of discrimination against people with disabilities, where people with disabilities are valued, integrated members of society who have full access to education, homes, health care, jobs, and families. We are also committed to ensuring people with disabilities are no longer segregated into, and overrepresented in, civil and criminal institutions such as nursing homes, psychiatric hospitals, jails, and prisons.

For millions of people with disabilities, Medicaid is a lifeline. Their ability to live free depends on the services and supports that Medicaid provides and allows them to get out of bed, go to work, and live in the community instead of an institution. It is no exaggeration to say that the lives and liberty of people with disabilities depend on a strong Medicaid program.

Medicaid is also the primary source of health care for millions of others. Medicaid matters because access to health care, facilitated by insurance coverage, enables individuals to participate in the economic, social, and civic life of the nation, advancing equal opportunity and personal liberty. It is a critical safety net program that extends dignity to millions.

The ACLU's reproductive justice work is grounded in the United States Constitution, case law, federal and state laws. Our reproductive justice work spans

a range of issues, including but not limited to, protecting access to affordable contraception, ensuring equitable access to prenatal care, protecting a woman's ability to make personal, private decisions about pregnancy and abortion, supporting pregnant and parenting students, fighting pregnancy and gender-based discrimination, and ensuring breastfeeding rights. A decision about having a baby or having an abortion is a deeply personal, private decision best left to a woman, her family, and her doctor. The constitutional right to privacy mandates that all reproductive decisions be personal, private, and made free from government intrusion. Realistically, there can be no freedom of choice in this realm without access to care. Women make up the majority of those enrolled in Medicaid. Nearly 40 million women rely on the program for care. This includes millions of women of reproductive age — 20 percent of all women aged 15-44, with women of color enrolled at higher rates.

ACLU
AMERICAN CIVIL LIBERTIES UNION FOUNDATION
Nebraska

Medicaid ensures that these millions of women have access to critical family planning services. It enables many women to decide when, whether, and how to start families. It also provides maternity care, covering approximately half of all births in the U.S. And when women enrolled in Medicaid give birth, it ensures that their newborns are covered as well.

The ACLU Campaign for Smart Justice is an unprecedented, multiyear effort to reduce the US jail and prison population by 50% and combat racial disparities in the criminal justice system. Nebraska continues to have a prison overcrowding and conditions crisis and currently ranks as the second most overcrowded system in the country. Studies show that states that have expanded Medicaid have positive impacts on decarceration.

In conclusion, the ACLU along with our coalition partners and our Nebraska neighbors believe Nebraskans are needlessly waiting for lifesaving coverage while the Department chooses to experiment with a proposed Section 1115 waiver that is incredibly confusing and imposes additional barriers and reduced benefits. It is especially concerning that work requirements have been included in this proposal, especially when work requirements have been shown to be expensive, burdensome, and legally suspect. Nebraskans voted to implement Medicaid expansion with their neighbors, friends, and family in mind. It's long past time to honor the vote of the people and swiftly begin the program without barriers or unnecessary experiments.

Thank you in advance for your time and consideration of this important matter. Please let us know if we can be of any additional assistance.

Danielle Conrad, J.D.
Executive Director

Valerie Bower, BSN, RN
[redacted]

October 29, 2019

Division of Medicaid and Long-Term Care
Nebraska Department of Health and Human Services
301 Centennial Mall South
Lincoln, NE 68509

To whom it may concern,

I am writing to express my opposition to the section 1115 demonstration waiver filed by the Nebraska Department of Health and Human Services (NE DHHS) and the proposed Heritage Health Adult Program. I am writing not only as a Nebraskan, a registered nurse, and a health policy advocate, but also as someone who has lived in poverty for most of my life. I am writing to try and explain to you why the news of this plan and expansion dely elicited such a strong, negative emotional response from me, and why I believe Nebraskans deserve something better.

I grew up in Nebraska in an unstable home run by unstable adults. I grew up as a child dependent on government programs for my education, my health, and during some periods, my housing. As many of you undoubtedly know, we live in a world where children born into poverty still die premature deaths due to preventable and/or treatable illnesses in other parts of the world. I credit my survival to state and federal programs. You see, I was vaccinated against deadly and crippling diseases. I had access to doctors and medications and even surgeries when I needed them. I had access to enough food to sustain life. I had a roof over my head, and even though the electricity might have been shut off every now and then, I was never subjected to a harsh Nebraska winter without a warm place to sleep at night.

I didn't just survive childhood. I spent it learning and growing and eventually graduated from a public high school (go Links!). I could not have done any of that without corrective lenses, paid for by Medicaid. I could not and cannot see more than a few inches in front of my face without glasses. The cost of even a basic pair was prohibitive for my family and yet, for most of my childhood, barring an extremely unpleasant few months in the 6th grade, I had glasses. I could see, and so I could read the chalkboard, follow the lesson, do my homework, etc. Not having access to this basic need would have crippled me and stunted my education.

I also, thankfully, had access to dental care as a child (you guessed it...through Medicaid). My visits to the dentist definitely didn't occur at recommended six-month intervals, however. The main contributing factors here were the aforementioned instability of my home and lack of transportation. Children don't make their own appointments, and my parents were not reliable

managers of my dental health. In addition, it was common for my family to be without a vehicle when I was a child. Even when we did have a vehicle, the cost of fuel was often a barrier. I have a lot of residual dental issues even now at the age of 33 that began when I was a child. However, coverage was not the issue. When the appointments were made and the transportation was available, I got to see the dentist. Whatever the dentist thought I needed, I got. I have many, many fillings as evidence of this. Every cleaning, every fluoride rinse, every filling, every emergency tooth repair, was paid for by government aid. While I did not pass from childhood to adulthood with perfect dental health, I doubt I would have had many teeth left if it wasn't for the dental care that I did receive when conditions were favorable.

What I'm trying to explain in this first section of my letter is that even though poor kids in Nebraska still have it rough, Nebraska is and has been doing some things right. I had access to medical, vision, and dental care as a child through state- and federally-funded programs that still operate today. Programs that have only improved since I was a child. Where we are going wrong, where this new plan goes wrong, is with poor adults.

When I became an adult, I no longer had access to the benefits that I had as a child. I went from being poor, but insured, to being poor and uninsured. This contributed to many negative life experiences...a few that I intend to share with you now. These experiences, and many others that I will refrain from sharing outside of a full-length autobiography, are at the core of my deeply-held belief that healthcare is a right. These experiences are also, collectively, the trauma behind the strong emotional response that I had while reading through the Heritage Health Adult Plan Concept Paper for the first time.

When I was 19 I got an ear infection. I didn't have insurance so I ignored it, hoping it would go away on its own. I was afraid to even call to make an outpatient appointment for fear that I'd be turned away for my inability to pay, or that I'd be treated but then slapped with a bill I couldn't afford, or handed a prescription that I couldn't fill. Like most infections, it didn't go away on its own. The pain became so unbearable that I wound up in the Emergency Room at Bryan LGH West. I was examined, diagnosed, given a prescription, and discharged. I didn't tell the doctor that I couldn't afford the prescription. In retrospect, I see that my shame and insecurity kept me silent. I left, only to return again with the same problem. During this second visit, the doctor asked me bluntly why I didn't fill the prescription. When I explained, he rolled his eyes, left the room, came back with a full course of the necessary medication, and sent me on my way.

After this second visit, my ear got better. But, then the bill came. I can't describe to you how emotionally crippling a bill for a few thousand dollars can be to a poor person. At this time in my life, I had a baby, no job, and a romantic partner who was working part-time for minimum wage. The hospital may as well have sent the bill to Santa Claus. I shut down. In my immaturity and insecurity I ignored the bill like I'd ignored the infection, hoping it would go away. But instead of festering in my body like the bacteria that had invaded my middle ear, the bill went to collections. I had started my adult life with no credit, and within the first year I officially had bad credit.

Bad credit for a poor person with poor friends and poor family members means a complete inability to borrow money. No car loans, no home loans, no private education loans. But, it means more than that. Apartment management companies wouldn't rent to me because of my credit score, which limited my access to adequate housing beyond the limitations inherent to my financial situation. I'm sure that there were other dings along the way; other bills that went unpaid and affected my credit negatively. But I started my adult life behind in this measurable way because I got sick while I was poor and uninsured. It took me almost a decade to recover and rebuild my credit.

Access to Medicaid might have made this part of my story different. It definitely would have improved my quality of life as a young adult, and it may have been the key to preventing financial calamity. But, under this new proposed plan, a lot of other problems would have been unavoidable. According to the concept paper published by NE DHHS on April 1st, 2019, the proposed Heritage Health Adult Program includes tiered benefits. Basic coverage, modeled after a commercial plan, will be available to beneficiaries initially, with "Prime Coverage" becoming effective for many members only after compliance is demonstrated. "Prime Coverage" is described as including benefits "that have not traditionally been covered by commercially available insurance, such as dental and vision services and over-the counter medications" (p. 4).

I find this specific tiered benefit model disturbing on many levels. First, it is reasonable to assume that an individual capable of affording a commercial plan like the one in question would also be capable of affording separate vision and dental coverage, not to mention a bottle of ibuprofen or acetaminophen. On this basis alone, modeling coverage for poor people using a commercial plan as a strict model just isn't logical. This plan was likely developed for a population capable of paying for their own insurance, and it stands to reason that it would not work as a "one size fits all" plan that meets the needs of the rich and poor alike.

This first argument is based on my knowledge of population-based health care, my experience with the insurance industry, and my perspective as a healthcare professional. While relevant, that's not primarily what this letter is about. This letter is about my knowledge, experience, and perspective as someone who has actually been poor. The goal of this letter is to offer insight into what life as a poor person is really like, and how this proposed plan falls short. And so, the next portion of my letter involves real-life experiences related to my vision and my dental health.

One of my first college writing assignments was to produce an essay on "a deeply meaningful personal experience." It could be positive or negative, but it needed to be autobiographical. I chose to write about a fresh, painful memory: being stuck in an airport with my son, who was a toddler, without my glasses. When my eldest son, Jude, was about 14-months old, an age when most children have learned to walk and resent any restrictions on their movement, I had a four-hour layover in a large, strange city. Under normal circumstances, this would have been annoying, frustrating, and exhausting. Being a young mother with a toddler stuck in an airport is no one's idea of a good time. For me though, this experience was traumatic.

I remember that he was wearing a red sweater. I remember this because it was all I could really make out if he got more than a few feet away from me. He wouldn't let me hold him, he cried if I

held his hand for too long. He was eager to run and play and explore. And my glasses had been broken a few days before and *I could not see*. There was no backup pair, and there was no money to see an eye doctor, get a new prescription (mine was expired), and get a new pair before my flight. I was trapped in this airport, solely responsible for the safety and wellbeing of my precious child, and I couldn't see. This experience was formative for me, and it was, as I mentioned, traumatic. It was essay-worthy. And over a decade later the memory still triggers feelings of immense panic and sadness. This is an example, albeit an extreme one, of what lack of access to vision care looks like. Less extreme examples would be my inability to operate a vehicle, read a PowerPoint slide or computer screen, or recognize a loved one on the street. Vision care is necessary not just for success, but for survival in our society. It is a core element of comprehensive healthcare.

And teeth...as a nurse I know that dental health affects many things. Dental infections can lead to sepsis and even chronic heart conditions. Dental pain can lead to poor nutrition and crippling headaches. Missing or broken teeth can affect a person's ability to get a job. And here I go, speaking as a nurse now. It's hard to turn that off. Let me speak again from the perspective of a poor person. I mentioned previously that I did not make it out of childhood with my teeth in perfect condition. That's really an understatement, as I'm sure my current dentist can corroborate.

When I was in my early 20s and had my first good job...a job that paid me a livable wage and actually offered benefits...I still couldn't afford dental insurance. It cost extra, and the extra was too much. After not seeing a dentist for several years, I wound up with an infected tooth. The pain was such that I had to call in sick and seek emergency dental services. I called around all morning until I found a dentist who would see me. They treated the infection, but told me I'd need a root canal in a few weeks. Then, the dentist perforated my tooth while attempting the root canal, necessitating an extraction.

To summarize...lack of access to dental care led to a dental infection which led to a botched root canal which led to the extraction of a once healthy molar. And I wish the story ended there. The molar behind the extracted tooth has shifted forward over the years, so now I need a bridge or an implant in order to salvage that tooth. Notice the tense: "need." My dentist in Hastings has been waiting patiently for years for me to finish nursing school and get a job so that we can proceed with this necessary dental work. The treatment for that infection, the botched root canal, and the extraction...all of that was out-of-pocket. This procedure, because it is the result of a pre-existing condition (still an exclusion for dental plans), will be out-of-pocket. I can only now afford this procedure, which will cost me over $2,000 out of pocket. That amount of money might as well have been a million dollars before I had my nursing degree. I know that may sound ridiculous to some, but it's true. Ask any poor person.

The NE DHHS refers to the proposed tiered benefit model as a way to "incentivize personal responsibility by promoting wellness activities and life success" and states that "an important aspect to improving the health of populations and each individual's self-reliance and independence is active engagement with the community (p. 4-5). Promoting wellness is a good thing. Promoting community engagement is a good thing. However, withholding vision and

dental benefits from poor Nebraskans is not a reasonable or compassionate way to achieve these noble goals. The proverbial "carrot" can be helpful, and providing an incentive for changed behavior does sometimes lead to changed behavior. However, that "carrot" should not be essential health services.

In your roles at the NE DHHS, you have the power to influence health policy and thereby influence the lives of your fellow Nebraskans...for better or for worse. My story is just one story. Some of the details are unique to me, but the broad strokes are sadly common...almost to the point of being cliché: lack of access to essential health services can have devastating and long-lasting effects on a person physically, emotionally, and financially. By all measures I am a "success story." That romantic partner I mentioned earlier is now my spouse. He is a pastor. We have four wonderful sons. I am now a nurse, living my purpose in a way that helps others and also provides financial stability for my family. We made it, and yet the ill effects of these experiences I've mentioned still ripple into our lives today.

I hope and pray that my story has offered you some insight into the life of a poor Nebraskan...into the life of someone who would have benefited from Medicaid expansion and who can testify to the importance of including vision and dental benefits as Basic Coverage. October of 2020 is too far away, and this plan falls far short of what is needed. While I would no longer benefit directly from Medicaid expansion, there are approximately 90,000 Nebraskans who will. Those 90,000 Nebraskans deserve better than what is currently on the table. Their struggle was my struggle. Their pain was my pain. Their fight is my fight.

Thank you for taking the time to read this letter. I know that your time is valuable, and I am sure that the pressure of making decisions that affect so many is immense. You have an opportunity to course-correct where Medicaid expansion is concerned, and I hope that you seize it.

Sincerely,

[redacted]

Valerie Bower, RN BSN

[redacted]

Attachment 9

Medicaid 1115 Waiver Public Hearing

October 29, 2019

Good Evening.

My name is Ron Konecny. I am a resident of Kearney and a Professor of Management at the University of Nebraska Kearney. I am` speaking as a private citizen, not as a representative of the university.

My statements are in opposition to the Medicaid expansion 1115 waiver proposal known as the Heritage Health Adult Demonstration.

My opposition lies in the observation that the waiver does not represent the needs of Nebraska. In the following figures I will show that the barriers to coverage proposed in the Medicaid expansion 1115 waiver are punitive on an economic basis, a geographic basis, and a human basis. The Hippocratic Oath includes the promise "to abstain from doing harm".

On the handout, the first figure shows the distribution of private industry employee access to medical care benefits. Notice, the percent of workers offered employer sponsored health insurance is significantly lower for workers in the bottom half of the wage scale. Most workers with the lowest incomes are not even offered employer insurance (blue line) and the proportion that are able to participate in these plans are also low (red line). As we all know, privately paid insurance is not only expensive, but disproportionately more expensive for lower incomes. Surprisingly, the proportion of people participating in offered health plans is fairly level across all incomes.

The second and third figures examine the impact geography has on healthcare coverage. The percent of establishments offering health insurance diminishes with the smaller firms. Rural Nebraska's economy is dominated by medium and small sized businesses. A second observation is that over the last decade healthcare insurance offered by the smallest firms in the nation fell from 35.6% to 23.5%. On the Nebraska map, we see rural Nebraska has a substantially higher uninsured rate than counties with more economic opportunity. Workers with lower wages often have multiple jobs. They obviously are not lazy. According to the Nebraska Department of Labor, there are only 32,209 unemployed workers in a labor force of over one million. Nebraska has a significant number of "the working poor."

From a human perspective, we are not all the same or even close to average. The last figure shows the distribution of the population by IQ. Twenty-five percent of all Nebraskans have an IQ of 90 or less. It is these individuals that dominate the lower income scale, have a lower chance of having employer offered healthcare insurance, and who hold multiple jobs just to survive.

In conclusion, I encourage you to "do no harm" Do not advance the Medicaid expansion 1115 waiver.

Figure 1

Private industry employee access to medical care benefits and participation rates by wage category, March 2016

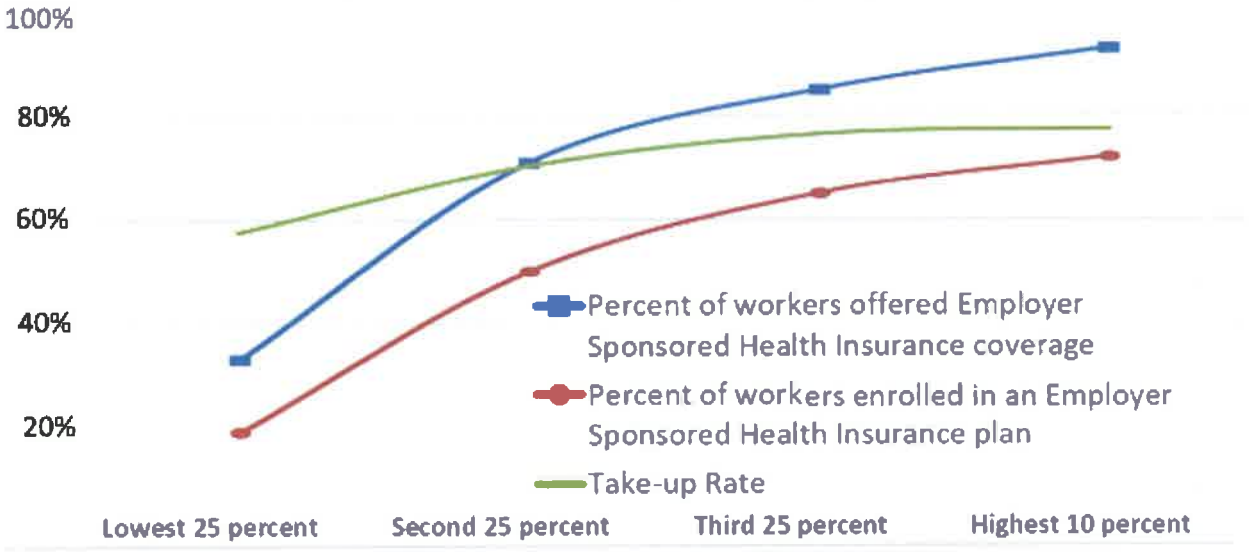


Figure 2

Percent of Private-Sector Establishments that offer health insurance, by establishment size (number of employees), 2008-2017

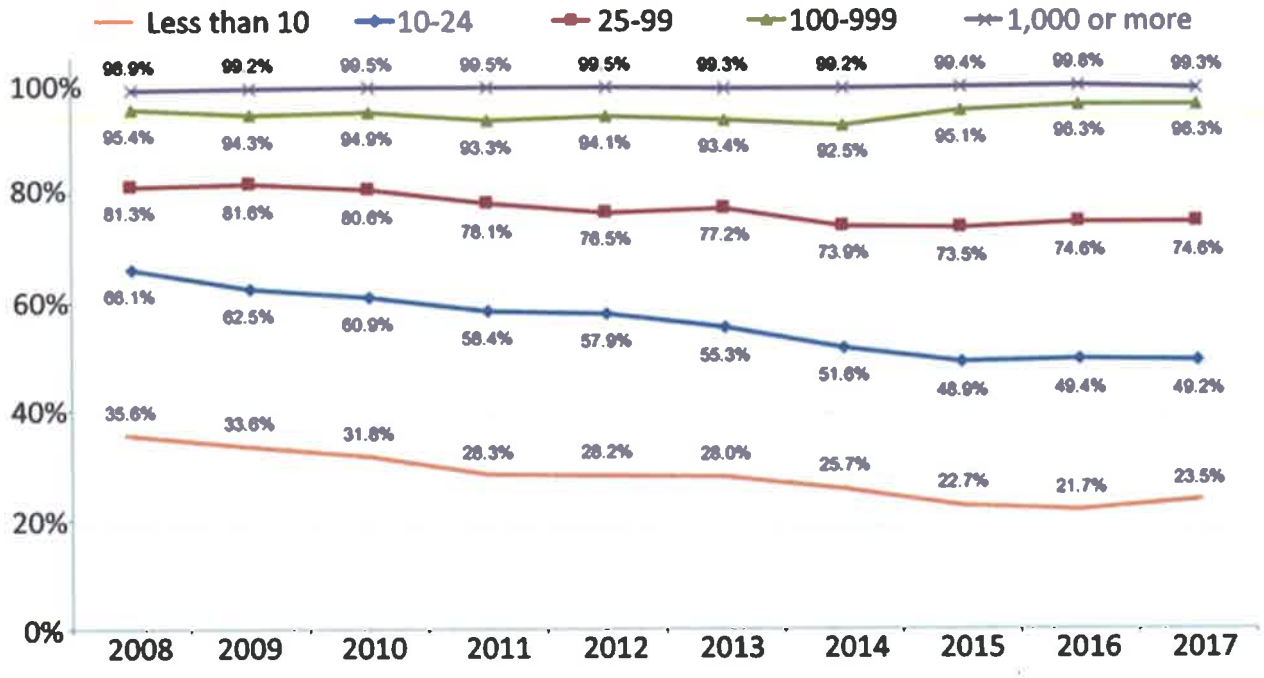
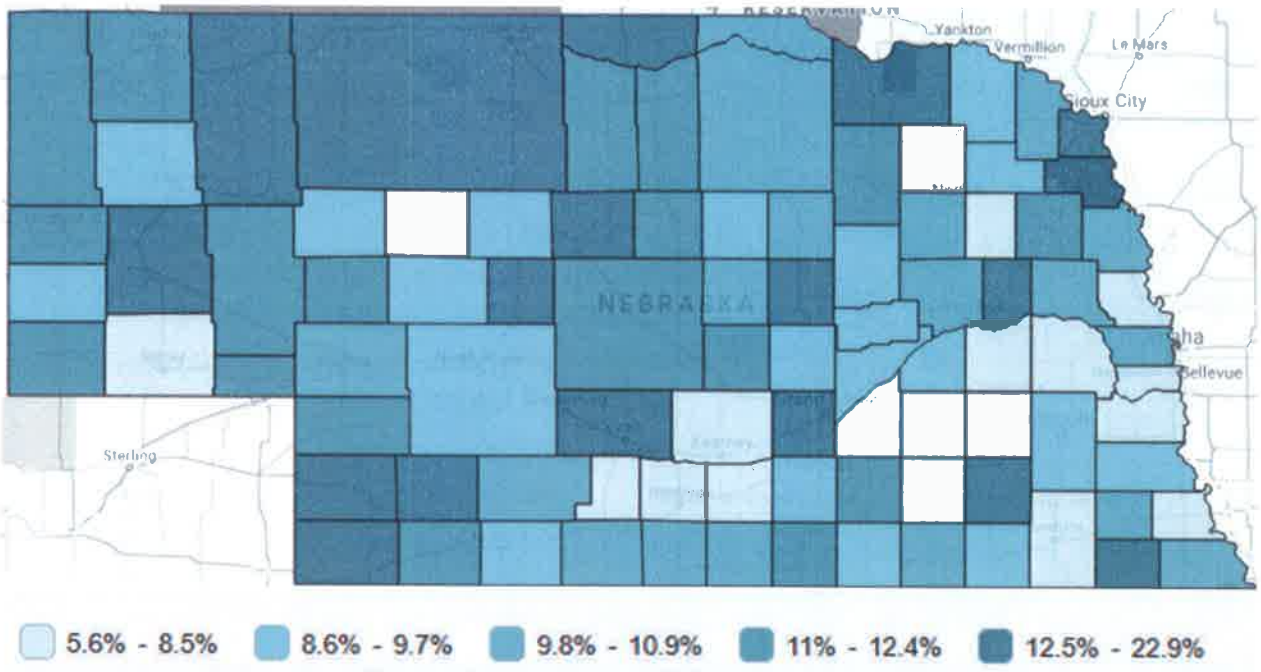


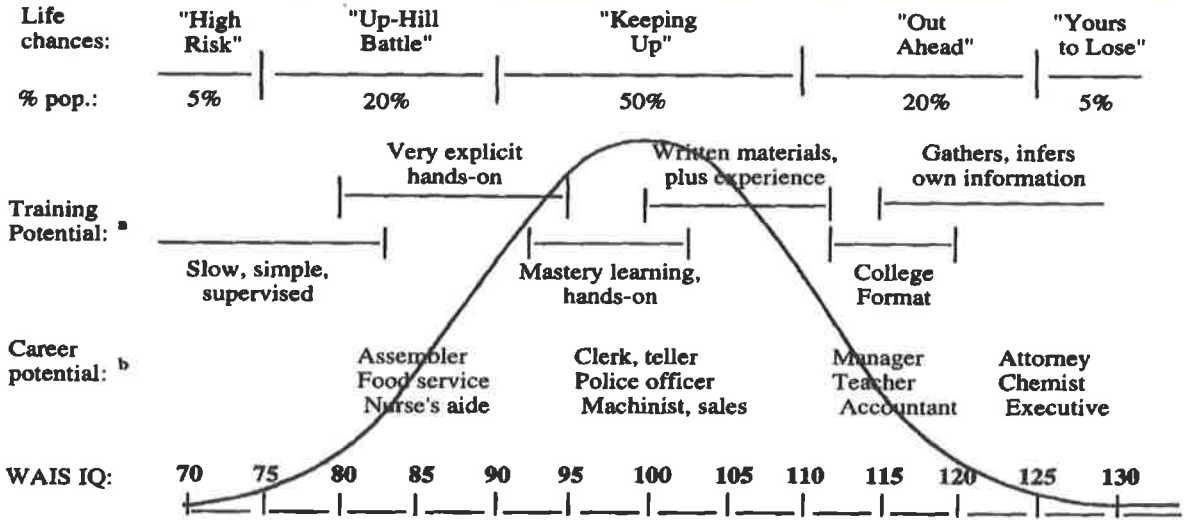
Figure 3

Nebraska Percent Uninsured by County, Under 65 Years of age, 2017



Source material (figures 1-3): Nebraska Medicaid Expansion 2018 Update: Protecting a Critical Infrastructure, Supporting Main Street, Improving Worker Health and Productivity
Allan Jenkins PhD & Ron Konecny PhD

Figure 4



"Speak up and judge fairly; defend the rights of the poor and needy."

CENTER *for* RURAL AFFAIRS
VALUES | WORTH | ACTION

October 30, 2019

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

Attn: Nebraska Medicaid Expansion 1115 Waiver
Re: Center for Rural Affairs Statement

Dear Dr. Van Patton,

The Center for Rural Affairs is a private non-profit organization, established in 1973 and based in Lyons, Nebraska. The Center works to promote social and economic justice, environmental stewardship and strengthen rural communities. A significant part of this work is engaging with people about the decisions that affect the future of their communities and the quality of their lives. Health care access and its radiating economic consequences has a direct impact upon the well-being of rural residents and communities.

I. Upholding the will of the voters

Last year, voters in our state accomplished what the Legislature could not—the expansion of Medicaid coverage for 90,000 Nebraskans who earned too little to qualify for subsidies to purchase coverage from the insurance marketplace and too much to qualify for Medicaid. With this vote, Nebraskans from across the state recognized the importance of access to health insurance coverage for their neighbors. Yet, almost a year later, these neighbors still have another year to wait until they will be able to access coverage, due to the state's unnecessarily drawn out implementation timeline and proposed waiver.

Moreover, under the proposed 1115 waiver, these Nebraskans and an estimated 25,000 additional residents currently enrolled in Medicaid stand to lose access to vision, dental and over-the-counter drug benefits. These ancillary benefits are crucial to improving and achieving overall health outcomes. Nebraskans certainly did not vote for these barriers and delays in coverage.

II. Dental care as a first line of defense

Dental health is essential to overall health. Affecting not only physical but mental and emotional wellbeing, oral health is a critical and complex issue that spans beyond straight teeth and a white smile. While many oral conditions are preventable and treatable if diagnosed early, thousands of Nebraskans are unable to access regular dental care.

Dental conditions, like periodontitis, or the infection and inflammation of the gums, have been identified as indicators for a number of chronic diseases including: cardiovascular disease, stroke, diabetes and Alzheimer's Disease.[1] The Nebraska Department of Health and Human Services' 2016 Health Assessment found that the mortality rates for heart disease and stroke were greatest in the state's rural counties.

Mortality Rates by Urban/Rural Nebraska, 2010-2014 Combined

Cause of Death	Urban-Large	Urban-Small	Rural
Heart Disease	142.2	152.2	153.1
Stroke	37.6	33.6	37.7
Diabetes	20.7	23.1	21.6
Alzheimer's Disease	24.8	26.7	21.1

Source: Nebraska Department of Health and Human Services

The report also finds that residents of urban counties are 12% more likely to have seen a dentist than rural residents.[2] Without adequate oral hygiene, awareness of dental health issues, or regular visits to a dentist, individuals may disregard warning signs, allowing underlying conditions to advance into more costly chronic illnesses.

III. The economics of dental care coverage

Data from the Bureau of Labor Statistics Consumer Expenditure Surveys found that Americans spent $36.8 billion on dental services in 2016, $600 million more than was spent on physician and clinical services that year.[3] This equates to an annual per person expense for dental care of $696. Of these personal dental expenses incurred, 44 percent were paid out-of-pocket, 43 percent by private dental insurance and just over 8 percent paid by public coverage, such as Medicaid.[4] For rural residents, these costs for dental services can present a significant barrier to care.

In Nebraska, cost undoubtedly inhibits residents from visiting the dentist. The American Dental Association found 54 percent of Nebraskans who had not visited their dentist in the past 12 months did not go because they could not afford the costs associated with care. Unsurprisingly, this percentage is significantly higher for low-income households, 74 percent of which said cost prevented them from seeking care. For high-income households, this percentage shrinks to 1 percent.[5]

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[1] "Oral Health-Total Health: Know the Connection". American Dental Hygienists' Association. www.adha.org/sites/default/files/7228_Oral_Health_Total.pdf.

[2] 2016 State Health Assessment: Nebraska. Nebraska Department of Health and Human Services. http://dhhs.ne.gov/Reports/Statewide%20Health%20Needs%20Assessment%20-%202016.pdf

[3] Foster, Ann C. "Household Healthcare Spending: Comparing Estimates from the Consumer Expenditure Survey and the National Health Expenditure Accounts, 2013-16." Bureau of Labor Statistics, https://www.bls.gov/cex/nhe-compare-201316.pdf.

[4] "Dental Services: Use, Expenses, Source of Payment, Coverage and Procedure Type, 1996-2015." Medical Expenditure Panel Survey, Agency for Healthcare Research and Quality, Research Findings #38, https://meps.ahrq.gov/data_files/publications/rf38/rf38.pdf.

[5] "Oral Health and Well-Being in Nebraska". American Dental Association, www.ada.org/~/media/ADA/Science%20and%20Research/HPI/OralHealthWell-Being-StateFacts/Nebraska-Oral-Health-Well-Being.pdf.

When Nebraskans cannot access the dental care they need through planned visits to the dentist's office, they go to our emergency rooms. Between 2003 and 2015, the number of non-traumatic dental visits to the emergency room nearly doubled from 4,829 to 8,213, with a price tag of nearly $10 million. Of these emergency room dental visits, more than 2,800 were made by rural residents.[6] Creating additional barriers to dental health care coverage for current and expansion Medicaid clients through the proposed 1115 waiver will only exacerbate the utilization of emergency services for dental care. (See attached Fact Sheet.)

IV. Rural Nebraska's stake in Medicaid expansion

Nebraskans in the state's rural counties have much to gain with the state's expansion of Medicaid coverage. Of the state's residents that are estimated to be in the Medicaid coverage gap, nearly 36 percent live in rural counties. These uninsured residents account for nearly 4.24 percent of the total rural population. [7] [8]

This greater percentage of uninsured in rural counties matters not only because of the number of rural Nebraskans who are left uninsured, but also for those in their communities who are left to shoulder higher insurance premiums and the radiating effects of uncompensated care on health care systems.

V. Conclusion

While expansion does not offer the solution to all of the challenges of rural health care delivery the expedient and unencumbered implementation of Medicaid expansion will make a difference for thousands of rural residents and the communities they call home. It is time to move forward with the will of voters and implement Medicaid expansion without barriers.

Respectfully submitted,

[redacted]

Jordan G. Rasmussen
Policy manager

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[6] Emergency Department Use in Nebraska for Non-Traumatic Dental Conditions, 2009-2016. Nebraska Department of Health and Human Services. http://dhhs.ne.gov/Reports/Emergency%20Department%20Use%20in%20Nebraska%20for%20Non-Traumatic%20Dental%20Conditions%20-%202009-2016.pdf

[7] "Rural Urban Continuum Codes Documentation." *USDA ERS - Food Environment Atlas*, www.ers.usda.gov/data-products/rural-urban-continuum-codes/documentation.aspx

[8] "Selected Characteristics of Health Insurance Coverage in the US." 2012-2016 American Community Survey Five-Year Estimates, S2701," U.S. Census Bureau, www.factfinder.census.gov.

Attachment 9

Mid-Plains Center
for Behavioral Healthcare Services, Inc.

October 30, 2019

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

Attention: Nebraska Medicaid, Section 1115; Heritage Health Adult Expansion Demonstration-Improving Health Outcomes and Encouraging Life Successes for Adult Medicaid Beneficiaries

My name is Corrie Edwards. I am the CEO and President of Mid-Plains Center for Behavioral Healthcare Services, Inc. We are a non-profit, COA accredited, behavioral health organization, that was founded nearly 50 years ago. Mid-Plains Center is pleased to provide comment to the Division of Medicaid and Long-Term Care on the draft proposal of the Heritage Health Adult (HHA) expansion program.

This program proposes the use of a specific waiver, Section 1115. Section 1115 gives Nebraska Medicaid the flexibility to design and improve the current Medicaid program. The purpose of the waiver is to expand eligibility, provide services not typically covered by Medicaid and use innovative service delivery systems that improve care, increase efficiency and reduce cost.

When reading this draft document, I am surprised to see that a primary focus is the Beneficiary Engagement Requirements, in part, Community Engagement Activities (i.e. work requirements). Medicaid is a program intended to provide health care services to people who wouldn't otherwise be able to get the care they need, services including dental and vision services.

Work requirements conflict with Medicaid's basic purpose, and such requirements are not necessary and counter-productive to ensure that many beneficiaries are employed. Placing such requirements on people can cause them to remain out of Medicaid and uninsured; thus resulting in many missing out on necessary services such as mental health, substance abuse, or other treatment that might help them become more employable.

This waiver is an opportunity to go beyond routine medical care, and focus on evidenced-based interventions that drive better health outcomes and quality of life improvements. There are a number of strategies that promote personal responsibility and ensure appropriate use of health care, which would also help lower Medicaid spending and improve health outcomes. Innovations,

such as Health Homes and Integrated Care Models, that use patient-centered medical homes and accountable care organizations. These models focus on improving the delivery of care instead of eliminating services and imposing harsh requirements that prevent people from getting the care they need.

Dramatic redesign takes time. Nebraskans are counting on a proposal that improves the integrity and effectiveness of the current Medicaid program, one that is grounded in ideas that reflect the dynamics and culture of where we live.

I urge Nebraska Medicaid to take advantage of the waiver flexibility and move in this direction, as opposed to using punitive measures to punish our most vulnerable and low-income individuals.

Thank you for the opportunity to submit these comments.

Respectfully Submitted,

Corrie L. Edwards, MPA
CEO and President

Dustin Bower

[redacted]

October 30th, 2019

Division of Medicaid and Long-Term Care
Nebraska Department of Health and Human Services
301 Centennial Mall South
Lincoln, NE 68509

To Whom it May Concern,

As a Christian pastor and resident of Hastings, NE, I am writing to express my disapproval of the Section 1115 Demonstration Waiver submitted by the Department, and the proposed Heritage Health Adult Program. Based on my review of the concept paper published by the Department in August of 2019, the proposed plan includes several elements that I strongly believe are not in the best interests of Nebraskans, including:

- A tiered benefit model, which withholds critical health services such as dental and vision care from low-income Nebraskans.
    - Lack of dental care can lead to poor nutrition, infection, heart disease, and even death. Dental care is NOT a luxury and should be considered an essential health service.
    - Lack of vision care can contribute to unnecessary burdens with transportation, job seeking, and even activities of daily living (ADLs). Serious vision problems may remain undiagnosed and untreated, and may progress to blindness or systemic health problems. Vision care is NOT a luxury and should be considered an essential health service.
- Work and community engagement requirements, which will result in an increased administrative and financial burden on the state of Nebraska.
    - Determining eligibility for "Prime Coverage" will require additional time and resources, all of which costs Nebraskans money.
    - Requirements such as these have been litigated and "struck down" in other states, including KY, AK, and NH. The proposed plan may open DHHS up to similar litigation and cost Nebraskans financially due to wasted time and resources, as well as legal fees.

- A delay in the expansion process, which has already impeded low-income Nebraskans from accessing care that they desperately need, and cost Nebraska financially in terms of Federal matching dollars.
    - The proposed plan is so complex that implementation has been delayed until October of 2020 - nearly two years after Nebraskans voted to expand the program. The cost to Nebraskans who would qualify for Medicaid under the expanded program cannot be quantified. These are real people, real Nebraskans, who are still waiting for health care.
    - The Federal matching rate for expansion started at 100% from 2014-2016, and drops every year until 2020. The rate for 2019 is 93%, and beginning in 2020 it will be 90%. This cost can be quantified and is unjustifiable.

The proposed plan is neither fiscally nor ethically defensible. As a Nebraskan, I implore the Department to do what is truly best for our state: to move forward with a simple, streamlined, cost-effective program expansion and do away with the proposed two-tiered plan and increased eligibility requirements. Now is the time to change course.

Sincerely,

Dustin Bower, Pastor
[redacted]

Attachment 9

Sandi Rasser-Herbek
[redacted]

October 30, 2019

Division of Medicaid and Long-Term Care
Nebraska Department of Health and Human Services
301 Centennial Mall South
Lincoln, NE 68509

To Whom it May Concern,

My name is Sandi Rasser-Herbek. I live in Lawrence, Nebraska and I represent one of the working families in Nebraska harmed by the delay of the Medicaid Expansion. My husband and I both work and raise 3 kids. My husband's employer doesn't offer family health coverage and I have mostly worked multiple part-time jobs for the last several years. For every illness – every sore throat, every banged up knee, every migraine, every worry in the back of my head, I weigh whether visiting the doctor is necessary. I have a problem knee that probably needs surgery, but I've gone for years occasionally limping and managing with a brace and crutches because I can't afford surgery while uninsured. I have a thyroid condition that requires regular medication to regulate my mood, appetite and energy level, but I have long periods of interruption due to financial obligations or being unable to get in to see a doctor.

For those times that I have taken myself or my kids to the doctor, it has cost me. A lot. The reason I weigh or delay the decision to see a doctor so long is because the hospital in my area requires that you give them permission to garnish your wages if you have an outstanding bill. I lose the ability to say when and how much I am able to pay, and I can't tell you the number of times the garnishment came when I needed the money for utilities, or gas, or my medication, or food for my family. Last year the hospital took over $2000 of my income throughout the year and we skimped and scraped our way through. Several years ago I had an emergency appendectomy while uninsured. The bill for that was near $30,000. My husband and I were trying to start a Hay business at that time, and we were getting ready to make payroll for our employees. Even though we had just mailed the forms for our payment plan, Mary Lanning Hospital swiped $24,000 from our account, putting our business in serious crisis.

This year our income has finally increased enough that I am able to enter the ACA Marketplace and get insurance for myself and my children; and yet just last week I received a bill for $1600 from the hospital that is nearly 2 years old. This is despite the fact that I requested discounted or charity care at the time since I was uninsured.

Lawmakers with insurance have no understanding of what medical care costs those of us living without insurance – how it takes huge sums from my hard-earned paychecks, sometimes cutting them in half for weeks on end. Please act quickly to expand Medicaid for all the other families out there like mine. Continuing to delay will cost them – maybe $1600, maybe $3000, maybe $24,000 if they are unlucky. Medical care is incredibly important and incredibly expensive, and the state of Nebraska has the ability to take care of this huge burden and concern for families like mine with the federal government paying the majority of the cost. Delaying makes no sense.

Your proposed plan is neither fiscally nor ethically defensible. As a Nebraskan, I ask you do what was voted for: simply move forward with the most cost-effective Medicaid expansion and do away with the proposed two-tiered plan and increased eligibility requirements. Now is the time to change course. Please, do the right thing and follow the will of Nebraskans as expressed at the ballot, rather than imposing complex requirements and unnecessary delays. Thank you.

Sincerely,

Sandi Rasser-Herbek

Nebraska
Dental Hygienists' Association

November 1, 2019

Department of Health and Human Services
Nebraska Medicaid
ATTN: HHA Waiver
301 Centennial Mall South
Lincoln, NE 68509-5026

Testimony in opposition to the Section 1115 Waiver

Deb Schardt, RDH, PHRDH representing the Nebraska Dental Hygienists' Association.

The Nebraska Dental Hygienists' Association does not support the removal of dental benefits through the 1115 Waiver. Currently, over one-half of the 93 Nebraska Counties are in a dental shortage area. One third of Nebraskans have not had a dental visit in the last year, and 80% of American adults have some form of gum disease. Less than 1/3 of Nebraska dentists even accept Medicaid as a payment source. By adding additional burdens on people to get the dental care that they need we are setting ourselves up for bigger costs down the road.

The number of Nebraska emergency room visits for non-traumatic dental conditions have dramatically increased over time, for example, there were 4,829 visits in 2003 and 8,213 visits in 2015. This equates to an average of $1,375 per visit in 2016, leaving total emergency room visits for dental conditions a staggering $10 Million in 2016 as compared to $1.4 Million in 2003.

The mouth-body connection is one that cannot be denied. Ninety-five percent of Americans who have diabetes, also have periodontal disease. Treating gum disease lowers annual medical costs associated with diabetes, stroke, heart disease, and pre-term low birth weight babies.

Oral bacteria have been implicated in the development of Alzheimer's disease and dementia. People with gum disease are nearly twice as likely to suffer from heart disease. Bacteria in the mouth have been linked to oral, esophageal, lung, colorectal, pancreatic and breast cancers. Oral bacteria travels through the bloodstream and can have an effect on many organs and processes. Having gum disease can also interfere with the success of joint replacement surgeries. Poor oral hygiene is common in elderly populations, further increasing the risk of aspiration pneumonia. Aspiration pneumonia causes high mortality in nursing homes, where it is the second most common infection, with a prevalence between 30-70%. This is also a huge expense when it comes to hospital readmissions for this bacterial infection.

Nebraska Public Health dental hygienists have worked to meet the needs of the underserved in places where they live, work and go to school. In 2018, these hygienists provided 100,598 services. Only about 40 percent of these services were reimbursed by Medicaid. As a public health provider navigating the Medicaid system is cumbersome enough, without these additional tiers and restrictions.

It is obvious that the Heritage Health Adult Program with this waiver will not achieve the goals of the Quadruple Aim to improve the patient experience of care, improve the provider experience of care, improve the health of populations and reduce the per capita cost of health care.

Thank you.

Deb Schardt, RDH, PHRDH
Legislative Chair of Nebraska Dental Hygienists' Association
[redacted]
[redacted]

Attachment 9

I have listed the approved procedures for the Nebraska Public Health Registered Dental Hygienist that are not billable through MCNA.

The expansion of approving the top two billable codes (one & two) would help children with dental disease to connect with a dentist for needed treatment and help nursing home residents and other adults with a dental disease to connect with a dentist for needed treatment.

1. **Screening of a Patient D0190**
2. **Assessment of a Patient D0191**

Code three would promote the importance of oral health to children and lead to fewer dental problems.

3. **Education/Oral Health Instructions D1330**

Code four would relieve pain, promote healing and prevent further deterioration of a dental concern for a child and a nursing home resident and other adults.

4. **Protective restoration D2940**

Code five and six would allow a nursing home resident to have a denture adjustment done without leaving the facility.

5. **Denture Adjustment D5410 (Maxillary/upper)**
6. **Denture Adjustment D5411 (Mandibular/lower)**

Code seven would enable a nursing home resident or other adults have gross amounts of calculus removed and referred to a dental home.

7. **Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis D4355**

Code eight, nine and ten would allow caries risk assessment on a child or an adult.

8. **Caries risk assessment-low risk D0601**
9. **Caries risk assessment-moderate risk D0602**
10. **Caries risk assessment-high risk D0603**

I could give you numerous reasons why the above codes should be billable by the Public Health Hygienist, and I would be happy to help answer any questions you may have.

Emergency Department Use in Nebraska for Non-Traumatic Dental Conditions, 2009-2016

NEBRASKA DHHS Office of Oral Health & Dentistry

NEBRASKA Good Life. Great Mission. DEPT. OF HEALTH AND HUMAN SERVICES

Average 7,982 visits/year

Average 4,617 patients/year

Number of emergency room visits have dramatically increased over time, for example, **4,829** in 2003** to **8,213** in 2015.

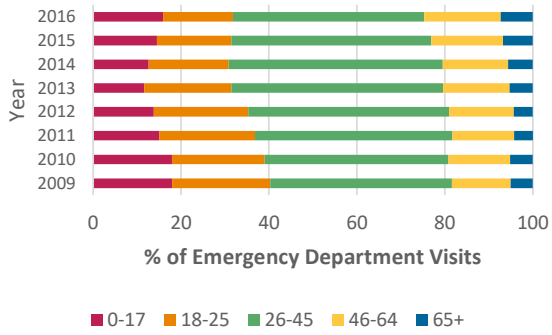
In 2014, only 43.2% of Americans visited their dentists at least once a year!

-CDC HP 2020 OH-7

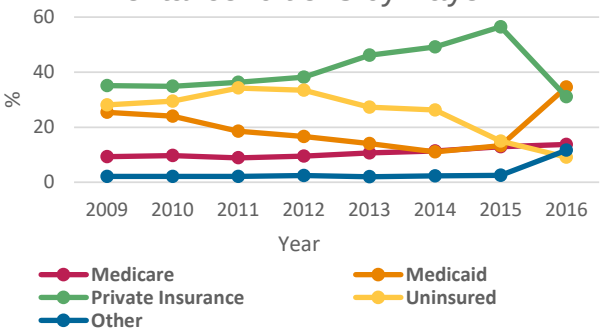
Total costs of emergency room visits for dental conditions were about **$10 Million** in 2016 which is much higher than **$1.4 Million** in 2003**

Average cost per emergency room visit for dental conditions was **$712** in 2012** which has significantly risen to **$1,375** in 2016

Emergency Department Visits for Dental Conditions by Age



Emergency Department Visits for Dental conditions by Payer



*Quarter 4 of 2015 and 2016 data uses diagnoses by ICD-10 that may limit comparability with ICD-9 diagnoses for previous years.

55% of emergency department visits were made by females

45% of emergency department visits were made by 26-45 year olds

15% of emergency department visits were made by children

32 of 105 emergency departments are located in rural Nebraska

Average number of emergency room visits made by rural residents was **2,803** per year

Source: Hospital Discharge Data, Nebraska Hospital Association, 2009-2016; ** 2016 Nebraska State Oral Health Assessment Report using ICD-9 codes

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nebraskahospitals.org

Nebraska Hospital Association
The influential voice of Nebraska's hospitals

November 8, 2019 Submitted via email

Matthew Van Patton, DHA
Division of Medicaid and Long-Term Care
Department of Health and Human Services
P.O. Box 95026
Lincoln, NE 68509-5026

Dear Dr. Van Patton:

The Nebraska Hospital Association (NHA) offers the following comments regarding the state's plan for the expanded adult Medicaid population. While the NHA believes that everyone should have access to quality health care, we understand the complications that the department faces delivering services to an additional 94,000 individuals. We will continue to work with DHHS to ensure that the implementation process is conducted correctly and efficiently.

We still have some concerns regarding the structure of the Heritage Health Adult program. The benefits provided to the expanded Medicaid population are different from the benefits available to the traditional Medicaid population. Our concern is that the differences in benefits for the two populations will create administrative issues for the Heritage Health MCOs. Since the inception of Heritage Health, healthcare providers have struggled with the MCOs and their ability to appropriately pay claims. Adopting a different benefit plan for the expansion population will only magnify these concerns and cause administrative burdens on providers to address payment issues. Additionally, we are concerned about the burdens these differences will place on providers to determine what services are covered regarding the expansion population. The Medicaid population is a fluid population, and unlike Medicare beneficiaries, Medicaid beneficiaries move in and out of the program. As an example, it is likely that someone eligible under the traditional Medicaid program one month may not be eligible the next month. Thus, they could be eligible for dental services one month and not the next. How do providers explain to the beneficiary that the service covered last month is not covered this month? Maintaining two separate benefit structures creates an administrative complexity that isn't necessary.

Another area of administrative concern is the process of eligibility checking every six months for the adult expansion population. Under this, eligible beneficiaries may flip back and forth between Prime and Basic coverage every six months. This is another administrative burden that providers will have to endure.

A major area of concern in terms of services is that under traditional Medicaid, beneficiaries are eligible for dental services while under the expansion program the adult population would only be eligible for dental services if they are approved for Prime coverage under the plan. Studies have shown a strong association between oral health and several chronic illnesses such as heart disease, diabetes and cancer. Providing dental services are critical to both the prevention and treatment of these chronic diseases.

Another concern related to the provision of services is the elimination of the three-month retroactive period. Elimination of this process would have a significant impact, financially, for both beneficiaries and providers. It will increase uncompensated care costs for providers and medical debt for beneficiaries.

The NHA recommends the Division of Medicaid mirror the benefits available to the expanded adult Medicaid population to those of the traditional Medicaid population and to maintain the three-month retroactive period. We believe it would reduce the administrative burden on providers and the Heritage Health MCOs to administer benefits appropriately and would increase the quality and access to services that this population will need.

The NHA and its member hospitals appreciate the opportunity to provide these comments regarding the Heritage Health Adult program. We look forward to working with DHHS to assist with the implementation of Medicaid expansion in our state. Please direct any questions regarding these comments to Michael Feagler, Vice President, Finance at 402-742-8144 or mfeagler@nebraskahospitals.org. Thank you for considering our concerns.

Sincerely,

Laura J. Redoutey, FACHE
President

cc: Nate Watson
Matt Litt

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

11/10/2019

We are a 54 year old married couple, Nebraska voters, both of us professionals with college degrees. We have been fortunate to have been able to afford good dental, vision and general health care throughout our lives. We are financially comfortable and we are in favor of providing these services to those who cannot afford them.

When we collected signatures to get Medicaid Expansion on the ballot and voted in favor of it we were looking for a speedy, uncomplicated process that would provide the badly needed services for those unable to afford them. Without dental care there will be people who wind up at the ER with abscesses and other serious issues and without vision care there can be difficulty learning in school, accidents and a myriad of serious conditions that can be taken care of early in their progression before they become significantly more costly. Work requirements seem on the face to be fiscally responsible but we have seen programs like these in practice that do not function well and only end up providing additional burdens to those who are struggling. One of the proposals, that recipients "maintain employer-sponsored health coverage if it is available to him or her" completely overlooks the fact that if they could afford their employer's health care they wouldn't need Medicaid. Let's not penalize the working poor.

As a psychiatric nurse practitioner and the director of human resources at a non-profit we see daily those who desperately need those services. We are very unhappy with the way we have been dragging our feet with these programs.

We want Medicaid expansion provided **with vision and dental and without work requirements.**

Sincerely,

[redacted]

Steve and Kathleen Langdon

[redacted]

LEUKEMIA & LYMPHOMA SOCIETY®

November 12, 2019

Matthew Van Patton, DHA
Director, Division of Medicaid and Long-Term Care
301 Centennial Mall South
Lincoln, Nebraska 68509

Dear Dr. Van Patton:

At The Leukemia & Lymphoma Society (LLS), our mission is to cure leukemia, lymphoma, Hodgkin's disease and myeloma, and to improve the quality of life of patients and their families. We support that mission by advocating that blood cancer patients have sustainable access to quality, affordable, coordinated healthcare. On behalf of the more than 8,000 Nebraskans living with blood cancer, we appreciate this opportunity to comment on the Heritage Health Adult Demonstration coverage proposal.

Medicaid covers 1 in 5 Americans, including low-income children, adults, seniors, and people with disabilities.[i] Many of these neighbors among us have complex and costly health care needs. Expanding access to Medicaid thoughtfully – as a majority of Nebraskans voted to do last November – is essential to improving health and saving lives.

Specific to cancer, Medicaid expansion has helped close disparities in cancer treatment. The American Society of Clinical Oncology reported this year that expansion states showed no significant difference in timely receipt of treatment between African American and white patients. The same can unfortunately not be said for non-expansion states.[ii] Expansion has also been associated with a reduced risk of hospital closures, especially in rural areas,[iii] and reduces the uncompensated care burden for public and rural hospitals.[iv]

The LLS Office of Public Policy's *Principles for Meaningful Coverage* give us an objective and constructive means of evaluating healthcare coverage proposals.[v] They informed our support for the 2018 Insure the Good Life campaign, and inform our concerns about the Heritage Health draft plan's impact on timely access to stable coverage:

- This plan won't launch for another full year. Instead of striving to extend coverage quickly to the 90,000 uninsured Nebraskans who could be helped by expansion, Heritage Health won't be available until October 2020. That's nearly two years after voters approved the ballot measure – a harmful and needless delay.
- This plan has work reporting requirements. Implementing these requirements creates unnecessary red tape and diverts state revenue that could be more effectively be spent on health coverage itself. In addition, these requirements have been successfully challenged in federal courts and could make the Nebraska plan vulnerable to costly lawsuits that would further delay access to coverage. A recent report found that these requirements place a significant financial burden on state agencies charged with implementing them.[vi]

National Office
3 International Drive
Suite 200
Rye Brook, NY 10573
main 914.949.5213
www.LLS.org

LEUKEMIA & LYMPHOMA SOCIETY®

- This plan has what is known as a retroactive-coverage waiver. When someone enrolls in Medicaid, coverage is usually extended retroactively to the three months before enrollment, provided they were eligible at that time. That's helpful when a life event – such as a cancer diagnosis – triggers both medical expenses and coverage eligibility. Waiving this retroactive coverage increases the likelihood of people on Medicaid carrying major medical debt, and increases the odds that hospitals will not be compensated for the care they provide.[vii]

The Heritage Health draft plan takes some positive steps to improve access to healthcare, but limits its effectiveness by departing from the Medicaid best practices that Nebraska voters endorsed. We would encourage your agency to revise the draft plan and pursue a faster and cleaner expansion process for the sake of all Nebraskans.

Sincerely,

[redacted]

Dana Bacon
Regional Director, Government Affairs
The Leukemia & Lymphoma Society
dana.bacon@lls.org

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[i] Rachel Garfield, Robin Rudowitz, and Anthony Damico, "Understanding the Intersection of Medicaid and Work," *Kaiser Family Foundation*, January 2018. https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work/

[ii] *American Society of Clinical Oncology*, June 2, 2019. https://www.asco.org/about-asco/press-center/news-releases/racial-disparities-access-timely-cancer-treatment-nearly

[iii] Richard Lindrooth, Marcelo Perraillon, Rose Hardy, and Gregory Tung, "Understanding the Relationship Between Medicaid Expansions and Hospital Closures," *Health Affairs*, 27, no. 1 (January 2018): pp. 111-120. https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2017.0976

[iv] Jordan H. Rhodes, Thomas C. Buchmueller, Helen G. Levy, and Sayeh S. Nikpay, "Heterogeneous Effects of the ACA Medicaid Expansion on Hospital Financial Outcomes," *Contemporary Economic Policy* (April 10, 2019). https://onlinelibrary.wiley.com/doi/abs/10.1111/coep.12428

[v] *The Leukemia & Lymphoma Society*, "Principles for Meaningful Coverage." https://www.lls.org/cancercost/principles

[vi] Government Accountability Office. "Medicaid Demonstrations: Actions Needed to Address Weaknesses in Oversight of Costs to Administer Work Requirements." GAO-20-149. Washington, D.C.: October 1, 2019. https://www.gao.gov/assets/710/701885.pdf.

[vii] Harris Meyer, "New Medicaid barrier: Waivers ending retrospective eligibility shift costs to providers, patients," *Modern Healthcare*, February 9, 2019. https://www.modernhealthcare.com/article/20190209/NEWS/190209936/new-medicaid-barrierwaivers-ending-retrospective-eligibility-shift-costs-to-providers-patients.

Testimony in Opposition to the Proposed
Section 1115 Waiver to Implement Expanded Medicaid in Nebraska
November 12, 2019

My name is Mary Spurgeon. I am testifying, as a citizen of the state, on behalf of 90,000 Nebraskans, "living the American dream" on less than $17,000 per year, most of whom are working outside the home in one or more jobs. The rest are providing care to family members inside the home, or perhaps they are unwell. I oppose this Section 1115 waiver proposal, and I am furious and disgusted.

One doesn't have to read deeply into the waiver plan to notice that it blatantly violates three of the five provisions of the pertinent section of Initiative 427, Section 2.

Sec. 2 #1 simply defines the population to be covered.

Sec. 2 #2 requires DHHS to submit a state plan amendment for approval, to the federal Centers of Medicare and Medicaid Services, on or before April 1, 2019. Done.

Sec. 2, #3 of the law states: **"(3) The Department of Health and Human Services shall take all actions necessary to maximize federal financial participation in funding medical assistance pursuant to this section."** Postponing implementation to October 2020 through this waiver means that the State of Nebraska will *not* receive $460 million in federal matching funds for *this* year, clearly NOT maximizing federal financial participation.

Sec. 2, #4 of the law states: **"(4) No greater or additional burdens or restrictions on eligibility, enrollment, benefits, or access to health care services shall be imposed on persons eligible for medical assistance pursuant to this section than on any other population eligible for medical assistance."** This waiver proposal has nothing but "greater AND additional burdens AND restrictions on eligibility, enrollment and benefits . . ." on eligible persons.

Section 2, #5 reinforces the status of provisions 1- 4 of Section 2 stating: **"(5) This section shall apply notwithstanding any other provision of law or federal waiver."** This section makes the substance of this waiver proposal unlawful and without agency.

This plan is not mere administrative guidelines, but *new legislation*, unapproved by the Unicameral or the voters, the only two groups that can constitutionally create legislation. It violates the Nebraska Constitution: **"Article II, Distribution of Powers**
Sec. 1. Legislative, executive, judicial. (1) The powers of the government of this state are divided into three distinct departments, the legislative, executive, and judicial, and no person or collection of persons being one of these departments shall exercise any power properly belonging to either of the others except as expressly directed or permitted in this Constitution."

With this waiver proposal, the executive branch is unlawfully legislating and thereby harming individuals, families, and communities. This plan should be immediately abandoned, and Medicaid expanded as required by the law.

(Attached: Copy of Petition with language of Initiative 427.)

Mary Spurgeon [redacted]

INITIATIVE PETITION

For Secretary of State Use Only

The object of this petition is to: (See reverse side for actual text of measure)

add Section 2 to Section 68-901 of the Revised Statutes of Nebraska to provide that the state shall amend its Medicaid state plan to expand eligibility to cover certain adults ages 19 through 64 whose incomes are one-hundred thirty-eight percent (138%) of the federal poverty level or below as defined and authorized by federal law, and to maximize federal financial participation to fund their care.

To the Honorable John Gale, Secretary of State for the State of Nebraska:

We, the undersigned residents of the State of Nebraska and the county of _____, respectfully demand that the following proposed law shall be referred to the registered voters of the state for their approval or rejection at the general election to be held on the 6th day of November 2018, and each for himself or herself says: I have personally signed this petition on the date opposite my name; I am a registered voter of the State of Nebraska and county of _____ and am qualified to sign this petition or I will be so registered and qualified on or before the date on which this petition is required to be filed with the Secretary of State; and My printed name, date of birth, street and number or voting precinct, and city, village, or post office address are correctly written after my signature.

WARNING TO PETITION SIGNERS-- VIOLATION OF ANY OF THE FOLLOWING PROVISIONS OF LAW MAY RESULT IN THE FILING OF CRIMINAL CHARGES: Any person who signs any name other than his or her own to any petition or who is not qualified to sign the petition shall be guilty of a Class I misdemeanor. Any person who falsely swears to a circulator's affidavit on a petition, who accepts money or other things of value for signing a petition, or who offers money or other things of value in exchange for a signature upon any petition shall be guilty of a Class IV felony.

Attachment 9

THIS PETITION IS CIRCULATED BY A VOLUNTEER CIRCULATOR.

	DATE	SIGNATURE	PRINTED NAME	DATE OF BIRTH	ADDRESS (Street Number & Name)	CITY OR VILLAGE	ZIP CODE
1							
2							
3							
4							
5							
6							

Proposed Statutory Language:

FOR AN ACT relating to the Medical Assistance Act; to amend section 68-915, Revised Statutes Cumulative Supplement, 2016, and section 68-901, Revised Statutes Supplement, 2017; to change provisions relating to eligibility for medicaid; to harmonize provisions; to provide severability; and to repeal the original sections.

Be it enacted by the people of the State of Nebraska,

Section 1. Section 68-901, Revised Statutes Supplement, 2017, is amended to read:

68-901 Sections 68-901 to 68-991 and section 2 of this act shall be known and may be cited as the Medical Assistance Act.

Sec. 2. (1) Eligibility for medical assistance shall be expanded to include certain adults ages nineteen through sixty-four whose income is equal to or less than one hundred thirty-eight percent of the federal poverty level, as authorized and using the income methodology defined by 42 U.S.C. 1396a(a)(10)(A)(i)(VIII) and related federal regulations and guidance, as such statute, regulations, and guidance existed on January 1, 2018.

(2) On or before April 1, 2019, in order to ensure that eligibility for medical assistance is expanded as required by this section, the Department of Health and Human Services shall submit a state plan amendment and all other necessary documents seeking required approvals or waivers to the federal Centers for Medicare and Medicaid Services.

(3) The Department of Health and Human Services shall take all actions necessary to maximize federal financial participation in funding medical assistance pursuant to this section.

(4) No greater or additional burdens or restrictions on eligibility, enrollment, benefits, or access to health care services shall be imposed on persons eligible for medical assistance pursuant to this section than on any other population eligible for medical assistance.

(5) This section shall apply notwithstanding any other provision of law or federal waiver.

Sec. 3. Section 68-915, Revised Statutes Cumulative Supplement, 2016, is amended to read:

68-915 The following persons shall be eligible for medical assistance:

(1) Dependent children as defined in section 43-504;

(2) Aged, blind, and disabled persons as defined in sections 68-1002 to 68-1005;

(3) Children under nineteen years of age who are eligible under section 1905(a)(i) of the federal Social Security Act;

(4) Persons who are presumptively eligible as allowed under sections 1920 and 1920B of the federal Social Security Act;

(5) Children under nineteen years of age with a family income equal to or less than two hundred percent of the Office of Management and Budget income poverty guideline, as allowed under Title XIX and Title XXI of the federal Social Security Act, without regard to resources, and pregnant women with a family income equal to or less than one hundred eighty-five percent of the Office of Management and Budget income poverty guideline, as allowed under Title XIX and Title XXI of the federal Social Security Act, without regard to resources. Children described in this subdivision and subdivision (6) of this section shall remain eligible for six consecutive months from the date of initial eligibility prior to redetermination of eligibility. The department may review eligibility monthly thereafter pursuant to rules and regulations adopted and promulgated by the department. The department may determine upon such review that a child is ineligible for medical assistance if such child no longer meets eligibility standards established by the department;

(6) For purposes of Title XIX of the federal Social Security Act as provided in subdivision (5) of this section, children with a family income as follows:

(a) Equal to or less than one hundred fifty percent of the Office of Management and Budget income poverty guideline with eligible children one year of age or younger;

(b) Equal to or less than one hundred thirty-three percent of the Office of Management and Budget income poverty guideline with eligible children over one year of age and under six years of age; or

Attachment 9

(8) As allowed under 42 U.S.C. 1396a(a)(10)(A)(ii), disabled persons as defined in section 68-1005 with a family income of less than two hundred fifty percent of the Office of Management and Budget income poverty guideline and who, but for earnings in excess of the limit established under 42 U.S.C. 1396d(q)(2)(B), would be considered to be receiving federal Supplemental Security Income. The department shall apply for a waiver to disregard any unearned income that is contingent upon a trial work period in applying the Supplemental Security Income standard. Such disabled persons shall be subject to payment of premiums as a percentage of family income beginning at not less than two hundred percent of the Office of Management and Budget income poverty guideline. Such premiums shall be graduated based on family income and shall not be less than two percent or more than ten percent of family income;

(9) As allowed under 42 U.S.C. 1396a(a)(10)(A)(ii), persons who:

(a) Have been screened for breast and cervical cancer under the Centers for Disease Control and Prevention breast and cervical cancer early detection program established under Title XV of the federal Public Health Service Act, 42 U.S.C. 300k et seq., in accordance with the requirements of section 1504 of such act, 42 U.S.C. 300n, and who need treatment for breast or cervical cancer, including precancerous and cancerous conditions of the breast or cervix;

(b) Are not otherwise covered under creditable coverage as defined in section 2701(c) of the federal Public Health Service Act, 42 U.S.C. 300gg(c);

(c) Have not attained sixty-five years of age; and

(d) Are not eligible for medical assistance under any mandatory categorically needy eligibility group; ~~and~~

(10) Persons eligible for services described in subsection (3) of section 68-972; and

(11) Persons eligible pursuant to section 2 of this act.

Except as provided in section 68-972, eligibility shall be determined under this section using an income budgetary methodology that determines children's eligibility at no greater than two hundred percent of the Office of Management and Budget income poverty guideline and adult eligibility using adult income standards no greater than the applicable categorical eligibility standards established pursuant to state or federal law. The department shall determine eligibility under this section pursuant to such income budgetary methodology and subdivision (1)(q) of section 68-1713.

Sec. 4. If any section in this act or any part of any section is declared invalid or unconstitutional, the declaration shall not affect the validity or constitutionality of the remaining portions.

Sec. 5. Original section 68-915, Revised Statutes Cumulative Supplement, 2016, and section 68-901, Revised Statutes Supplement, 2017, are repealed.

Attachment 9

My name is Suzan DeCamp, here on behalf of AARP Nebraska to testify in opposition to the 1115 waiver.

Nebraskans voted to include medical services through Medicaid through the passage of Initiative 427. They did not vote to delay or redesign the Medicaid program as currently being proposed. The Plan delays implementation nine months later than the anticipated January 1, 2020 start date. This delay fails to capture $149 million in federal reimbursement for the program.

Having two levels of coverage, with frequent redeterminations and work and community requirements, will lead to ongoing movement between the levels, increasing overall health costs, and result in poorer health outcomes.

When a participant is moved from the Prime Plan to the Basic Plan, they lose dental, vision, and over the counter drug benefits. This could cause chronic conditions to worsen and increase costs through later diagnosis or untreated conditions, pushing the participant to turn to expensive emergency treatment services.

We recognize the importance that wellness visits serve in prevention and treatment, but struggle with the additional hurdle it creates for those trying to access care. Hourly wage earners who lack personal/sick leave, or work in communities with limited health care facilities which may require travel to other communities during week-day hours, are at risk of being non-compliant, yet these access barriers are not the fault of the participants.

The work/community requirements are not necessary. Kaiser shows that about 60% of non-disabled adults under 65 who are on Medicaid are employed; a large majority

of the expanded population is already working, ill, disabled, providing caregiving or attending school.

Successful enrollment outreach is critical. DHHS must define how increased outreach, education, support and tracking will be provided to reach populations such as those with cognitive limitations, no internet access, and those with disabling conditions who may not be able to comply due to lack of understanding.

It is unclear how a participant, provider, employer, or others will document work, community, or wellness requirements. New reporting systems will impose new administrative burdens and increased costs on providers, employers, and others. DHHS will incur increased operating costs in the form of hiring new staffing, expanding or developing a reporting system, verifying the accuracy of reporting, and participating in fact finding and fair hearings.

The October 2019 Government Accountability office study shows that administering work requirement waivers was estimated to cost anywhere between $10 million and $250 million in the 5 states it reviewed.

Healthcare is a basic human right. Expanding affordable coverage without delay and hoops to jump through, provides access to preventative and comprehensive care that saves lives and reduces the cost of healthcare overall.

Thank you for the opportunity to comment.

Frank Herzog Testimony re: Section 1115 Heritage Health Adult Expansion Demonstration

My name is Frank Herzog. I offer the following testimony in opposition to the Heritage Health Adult Plan.

In early November 2018, voters in Nebraska were presented the following question,

" Shall Nebraska statutes be amended to provide that the state shall amend its Medicaid state plan to expand eligibility for medical assistance to cover certain adults ages 19 through 64 whose incomes are one hundred thirty-eight percent (138%) of the federal poverty level or below as defined by federal law, and to maximize federal financial participation to fund their care?[8]

I, along with over 53.5% of those voting, chose to answer the question in the affirmative. There were no work or wellness requirements mentioned in the question. The only addition to the expansion question was that of maximizing federal financial participation in the funding.

But here we are over a year later, discussing plan implementation that will not take effect for almost another full year and that will include costly work and wellness requirements that will actually create barriers to the medical coverage that we voted for in November. It makes me suspect that DHHS is not operating in good faith.

There has been consistent and strong opposition to The Affordable Care Act and its provisions for Medicaid Expansion by Nebraska's executive political leadership since the ACA was passed in 2010. As a result, working-poor Nebraskans have suffered emotionally, physically and financially, while our state as a whole missed out on millions of dollars of federal matching funds and the thousands of jobs that money would support.

Please DHHS, prove my suspicions wrong by expeditiously abandoning the Heritage Health Adult Plan waiver and giving your working-poor brothers and sisters in Nebraska medical coverage without needless and harmful barriers – just as we voted for in November 2018.

Thank you for the opportunity to comment.

Omaha Together One Community

Testimony in Opposition to the Proposed
Section 1115 Waiver to Implement Expanded Medicaid in Nebraska
November 12, 2019

My name is Dr. Linda Ohri, and I am testifying on behalf of Omaha Together One Community (OTOC). OTOC is a coalition of 20-plus congregations and other community organizations that work together for the common good. OTOC opposes this waiver plan.

The Medicaid Expansion Initiative (427) was passed on November 6, 2018, by a solid majority of Nebraska voters. This citizen's Initiative mandates and I quote, "No greater or additional burdens or restrictions on eligibility, enrollment, benefits, or access to health care services shall be imposed on persons eligible for medical assistance pursuant to this section than on any other population eligible for medical assistance."

Yet Nebraska Health and Human Services has delayed implementation of this law for 2 years, in order to seek a waiver that does indeed add greater and additional burdens and restrictions on this group of uninsured Nebraska citizens!

As a result, these citizens, as well as the Nebraska communities where they reside, suffer from delays in their access to the health insurance coverage mandated by this law.

If the waiver as currently formulated is implemented, these families, their communities, and the health care providers, hospitals and other institutions serving them, will be hampered with frequent eligibility reviews and excessive threat of lost access to covered health services.

This plan is counter-productive, inefficient and expensive, unnecessarily spending state dollars to create restrictions and barriers that only hinder our goal of improving the health of low-income families, and which will sabotage the productivity of these families, in jobs which may then go unfilled for their communities.

In summary, the members of OTOC assert that this Waiver constitutes a betrayal of the state's moral duty to these needy citizens of Nebraska, and it is incompatible with the will of the people.

Sources: Medicaid Expansion Petition, received by Secretary of State on March 9, 2018; passed by Nebraska voters on November 6, 2018. https://sos.nebraska.gov/elec/2018/pdf/medicaid-expansion-petition.pdf

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Attachment 9

Omaha Together One Community

Testimony in Opposition to the Proposed Section 1115 Waiver to Implement Expanded Medicaid in Nebraska

November 12, 2019

My name is Gerald Rathouz, and I am testifying on behalf of OTOC (Omaha Together One Community), a coalition of 20-plus congregations and other community organizations that work together for the common good. At our core, we emphasize teachings such as "what you do for the least, you do unto me" and "doing what is right".

I have experience serving with the State Health Insurance Program for a number of years, enrolling and assisting people in selecting Medicare and Medicaid Insurance. I know how grateful and relieved people are to be treated with dignity and respect and not forced to jump through a maze of hoops in the process. I support the Affordable Care Act and understand the wisdom of moving low-income people into the states' Medicaid domain because they are better equipped to handle all the issues and services which may be required. The ACA provided 100% of the cost of the program for 3 years, declining to 90% in 2020 and beyond, which is currently around $325 million per year.

I was disappointed to see the courts rule that States can refuse this federal assistance, which Nebraska's Governor did. Subsequently, I was encouraged that our State Representatives had the votes to enact a law to accept the assistance, but not enough to overcome a filibuster! Is this doing the right thing - "what you do for the least"? OTOC, along with Appleseed, put together presentations explaining why it is not only mean-spirited to turn down this opportunity, it assaults the economic rights of the more than 90,000 Nebraskans in most need! Recognizing that, we the citizens across Nebraska rose up, pulling together to petition the State to put this to a vote and make it law. We collected enough signatures, we pressed to get out the vote, kept educating the voters, and won, making Expanded Medicaid a reality in Nebraska!

We succeeded! Right? Wrong! Under President Trump's Administration, the Centers for Medicare and Medicaid Services of the USA, issued "guidance" for State Medicaid waiver proposals that would impose work requirements in Medicaid as a condition of eligibility – one more mean-spirited ploy! And Nebraska's Health and Human Services, over the vote of the people, decided to take us into the maze of obstacles.

I refer you to a paper written by the Kaiser Family Foundation titled Understanding the Intersection of Medicaid and Work: What Does the Data Say? I have included its key findings; the most important being that, quote, "most Medicaid adults are already working; among those who are not working, most report barriers to work." In the case of Nebraska, those who are already working or otherwise qualify, amounts to over 75% of that population. So I ask you, is it fair to create a maze of hoops for this majority who are already meeting this proposed requirement? This is not in the spirit of the Affordable Care Act.

I am here tonight in opposition to this proposal and want to see our vote carried out in a straight-forward manner without work requirements. I think this is "doing what is right."

Sources: https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work-what-does-the-data-say/

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My name is Mark Darby. I live at 8512 Emmet St in Omaha. I am a advanced practice registered nurse, a nurse practitioner. I work at several clinics that cater to those without insurance. I know the effects of insurance on people. I want to be clear ...in this country to have insurance means to be alive. This is not an exaggeration. To have insurance is to be alive.

One of my patients is James. He is 50, a skill carpenter. A work accident caused back pain so severe he could not stand. He lost his job and his insurance. His health went down hill. He had a heart issues all his life. Because of uncontrolled blood pressure he had a heart attack for which he was treated in an ED at public expense. He was so weak he could not move. He developed arthritis in his knees and COPD. He struggled for awhile paying for visits when his limited income allowed him to afford it. He used the $4 dollar list from Walmart. Then he had another heart attack

and needed a pacemaker. His breathing was so bad he could not walk 10 feet without stopping. He was getting worse all the time. It did not look like James would be alive much longer.

Then he got lucky. Very lucky. He got so bad he developed Congestive Heart Failure and severely osteoarthritic knees. He could barely breath and could barely walk. I say luck because his health became so poor, he qualified for disability and with this he obtained Medicare. Now, after a pacemaker placement, a COPD med that costs thousands per year he is stable. He is losing weight and quitting smoking. He will also have a hip replacement next year. Don't get me wrong I am happy that James is doing well. But after he got so bad, he qualified for insurance but in order to get him back to the level of health he had when he first lost insurance we spent literally hundreds of thousands of dollars. What would have happened if he had insurance all along? How

much would we have saved?

Nebraskans need Medicaid expansion. The tiered benefits package proposed, the work requirements all make sense to a governor who has insurance and money. It does not make sense to me who sees people every day without insurance. It certainly does not make sense to people who are dying.

David J Hoe / Title MD
Representing 1) NMA 2) NAFP 3) AAFP 4) Health Centers 5) Ne Assoc. of Behavioral Health orgs

Attachment 9

Medicaid Expansion Advocacy Priorities

General Concerns:

- Additional reporting burden on patients
- Additional administrative burden on providers
- Churn within Medicaid population because of additional reporting burdens
- Legal uncertainty around work requirements
- Educating the public on new Expansion requirements

Priorities for Discussion

- Six-Month Redetermination
  - Additional burden on enrollees
  - Additional Administrative cost for the State
  - Data from other states that have attempted more frequent redetermination periods show that approximately 5% of enrollees lose coverage due to inability to complete the redetermination process.
  - **Recommendations and Clarifications:**
    - Eliminate this provision from the waiver package
    - Note: Based on latest report to the Legislature, this process may have changed. Will want clarification on how redeterminations will be handled.

- Wellness and Work Requirements:
  - Unclear who will be responsible for tracking wellness requirements – likely to fall to providers
  - Patient confusion over visiting the doctor once a year versus completing an "annual wellness visit"
    - As an example, less than 20% of Medicare recipients have an annual visit that meets the definition for an "annual wellness visit"
  - What if an individual is auto-assigned a PCP but visits another provider?
  - Community Engagement (Work) Requirements
    - Majority of those eligible for expansion are already working
    - Hospitality and seasonal workers may struggle to meet hours requirements as their schedules can vary dramatically
    - How is the caretaker relationship being defined?
  - **Recommendations and Clarifications:**
    - Allow for any visit to count as annual visit – not just a wellness/physical visit
    - Define responsibility for tracking missed appointments
    - Work with MCOs and providers to streamline attribution process so providers have a better understanding of who their patients are
      - Note: Some FQHCs have reported that on 25% of patients on the attribution list are actually seen at the health center
    - Evaluate work requirements on an annual basis, not monthly
    - Ensure non-traditional caretaker relationships are considered

  - Explore an exemption from work requirements for people who live in areas of great economic distress or poverty
  - Allow for care and case management through the providers, not just the MCOs
  - Set a cap to discontinue work requirements if a certain threshold of enrollees lose coverage
    - e.g. if xxx% of individuals are disenrolled over a certain period, DHHS will freeze the requirement to determine whether the reporting requirements are creating a barrier
    - Montana's pending waiver requires a reevaluation of the work program if more than 5% of enrollees are dropped from coverage due to not complying with the new work and reporting requirements. If an independent auditor finds that more than 10% of people losing coverage were wrongly dropped, the Legislature would have to reconsider the program.
  - Use this waiver to incorporate payment models that address social determinants

- Educating the Public
  - What resources will be available for educating the public on enrollment and program specifics?
  - How can communities partner together to educate individuals?
  - **Recommendations and Clarifications:**
    - Funding to enhance and expand existing outreach and enrollment programs

- Concerns with Tiered Benefits:
  - Lack of access to dental care in Basic coverage is concerning
  - Treatment plans may be disrupted or discontinued if patients move between plans
  - Administrative burden on providers to constantly track what plan patient is enrolled in
  - How is Medically Frail defined?
    - How is someone deemed Medically Frail?
  - What is included in the definition of Disabled?
  - **Recommendations and Clarifications:**
    - Request an explanation as to why everyone is starting in Basic Coverage as opposed to Prime
    - Start all patients in Prime Coverage
    - Consider the inclusion of serious mental illness and substance use disorder in the definition of Disabled or Medically Frail
    - Craft broad Medically Frail definition and provide a clear process for determination
    - What consideration is given for OTC that has a high impact on chronic illness (e.g. aspirin for heart disease)?

Attachment 9

NEBRASKA APPLESEED
STAND UP FOR JUSTICE

November 14, 2019

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

To Whom It May Concern:

Nebraska Appleseed, a nonprofit organization that fights for justice and opportunity for all Nebraskans, is providing its comments to the Heritage Health Adult (HHA) Plan Section 1115 waiver. Voters passed Initiative 427 over one year ago, and the Nebraska Department of Health and Human Services (DHHS) just recently revealed its plan to impose unnecessary barriers to coverage, contrary to the will of the voters, through its Section 1115 waiver. Coverage is not scheduled to take effect until October 2020, nearly two years after the voters passed Initiative 427 to expand Medicaid.

Nebraska Appleseed opposes the Section 1115 waiver in its entirety, and urges DHHS to abandon the Section 1115 waiver and promptly implement Medicaid expansion without barriers to coverage. Because the Section 1115 waiver is unnecessary, costly, administratively burdensome, legally suspect, and imposes restrictive barriers to coverage that will cause people to lose coverage, Nebraska Appleseed opposes this Section 1115 waiver.

Section 1115 Waiver is not Required under Initiative 427

A Section 1115 waiver is not necessary to implement Medicaid expansion in Nebraska. Under the language passed by voters through Initiative 427, codified in Nebraska Revised Statute § 68-992, a Section 1115 waiver is not required. This language does not require or contemplate a two-tiered benefits system, work requirements, or wellness requirements. It certainly does not contemplate enrollees needing to fulfill nine separate requirements to retain dental, vision, and over-the-counter drug coverage or changes to retroactive eligibility for the expansion group and other Medicaid groups. Rather, the HHA Plan is an option the state is pursuing, one that is administratively complex, unnecessarily confusing, and burdensome for enrollees and providers. After reviewing the proposal, we are left with many unanswered questions about how the plan will be implemented and the potential burdens it places on providers, employers, and enrollees.

Administrative Costs

This Section 1115 waiver will result in unnecessary state administrative costs. The nine requirements will require logging, tracking, and verification by DHHS, which will require significant upfront and ongoing costs and will be costly to implement.[1] Additionally, there is ample evidence that implementing work requirements in other states has caused states to incur high administrative costs with little oversight or transparency.[2] Here, DHHS has already required increased administrative expenses and significant staffing increases, as demonstrated in the FY 2019-2021 biennial budget and the June 2019 report from DHHS to the Nebraska Legislature's Appropriations Committee, which notes the immediate need to create 108 new jobs.[3]

Tiered Benefits

We oppose the inclusion of a tiered benefits structure in the HHA waiver. Under the language passed under the ballot initiative, voters intended that Medicaid expansion enrollees would receive the full Medicaid benefits package. We oppose any structure that results in decreased benefits, as continuous access to comprehensive care is important for enrollees and saves the state money by providing preventing care in the least expensive setting. We also believe that this tiered structure is confusing and will result in a lack of continuity in care, with enrollees churning on and off of the Prime benefits package.

The tiered benefits structure does not recognize the importance of vision and dental care and over-the-counter drugs for all enrollees and their importance in maintaining overall health. Vision and dental care keeps medical costs down and helps ensure that people are healthy and able to work. Without access to vision and dental care, severe health issues go untreated, contributing to higher medical costs, which can even escalate to emergency room visits,[4] and lower productivity. While vision and dental care are essential for healthy eyes and mouths, general health conditions have impacts on vision[5] and dental[6] health, making regular vision and dental screenings and care key to overall health. Furthermore, regular vision and dental screenings can identify many

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[1] Community Catalyst, 5 Reasons Work Requirements in Medicaid Won't Work, https://www.communitycatalyst.org/resources/publications/document/Why-Work-Requirements-in-Medicaid-Wont-Work_FINAL.pdf.

[2] United States Government Accountability Office, Medicaid Demonstrations Actions Needed to Address Weaknesses in Oversight of Costs to Administer Work Requirements, October 2019, https://www.gao.gov/assets/710/701885.pdf.

[3] Nebraska Department of Health and Human Services, Division of Medicaid and Long-Term Care, Nebraska Medicaid Adult Expansion Report - June 2019, July 31, 2019, https://nebraskalegislature.gov/FloorDocs/106/PDF/Agencies/Health_and_Human_Services_Department_of/696_20190801-085617.pdf.

[4] Laura Ungar, ER Visits for dental problems on the rise, USA Today, June 29, 2015, https://www.usatoday.com/story/news/nation/2015/06/29/er-dental-visits/29492599/.

[5] Rebecca Mukamal and D. Rebecca Taylor, Your Eyes Could be the Windows to Your Health, American Academy of Ophthalmology, December 3, 2014, https://www.aao.org/eye-health/tips-prevention/diagnosing-systemic-diseases-eye-exams.

[6] Mayo Clinic, Oral health: A window to your overall health, June 4, 2019, https://www.mayoclinic.org/healthy-lifestyle/adult-health/in-depth/dental/art-20047475.

serious physical health conditions.[7] There is also evidence that untreated vision and dental issues contribute to poor overall health.[8]

We are concerned that eliminating over-the-counter drug coverage will lead to overprescribing more powerful medications that cannot be obtained over the counter and that individuals who need over-the-counter drugs to manage chronic conditions will be unable to access them. Recently, when DHHS reevaluated the drug formulary in which over-the-counter drugs were covered under Medicaid without a copayment and began requiring copayments, our office received numerous calls from enrollees for whom even the nominal copayment presented an insurmountable barrier to maintaining good health.

Administrative Complexity

There is a multitude of unanswered questions regarding the administration of this Section 1115 waiver, and the draft Section 1115 waiver does not offer any guidance on the practical administration of such program. We have questions about how individuals will prove compliance with different requirements and how employers and providers will be involved in this process. There is no guidance as to who is responsible for tracking compliance with each of the nine separate requirements that beneficiaries have to meet, and prove that they meet, every six months. Furthermore, there is no guidance as to what type of evidence will be accepted as satisfactory proof that requirements have been met. For example, will employers be required to send pay stubs to DHHS to verify working hours? Who will verify employment? Who will verify wellness requirements - the provider, DHHS, or the managed care company? Who will ensure that prescription medication is timely filled and that labs that were ordered were actually drawn?

The administration of this program is of great significance to enrollees and providers attempting to participate in the program. Because there are so many different requirements that must be frequently evaluated and verified, the administrative implementation of this program will be extremely complicated and require coordination, cooperation, and time from providers and beneficiaries. We are concerned that, similar to what has been experienced by Arkansas, eligible enrollees will lose benefits due to administrative errors or the failure to meet overly arduous tracking requirements.[9] We are concerned about factors like lack of quality Internet and technology access and lost paperwork leading to eligible individuals losing access to Prime coverage.

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[7] Rebecca Mukamal and D. Rebecca Taylor, Your Eyes Could be the Windows to Your Health, American Academy of Ophthalmology, December 3, 2014, https://www.aao.org/eye-health/tips-prevention/diagnosing-systemic-diseases-eye-exams.

[8] Mayo Clinic, Oral health: A window to your overall health, June 4, 2019, https://www.mayoclinic.org/healthy-lifestyle/adult-health/in-depth/dental/art-20047475; U.S. Department of Health and Human Services Centers for Disease Control and Prevention, Looking Ahead: Improving Our Vision for the Future, last reviewed December 18, 2017, https://www.cdc.gov/visionhealth/resources/infographics/future.html.

[9] Jennifer Wagner & Jessica Schubel, States' Experiences Confirming Harmful Effects of Medicaid Work Requirements, Center on Budget & Policy Priorities, Oct. 22, 2019, https://www.cbpp.org/health/commentary-as-predicted-arkansas-medicaid-waiver-is-taking-coverage-away-from-eligible-people.

Work Requirements

While each state that pursues a waiver chooses to take a slightly different approach, ultimately, work requirements are contrary to the purpose of the Medicaid program and are legally suspect. The purpose of Medicaid is to provide medical assistance to individuals whose income and resources are insufficient to afford medical services.[10] Reducing services to those who do not fulfill work and other requirements conflicts with Medicaid's purpose.

The proposed hypotheses to be tested by the HHA program raise a number of questions, both in terms of the final outcomes desired and the process for reaching the hypotheses. For example, the hypotheses of "HHA beneficiaries participating in community engagement activities will have higher average income compared to non-participating beneficiaries" and "HHA beneficiaries participating in community engagement activities have a higher percentage of ceasing Medicaid compared to those non participating beneficiaries" are not outcomes that align themselves with the core purpose of Medicaid. Additionally, it is unclear how these hypotheses could be fulfilled without access to services to overcome barriers to advancement, like child care and transportation.

Successful challenges to work requirement waivers in other states further demonstrate that work requirements are legally suspect. Work requirements have been struck down in three states, and a lawsuit challenging work requirements in a fourth state, Indiana, which is the only other state to have implemented work requirements, was recently filed in federal court.[11] The court has indicated that federal approval of work requirements proposed by Kentucky, Arkansas, and New Hampshire were invalid because, in approving the Section 1115 waivers that contain work requirements, the federal Centers for Medicare and Medicaid Services did not address how work requirements are related to the core objective of Medicaid, which is the provision of medical care to the needy.[12] Both Indiana and Arizona have voluntarily ceased their work requirements programs due to the ongoing legal disputes over these programs.[13]

The majority of Nebraskans in the coverage gap are already working, except in jobs that pay low wages and do not provide insurance;[14] however, due to potentially challenging reporting requirements and layers of red tape, we are concerned that individuals who should be eligible for benefits will lose them. Additionally, evidence suggests that work requirements do not actually promote employment because they do not address underlying barriers to employment, like transportation or child care. Rather, Medicaid itself is a program that supports work. It provides

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[10] 42 U.S.C. § 1396-1.

[11] Kaiser Family Foundation, Work Requirement Waivers: Approved and Pending as of November 11, 2019, https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/#Table2; AP News, Lawsuit seeks to block Indiana's Medicaid work requirements, September 24, 2019, https://apnews.com/1b5c2b25207a4d09b0f887cb751a3657.

[12] *See Gresham v. Azar*, 363 F. Supp. 3d 165 (D.D.C. 2019); *Philbrick v. Azar*, 2019 U.S. Dist. LEXIS 125675, 2019 WL 3414376 (D.D.C. 2019); *Stewart v. Azar*, 366 F. Supp. 3d 125 (D.D.C. 2019).

[13] Amy Goldstein, Indiana backs away from Medicaid work requirements, The Washington Post, Oct. 31, 2019, https://www.washingtonpost.com/health/indiana-backs-away-from-medicaid-work-requirements/2019/10/31/b2504256-fc04-11e9-8190-6be4deb56e01_story.html.

[14] Families USA, Careers of Working Nebraskans who would Receive Coverage through Medicaid Expansion, Sept. 2018, http://www.familiesusaaction.org/careers-of-working-nebraskans-who-would-receive-coverage-through-medicaid-expansion.

coverage that workers in low-wage jobs need to stay healthy and support themselves and their families.[15]

Wellness Requirements

We have additional concerns about the wellness and "personal responsibility" requirements included in the HHA Plan. First, these requirements add an additional layer of complexity and administrative burden for both enrollees and providers. Second, examples from other states, like Iowa, exist to demonstrate the unworkable nature of such requirements. Because of the complexity of the wellness requirements, we have concerns that, like in Iowa, enrollees will not be aware that they must complete the requirements or know how to complete them and that there will be confusion among managed care organizations, providers, and enrollees.

Additionally, DHHS needs to provide additional clarity as to how the commercial insurance requirements will work. The language in the draft, the notice, and explanatory materials is not consistent or sufficiently transparent for enrollees to understand what is expected of them.

Retroactivity

In addition to the other elements of the waiver, DHHS should abandon its waiver of retroactive eligibility. Waiving retroactive eligibility will shift the cost of care to patients and providers, especially hospitals in the form of uncompensated care. There is no evidence that eliminating retroactive eligibility will cause eligible people to enroll sooner. In fact, in Indiana in 2016, after the state waived retroactive eligibility, the state reported that "14% of beneficiaries to whom the waiver applied ran up significant out-of-pocket medical expenses as a result, averaging more than $1,500 per person. Sixteen percent of providers said they saw charity cases and bad debt increase as a result of the policy."[16] Catastrophic events or accidents that often make people aware that they have been eligible for Medicaid will send vulnerable people into financial ruin, and providers will bear the burden of uncompensated costs.

Conclusion

The Section 1115 Waiver proposes to impose barriers to coverage, contrary to the will of the voters that approved Medicaid expansion over a year ago. Nebraska Appleseed opposes the unnecessary and burdensome Section 1115 waiver and urges DHHS to abandon the Section 1115 waiver and promptly implement Medicaid expansion without barriers to coverage.

Sincerely,

[redacted]

Sarah Maresh
Staff Attorney, Health Care Access Program

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[15] Judith Solomon, Medicaid Work Requirements Can't Be Fixed, Center on Budget and Policy Priorities, Jan. 10, 2019, https://www.cbpp.org/research/health/medicaid-work-requirements-cant-be-fixed.

[16] Harris Meyer, New Medicaid barrier: Waivers ending retrospective eligibility shift costs to providers, patients, Modern Healthcare, Feb. 9, 2019, https://www.modernhealthcare.com/article/20190209/NEWS/190209936/new-medicaid-barrier-waivers-ending-retrospective-eligibility-shift-costs-to-providers-patients.

November 20, 2019

Submitted via: DHHS.MedicaidSPA@nebraska.gov

Matthew Van Patton
Director of Nebraska Medicaid
Department of Health and Human Services
301 Centennial Mall South
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Lincoln, Nebraska 68509-5026

Re: Nebraska Medicaid Section 1115 Heritage Health Adult Expansion Demonstration

Dear Director Van Patton,

ViiV Healthcare (ViiV) appreciates the opportunity to submit comments to the Nebraska Department of Health and Human Services Division of Medicaid and Long-Term Care (MLTC) regarding the proposed Nebraska Medicaid Section 1115 Heritage Health Adult Expansion Demonstration.[1] ViiV commends the state on many of the aspects of this waiver proposal that will expand health coverage in the state, and incentivize certain beneficiary actions rather than to impose punitive measures. We encourage the state to further ensure that people living with HIV (PLWH) are ensured access to optimal health coverage and services such as case management under the Prime benefit option, through designation as a "medically frail" population in this waiver.

I had the pleasure of meeting you in person in September 2018, as we discussed quality metrics related to HIV Care, and the importance of access to prescribed treatments and care. ViiV is the only independent, global specialist company devoted exclusively to delivering advancements in human immunodeficiency virus (HIV) treatment and prevention to support the needs of PLWH. From its inception in 2009, ViiV has had a singular focus to improve the health and quality of life of people affected by this disease and has worked to address significant gaps and unmet needs in HIV care. In collaboration with the HIV community, ViiV remains committed to developing meaningful treatment advances, improving access to its HIV medicines, and supporting the HIV community to facilitate enhanced care and treatment.

As an exclusive manufacturer of HIV medicines, ViiV is proud of the scientific advances in the treatment of this disease. These advances have transformed HIV from a terminal illness to a manageable chronic condition. Effective HIV treatment can help people living with HIV (PLWH) to live longer, healthier lives, and

[1] Nebraska Medicaid Section 1115 Heritage Health Adult Expansion Demonstration, "Improving Health Outcomes and Encouraging Life Successes for Adult Medicaid Beneficiaries" Page 9 http://dhhs.ne.gov/Documents/HHAWaiverDraftApp.pdf, Accessed November 11, 2019

has been shown to reduce HIV-related morbidity and mortality at all stages of HIV infection.[2,3] Furthermore, effective HIV treatment can also prevent the transmission of the disease.[4]

Despite groundbreaking treatments that have slowed the progression and burden of the disease, treatment of the disease is low – only half of PLWH are retained in medical care, according to the Centers for Disease Control and Prevention (CDC).[5] Medicaid has played a critical role in HIV care since the epidemic began, and it is the largest source of coverage for people living with HIV.[6] It is imperative to preserve continuous access to comprehensive health care, including antiretroviral therapy (ART) for people with HIV in order to improve health outcomes and reduce new transmissions.

Effective HIV Treatment

More than 1.1 million people living in the United States are living with HIV, and fifteen percent are unaware that they have the virus.[7] Treatment of HIV is a dynamic area of scientific discovery, and treatment protocols are changed and updated to reflect advances in medical science. PLWH often face a variety of medical challenges that impede access to, engagement in, and adherence to HIV care and treatment.

Strict adherence to (ART) – taking HIV medicines every day and exactly as prescribed – is essential to sustained suppression of the virus, reduced risk of drug resistance, and improved overall health.[8] The Health Resources and Services Administration (HRSA) states in its *Guide for HIV/AIDS Clinical Care* that "adherence to ART is the major factor in ensuring the virologic success of an initial regimen and is a significant determinant of survival."[9] Nonadherence – or skipping HIV medicines – may lead to drug-resistance, and reduce or eliminate the effectiveness of treatment with some HIV medicines.[10] In fact, the World Health Organization (WHO) recently reported that resistance among people retained on ART ranged from four to 28 percent, while among people with unsuppressed viral load on first-line ART regimens, resistance ranged from 47 to 90 percent.[11] Federal HIV clinical treatment guidelines (Department of Health and Human Services (DHHS) Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV) also emphasize the importance of adherence to ensure long-term treatment success.[12]

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[2] Severe P, Juste MA, Ambroise A, et al. Early versus standard antiretroviral therapy for HIV-infected adults in Haiti. *N Engl J Med*. Jul 15 2010;363(3):257-265. Available at http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Citation&list_uids=20647201

[3] Kitahata MM, Gange SJ, Abraham AG, et al. Effect of early versus deferred antiretroviral therapy for HIV on survival. *N Engl J Med.* Apr 30 2009;360(18):1815-1826. Available at http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Citation&list_uids=19339714

[4] Rodger et al. Risk of HIV transmission through condomless sex in serodifferent gay couples with the HIV-positive partner taking suppressive antiretroviral therapy (PARTNER): final results of a multicentre, prospective, observational study. The Lancet. Published Online May 2, 2019 http://dx.doi.org/10.1016/S0140-6736(19)30418-0.

[5] Understanding the HIV Care Continuum, CDC, https://www.cdc.gov/hiv/pdf/library/factsheets/cdc-hiv-care-continuum.pdf Accessed June 19, 2019

[6] Kaiser Family Foundation. Medicaid and HIV, http://www.kff.org/hivaids/fact-sheet/medicaid-and-hiv/.

[7] HIV in the United States: At a Glance, CDC, https://www.cdc.gov/hiv/statistics/overview/ataglance.html. Accessed June, 19, 2019.

[8] AIDS info.gov, NIH, Following an HIV Regimen: Steps to Take Before and After Starting HIV Medicines, January 31, 2019 https://aidsinfo.nih.gov/understanding-hiv-aids/fact-sheets/21/55/following-an-hiv-regimen---steps-to-take-before-and-after-starting-hiv-medicines

[9] HRSA, Guide for HIV/AIDS Clinical Care (April 2014), https://hab.hrsa.gov/sites/default/files/hab/clinical-quality-management/2014guide.pdf. Accessed October 13, 2017.

[10] AIDS Info, HIV Treatment Fact Sheet (March 2, 2017), https://aidsinfo.nih.gov/understanding-hiv-aids/fact-sheets/21/56/drug-resistance. Last accessed October 13, 2017.

[11] WHO, HIV Drug Resistance Report 2017, http://apps.who.int/iris/bitstream/10665/255896/1/9789241512831-eng.pdf?ua=1. Accessed October 13, 2017.

[12] DHHS Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV, NIH.gov https://aidsinfo.nih.gov/guidelines Accessed on 6/26/2019

When a PLWH receives and maintains effective HIV treatment, they can reach viral suppression. Viral suppression means that the virus has been reduced to an undetectable level in the body with standard tests.[13] Viral suppression results in reduced mortality and morbidity and leads to fewer costly medical interventions.[14]

HIV Treatment as Prevention

Viral suppression also helps to prevent new transmissions of the virus. When successful treatment with an antiretroviral regimen results in virologic suppression, secondary HIV transmission to others is effectively eliminated. In studies sponsored by the National Institutes of Health (NIH), investigators have shown that when treating the HIV-positive partner with antiretroviral therapy, there were no linked infections observed when the HIV+ partner's HIV viral load was below the limit of detection.[15] The National Institute of Allergy and Infectious Diseases (NIAID) supported research that demonstrated when PLWH achieve and maintain viral suppression, there is *effectively no risk* scientifically of transmitting HIV to their HIV-negative sexual partner.[16] Multiple subsequent studies also showed that PLWH on ART who had undetectable HIV levels in their blood, had essentially no risk of passing the virus on to their HIV-negative partners sexually.[17,18] As a result, the CDC estimates viral suppression effectiveness in preventing HIV transmission at 100 percent.[19]

The scientific news that HIV treatment also offers the benefit of prevention of HIV transmission led to the development of a movement called "U=U" or Undetectable = Untransmittable. Backed by scientific data, U=U reinforces the message that viral suppression can help end the HIV epidemic.[20] Today, the NIH, CDC and health authorities in many other countries have endorsed the U=U message.[21, 22] The scientific success of U=U reaffirms the need for PLWH to have uninterrupted access to prescribed drug treatment and the ability to stay engaged in care.

Reduced transmissions not only improve public health, but also save money. Therefore, preventing new transmissions offers a substantial fiscal benefit to the state.

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[13] National Institutes of Health (NIH) "Ten things to Know about HIV Suppression" https://www.niaid.nih.gov/news-events/10-things-know-about-hiv-suppression

[14] "Retention in Care and Adherence to ART are Critical Elements of HIV Care Interventions," Stricker, et al, AIDS and Behavior, October 2014, Volume 18, Supplement 5, pp 465–47,: https://link.springer.com/article/10.1007/s10461-013-0598-6

[15] Rodger et al. Risk of HIV transmission through condomless sex in serodifferent gay couples with the HIV-positive partner taking suppressive antiretroviral therapy (PARTNER): final results of a multicentre, prospective, observational study. The Lancet. Published Online May 2, 2019 http://dx.doi.org/10.1016/S0140-6736(19)30418-0 .

[16] NIAID, https://www.niaid.nih.gov/news-events/undetectable-equals-untransmittable. Accessed August 1, 2018.

[17] Bavinton, et al. The Opposites Attract Study of viral load, HIV treatment and HIV transmission in serodiscordant homosexual male couples: design and methods. BMC Public Health. 2014; 14: 917. doi: 10.1186/1471-2458-14-917

[18] Prevention of HIV-1 infection with early antiretroviral therapy. Cohen, et. al; HPTN 052 Study Team. N Engl J Med. 2011 Aug 11;365(6):493-505.

[19] Centers for Disease Control and Prevention (CDC) "Effectiveness of Prevention Strategies to Reduce the Risk of Acquiring or Transmitting HIV" https://www.cdc.gov/hiv/risk/estimates/preventionstrategies.html Accessed September 20, 2019.

[20] "HIV Undetectable=Untransmittable (U=U), or Treatment as Prevention" National Institute of Allergy and Infectious Diseases https://www.niaid.nih.gov/diseases-conditions/treatment-prevention

[21] "Effectiveness of Prevention Strategies to Reduce the Risk of Acquiring or Transmitting HIV," CDC, https://www.cdc.gov/hiv/risk/estimates/preventionstrategies.html

[22] "For HIV, Treatment is Prevention" Dr. Francis Collins, NIH Director's Blog, posted January 22nd, 2019 https://directorsblog.nih.gov/2019/01/22/for-hiv-treatment-is-prevention/

In studies sponsored by the National Institutes of Health (NIH), investigators have shown that when treating the HIV-positive partner with antiretroviral therapy,[23] there were no linked infections observed when the infected partner's HIV viral load was below the limit of detection. Reduced transmissions not only improve public health, but also save money. It is estimated PLWH who are not retained in medical care may transmit the virus to an average of 5.3 additional people per 100-person years.[24] Other studies estimate that each HIV positive patient may approach $338,400 in additional costs to the healthcare system over his or her lifetime even if diagnosed early and retained in care.[25] Successful treatment with an antiretroviral regimen results in virologic suppression and virtually eliminates secondary HIV transmission to others. As a result, it is possible to extrapolate that successful HIV treatment and medical care of each infected patient may save the system up to $1.79 million by preventing[26] further transmission to others. These savings can only occur, however, if PLWH are diagnosed, have access to medical care, receive treatment, and remain adherent to their prescribed therapy.

HIV and Medicaid

Medicaid has played a critical role in HIV care since the epidemic began. Medicaid is the largest source of coverage for people living with HIV.[27] In fact, more than half of PLWH who are engaged in medical care have incomes at or below the federal poverty level.[28] Medicaid is an essential source of access to medical care and ART drug coverage for people living with HIV. This medical care and drug treatment not only maintains the health and wellness of PLWH and improves health outcomes, but it also prevents new HIV transmissions.

Proposed Waiver

ViiV applauds the state of Nebraska for expanding Medicaid services up to 138% FPL with this waiver, [29] and for assuring the entire expansion population has access to essential health benefits and basic health coverage, while also pursuing the state's other demonstration goals. As such, we would like to call attention to several issues below, for your consideration:

1. People Living With HIV & Medical Frailty

ViiV commends the state of Nebraska for exempting medically frail individuals from this demonstration, and providing assured access to health coverage for this population.[30] However, we urge the state to specifically identify PLWH as part of the medically frail population in this waiver.

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[23] Rodger et al. Risk of HIV transmission through condomless sex in serodifferent gay couples with the HIV-positive partner taking suppressive antiretroviral therapy (PARTNER): final results of a multicentre, prospective, observational study. The Lancet. Published Online May 2, 2019 http://dx.doi.org/10.1016/S0140-6736(19)30418-0.

[24] Skarbinski, et al. *JAMA Intern Med*. 2015;175(4):588-596.

[25] Schackman BR, Fleishman JA, Su AE, Berkowitz BK, Moore RD, Walensky RP, et al. The lifetime medical cost savings from preventing HIV in the United States. Medical care. 2015;53(4):293–301, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4359630/

[26] Schackman BR, Fleishman JA, Su AE, Berkowitz BK, Moore RD, Walensky RP, et al. The lifetime medical cost savings from preventing HIV in the United States. Medical care. 2015;53(4):293–301, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4359630/

[27] Kaiser Family Foundation. Medicaid and HIV, http://www.kff.org/hivaids/fact-sheet/medicaid-and-hiv/.

[28] CDC, Behavioral and Clinical Characteristics of Persons Receiving Medical Care for HIV Infection—Medical Monitoring Project, United States, https://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-hssr-mmp-2014.pdf 2014 cycle (June 2014-May 2015). Surv report 17

[29] Nebraska Medicaid Section 1115 Heritage Health Adult Expansion Demonstration, "Improving Health Outcomes and Encouraging Life Successes for Adult Medicaid Beneficiaries" Page 9 http://dhhs.ne.gov/Documents/HHAWaiverDraftApp.pdf, Accessed November 11, 2019

[30] Nebraska Medicaid Section 1115 Heritage Health Adult Expansion Demonstration, "Improving Health Outcomes and Encouraging Life Successes for Adult Medicaid Beneficiaries" http://dhhs.ne.gov/Documents/HHAWaiverDraftApp.pdf, Accessed November 11, 2019

Uninterrupted access to medical care and drug treatment benefits is directly linked to the health and wellness of PLWH covered by public health programs. For PLWH, adherence to antiretroviral medication is paramount in maintaining their health, avoiding viral resistance, and preventing medical complications and co-morbidities.[31] [32] In a study, PLWH who faced drug benefit design changes were found to be nearly six times more likely to face treatment interruptions than those with more stable coverage, which can increase virologic rebound, drug resistance, and increased morbidity and mortality.[33] To achieve optimal clinical outcomes for PLWH and to realize the potential public health benefit of treatment as prevention, adherence to antiretroviral therapy (ART) and retention in care are essential. The DHHS HIV Treatment Guidelines state, *"… high-quality system processes are vital in promoting rapid linkage and sustained retention in care and adherence to ART*."[34] Access to qualified medical care providers is also very important for PLWH in order to monitor disease progression and ensure viral suppression is maintained.[35] [36] Disruptions in benefits and loss of coverage may lead to increased overall health costs and may result in increased HIV transmission.[37] For this reason, ViiV recommends that PLWH be assured access to necessary medications and high quality medical care, and services such as case management, similar to other complex medical conditions or medically frail populations.

Although the proposed waiver exempts medically frail individuals from the Community Engagement (CE) requirements, and provides coverage under the ABP Prime, it does not specifically designate PLWH as included in the medically frail/exempted population.

The proposed waiver states that:

> *"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)."*[38]

Section 1937(a)(2) of the Social Security Act states that:

> *"(vi) MEDICALLY FRAIL AND SPECIAL MEDICAL NEEDS INDIVIDUALS—The individual is medically frail or otherwise an individual with special medical needs (as identified in accordance with regulations of the Secretary)"*[39]

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[31] Chesney MA. The elusive gold standard. Future perspectives for HIV adherence assessment and intervention. J Acquir Immune Defic Syndr. 2006;43 Suppl 1:S149-155, http://www.ncbi.nlm.nih.gov/pubmed/17133199.

[32] HRSA, Guide for HIV/AIDS Clinical Care (April 2014), https://hab.hrsa.gov/sites/default/files/hab/clinical-quality-management/2014guide.pdf. Accessed October 13, 2017.

[33] Das-Douglas, Moupali, et al. "Implementation of the Medicare Part D prescription drug benefit is associated with antiretroviral therapy interruptions." AIDS and Behavior 13.1 (2009): 1

[34] DHHS Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV, NIH.gov https://aidsinfo.nih.gov/guidelines Accessed on 6/26/2019

[35] Kitahata MM, Koepsell TD, Deyo RA, Maxwell CL, Dodge WT, Wagner EH. Physicians' experience with the acquired immunodeficiency syndrome as a factor in patients' survival. New Engl J Med. 1996;334:701–7. [PubMed]

[36] Gallant, Joel E. et al. "Essential Components of Effective HIV Care: A Policy Paper of the HIV Medicine Association of the Infectious Diseases Society of America and the Ryan White Medical Providers Coalition." Clinical Infectious Diseases: An Official Publication of the Infectious Diseases Society of America53.11 (2011): 1043–1050. PMC. Web. 20 Dec. 2017.

[37] Schackman BR, Fleishman JA, Su AE, Berkowitz BK, Moore RD, Walensky RP, et al. The lifetime medical cost savings from preventing HIV in the United States. Medical care. 2015;53(4):293–301, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4359630/

[38] Nebraska Medicaid Section 1115 Heritage Health Adult Expansion Demonstration, "Improving Health Outcomes and Encouraging Life Successes for Adult Medicaid Beneficiaries" Page 9 http://dhhs.ne.gov/Documents/HHAWaiverDraftApp.pdf, Accessed November 11, 2019

[39] Social Security Act, *Section 1902(i)(26)* https://www.ssa.gov/OP_Home/ssact/title19/1937.htm

In its "Heritage Health Adult Program - Section 1115 Waiver Concept Paper," Nebraska defines medically frail as:

> *"See 42 CFR §440.315(f): "The individual is medically frail or otherwise an individual with special medical needs. For these purposes, the State's definition of individuals who are medically frail or otherwise have special medical needs must at least include those individuals described in § 438.50(d)(3) of this chapter, individuals with disabling mental disorders (including children with serious emotional disturbances and adults with serious mental illness), individuals with chronic substance use disorders, individuals with serious and complex medical conditions, individuals with a physical, intellectual or developmental disability that significantly impairs their ability to perform 1 or more activities of daily living, or individuals with a disability determination based on Social Security criteria or in States that apply more restrictive criteria than the Supplemental Security Income program, the State plan criteria."*[40]

The federal definition of medically frail populations is found in 42 CFR 440.315 and says:

> *"… the State's definition of individuals who are medically frail or otherwise have special medical needs must at least include those … with serious and complex medical conditions…"*[41]

According to one analysis, this means that CMS has left it up to the states to establish their own definition of which populations should be included in the designation of medically frail.[42]

Many other states have defined populations that should be exempted from proposals due to their health and medical needs using terms such as "medically complex populations" or those with "high medical need," "serious medical conditions," "chronic conditions" and/or "special medical needs." As an alternative, the state of Oklahoma simply included a list of populations exempt from their proposed SoonerCare "Community Engagement" 1115 waiver amendment, without any further designations.[43] Several states, including Kentucky, Indiana, Michigan and Arizona have included HIV in their definition of "medical frailty" when designing work requirements.[44, 45, 46]

ViiV encourages the state of Nebraska to specifically designate PLWH as a medically frail population with special medical needs, and serious and complex medical conditions, and ensure access to the Prime level coverage of medical care and treatment.

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[40] Heritage Health Adult Program - Section 1115 Waiver Concept Paper: http://dhhs.ne.gov/Documents/HeritageHealthAdultProgramConceptPaper.pdf

[41] Government Publishing Office, "42 CFR § 440.315 - Exempt individuals," https://www.govinfo.gov/content/pkg/CFR-2013-title42-vol4/pdf/CFR-2013-title42-vol4-sec440-315.pdf

[42] Mosbach, Peter and Campanelli, Sherry J., "State Differences in the Application of Medical Frailty Under the Affordable Care Act: 2017 Update" (2017). Commonwealth Medicine Publications. 40. https://escholarship.umassmed.edu/commed_pubs/40

[43] CMS, Medicaid Waivers, Oklahoma https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/?entry=8258

[44] Mosbach, Peter and Campanelli, Sherry J., "State Differences in the Application of Medical Frailty Under the Affordable Care Act: 2017 Update" (2017). Commonwealth Medicine Publications. 40. https://escholarship.umassmed.edu/commed_pubs/40

[45] Arizona Section 1115 Waiver Amendment Request: AHCCCS Works Waiver, 2017 https://www.azahcccs.gov/shared/Downloads/News/AHCCCSWorks1115WaiverAmendmentRequest.pdf

[46] Section 1115 Demonstration Extension Application, Healthy Michigan Plan Project No. 11-W-00245/5, AMENDED: September 10, 2018 https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mi/mi-healthy-michigan-pa3.pdf

2. Case Management

ViiV applauds the state of Nebraska for requiring Heritage Health managed care plans to provide case and care management services to Heritage Health beneficiaries including those newly eligible under the HHA program.[47]

ViiV encourages the state to make care coordination/ case management services available to all PLWH. When HIV infection is effectively managed to a state of viral suppression, it becomes, in effect, a chronic condition. Achieving this level of success in HIV care and treatment with a vulnerable population often requires addressing a combination of multiple health and social needs, such as housing, food, nutrition, and medical case management services, among others. The CDC's HIV treatment cascade highlights the fact that a significant portion of the HIV population is experiencing a poorly controlled chronic condition. Many PLWH also experience co-occurring conditions such as substance abuse and mental health disorders and increasing numbers of PLWH are joining the elderly population. This further indicates that PLWH are a population who would benefit from increased care management.

Additionally, health systems that have implemented care management services have been able to vastly improve clinical outcomes and quality while reducing overall health care costs.[48, 49] The Ryan White HIV/AIDS Program uses integrated care models offer comprehensive medical case management.[50] As of 2017 over 85 percent of Ryan White HIV/AIDS Program clients were virally suppressed, far exceeding the national viral suppression average of 59.8 percent.[51]

3. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) for Adults

The waiver proposes to provide EPSDT requirements only for adults in the Prime Benefit Package.[52]

The EPSDT benefit was designed to provide comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. EPSDT is key to ensuring that children and adolescents receive appropriate diagnostic, screening, treatment, and specialty services.

Youth aged 13 to 24, had the second largest rate of new HIV diagnoses for the last two years.[53] Moreover, youth with HIV are the least likely out of any age group to be linked to care and have a suppressed viral load. Addressing HIV in youth requires that we provide young people with the information and tools they need to reduce their risk of acquiring and transmitting HIV, make healthy decisions, and obtain treatment and care if needed.[54]

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[47] Nebraska Medicaid Section 1115 Heritage Health Adult Expansion Demonstration, "Improving Health Outcomes and Encouraging Life Successes for Adult Medicaid Beneficiaries" Page 13 http://dhhs.ne.gov/Documents/HHAWaiverDraftApp.pdf, Accessed November 11, 2019

[48] The Patient-Centered Medical Home: Integrating Comprehensive Medication Management to Optimize Patient Outcomes Resource Guide 2nd Edition June 2012, http://www.pcpcc.org/sites/default/files/media/medmanagement.pdf Accessed October 16, 2017.

[49] Center for Care Innovations- Care Integration Webinar #4: Integrating Pharmacy Care and Primary Care presented by Steven Chen, PharmD and Michael Hochman, MD, http://www.careinnovations.org/knowledge-center/care-integration-webinar-4-integrating-pharmacy-care-and-primary-care

[50] The Impact of the Ryan White HIV/AIDS Medical Case Management Program on HIV Clinical Outcomes: A Longitudinal Study https://hab.hrsa.gov/publications/library/impact-ryan-white-hivaids-medical-case-management-program-hiv-clinical-outcomes

[51] "HRSA Announces Highest HIV Viral Suppression Rate in New Ryan White HIV/AIDS Program Client-Level Data Report" Press Release, Dec. 11, 2018 https://www.hrsa.gov/about/news/press-releases/hrsa-announces-highest-hiv-viral-suppression-rate

[52] Nebraska Medicaid Section 1115 Heritage Health Adult Expansion Demonstration, "Improving Health Outcomes and Encouraging Life Successes for Adult Medicaid Beneficiaries" Page 11 http://dhhs.ne.gov/Documents/HHAWaiverDraftApp.pdf, Accessed November 11, 2019

[53] Utah Department of Health, "2017: Annual HIV Surveillance Report" http://health.utah.gov/epi/diseases/hivaids/surveillance/HIV_2017_report.pdf

[54] CDC, HIV Among Youth, https://www.cdc.gov/hiv/group/age/youth/index.html.

EPSDT services should be provided to the entire Medicaid population, ages 19 and 20. The educational services that are often offered during HIV testing – especially if the test is negative – are important for people in this age range so that they can protect themselves from acquiring HIV.

4. HIV Stigma

The waiver proposes to provide screening for social determinants of health as a condition of the Prime Benefit Package.[55] We urge the state to use caution when developing this screening tool, as stigma is a significant concern in the HIV epidemic.

HIV stigma - the negative attitudes or beliefs around HIV disease - can lead to discrimination and prejudice from others, and even by healthcare providers. HIV stigma is often rooted in lack of information and awareness combined with outdated beliefs and scientific misconceptions about how HIV is transmitted and what it means to live with HIV today. According to the CDC, HIV stigma and discrimination can keep people from getting tested and treated for HIV.[56] ViiV Healthcare supports appropriate education and awareness on HIV that references the CDC and NIH approved U=U messaging referenced above, which seeks to reduce stigma and discrimination against those living with HIV.

Conclusion

ViiV Healthcare looks forward to working with the state and other stakeholders to ensure that Nebraska's public programs continue to ensure that PLWH have access to quality care and to improved health outcomes.

Please feel free to contact me at (404) 313-5840 or Kristen.X.Tjaden@viivhealthcare.com should you have any questions.

Sincerely,

Kristen Tjaden
Government Relations Director
ViiV Healthcare

[55] Nebraska Medicaid Section 1115 Heritage Health Adult Expansion Demonstration, "Improving Health Outcomes and Encouraging Life Successes for Adult Medicaid Beneficiaries" Page 11 http://dhhs.ne.gov/Documents/HHAWaiverDraftApp.pdf, Accessed November 11, 2019
[56] "What is HIV stigma?" CDC.gov https://www.cdc.gov/hiv/basics/hiv-stigma/index.html

CLASP
Policy solutions that work for low-income people

November 22, 2019

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

Re: Nebraska Medicaid Section 1115 Heritage Health Adult Expansion Demonstration

Dear Nebraska Medicaid Department,

I am writing on behalf of the Center for Law and Social Policy (CLASP). CLASP is a national, nonpartisan, anti-poverty nonprofit advancing policy solutions for low-income people. We work at both the federal and state levels, supporting policy and practice that makes a difference in the lives of people living in conditions of poverty. CLASP submits the following comments in response to the proposed Nebraska Medicaid Section 1115 Heritage Health Adult Expansion Demonstration and raises serious concerns about the effects of the waiver, as proposed, on the health outcomes of Medicaid beneficiaries in Nebraska.

This waiver proposes to expand Medicaid coverage for adults up to 138% of the Federal Poverty Level (FPL) but it imposes restrictive conditions and a significant paperwork burden on the enrollees to receive and maintain comprehensive health insurance. Specifically, the waiver proposes to give comprehensive "Prime Medicaid" *only* to beneficiaries who meet certain criteria—including work requirements. The waiver proposal also eliminates retroactive eligibility in the state's Medicaid program for all enrollees except pregnant women, children, dual eligibles and individuals in a nursing facility. The proposal runs counter to the will of Nebraskans who voted for expansion without work requirements. CLASP opposes the provisions of this waiver and urges Nebraska to immediately withdraw this proposal. Instead, the state should do a straight expansion of comprehensive Medicaid services to all adults under 138% of FPL.

Comprehensive Benefits Contingent On Burdensome Requirements

While all enrollees will receive basic health care services, under this waiver proposal, only certain people will be able to access comprehensive coverage. Nebraska proposes to make comprehensive coverage—known as Prime Medicaid, contingent on enrollees completing burdensome administrative tasks every six months.

Only enrollees who receive Prime Medicaid will have access to vision and oral health coverage, as well as

over-the-counter medications. Certain categories of beneficiaries will automatically receive Prime Medicaid, including medically frail populations; young adults age 19-20; and women who are pregnant and eligible under the expansion. All other adults who receive coverage under this waiver will be required to participate in certain initiatives and activities in order to *earn* and then maintain Prime Medicaid. To qualify for Prime Medicaid, an enrollee must:

- Participate in case and care management (including completing a health risk screening and a social determinants of health assessment; must fill medications routinely and have clinical labs as ordered by provider);
- Complete an annual health visit;
- Select a primary care provider;
- Not miss three or more scheduled appointments;
- Notify the state of any changes in your status;
- Maintain employer-sponsored health coverage; and
- In year 2, participate in work/community engagement.

Taken together, these activities represent a significant burden on enrollees which can have a negative impact on their ability to qualify for Prime Medicaid. CLASP has deep experience with Temporary Assistance for Needy Families (TANF) and the Supplemental Nutrition Assistance Program (SNAP), two programs where work reporting requirements have already been implemented – and been shown to be significant barriers to low-income people getting and retaining benefits. These comments also draw on CLASP's experience in working with six states under the Work Support Strategies project, where these states sought to dramatically improve the delivery of key work support benefits to low-income families, including health coverage, nutrition benefits, and child care subsidies through more effective, streamlined, and integrated approaches. From this work, we learned that reducing unnecessary steps in the application and renewal process both reduced burden on caseworkers and made it easier for families to access and retain the full package of supports that they need to thrive in work and school.

The Medicaid statute is clear that the purpose of the program is to furnish medical assistance to individuals whose incomes are not enough to meet the costs of necessary medical care and to furnish such assistance and services to help these individuals attain or retain the capacity for independence and self-care. States are allowed in limited circumstances to request to "waive" provisions of the rule but the Secretary of Health and Human Services (HHS) may only approve a project which is "likely to assist in promoting the objectives" of the Medicaid Act.[1] A waiver that does not promote the provision of health care would not be permissible.

This proposal's attempt to transform Medicaid and reverse its core function will result in individuals losing needed coverage for oral and vision services, poor health outcomes, and higher administrative costs. There is an extensive and strong literature that shows, as a recent New England Journal of Medicine review concludes "Insurance coverage increases access to care and improves a wide range of health outcomes."[2] This waiver is therefore inconsistent with the Medicaid purpose of providing medical assistance and improving health and should be rejected. Moreover, losing access to medically necessary oral and vision services will also make achieving work and education goals significantly more difficult for beneficiaries.

Oral and Vision Services Are Part of Comprehensive Coverage

CLASP strongly opposes the creation of a tiered Medicaid program and conditioning a *comprehensive* benefits package on meeting these bureaucratic conditions. Oral health and vision are critical components of an individual's overall health and prevent other costly health problems and supports social interaction, mobility and work readiness.

The converse is also true, individuals with poor oral and vision health put their overall health and wellbeing at risk—in both the short term and over the lifespan. Poor oral health can impact people's ability to eat, get and keep a job, interact socially. Poor appearance resulting from dental problems can contribute to social isolation, lower wages and loss of self-esteem.[3] Low vision and blindness have dramatic impacts on individuals—as well as their families and communities. Individuals experiencing vision problems experience barriers to work; limitations in transportation and mobility; and social isolation. Employed adults lose more than 164 million hours of work each year due to oral health problems or dental visits.[4]

Both oral health and eye disorders/vision loss are correlated with other chronic conditions; and dental diseases in particular can quickly develop life-threatening complications if they are not quickly treated. For example, there is a correlation between diabetes and eye disease; diabetes-related eye diseases can cause individuals significant vision problems and even blindness.[5] There is also a connection between uncontrolled diabetes and serious periodontal disease; untreated periodontal diseases makes it more difficult to control diabetes and can lead to significant complications.[6]

Poor oral health can also lead to a range of other chronic conditions. The data linking dental infections to increased risk of cardiovascular disease is clear: poor oral health appears to worsen blood pressure control and interferes with hyper tension treatment.[7] Periodontitis has been linked to premature birth and low birthweight.[8] For individuals with disabilities, prevalent chronic conditions that have known oral health connections include depression, diabetes, and kidney diseases;[9] and individuals with epilepsy and autism spectrum disorders may experience lifelong direct oral health consequences.[10]

There are direct economic impacts of poor oral and vision health. A recent study of hospital emergency department (ED) visits by adults for chronic dental conditions in Maryland found that in 2016 alone, more than 22,000 adults covered by Medicaid visited hospital EDs for their dental conditions. Medicaid paid nearly $10 million for those ED visits, in addition to $1.4 million for adults who required hospitalization for their dental needs.[11] An estimate from NORC on behalf of Prevent Blindness America estimates the total economic burden of eye disorders and vision loss to be $139 billion, based on the 2011 U.S. population in 2013 dollars.[12]

One key factor in oral and vision health is access to health care. Lack of access to oral health and vision services put individuals at greater risk of poor health outcomes. Low-income individuals and communities of color are less likely to have access to and/or receive oral health services[13], and the low-income population is more likely to experience oral diseases.[14]

Despite the huge health care and economic impacts of poor oral and vision health, and despite the high level of need for oral and vision services among low-income individuals, this proposal will deny oral and vision services to otherwise-qualified Medicaid enrollees unless they participate in a range of burdensome and unsustainable activities.

Prime Medicaid Eligibility Contingent on Work Requirements in Year 2

CLASP strongly opposes work requirements as a condition of eligibility for Medicaid. Below we provide additional comments that focus on the Year 2 Work Requirement as part of the eligibility for Prime Medicaid.

Proposals to Take Health Benefits Away from Individuals Who Do Not Meet New Work Requirements

CLASP does not support Nebraska's proposal to take away certain health benefits from individuals who do not meet new work requirements. CLASP strongly opposes work requirements for Medicaid beneficiaries and urges Nebraska to eliminate this request. Work requirements—and withholding benefits for failure to comply—are inconsistent with the goals of Medicaid because they would act as a barrier to access to coverage, particularly for those with chronic conditions and disabilities, but also for those in areas of high unemployment, or who work the variable and unpredictable hours characteristic of many low-wage jobs.

While the purported goal of this provision is to promote work, the reality is that denying access to oral and vision care creates obstacles for individuals to getting and maintaining work. People must be healthy in order to work, and consistent access to oral health and vision services is vital to being healthy enough to work.[15] Making oral and vision health services more difficult to access could have the exact opposite effect on employment that supporters of work requirements claim to be pursuing.

Proposals to Take Health Coverage Away from Individuals Who Do Not Meet New Work Requirements Do Not Lead to Employer-Sponsored Insurance

The waiver request assumes that if participants become employed, they will be able to transition to affordable employer-sponsored insurance (ESI). Unfortunately, this is simply not the reality of many jobs in America. Only 49 percent of people in this country receive health insurance through their jobs—and only 16 percent of poor adults do so.[16] The reality is that many low-wage jobs, particularly in industries like retail and restaurant work, do not offer ESI, and when they do, it is not affordable.[17] In fact, in 2017, only 24 percent of workers with earnings in the lowest 10 percent of wages were offered employer insurance, and only 14 percent actually received coverage under in their employer offered insurance.[18] People working multiple part-time jobs or in the gig economy are particularly unlikely to have access to ESI.

A recent study by the Urban Institute provides additional evidence in New Hampshire – a state that was recently approved to move forward with their work reporting requirement. The paper found that New Hampshire residents who could lose Medicaid under work reporting requirements will likely face limited and costly employer-sponsored insurance options. In particular, researchers found that less than one in tend part-time private-sector employees in New Hampshire were eligible for employer-sponsored coverage and just over half of full-time employees at firms with fewer than 50 employees were eligible for employer-sponsored coverage in 2017. Additionally, annual employee contributions for a single-coverage plan would represent 12.5 percent of annual income for a minimum-wage, full-time worker and 25.0 percent of annual income for a minimum-wage, part-time worker— more than ten times the percentage premium limit in the Marketplace for individuals earning 100 percent of the federal poverty level.[19]

Proposals to Take Health Benefits Away from Individuals Who Do Not Meet New Work Requirements Grow Government Bureaucracy and Increase Red Tape

Taking away benefits—and shifting enrollment between Basic and Prime Medicaid—from Medicaid enrollees who do not meet new work requirements in Year 2 would add new red tape and bureaucracy to the program and only serve as a barrier to health care for enrollees. Tracking work hours, reviewing proof of work, and keeping track of who is and is not subject to the work requirement is a considerable undertaking that will be costly and possibly require new technology expenses to update IT systems. What's more, the waiver proposes that the eligibility redeterminations for Prime Medicaid happen every six months.

One of the key lessons of the Work Support Strategies initiative is that every time a client needs to bring in a verification or report a change adds to the administrative burden on caseworkers and increases the likelihood that clients will lose benefits due to failure to meet one of the requirements. In many cases, clients remain eligible and will reapply, which is costly to families who lose benefits as well as to the agencies that must process additional applications. The WSS states found that reducing administrative redundancies and barriers used workers' time more efficiently and helped with federal timeliness requirements. As a result of Nebraska's new administrative complexity and red tape, ***eligible*** people will lose their Prime status because the application, enrollment, and on-going processes to maintain coverage are too cumbersome.

Recent evidence from Arkansas' implementation of work reporting requirements confirms that bureaucratic barriers for individuals who already work or qualify for an exemption will lead to disenrollment. More than 18,000 beneficiaries lost coverage before the program was suspended by a federal judge, likely becoming uninsured because they didn't report their work or work-related activities.[20] As reported by the Center on Budget and Policy Priorities, many of those who failed to report likely didn't understand the reporting requirements, lacked internet access or couldn't access the reporting portal through their mobile device, couldn't establish an account and login, or struggled to use the portal due to disability.[21] The recent study looking at the Arkansas program found that "work requirements have substantially exacerbated administrative hurdles to maintaining coverage". The study found a reduction in Medicaid of 12 percent, even though more than 95% of those who were subject to the policy already met the requirement or should have been exempt.[22]

Proposals to Take Health Benefits Away from Individuals Who Do Not Meet New Work Requirements Do Not Reflect the Realities of Our Economy

Proposals to take health benefits away from Medicaid enrollees who do not work a set number of hours do not reflect the realities of today's low-wage jobs. For example, seasonal workers may have a period of time each year when they are not working enough hours to meet a work requirement and as a result will churn on and off Medicaid Prime during that time of year. Or, some may have a reduction in their work hours at the last minute and therefore not meet the minimum number of hours needed to retain Medicaid. Many low-wage jobs are subject to last-minute scheduling, meaning that workers do not have advance notice of how many hours they will be able to work.[23]

Nebraska's proposal to require 80 hours of work per month throughout the entire year in order to qualify for Prime Medicaid does not represent the reality of low-wage work. An analysis by the Urban Institute of

Kentucky's similar proposal found that an estimated 13 percent of nondisabled, nonelderly working Medicaid enrollees who do not appear to qualify for a student or caregiver exemption in Kentucky's Medicaid program could be at risk of losing Medicaid coverage at some point in the year under the work requirements because, despite working 960 hours a year, they may not work consistently enough throughout the year to comply with the waiver.[24] Additional analysis from the Urban Institute shows that Medicaid enrollees who would potentially be subject to work reporting requirements are more likely to face barriers to employment, compared with privately insured adults. The analysis found that half of nonexempt Medicaid enrollees nationally reported issues related to the labor market or nature of employment, such as difficulty finding work and restricted work schedules, as reasons for not working more, and over one-quarter reported health reasons.[25]

Proposals to Take Health Benefits Away from Individuals Who Do Not Meet New Work Requirements Will Harm Persons with Illness and Disabilities

Many people who are unable to work due to disability or illness are likely to lose Prime Medicaid because of the Year 2 work requirement. A Kaiser Family Foundation study found that 36 percent of unemployed adults receiving Medicaid—but who are not receiving Disability/SSI—reported illness or disability as their primary reason for not working. Additional research from the Kaiser Family Foundation shows that people with disabilities were particularly vulnerable to losing coverage under the Arkansas work reporting requirements, despite remaining eligible.[26]

And, an Ohio study found that one-third of the people referred to a SNAP employment program that would allow them to keep their benefits reported a physical or mental limitation. Of those, 25 percent indicated that the condition limited their daily activities,[27] and nearly 20 percent had filed for Disability/SSI within the previous two years. Additionally, those with disabilities may have a difficult time navigating the increased red tape and bureaucracy put in place to administer a work requirement. The result is that many people with disabilities will, in fact, be subject to the work requirement and be at risk of losing health coverage.

Proposals to Take Health Benefits Away from Individuals Who Do Not Meet New Work Requirements Will Have a Disparate Impact on Communities of Color

CLASP strongly opposes the proposal due to its disproportionate impact on communities of color. As discussed in more detail in the sections that follow, many people of color face employment challenges and, under the proposed policy, would be disadvantaged in being able to gain oral and vision benefits through Prime Medicaid.

Employment discrimination limits access to the workforce for many people of color: Studies show that racial discrimination remains a key force in the labor market.[28] In a 2004 study, "Are Emily and Greg more employable than Lakisha and Jamal: A Field Experiment on Labor Market Discrimination," researchers randomly assigned names and quality to resumes and sent them to over 1,300 employment advertisements. Their results revealed significant differences in the number of callbacks each resume received based on whether the name sounded white or African American. More recent research indicates that this bias persists. A study from 2013 submitted fake resumes of nonexistent recent college graduates through online job applications for positions based in Atlanta, Baltimore, Portland, Oregon, Los Angeles, Boston, and Minneapolis. African-Americans were 16% less likely to get called in for an interview.[29]

Similarly, a 2017 meta-analysis of field experiments on employment discrimination since 1989 found that white Americans applying for jobs receive on average 36% more callbacks than African Americans and 24% more callbacks than Latinos.[30]

Hispanic and Black workers have been hardest hit by the structural shift toward involuntary part-time work: Despite wanting to work more, many low-wage workers struggle to receive enough hours from their employer to make ends meet. A report from the Economic Policy Institute found that 6.1 million workers were involuntary part-time; they preferred to work full-time but were only offered part-time hours. According to the report, "involuntary part-time work is increasing almost five times faster than part-time work and about 18 times faster than all work."[31] Hispanic and Black workers are much more likely to be involuntarily part-time (6.8 percent and 6.3 percent, respectively) than their White counterparts, of whom 3.7 percent work part time involuntarily. And Black and Latino workers are a higher proportion of involuntary part-time workers, together representing 41.1 percent of all involuntary part-time workers. The greater amount of involuntary part-time employment among Black and Hispanic workers is primarily due to their having greater difficulty finding full-time work and more often facing work conditions in which hours are variable and can be reduced without notice.[32]

People of color are more likely to live in neighborhoods with poor access to jobs: In recent years, majority-minority neighborhoods have experienced particularly pronounced declines in job proximity. Proximity to jobs can affect the employment outcomes of residents and studies show that people who live closer to jobs are more likely to work.[33] They also face shorter job searches and fewer spells of joblessness.[34] As residents from households with low-incomes and communities of color shifted toward suburbs in the 2000s, their proximity to jobs decreased. Between 2000 and 2012, the number of jobs near the typical Hispanic and Black resident in major metropolitan areas declined much more steeply than for white residents.[35]

Due to overcriminalization of neighborhoods of color, people of color are more likely to have previous histories of incarceration, which in turn limit their opportunities: People of color, particularly African Americans and Latinos, are unfairly targeted by the police and face harsher prison sentences than their white counterparts.[36] After release, formerly incarcerated individuals fare poorly in the labor market, with most experiencing difficulty finding a job after release. Research shows that roughly half of people formerly incarcerated are still unemployed one year after release.[37] For those who do find work, it's common to have annual earnings of less than $500.[38] Further, during the time spent in prison, many lose work skills and are given little opportunity to gain useful work experience.[39] People who have been involved in the justice system struggle to obtain a driver's license, own a reliable means of transportation, acquire relatively stable housing, and maintain proper identification documents. These obstacles often prevent them from successfully re-entering the job market and are compounded by criminal background checks, which further limit access to employment.[40] A recent survey found that 96 percent of employers conduct background checks on job applicants that include a criminal history search.[41]

Further, work reporting requirements are part of a long history of racially-motivated critiques of programs supporting basic needs. False race-based narratives have long surrounded people experiencing poverty, with direct harms to people of color. For decades these narratives have played a role in discussions around public assistance benefits and have been employed to garner support from working-class whites.[42] Below are a few examples of the relationship between poverty, racial bias, and access to basic needs programs.

- When the "Mother's Pension" program was first implemented in the early 1900s, it primarily served white women and allowed mothers to meet their basic needs without working outside of the home. Only when more African American women began to participate were work reporting requirements implemented.[43]
- Between 1915 and 1970, over 6 million African Americans fled the south in the hope of a better life. As more African Americans flowed north, northern states began to adopt some of the work reporting requirements already prevalent in assistance programs in the South.[44]
- As civil rights struggles intensified, the media's portrayal of poverty became increasingly racialized. In 1964, only 27 percent of the photos accompanying stories about poverty in three of the country's top weekly news magazines featured Black subjects; by 1967, 72 percent of photos accompanying stories about poverty featured Black Americans.[45]
- Many of Ronald Reagan's presidential campaign speech anecdotes centered around a Black woman from Chicago who had defrauded the government. These speeches further embedded the idea of the Black "welfare queen" as a staple of dog whistle politics, suggesting that people of color are unwilling to work.[46]
- In 2018, prominent sociologists released a study looking at racial attitudes on welfare. They noted that white opposition to public assistance programs has increased since 2008 — the year that Barack Obama was elected. The researchers also found that showing white Americans data suggesting that white privilege is diminishing led them to express more opposition to spending on basic needs programs. They concluded that the "relationship between racial resentment and welfare opposition remains robust."[47]

Prime Medicaid Eligibility Contingent on Not Missing Three Appointments, Participating in Case or Care Management, Attending an Annual Health Visit, and Choosing a Primary Care Provider

The proposed waiver will deny Prime Medicaid to beneficiaries who miss three or more scheduled appointments or do not actively participate in case or care management, attend an annual health visit, and choose a primary care provider. This policy places all the burden on the beneficiary and fails to acknowledge the challenges faced by low-income beneficiaries, including unpredictable shift work, challenges with reliable daycare, lack of reliable transportation or the challenges of public transportation.[48] Under this policy, a Medicaid recipient could be forced to choose between losing their job (when they are unexpectedly required to work additional hours) and getting the oral and vision health services they need to maintain their health—and their jobs.

In addition, evidence from states that have created incentives for various health-related behaviors under Medicaid shows at best, only moderate levels of participation in the designated activities.[49] A synthesis of the literature finds a consistent challenge in simply communicating information about the programs to participants, and that "most surveyed beneficiaries report low to moderate awareness about the existence of the incentive programs or how they work."[50] Along with similar results from the work reporting requirements implemented in Arkansas, this suggests that many people will be denied Prime Medicaid because they did not understand what they needed to do to retain benefits.

Removing Conditions Around Existing Retroactive Coverage Does Not Further the Objectives of the Medicaid Program

Nebraska's proposal would remove conditions around retroactive coverage which would allow the state

to waive the statutory provision requiring that Medicaid reimburse medical costs incurred by Medicaid beneficiaries for up to three months before they apply if they were eligible during the retroactive period. This waiver provision would apply to all Medicaid enrollees in the state except for pregnant women and children ages 0-18, beneficiaries dually-enrolled in Medicare and Medicaid, and recipients who are residing in a nursing facility.

Retroactive coverage, which has been a feature of Medicaid since 1972, helps prevent medical bankruptcy and provides financial security to vulnerable beneficiaries by making Medicaid payments available for expenses incurred during the three-month period before application if the beneficiary was eligible for Medicaid during that period. Data from Indiana show how important retroactive coverage is for low-income parents in the state who incurred costs prior to enrollment. Medicaid paid $1,561 on average on behalf of parents who incurred medical costs prior to enrolling in Medicaid.[51] Eliminating retroactive eligibility would instead lead to increased financial insecurity and instability for low-income families and higher uncompensated care costs for Medicaid providers.

As the court recognized in vacating approval of Kentucky's first waiver, the primary objective of Medicaid is to provide affordable coverage, including when an individual moves in and out of the program, or is sick and otherwise eligible for Medicaid. Taking months of coverage away from people and exposing them to financial harm does not promote the objectives of Medicaid. Without retroactive coverage, parents may go without needed medical care and incur significant medical debt for care they receive prior to the effective date of enrollment. Research shows that children's development can be negatively affected by issues resulting from poverty, such as toxic stress.[52]

In addition to helping individuals get the care they need, retroactive coverage ensures the financial stability of hospitals and other safety net providers as it allows them to be reimbursed for care they have provided during the three-month period that would otherwise have gone as uncompensated care, helping them meet their daily operating costs and maintain quality of care. Under waivers that eliminate retroactive coverage, a hospital would no longer get paid for, say, providing an emergency appendectomy or setting a broken bone for adults who are uninsured but Medicaid-eligible at the time of their accident, increasing the hospital's uncompensated care costs.

Conclusion

For all the reasons laid out above, the state should withdraw their waiver application and, instead, expand Medicaid to 138% of the Federal Poverty Level for all eligible adults, as demanded by the voters of Nebraska. If Nebraska is serious about promoting health and wellness, encouraging work, helping people move into jobs that allow for self-sufficiency, the state should commit to providing all adults access to comprehensive health insurance in order to ensure they are healthy enough to work.

Thank you for considering CLASP's comments. Contact Elizabeth Lower-Basch (**elowerbasch@clasp.org**) and Renato Rocha (**rrocha@clasp.org**) with any questions.

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Attachment 9

Dept. of Health and Human Services

Subject: NE Medicaid

ATTN: HHA Waiver

I understand that due to modifications, Medicaid expansion has been delayed in NE until Oct. 1, 2020.

It appears that due to the delay our state will miss out on several million in federal funding in 2019. The delay adds unnecessary work and community engagement requirements that hurt many of our NE citizens. Delays hurt people and are unnecessary.

Some people in our state think those on Medicaid are lazy and not working like most of us. When I came to Hastings with an M.A. in teaching special education my two children qualified for reduced lunches due to the low salaries paid here. Many of our hard working citizens have jobs but they pay poorly and that means many of our children suffer for basic needs and medical help. Please realize the reality of our situations and help those deserving of aid.

Sincerely,

[redacted]

Karen A. Baker

open sky
POLICY INSTITUTE

November 25, 2019

Department of Health and Human Services
Nebraska Medicaid
ATTN: HHA Waiver
301 Centennial Mall South
Lincoln, NE 68509-5026

To Whom It May Concern:

OpenSky Policy Institute respectfully submits these comments in response to Nebraska's 1115 "Heritage Health Adult Demonstration," a proposal to limit access to health coverage for otherwise eligible Nebraskans by adding community engagement and wellness requirements to Nebraska Medicaid. OpenSky Policy Institute champions fiscally responsible policies that promote economic opportunity for Nebraska families. As explained in more detail below, the proposed demonstration is not fiscally responsible, as it would cost the state significantly more than simply allowing the expansion population to enroll in the state's traditional Medicaid program. We are concerned this would result in dollars shifting from health care for families to increased bureaucracy and contracts with vendors. As a result, we ask that the State of Nebraska not submit the application as drafted and instead implement Medicaid expansion as approved by the voters without further delay.

The proposed demonstration will be costly to the state.

The department has estimated it will spend more than three times as much in administrative costs to implement expansion with the demonstration than would be needed without it. In a 2017 fiscal note, DHHS projected it would need around $1.8 million in administrative costs in FY20 to implement expansion without a demonstration, assuming an enrollment date of January 1, 2020.[1] The agency amended its estimate in April 2019, when it announced the demonstration, saying it would need $6 million in FY20 even though enrollment wouldn't begin until October 2020. That's a significant increase in both cost to the state and the amount of time those otherwise eligible will have to wait to get health coverage.[2]

Other states have shown similar demonstrations led to increased costs.

Based on other states' experiences with complex Medicaid incentives structures, the increased costs for Nebraska's proposed program aren't hypothetical. An October report from the U.S. Government Accountability Office (GAO) found that taxpayers have

[1] Nebraska Legislature, "LB 441, Fiscal Note," March 8, 2017, https://nebraskalegislature.gov/FloorDocs/105/PDF/FN/LB441_20170308-103020.pdf (accessed September 19, 2019).
[2] Nebraska Department of Health and Human Services, "Medicaid Expansion Briefing," April 11, 2019, http://dhhs.ne.gov/Documents/ExpansionBriefingSlideshow.pdf (accessed September 13, 2019).

already spent at least $408 million on similar demonstrations in just five states, with about $270 million spent in Kentucky alone.[3] The GAO collected data directly from the states involved and emphasized that its estimate doesn't include all costs, as most states only reported up-front costs and not ongoing ones like staff and annual program evaluation, which is required by the federal government.

The proposed demonstration is unlikely to be budget neutral to the federal government.

Federal law requires that states show their proposed demonstrations won't increase federal Medicaid spending in the state above what it would have been without the demonstration.

This hasn't been shown in Nebraska's application. Instead of providing two sets of comparable estimates showing costs with and without the demonstration, DHHS provides only estimated costs for the expansion and non-expansion populations impacted by the demonstration. Budget neutrality cannot be assessed when only one side of the equation is provided.

The estimates provided are also vague, with little detail as to how they were calculated. In the application, DHHS estimates total aggregated expenditures of $3.9 billion over the five year demonstration period for just the adult expansion population. Yet in September 2018, the agency estimated that the first five years of Medicaid expansion as approved by voters would have a total cost of $2.4 billion. DHHS should explain why, under the proposed demonstration, their estimates for the cost of expansion are now $1.5 billion higher.

These costs are significant and unnecessary. As a result, we would encourage the state to abandon the proposed demonstration and move forward with expansion as approved by voters.

Thank you for your time and consideration.

Respectfully submitted,

[redacted]

Tiffany Friesen Milone
Policy Director
OpenSky Policy Institute

[3] U.S. Government Accountability Office, "Medicaid Demonstrations: Actions Needed to Address Weaknesses in Oversight of Costs to Administer Work Requirements," October 2019, https://www.gao.gov/assets/710/701885.pdf (accessed November 25, 2019).

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November 25, 2019

Department of Health and Human Services
Nebraska Medicaid
Attn: HHA Waiver
301 Centennial Mall South
PO Box 95026
Lincoln, NE 68509-5026

RE: Section 1115 Heritage Health Adult Expansion Demonstration

AARP Nebraska, on behalf of our more than 195,000 members and all older Nebraskans, is writing to comment on Nebraska's Medicaid Section 1115 Heritage Health Adult (HHA) Expansion Demonstration Application. AARP Nebraska is one of the many groups that has worked tirelessly in recent years to close the health care coverage gap for the nearly 90,000 low-income Nebraska adults, including 19,000 Nebraskans between the ages of 45 and 64 currently uninsured who have incomes below 138% of poverty.

Nebraska voters clearly expressed their support for a straightforward Medicaid expansion as set forth by the Affordable Care Act (ACA) as evidenced by over 53 percent of voters having approved Initiative 427 in November 2018. This proposed waiver is inconsistent with the will of Nebraska voters and a serious step backwards from ensuring that all Nebraskans receive the health insurance coverage they need.

This demonstration waiver establishes a Medicaid expansion program that dramatically differs from the current Nebraska Medicaid program, and in some instances, reduces key benefits of the current Medicaid program. The expansion population will receive fewer benefits and be subject to more restrictions than the Nebraska Medicaid population. The state will offer a two-tier Medicaid expansion package to enrollees: the first tier, Basic (comprehensive medical, behavioral health, and prescription drug coverage) and the second tier, Prime (Basic package plus dental, vision, and over the counter prescription drug benefits). The expanded coverage provided through Prime can only be accessed upon the completion of wellness, work and community engagement requirements, discussed below.

The application also includes the elimination of retroactive coverage for both the current Medicaid population and the new expansion population. Expanding Medicaid with these cumbersome requirements

is likely to worsen health outcomes, create financial hardship and increase administrative costs to enrollees and the state, while further exacerbating access issues to healthcare providers across Nebraska.

Wellness, Work and Community Engagement Requirements

The HHA proposal includes a wellness, work and community engagement provision that would permit a beneficiary who successfully engages in specified wellness, work or community engagement activities to qualify for additional healthcare benefits under the higher tier, Prime coverage. Prime coverage enrollees would receive all the healthcare services of Basic coverage, but with the addition of dental, vison, and over-the-counter prescription drug benefits.

AARP Nebraska does not believe that the proposed waiver provision seeking to impose a wellness, work and community engagement requirement for Prime coverage is authorized by Section 1115 of the Social Security Act because they are not "likely to assist in promoting the objectives" of the Medicaid Act. 42 U.S.C. § 1315(a). Specifically, this provision is not likely to assist in promoting the objective of enabling the state of Nebraska "to furnish medical assistance [to individuals and families] whose income and resources are insufficient to meet the costs of necessary medical services and rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care." 42 U.S.C. § 1396-1(1).

The proposed work requirement for Prime coverage would present an unnecessary barrier to health coverage for a sector of Nebraska's population that is most in need of coverage. Moreover, the recent court ruling in Stewart v. Azar reaffirmed these concerns, stating that the work requirements do not help to furnish medical coverage consistent with Medicaid program objectives. Such requirements would also prove challenging for Nebraska to administer.[1] In fact, a recent report from the United States Government Accountability Office (GAO) found that Medicaid work requirements have led to increased administrative costs, ranging from an estimated $6 million to over $250 million per state in the first five states that received CMS approval. The GAO also found several weaknesses in oversight of federal funds to states for administering work requirements, adding more unnecessary costs to taxpayers. The results show that these proposals harm taxpayers rather than deliver on the statutory mandate to provide affordable health care to the vulnerable.[2]

Despite our overall opposition to the wellness, work/community engagement requirement for Prime services, AARP Nebraska appreciates the inclusion of a list of qualifying exemptions and hardships/good cause exemptions, including categories based on medical frailty, those age 19 or 20, or pregnant women eligible under expansion. However, additional clarity is needed regarding the definitions of these

[1] More than 18,000 vulnerable individuals lost coverage in Arkansas when the state implemented its Medicaid work requirements before the federal court halted the program in that state. https://www.aarp.org/content/dam/aarp/ppi/2019/06/the-new-medicaid-waivers-coverage-losses-for-beneficiaries-higher-costs-for-states.doi.10.26419-2Fppi.00066.001.pdf

[2] U.S. Government Accountability Office. "Medicaid Demonstrations: Actions Needed to Address Weaknesses in Oversight of Costs to Administer Work Requirements." (October 2019). Available at: https://www.gao.gov/assets/710/701885.pdf

exemptions and how they would be determined, in particular the exemptions related to those who are medically frail. It is unclear which illnesses or ongoing courses of treatment would qualify for this exemption and how those determinations would be made. In addition, it is unclear how an individual will document that they have met the work requirements.

Any new reporting system and process will impose new administrative costs on the state, including new staffing needs, to develop or expand the reporting system, verify the accuracy of member reporting, and conduct fact-finding hearings. We believe that these costs will ultimately divert resources away from other pressing state priorities.

Additionally, AARP believes that any wellness, work/community requirement must include a clear exemption for family caregivers. Specifically, we strongly urge the state to ensure that beneficiaries who are family caregivers -- providing critical care for their loved ones of any age with chronic, disabling or serious health conditions -- will be provided an exemption.
Many family caregivers in Nebraska are providing millions of hours of uncompensated care allowing people to age in place or remain in their homes and out of costly institutional care.

Redeterminations

As part of the proposal, all beneficiaries enrolled in the Medicaid program (Nebraska Medicaid, Basic and Prime) would be subject to a redetermination of eligibility review every six months instead of the existing annual review for the current Medicaid population. This would add extra administrative burdens for the state and beneficiaries, and it would increase the risk of confusion and improper reclassifications that could negatively impact coverage for beneficiaries and payments to providers.

Retroactive Eligibility

Additionally, the HHA waiver application seeks federal approval to eliminate retroactive eligibility for not only expansion adults but also the entire Medicaid population. When Initiative 427 passed, Nebraskans voted to include medical services through Medicaid for 90,000 low income residents. They did not vote to redesign the existing Medicaid program as currently being proposed with the elimination of retroactive eligibility for all Medicaid enrollees. AARP strongly believes this should be reconsidered and that Nebraska should retain retroactive coverage as set forth under current Medicaid law.

Without retroactive coverage, future low-income enrollees could incur crippling medical debt, which would be exacerbated by their inability to take advantage of the more favorable provider reimbursement rates paid by Medicaid. In addition, limitations on retroactive coverage would increase the burden of uncompensated care on providers. It could also cause future enrollees to forego needed care, resulting in higher medical costs. For example, providers may be reluctant to provide care if there is not retroactive eligibility. In this case, an individual's conditions may deteriorate, forcing them to rely on more expensive emergency room care, increasing uncompensated care costs.

Education and Outreach

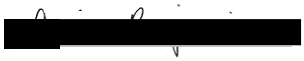
AARP is concerned that the proposal does not adequately lay out an effective outreach and education plan on how new potential beneficiaries would be reached and educated on the premium assistance demonstration and the options available to them, in the event this waiver is approved. It would be vital that statewide outreach, education and ongoing support be made available to all eligible Nebraskans. Working with existing public health programs, such as Every Woman Matters, could provide much of the experience, expertise, and community connections for success. Any outreach would need to be culturally and linguistically competent and accessible to people with disabilities. It would also be critical that resources and supportive services such as job training, job search activities, childcare, transportation, assistance for complying with reporting requirements and the development of options for reporting/applying options outside of electronic, online, etc. be made widely available across all communities.

Conclusion

The HHA waiver contains many changes to the Medicaid expansion that was passed by Nebraska voters in 2018. These changes have the potential to worsen health outcomes, create significant financial hardships for many Nebraska Medicaid beneficiaries in need of coverage, increase administrative costs for the state, and result in lost revenue and increased uncompensated care costs for Nebraska's health providers. AARP Nebraska has continued to push the state to adopt a full Medicaid expansion as provided for under the ACA. Although we believe that the Heritage Health Adult program would provide more individuals with critical healthcare coverage, we believe that a straightforward expansion, as voiced by Nebraska voters, should be implemented without delay.

Thank you for the opportunity to comment. We appreciate the Department's work on this initiative and appreciate the opportunity to express our thoughts and concerns on this proposal.

Sincerely,



Connie Benjamin
State Director
AARP Nebraska

AMERICAN LUNG ASSOCIATION.

November 25, 2019

Matthew Van Patton
Director, Division of Medicaid & Long-Term Care
State of Nebraska, Department of Health and Human Services
301 Centennial Mall South, 3rd Floor PO Box 95026
Lincoln, NE 68509-5026

Re: Nebraska Heritage Adult Expansion Demonstration

Dear Mr. Van Patton:

The American Lung Association in Nebraska appreciates the opportunity to submit comments on Nebraska's Medicaid Section 1115 Heritage Health Adult Expansion Demonstration.

The American Lung Association is the oldest voluntary public health association in the United States, currently representing the 35 million Americans living with lung diseases including asthma, lung cancer and COPD, including more than 205,000 Nebraska residents. The Lung Association is the leading organization working to save lives by improving lung health and preventing lung disease through research, education and advocacy.

The American Lung Association believes everyone, including Medicaid enrollees, should have access to quality and affordable health coverage. Medicaid expansion, as the voters approved in November, will expand coverage to 90,000 low-income Nebraskans. This will provide individuals with prevention, early detection and diagnostic services as well as disease management and treatment for their conditions. Medicaid expansion is critical for patients with and at risk of lung disease. For example, research shows an association between Medicaid expansion and early stage cancer diagnosis, when cancer is often more treatable.[1] Additionally, Medicaid expansion is associated with improvements in quality measures, including for asthma management, at federally qualified health centers, which are critical healthcare providers for low-income patients.[2] Medicaid expansion is also playing an important role in addressing health disparities—one recent study found that states that expanded Medicaid under the ACA eliminated racial disparities in timely treatment for cancer patients.[3] Clearly, Medicaid expansion is beneficial for patients with lung disease and other serious and chronic conditions.

Unfortunately, this waiver proposal will delay the implementation of Medicaid expansion until October 2020, almost two years after the voters approved the measure. This is unacceptable and will delay access to quality and affordable coverage for 90,000 Nebraskans. The Lung Association urges Nebraska to implement Medicaid expansion as soon as possible, without the proposed delay, to follow the will of the voters.

<u>Tiered Benefit Structure</u>
The American Lung Association supports Nebraska's Medicaid expansion, but is worried that some provisions of the waiver proposal will limit the potential benefit of the program.

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The Heritage Health Adult Expansion Demonstration waiver creates a two-tiered benefit structure. Initially, all expansion enrollees will have the "Basic" plan but can qualify for the "Prime" plan if they complete a set of wellness, personal responsibility and work reporting requirements. The Prime plan includes all of the benefits of the Basic plan plus vison, dental and over-the-counter drugs. The lack of coverage of over-the-counter drugs for Basic plan members is particular troubling for this population in terms of tobacco cessation treatment. Medicaid enrollees smoke at a rate over twice as high as those with private insurance.[4] Three of the seven Food and Drug Administration (FDA) approved treatments are available over-the-counter. These treatments are required to be covered for Medicaid expansion enrollees as part of the Preventive Services requirement and are effective in helping smokers quit.

The requirements to receive the Prime benefit package are very onerous. Patients have to "actively participate" in care and case management, which includes completing a health risk screening, completing a "social determinants of health" assessment, routinely refilling prescriptions and having recommended labs performed. Additionally, beneficiaries will be required to have an annual visit with their primary care provider. Beneficiaries would also have to comply with a personal responsibility requirement, which includes not missing more than three appointments within six months, maintaining commercial coverage if available, and notifying the state within 10 days of any changes that may affect their eligibility for Medicaid or benefit tier. For lung disease patients, especially those in active treatment and those with hourly jobs, wages and income can vary from week to week as hours fluctuate. Lung disease patients should not be in risk of losing benefits that help them manage their disease because of complicated reporting requirements.

Additionally, starting in year two of the demonstration, the expansion population between the ages of 21 and 59 would be required to prove that they work at least 80 hours per month or meet exemptions. One major consequence of this proposal will be to increase the administrative burden on individuals in the Medicaid program. Increasing administrative requirements will likely decrease the number of individuals with Prime coverage, regardless of whether they are exempt or not. For example, Arkansas implemented a similar policy requiring Medicaid enrollees to report their hours worked or their exemption. During the first six months of implementation, the state terminated coverage for over 18,000 individuals and locked them out of coverage until January 2019.[5] Enrollees have also found the reporting requirements confusing and added stress and anxiety to enrollees' lives.[6]

The state estimates that 40 percent of enrollees will not be able to comply with all the requirements and will receive the Basic benefit rather than Prime benefit. Each of these requirements adds additional red tape for Medicaid enrollees. Many of the requirements require significant access to transportation that can be a barrier for the low-income population. The Lung Association encourages Nebraska to provide the Prime benefit to all Medicaid enrollees in the expansion population. This will eliminate confusion and additional paperwork for patients with lung disease.

<u>Removing Retroactive Coverage</u>

As part of the 1115 waiver, Nebraska is asking to waive retroactive eligibility and start coverage on the first day of the month of the application. Retroactive eligibility in Medicaid prevents gaps in coverage, by covering individuals for up to 90 days prior to the month of application, assuming the individual is eligible for Medicaid coverage during that time frame. It is common that individuals are unaware they are eligible for Medicaid until a medical event or diagnosis occurs. Retroactive eligibility allows

patients who have been diagnosed with a serious illness, such as lung cancer, to begin treatment without being burdened by medical debt prior to their official eligibility determination.

Medicaid paperwork can be burdensome and often times confusing. A Medicaid enrollee may not have understood or received a notice of Medicaid renewal and only discovered the coverage lapse when picking up a prescription or going to see their doctor. Without retroactive eligibility, Medicaid enrollees could then face substantial costs at their doctor's office or pharmacy. When Ohio was considering a similar provision in 2016, a consulting firm advised the state that hospitals could accrue as much as $2.5 billion more in uncompensated care as a result of the waiver.[7] Nebraska estimates that over 29,000 adults will lose retroactive coverage as a result of the waiver. The American Lung Association urges Nebraska to remove this provision from the waiver application.

Lack of Evaluation Plan

The proposed 1115 waiver currently lacks an evaluation plan. While the state claims it will create a robust evaluation plan, there is nothing in the application for the public to review and provide input on. The Lung Association encourages Nebraska to write and solicit feedback on an evaluation plan before submitting the waiver to CMS so the public can accurately comment on the proposal.

The American Lung Association urges Nebraska to expand Medicaid without delay to fulfill the will of the voters. However, this waiver should be modified to provide optimal care to all Medicaid enrollees by eliminating the tiered benefit approach and keeping retroactive coverage. Thank you for the opportunity to submit comments.

Sincerely,

Julia R. McCarville
Executive Director

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[1] Aparna Soni, Kosali Simon, John Cawley, Lindsay Sabik, "Effect of Medicaid Expansions of 2014 on Overall and Early-Stage Cancer Diagnoses", American Journal of Public Health 108, no. 2 (February 1, 2018): pp. 216-218. Available at http://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2017.304166.

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[5] Robin Rudowitz, MaryBeth Musumeci, and Cornelia Hall, "A Look at November State Data for Medicaid Work Requirements in Arkansas," Kaiser Family Foundation, December 18, 2018. Available at: https://www.kff.org/medicaid/issue-brief/a-look-at-november-state-data-for-medicaid-work-requirements-in-arkansas/; Arkansas Department of Health and Human Services, Arkansas Works Program, December 2018. Available at: http://d31hzlhk6di2h5.cloudfront.net/20190115/88/f6/04/2d/3480592f7fbd6c891d9bacb6/011519_AWReport.pdf

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[7] Virgil Dickson, "Ohio Medicaid waiver could cost hospitals $2.5 billion", Modern Healthcare, April 22, 2016. (http://www.modernhealthcare.com/article/20160422/NEWS/160429965)

ACOG
The American College of Obstetricians and Gynecologists

Nebraska Section

November 25, 2019

Matthew Van Patton, DHA
Director, Nebraska Medicaid
Department of Health and Human Services
301 Centennial Mall South
P.O. Box 95026
Lincoln, Nebraska 68509-5026

RE: Nebraska Medicaid Section 1115 Heritage Health Adult Expansion Demonstration

Dear Director Van Patton:

The Nebraska Section of the American College of Obstetricians and Gynecologists (ACOG), representing more than 230 practicing obstetrician-gynecologists (ob-gyns), welcomes the opportunity to comment on the Nebraska Department of Health and Human Services Division of Medicaid and Long-Term Care's Section 1115 Waiver: Heritage Health Adult Expansion Demonstration. As physicians dedicated to providing quality care to women, we are concerned that the proposed waiver would place certain Medicaid beneficiaries at risk for financial harm and deter patients from seeking care. We urge the state to abandon this alternative to the voter-approved Medicaid expansion. It is with these concerns in mind that we submit the following comments for your consideration.

Demonstration Benefits

Under the proposed waiver, Nebraska seeks to implement a two-tiered benefit system for individuals enrolled in the state's Medicaid expansion [Heritage Health Adult (HHA)] plan. The two benefit categories include Basic, which includes all Medicaid benefits available under the state plan except dental, vision, and over-the-counter drugs, and Prime, which includes all Medicaid benefits available under the state plan plus dental, vision, and over-the-counter drugs. ACOG appreciates that pregnant and postpartum women are exempt from certain program requirements and therefore eligible to receive Prime benefits, however, we are concerned about the complexity of the state's proposed two-tiered system and the potential impact on patients.

Unless exempt, in order to qualify for the Prime benefit tier, Medicaid beneficiaries must meet nine separate requirements. They must: 1) satisfy a work and community engagement requirement; 2) routinely fill prescriptions; 3) have all clinical labs ordered by providers drawn; 4) participate in a health and social determinants screening upon enrollment and annually thereafter; 5) attend a qualifying annual health visit; 6) select a primary care provider; 7) not miss three or more appointments in a six-month period; 8) maintain commercial health insurance coverage, if available; and 9) provide notice to Nebraska Medicaid of any change that may impact eligibility within 10 days of such change occurring.

Medicaid was established to ensure that health care is available to all who are eligible. It is a critical part of a continuum of coverage that assures non-elderly adults have access to coverage even if their income fluctuates or their job status changes over time. While Nebraska will not terminate coverage for failure to comply with one of the waiver requirements, the state does propose to lock beneficiaries out of eligibility for the Prime benefit tier for up to one year.

The Nebraska waiver proposal is complex. Complying with the program and keeping up with the various requirements will be challenging for many patients; it is likely that some will be locked out of the Prime benefit tier over administrative noncompliance or administrative oversight. The proposed lockout will disrupt continuity of care by limiting services for otherwise-eligible patients. Additionally, these lockouts may disrupt the practice of medicine and increase the risk of adverse medical outcomes.

Beneficiary Engagement Requirements

ACOG has concerns with Nebraska's proposed beneficiary engagement requirements, including the wellness initiatives, personal responsibility activities, and the work and community engagement requirement. ACOG finds these efforts antithetical to the long-standing objectives of the Medicaid program, not to mention the will of Nebraska voters who overwhelmingly passed Medicaid expansion in November of 2018. These requirements create unnecessary barriers to coverage.

Work and Community Engagement Requirement

While pleased that pregnant and postpartum women are exempt from participation in the proposed work and community engagement requirement, ACOG does not support Nebraska's proposal to make work a condition of Medicaid eligibility beginning in year two of the Demonstration. Work requirements are contrary to the mission of the Medicaid program and will be burdensome on Medicaid patients with limited resources.[1,2] Indeed, as demonstrated by the experience of the Temporary Assistance for Needy Families (TANF) program, imposing work requirements on Medicaid beneficiaries would lead to the loss of health care coverage for substantial numbers of people who are unable to work or face major barriers to finding and retaining employment.[3]

Nearly eight in 10 non-disabled adults with Medicaid coverage live in working families, and 60 percent are working themselves.[4] Upwards of 80 percent of Medicaid workers are paid hourly, and 36 percent of these hourly workers earn a wage at or below $10 per hour.[5] Of those not working, most report that illness, disability, taking care of home or family, or school prohibit them from being fully employed.[6] Further, work reporting requirements like what Nebraska is proposing would disproportionately and adversely impact women. According to an April 2017 analysis of data published in *Health Affairs*, if these requirements were implemented nationwide, almost two-thirds (63 percent) of those at risk of losing coverage are women.[7] This is, in part, attributable to women representing nearly two-thirds of minimum wage workers across the country.[8]

In addition to burdening Medicaid patients, the work requirement will add considerable complexity and costs to Nebraska's Medicaid program.[9] State experience in implementing similar TANF requirements suggests that adding such requirements to Medicaid could cost Nebraska thousands of dollars per beneficiary.[10] In fact, a Fitch Ratings study found that in preparation for the implementation of Kentucky's work requirement, before it was blocked by a federal court, Kentucky Medicaid's administrative costs increased more than 40 percent, or $35 million, over previous expenditures.[11] These additional costs detract significantly from any anticipated savings and would ultimately divert much-needed funds from beneficiary care to cover unnecessary administrative costs. There is little evidence that Nebraska's proposal would result in less burden for the state's Medicaid staff.

ACOG is also concerned that physicians will have to provide documentation to support an exemption for patients that are physically or mentally unable to work in order to maintain their coverage. Increasing the paperwork burden for ob-gyns and other health care providers detracts from patient care and is antithetical to CMS' "Patients Over Paperwork" initiative. At a time when there are increasing reports of physician burnout, placing more administrative burdens on Nebraska's health care workforce may make it more difficult to attract and retain qualified medical professionals.[12] ACOG believes that state and federal policymakers should prioritize the reduction of barriers for ob-gyns to practice and care for Medicaid patients.

Retroactive Coverage

Under current law, once an individual is determined eligible for Medicaid, coverage is effective on the first day of the month of application. Medicaid must also cover state plan-approved services obtained in the three months prior to application if the individual would have been eligible during that period.[13] Under the proposed waiver, Nebraska seeks to end this long-standing protection for Medicaid beneficiaries. ACOG believes this proposal ignores the reality that many low-income individuals do not seek health care until the need is great – not because they are irresponsible, but because they cannot afford the cost of primary or preventive care without being enrolled in Medicaid. Further, many low-income individuals may not know that they are eligible for Medicaid and may not seek care for a condition until the condition becomes unmanageable. Ending retroactive eligibility may further encourage such self-imposed rationing of care as patients will likely try to avoid incurring medical bills they cannot pay. The complexity of Nebraska's waiver proposal will only exacerbate patient confusion and delay access to needed care.

Nebraska ACOG Recommendations:

- Do not submit a waiver request to implement a two-tiered benefit program.
- Do not submit a waiver request to implement a work and community engagement requirement in year 2 of the Demonstration.
- Do not submit a waiver request to waive retroactive coverage.

Thank you for the opportunity to provide comments on the Nebraska Department of Health and Human Services Division of Medicaid and Long-Term Care's Section 1115 Waiver: Heritage Health Adult Expansion Demonstration. We hope you have found our comments useful. To discuss these recommendations further, please contact Amanda Buskevicius, MD, FACOG,

Legislative Chair of the Nebraska Section, at amandabuskevicius@gmail.com, or Emily Eckert, ACOG Senior Health Policy Analyst, at eeckert@acog.org or 202-863-2485.

Sincerely,

[redacted]

Amanda Buskevicius, MD, FACOG
Legislative Chair, Nebraska Section

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[1] American College of Obstetricians and Gynecologists. ACOG opposes efforts to radically limit Medicaid access. January 2018. Available at: https://www.acog.org/About-ACOG/News-Room/Statements/2018/ACOG-Opposes-Efforts-to-Radically-Limit-Medicaid-Access

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[6] Kaiser Family Foundation. Understanding the intersection of Medicaid and Work. Revised January 2018. Available at: https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work/

[7] Ku L, Brantley E. Medicaid work requirements: Who's at risk? Health Affairs Blog, Apr. 12, 2017. Available at http://healthaffairs.org/blog/2017/04/12/medicaid-work-requirements-whos-at-risk/

[8] National Women's Law Center. Women and the minimum wage, state by state. August 2017. Available at: https://nwlc-ciw49tixgw5lbab.stackpathdns.com/wp-content/uploads/2017/07/Women-Minimum-Wage-7.24.17.pdf

[9] Hahn H, Pratt E, Allen E, Kenney G, Levy DK, Waxman E (2017). Work requirements in social safety net programs: A status report of work requirements in TANF, SNAP, Housing Assistance, and Medicaid. Available at: https://www.urban.org/sites/default/files/publication/95566/work-requirements-in-social-safety-net-programs.pdf

[10] Gayle Hamilton *et al*., "National evaluation of Welfare-to-Work strategies: How effective are different Welfare-to-Work approaches? Five-year adult and child impacts for eleven programs," Manpower Demonstration Research Corporation, December 2001, Table 13.1. Available at: https://www.mdrc.org/sites/default/files/full_391.pdf

[11] Fitch Ratings. Medicaid waiver actions limit US states' cost control. July 2018. Available at: https://www.fitchratings.com/site/pr/10038515

[12] Shanafel, TD, Hasan O, Dyrbye LN, Sinsky C, Satele D, Sloan J, and West CP (2015). Changes in burnout and satisfaction with work-life balance in physicians and the general US working population between 2011 and 2014. *Mayo Clinic Proceedings*, 90:1600-1613. Available at: https://www.ncbi.nlm.nih.gov/pubmed/26653297

[13] 42 C.F.R. 435.915.

Attachment 9

American Cancer Society
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402.260.3288
www.fightcancer.org/ne

November 25, 2019

Dr. Matthew Van Patton
Director
Department of Health and Human Services
Nebraska Medicaid
301 Centennial Mall South
P.O. Box 95026
Lincoln, NE 68509-5026

Re: Nebraska Medicaid Section 1115 Heritage Health Adult Expansion Demonstration

Dear Director Van Patton:

The American Cancer Society Cancer Action Network (ACS CAN) Nebraska appreciates the opportunity to comment on Nebraska's Medicaid Section 1115 "Heritage Health Adult" (HHA) Expansion Demonstration. ACS CAN is making cancer a top priority for public officials and candidates at the federal, state, and local levels. ACS CAN empowers advocates across the country to make their voices heard and influence evidence-based public policy change as well as legislative and regulatory solutions that will reduce the cancer burden. As the American Cancer Society's nonprofit, nonpartisan advocacy affiliate, ACS CAN is critical to the fight for a world without cancer.

We strongly support Nebraska's expansion of their Medicaid program. Access to health care is paramount for persons with cancer and survivors. An estimated 9,780 Nebraskans are expected to be diagnosed with cancer this year,[1] and there are nearly 108,500 cancer survivors in the state[2] – many of whom rely on Medicaid or will greatly benefit from receiving their health care through the expansion of the program. ACS CAN wants to ensure that cancer patients and survivors in Nebraska will have adequate access and coverage under the Medicaid program, and that specific requirements do not create barriers to care for low-income cancer patients, survivors, and those who will be diagnosed with cancer.

However, the proposed beneficiary engagement requirements, including the wellness initiative, personal responsibility activities, and community engagement activities, for the adult expansion group could limit – rather than expand – eligibility and access to care for some of the most vulnerable Nebraskans, including those with cancer, cancer survivors, and those who will be diagnosed with the disease. We strongly urge the Nebraska Department of Health and Human Services Division of Medicaid and Long-Term Care (MLTC or "the Department") to address the concerns that we and other stakeholders have before moving forward with the waiver process.

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[1] American Cancer Society. *Cancer Facts & Figures 2019*. Atlanta, GA: American Cancer Society; 2019.
[2] American Cancer Society. *Cancer Treatment & Survivorship Facts & Figures 2019-2021*. Atlanta, GA: American Cancer Society; 2019.

The following are our specific concerns with the Nebraska's Medicaid section 1115 demonstration waiver application:

Community Engagement Activities

Nebraska's waiver application would establish a two-tiered benefit package for the HHA population: Tier 1 - a "Basic" benefits package which would include medical, behavior health, and prescription drug coverage; and Tier 2 - the "Prime" benefits package which would include the basic benefits plus vision, dental, and over-the-counter medication. How beneficiaries comply with specific requirements, including community engagement requirements, would determine which package they receive.

For example, in order to be eligible for the Prime benefits package, adult enrollees over the age of 20 must either be employed or volunteer 80 hours per month. Some exemptions would be available. Although we appreciate that enrollees would not lose eligibility for Medicaid and would retain Basic benefit coverage, this requirement could still unintentionally disadvantage Medicaid enrollees with complex chronic conditions like cancer, who may need the additional services offered under Prime coverage. Many cancer patients in active treatment are often unable to work or require significant work modifications due to their treatment.[3,4,5] Research suggests that between 40 and 85 percent of cancer patients stop working while receiving cancer treatment, with absences from work ranging from 45 days to six months depending on the treatment.[6] Recent cancer survivors often require frequent follow-up visits[7] and suffer from multiple comorbidities linked to their cancer treatments.[8,9] Cancer survivors are often unable to work or are limited in the amount or kind of work they can participate in because of health problems related to their cancer diagnosis.[10,11] If work and community engagement is required as a condition of eligibility for the Prime benefits package, many recent cancer survivors and those with other chronic illnesses could find that they are ineligible for critical benefits and services that can improve their quality of life and improve the timeliness and effectiveness of their treatment. We also

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[3] Whitney RL, Bell JF, Reed SC, Lash R, Bold RJ, Kim KK, et al. Predictors of financial difficulties and work modifications among cancer survivors in the United States. *J Cancer Surviv.* 2016; 10:241. doi: 10.1007/s11764-015-0470-y.

[4] de Boer AG, Taskila T, Tamminga SJ, et al. Interventions to enhance return to work for cancer patients. *Cochrane Database Syst Rev.* 2011; 16(2): CD007569. doi: 10.1002/14651858.CD007569.pub2.

[5] Stergiou-Kita M, Pritlove C, van Eerd D, Holness LD, Kirsh B, Duncan A, Jones J. The provision of workplace accommodations following cancer: survivor, provider, and employer perspectives. *J Cancer Surviv.* 2016; 10:480. doi:10.1007/s11764-015-0492-5.

[6] Ramsey SD, Blough DK, Kirchhoff AC, et al. Washington State Cancer Patients Found to be at Greater Risk for Bankruptcy then People Without a Cancer Diagnosis," Health Affairs, 32, no. 6, (2013): 1143-1152.

[7] National Cancer Institute. *Coping with cancer: Survivorship, follow-up medical care*. Accessed November 2019. https://www.cancer.gov/about-cancer/coping/survivorship/follow-up-care.

[8] Mehta LS, Watson KE, Barac A, Beckie TM, Bittner V, Cruz-Flores S, et al. Cardiovascular disease and breast cancer: Where these entities intersect: A scientific statement from the American Heart Association. *Circulation*. 2018; 137(7): CIR.0000000000000556.

[9] Dowling E, Yabroff R, Mariotto A, et al. Burden of illness in adult survivors of childhood cancers: Findings from a population-based national sample. *Cancer.* 2010; 116:3712-21.

[10] Ibid.

[11] Guy GP Jr, Berkowitz Z, Ekwueme DU, Rim SH, Yabroff R. Annual economic burden of productivity losses among adult survivors of childhood cancers. *Pediatrics*. 2016; 138(s1):e20154268; Zheng Z, Yabroff KR, Guy GP Jr, et al. Annual medical expenditures and productivity loss among colorectal, female breast, and prostate cancer survivors in the United States. *JNCI J Natl Cancer Inst.* 2016; 108(5):djv382; and Kent EE, Davidoff A, de Moor JS, et al. Impact of sociodemographic characteristics on underemployment in a longitudinal, nationally representative study of cancer survivors: Evidence for the importance of gender and marital status. *J Psychosoc Oncol*. 2018; 36(3):287-303.

note that imposing work or community engagement requirements on lower income individuals as a condition of coverage could impede individuals' access to preventive care, including cancer screenings.

Therefore, ACS CAN opposes tying access to comprehensive health care for lower income persons to work or community engagement requirements, because cancer patients, survivors, and those who will be diagnosed with the disease – as well as those with other complex chronic conditions – could be seriously disadvantaged and find themselves without necessary Medicaid coverage because they are physically unable to comply.

Further, increased administrative reporting requirements for enrollees to attest to their work or exemption status would likely reduce the number of individuals with Prime Medicaid coverage, regardless of whether they are exempt.[12,13] While we appreciate the state using as many automated tools as possible to determine compliance and exemptions for the work requirements, the Department cannot ensure without a doubt that automated tools will catch all eligible enrollees; therefore, individuals will likely fall through the cracks and lose access to important vision and dental coverage.

Given the recent experience with Arkansas' work requirement, where uninsured rates were driven up and employment actually declined in the state after the work requirement went into effect,[14] Nebraska must consider the number of state residents whose health could be negatively impacted due to this proposal. Additionally, it is clear from the preliminary data from Arkansas that the work requirements are not meeting the state's goal of incentivizing employment and increasing the number of employed Arkansas Works beneficiaries. Therefore, the Department should consider the negative impact that the community engagement requirements could have on state residents before moving forward with this waiver proposal.

Wellness Initiative Requirements

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."[15] If the beneficiary does not engage in these activities, they will not gain the Prime benefits package and will remain in the Basic benefits package for the subsequent two, six-month benefit periods, with the possibility to gain the Prime benefits after the second six month benefit tier review. In other words, if the beneficiary does not comply with the wellness initiative requirements, he/she could be locked out of Prime benefits for at least a year.

Case and Care Management Activities

ACS CAN supports Nebraska's goal of improving health outcomes of its residents through the wellness initiative requirements; however, the state is proposing a mandatory, outcomes-based program that would require adult expansion beneficiaries to complete an annual health risk screening, an annual

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[12] Garfield R, Rudowitz R, Musumeci M. Implications of a Medicaid work requirements: National estimates of potential coverage losses. Kaiser Family Foundation. Published June 2018. Accessed November 2019. http://files.kff.org/attachment/Issue-Brief-Implications-of-a-Medicaid-Work-Requirement-National-Estimates-of-Potential-Coverage-Losses.

[13] Sommers BD, Goldman AL, Blendon RJ, et al. Medicaid work requirements – Results from the first year in Arkansas. *NEJM*. 2019. DOI: 10.1056/NEJMsr1901772.

[14] Ibid.

[15] See Waiver Application pg. 4.

social determinants of health assessment, fill medications routinely, and have clinical labs drawn as ordered by their provider (on top of all of the other requirements) as a condition of receiving the Prime benefits package.

Research indicates that penalizing enrollees for non-compliance or failing to meet outcomes dictated by the state will not likely generate cost savings or improve the health of low-income Medicaid enrollees.[16] Nebraska's wellness initiatives also appear to focus on administrative activities, like completion of health risk screenings and social determinants of health assessments (which rely heavily on availability of office appointments by the managed care plan), rather than evidence-based quality improvement programs. We believe state residents would be better served by a comprehensive, evidence-based participatory wellness initiative based on incentives that provides adequate and comprehensive coverage of preventive services (including tobacco cessation, weight loss, and cancer screenings) and that emphasize evidence-based interventions to educate, promote, and encourage patients to participate in prevention, early detection, and wellness. Evidence shows that unhealthy behaviors can be changed or modified by modest incentives, rather than penalties, as long as they are combined with adequate medical services and health promotion programs.[17] Providing enrollees incentives could lead to a change in behavior whereas penalties do little to improve health and could reduce access to necessary health care services. Therefore, we urge the Department to change their wellness initiative to an optional, evidence-based incentive program that focuses on activities that can improve health, rather than just administrative hoops that beneficiaries must go through to gain Prime benefits or prevent from losing Prime benefits.

Annual Health Visit and Primary Care Provider Selection

We support Nebraska's proposal for HHA beneficiaries to have an annual health visit and choose a primary care provider. Having a usual source of care increases the likelihood that individuals receive recommended preventive services, including cancer screenings.[18,19] However, we caution against making the annual health visit a requirement in order to receive or prevent losing Prime benefits. As mentioned above, research indicates that penalizing enrollees for non-compliance or failing to meet outcomes dictated by the state will not likely generate cost savings or improve the health of low-income Medicaid enrollees.[20] Instead, we believe the Department should consider incentivizing enrollees to attend an annual health visit to better increase participation and health outcomes in the long term.

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[16] Consensus statement of the Health Enhancement Research Organization, American College of Occupational and Environmental Medicine, American Cancer Society and American Cancer Society Cancer Action network, American Diabetes Association, and American Heart Association. Guidance for a reasonably designed, employer-sponsored wellness program using outcomes-based incentives. *JOEM.* 2012; 54(7): 889-96.

[17] Ibid.

[18] Blewett LA, Johnson PJ, Lee B, Scal PB. When a usual source of care and usual provider matter: adult prevention and screening services. *J Gen Intern Med*. 2008; 23(9): 1354–60.

[19] O'Malley AS, Mandelblatt J, Gold K, Cagney KA, Kerner J. Continuity of care and the use of breast and cervical cancer screening services in a multiethnic community. *Arch Intern Med*. 1997; 157(13): 1462–70.

[20] Consensus statement of the Health Enhancement Research Organization, American College of Occupational and Environmental Medicine, American Cancer Society and American Cancer Society Cancer Action network, American Diabetes Association, and American Heart Association. Guidance for a reasonably designed, employer-sponsored wellness program using outcomes-based incentives. *JOEM.* 2012; 54(7): 889-96.

Personal Responsibility Requirements

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; and provide timely notification to the State of any change in status that will impact the beneficiary's Medicaid eligibility or benefit tier."[21] If the beneficiary does not engage in these activities, they will be locked out of Prime coverage for a year with the possibility to gain the Prime benefits after the second six month benefit tier review.

Attending Appointments

We appreciate the Department wanting Medicaid beneficiaries to keep scheduled medical appointments. No show appointments not only cost physicians time and income but penalize other patients who could have used the appointment. At the same time, many low-income individuals frequently have issues with reliable transportation,[22] flexible work hours,[23] and childcare.[24] We ask the Department to consider these challenges and to take them into account when defining what constitutes a "reasonable notice of a cancellation."

Maintaining Commercial Coverage

We appreciate Nebraska wanting individuals with employer-sponsored insurance (ESI) to use their ESI rather than Medicaid, but ESI is not always an affordable option. Many of these plans have higher out-of-pocket costs which decrease the likelihood that a lower income person would seek health care services, including preventive screenings.[25,26,27] Cancers that are found at an early stage through screening are less expensive to treat and lead to greater survival.[28] Uninsured and underinsured individuals already have lower screening rates resulting in a greater risk of being diagnosed at a later, more advanced stage of disease.[29] Proposals that place greater financial burden on the lowest income residents create barriers to care and could negatively impact Medicaid enrollees – particularly those individuals who are high service utilizers with complex medical conditions.

Moving cancer patients and survivors out of the more robust Medicaid program and into ESI could result in reduced benefits and a significant increase in out-of-pocket cost sharing - making coverage less

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[21] See Waiver Application pg. 4.
[22] Syed ST. Gerber BS, Sharp LK. Traveling towards disease: Transportation barriers to health care access. *J Community Health.* 2013; 38(5): 976-93.
[23] Henly JR, Lambert SJ. Unpredictable work timing in retail jobs: Implications for employee work-life conflict. *ILR Review*. 2014; 67(3):986-1016.
[24] The Lewin Group, Inc. Indiana HIP 2.0: Evaluation of non-emergency medical transportation (NEMT) waiver. Updated March 11, 2016. Accessed November 2019. https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-nemt-eval-03112016.pdf.
[25] Solanki G, Schauffler HH, Miller LS. The direct and indirect effects of cost-sharing on the use of preventive services. *Health Services Research.* 2000; 34: 1331-50.
[26] Wharam JF, Graves AJ, Landon BE, Zhang F, Soumerai SB, Ross-Degnan D. Two-year trends in colorectal cancer screening after switch to a high-deductible health plan. *Med Care.* 2011; 49: 865-71.
[27] Trivedi AN, Rakowsi W, Ayanian JA. Effect of cost sharing on screening mammography in Medicare health plans. *N Eng J Med.* 2008; 358: 375-83.
[28] American Cancer Society. *Cancer prevention & early detection facts & figures 2019-2020*. Atlanta: American Cancer Society; 2019.
[29] Ibid.

comprehensive and unaffordable. We are concerned that the proposal would leave individuals exposed to significant cost-sharing, beyond what is permitted under current federal requirements.

Premiums and cost sharing above the five percent of family income maximum for Medicaid enrollees would be particularly burdensome for a high-utilizer of health care services, such as an individual in active cancer treatment or a recent survivor. Cancer patients in active treatment require many services shortly after diagnosis and thus incur a significant portion of cost sharing over a relatively short period of time.[30] It can be challenging for an individual – particularly an individual with limited means – to be able to afford their cost-sharing requirements. Likewise, a recent survivor may require frequent follow-up visits to prevent cancer recurrence. Having to pay the full cost up front would likely result in many cancer patients and survivors delaying their treatment and could result in them forgoing their treatment or follow-up visits altogether. We strongly urge the Department to reconsider the proposals to require low-income individuals to maintain commercial coverage.

Waiving Retroactive Eligibility

Medicaid currently allows retroactive coverage if: 1) an individual was unaware of his or her eligibility for coverage at the time a service was delivered; or 2) during the period prospective enrollees were preparing the required documentation and Medicaid enrollment application. Policies that would reduce or eliminate retroactive eligibility could place a substantial financial burden on enrollees and cause significant disruptions in care, particularly for individuals battling cancer. Therefore, we are concerned about the Department's proposal to waive retroactive eligibility, as it would also apply to non-expansion populations, including women on the Breast and Cervical Cancer Early Detection Program.

Many uninsured or underinsured individuals who are newly diagnosed with a chronic condition already do not receive recommended services and follow-up care because of cost.[31,32] In 2017, one in five uninsured adults went without care because of cost.[33] Waiving retroactive eligibility could mean even more people are unable to afford care and forgo necessary care due to cost.

Safety net hospitals and providers also rely on retroactive eligibility for reimbursement of provided services, allowing these facilities to keep the doors open. For example, the Emergency Medical Treatment and Labor Act (EMTALA) requires hospitals to stabilize and treat individuals in their emergency room, regardless of their insurance status or ability to pay.[34] Retroactive eligibility allows hospitals to be reimbursed if the individual treated is eligible for Medicaid coverage. Likewise, Federally

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[30] American Cancer Society Cancer Action Network. *The costs of cancer: Addressing patient costs*. Washington, DC: American Cancer Society Cancer Action Network: 2017.

[31] Hadley J. Insurance coverage, medical care use, and short-term health changes following an unintentional injury or the onset of a chronic condition. *JAMA*. 2007; 297(10): 1073-84.

[32] Foutz J, Damico A, Squires E, Garfield R. The uninsured: A primer – Key facts about health insurance and the uninsured under the Affordable Care Act. *The Henry J Kaiser Family Foundation*. Published January 25, 2019. Accessed November 2019. https://www.kff.org/report-section/the-uninsured-a-primer-key-facts-about-health-insurance-and-the-uninsured-under-the-affordable-care-act-how-does-lack-of-insurance-affect-access-to-health-care/.

[33] The Henry J. Kaiser Family Foundation. Key facts about the uninsured population. Updated December 7, 2018. Accessed November 2019. https://www.kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/.

[34] Centers for Medicare & Medicaid Services. Emergency medical treatment & labor act (EMTALA). Updated March 2012. Accessed October 2019. https://www.cms.gov/regulations-and-guidance/legislation/emtala/.

Qualified Health Centers (FQHCs) offer services to all persons, regardless of that person's ability to pay or insurance status.[35] Community health centers also play a large role in ensuring low-income individuals receive cancer screenings, helping to save the state of Utah from the high costs of later stage cancer diagnosis and treatment. Therefore, we urge the Department to consider these providers and their contribution to Nebraska's safety net, as well as the patients who rely on Medicaid for health care coverage, before waiving retroactive eligibility for its Medicaid beneficiaries.

Conclusion

We appreciate the opportunity to provide comments on Nebraska's Medicaid 1115 HHA Expansion Demonstration. Expanding eligibility and coverage through the Medicaid program is critically important for many low-income Nebraskans who could greatly benefit from the program for cancer prevention, early detection, diagnostic, and treatment services. However, the proposed policies included in the 1115 waiver could negatively impact Nebraska residents. We ask the Department to weigh the potential impact the proposed policies could have on low-income Nebraskans' access to lifesaving health care coverage, particularly those individuals with cancer, cancer survivors, and those who will be diagnosed with cancer during their lifetime.

Maintaining access to quality, affordable, accessible, and comprehensive health care coverage and services are a matter of life and survivorship for thousands of low-income cancer patients and survivors, and we look forward to working with the Department to ensure that all Nebraskans are positioned to win the fight against cancer. If you have any questions, please feel free to contact me at nick.faustman@cancer.org or 402-260-3288.

Sincerely,

[redacted]

Nick Faustman
Nebraska Government Relations Director
American Cancer Society Cancer Action Network

[35] National Association of Community Health Centers. Maine health center fact sheet. Published March 2017. Accessed November 2019. http://www.nachc.org/wp-content/uploads/2016/03/ME_17.pdf.

November, 25 2019

Matthew Van Patton
Director, Division of Medicaid & Long-Term Care
State of Nebraska, Department of Health and Human Services
301 Centennial Mall South, 3rd Floor PO Box 95026
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Re: NORD Comments on Nebraska's 1115 Medicaid Waiver Application

Dear Mr. Van Patton:

The National Organization for Rare Disorders (NORD) appreciates the opportunity to submit comments on Nebraska's Medicaid Section 1115 Heritage Health Adult Expansion Demonstration.

NORD is a unique federation of voluntary health organizations dedicated to helping people with rare "orphan" diseases and assisting the organizations that serve them. We are committed to the identification, treatment, and cure of rare disorders through programs of education, advocacy, research, and patient services.

NORD believes everyone, including Medicaid enrollees, should have access to quality and affordable health coverage. Medicaid expansion, as the voters approved in November, will expand coverage to 90,000 low-income Nebraskans. This will provide individuals with prevention, early detection and diagnostic services as well as disease management and treatment for their conditions. Medicaid expansion is critical for patients with rare diseases.

Unfortunately, this waiver proposal will delay the implementation of Medicaid expansion until October of 2020, almost two years after the voters approved the measure. This is unacceptable and will delay access to quality and affordable for 90,000 Nebraskans. NORD urges Nebraska to implement Medicaid expansion as soon as possible, without the proposed delay, to follow the will of the voters.

<u>Tiered Benefit Structure</u>
NORD supports Nebraska's Medicaid expansion, but is worried that some provisions of the waiver proposal will limit the potential benefit of the program.

The Heritage Health Adult Expansion Demonstration waiver creates a two-tiered benefit structure. Initially, all expansion enrollees will have the "Basic" plan but can qualify for the "Prime" plan if they complete a set of wellness, personal responsibility and work reporting requirements. The Prime plan includes all of the benefits of the Basic plan plus vison, dental and over-the-counter drugs.

The requirements to receive the Prime benefit package are very onerous. Patients have to "actively participate" in care and case management, which includes completing a health risk screening, completing a "social determinants of health" assessment, routinely refilling prescriptions and having recommended labs performed. Additionally, beneficiaries will be required to have an annual visit with their primary care provider. Beneficiaries would also have to comply with a personal responsibility requirement, which includes not missing more than three appointments within six months, maintaining commercial coverage if available, and notifying the state within 10 days of any changes that may affect a beneficiary's eligibility for Medicaid or benefit tier. This level of complexity could harm rare disease patients who rely on Medicaid for lifesaving care.

Additionally, starting in Year Two of the demonstration, the expansion population between the ages of 21 and 59 would be required to prove that they work at least 80 hours per month or meet exemptions. One major consequence of this proposal will be to increase the administrative burden on individuals in the Medicaid program. Increasing administrative requirements will likely decrease the number of individuals with Medicaid Prime coverage, regardless of whether they are exempt or not. For example, Arkansas implemented a similar policy requiring Medicaid enrollees to report their hours worked or their exemption. During the first six months of implementation, the state terminated coverage for over 18,000 individuals and locked them out of coverage until January 2019.[i] In other states with similar policies, enrollees have found the reporting requirements confusing and added stress and anxiety to enrollees' lives.[ii]

The state estimates that 40 percent of enrollees will not be able to comply with all the requirements and will receive the Basic benefit rather than Prime benefit. Each of these requirements adds additional red tape for Medicaid enrollees. Many of the requirements require significant access to transportation that can be a barrier for the low-income population. NORD encourages Nebraska to provide the Prime benefit to all Medicaid enrollees in the expansion population. This will eliminate confusion and additional paperwork for patients with rare diseases.

<u>Removing Retroactive Coverage</u>

As part of the 1115 waiver, Nebraska is asking to waive retroactive eligibility and start coverage on the first day of the month of the application. Retroactive eligibility in Medicaid prevents gaps in coverage, by covering individuals for up to 90 days prior to the month of application, assuming the individual is eligible for Medicaid coverage during that time frame. It is common that individuals are unaware they are eligible for Medicaid until a medical event or diagnosis occurs. Retroactive eligibility allows patients who have been diagnosed with a serious illness, including rare diseases, to begin treatment without being burdened by medical debt prior to their official eligibility determination.

Medicaid paperwork can be burdensome and often times confusing. A Medicaid enrollee may not have understood or received a notice of Medicaid renewal and only discovered the coverage lapse when picking up a prescription or going to see their doctor. Without retroactive eligibility,

Medicaid enrollees could then face substantial costs at their doctor's office or pharmacy. For example, when Ohio was considering a similar provision in 2016, a consulting firm advised the state that hospitals could accrue as much as $2.5 billion more in uncompensated care as a result of the waiver.[iii] Nebraska estimates that over 29,000 adults will lose retroactive coverage as a result of the waiver. NORD urges Nebraska to remove this provision from the waiver application.

Lack of Evaluation Plan

The proposed 1115 waiver currently lacks an evaluation plan. While the state claims it will create a robust evaluation plan, there is nothing that is currently set up to evaluate the waiver. NORD encourages Nebraska to write and solicit feedback on an evaluation plan so the public can accurately comment on the proposal.

NORD urges Nebraska to expand Medicaid without delay to fulfill the will of the voters. However, this waiver should be modified to provide optimal care to all Medicaid enrollees by eliminating the tiered benefit approach and keeping retroactive coverage. Thank you for the opportunity to submit comments.

Sincerely,

/s/

Rachel Sher,
Vice President of Policy and Regulatory Affairs

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[i] Robin Rudowitz, MaryBeth Musumeci, and Cornelia Hall, "A Look at November State Data for Medicaid Work Requirements in Arkansas," Kaiser Family Foundation, December 18, 2018. Available at: https://www.kff.org/medicaid/issue-brief/a-look-at-november-state-data-for-medicaid-work-requirements-in-arkansas/; Arkansas Department of Health and Human Services, Arkansas Works Program, December 2018. Available at: http://d31hzlhk6di2h5.cloudfront.net/20190115/88/f6/04/2d/3480592f7fbd6c891d9bacb6/011519_AWReport.pdf

[ii] Musumeci, MaryBeth, Robin Rudowitz, Barbara Lyons. Medicaid Work Requirements in Arkansas: Experience and Perspectives of Enrollees. Kaiser Family Foundation. Dec 18, 2018. Available at: https://www.kff.org/medicaid/issue-brief/medicaid-work-requirements-in-arkansas-experience-and-perspectives-of-enrollees/

[iii] Virgil Dickson, "Ohio Medicaid waiver could cost hospitals $2.5 billion", Modern Healthcare, April 22, 2016. (http://www.modernhealthcare.com/article/20160422/NEWS/160429965)

HCAN
Health Center Association
OF NEBRASKA

November 25, 2019

Dr. Matthew Van Patton
Director, Division of Medicaid and Long Term Care
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Nebraska Medicaid
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Lincoln, Nebraska 68509-5026

Re: Comments regarding the proposed 1115 Demonstration Waiver

Director Van Patton:

On behalf of the Health Center Association of Nebraska (HCAN), our seven Federally Qualified Health Centers (FQHCs), and the over 100,000 Nebraskans served by our health centers annually, we respectfully submit these comments regarding the implementation of Medicaid expansion as proposed in the draft 1115 waiver.

Nebraska's health centers have, historically, experienced one of the highest rates of uninsured patients compared to health centers nationally, with nearly 50% of our patients lacking health insurance. Over 90% of our patients have incomes below 200% of the Federal Poverty Level and 67% are of a racial or ethnic minority. Our health centers are the safety net providers in the state. And while we serve all who enter our health centers, regardless of insurance status or ability to pay, we do not provide secondary or specialty services. Nor do we have center locations in every part of the state. We witness, daily, the struggles caused by being uninsured or underinsured. The opportunity to expand Medicaid in Nebraska is pivotal to ensuring consistent medical, behavioral health, dental and vision care for all Nebraskans.

We are concerned that the program outlined in the proposed 1115 waiver runs contrary to the will of the voters who successfully passed the ballot initiative expanding Medicaid and will create barriers to accessing and maintaining health care coverage. In addition, the reporting requirements will place an undue burden on providers and may further reduce an already limited pool of Medicaid providers.

Statutory Requirements for Medicaid Expansion

The proposed waiver produced by the Department is incompatible with Nebraska state law, specifically §68-992(4). In relation to the Medicaid expansion population the law states: "No greater or additional burdens or restrictions on eligibility, enrollment, benefits, or access to health care services shall be imposed on persons eligible for medical assistance pursuant to this section than on any other population eligible for medical

assistance."[1] The proposed waiver creates restrictions on benefits such as dental services and over-the-counter medication. Only Heritage Health Adult beneficiaries would be subject to this tiered benefits plan; current beneficiaries with similar health profiles, such as Parents and Caretaker Relatives, are excluded from the proposed waiver. By creating a tiered benefits package that only applies to the new expansion population the proposed waiver violates both the intent and the letter of the law.

Retroactive Eligibility

As part of the proposed waiver, retroactive eligibility is severely curtailed. Retroactive eligibility is an important part of the Medicaid program, protecting vulnerable individuals who are eligible but not yet enrolled in Medicaid from large medical bills if they get sick or injured. This program also helps prevent uncompensated care for safety net providers and hospitals. The Department posits that curtailing retroactive eligibility will promote "Early and continuous coverage, Enrollment of eligible people at the time when care and case management can assist and consistency with Commercial and Federal Markets."[2] The Department fails to cite any research or demonstrate that these outcomes would be likely, or most importantly outweigh the consequences of lost coverage.

Waiver proposals from other states that proposed to waive retroactive eligibility, such as a proposed waiver in Iowa, projected significant coverage losses and corresponding spending reductions. Estimates of lost member months and spending are inconsistent with claims of improved continuity of coverage overall. Evidence suggests that 5% of total Medicaid spending is spent on retroactive Medicaid coverage.[3] A loss of roughly 1,500 average enrollees is a reasonable estimate of the effect absent specific retroactive eligibility data from the Department.[4] These losses are likely to disproportionately affect hospitals, especially rural critical access hospitals. Data from Indiana indicates that increased use of presumptive eligibility is not sufficient to cover the loss of retroactive eligibility.

The assertion that eliminating retroactive coverage will lead to more people enrolling earlier relies on assumptions that retroactive eligibility in Medicaid is an option that is widely known among potential enrollees. However, studies of other proposed waiver programs indicate that awareness of specific provisions in Medicaid is extremely low, even among those enrolled in the program. For example, in Indiana nearly 40% of individuals had not heard about POWER accounts, a key element of the Indiana 1115 waiver program.[5] Other studies have indicated that low-income individuals have lower health literacy than others, particularly among racial and ethnic minorities, those with lower levels of education, and those whose primary language is

[1] https://nebraskalegislature.gov/laws/statutes.php?statute=68-992
[2] http://dhhs.ne.gov/Documents/HHAWaiverPresentation.pdf
[3] https://www.commonwealthfund.org/publications/fund-reports/2017/jun/financial-impact-american-health-care-acts-medicaid-provisions?redirect_source=/publications/fund-reports/2017/jun/financial-impact-ahca-on-safety-net-hospitals#/
[4] Calculation based on estimated number of persons impacted by retroactive eligibility proposed waiver
[5] Sommers, B. D., Fry, C. E., Blendon, R. J., & Epstein, A. M. (2018). New approaches In Medicaid: Work requirements, health savings accounts, and health care access. *Health Affairs*, *37*(7), 1099-1108.

not English.[6] This raises concerns that waving retroactive eligibility may create a differential impact to certain minority groups.

Similarly, we are unclear as to how curtailing retroactive eligibility would meaningfully increase the welfare of eligible persons through increased case management. As noted earlier the assumption that substantially more persons would enroll early does not appear supported by available evidence. Moreover, this assumes that spending on retroactive eligibility is concentrated among conditions that can be case managed. Medical costs resulting from injuries sustained automotive accidents, for example, are highly unlikely to be responsive to care management. It would be helpful for the Department to provide data on what percentage of retroactive claims are potentially mitigated by case management in a cost effective manner.

Tiered Benefit Structure

In addition to the impact of the loss of retroactive eligibility, a significant portion of enrollees are likely to lose coverage for benefits by virtue of being enrolled in Basic Coverage. Despite its framing, "Prime Coverage" is simply the current Medicaid state plan benefits package. Rather than providing extra benefits to the Prime Coverage group as an incentive, the proposed waiver takes a punitive approach to those in Basic Coverage by restricting access to typically covered services such as dental, over-the-counter medications and vision services. The waiver does not include any cost-benefit analysis of the impact of losing these services relative to the purported benefits on health due to the waiver, which is fundamental to understanding the projected impacts of the waiver. By the Department's own estimates more than 50% enrollees in the expansion group will be in Basic Coverage in year one. This represents a substantial coverage loss to a significant number of enrollees.

Oral health coverage is an important element of health coverage. Loss of oral health coverage will likely have a negative effect on the health of enrollees in Basic Coverage. The U.S. Department of Health and Human Services Oral Health Strategic Framework, 2014–2017 states that "poor oral health is associated with increased bacterial systemic exposure and increased inflammatory factors that can lead to adverse health outcomes, such as uncontrolled diabetes, cardiovascular disease, and respiratory disease."[7] Loss of dental services is likely to impede goals of improving care for chronic conditions, and create barriers to creating integrated care models. FQHCs in particular integrate dental services as part of a focus on the health of the whole person. In addition, dental services often serve as an important employment support as dental diseases are often associated with missed days of work. Likewise, vision services are an important to treating the whole health of a person as well as supporting activities that promote work and higher wage earnings. Lack of vision coverage is associated with poorer visual health and poorer detections and outcomes related to degenerative diseases such as glaucoma and cataracts.[8]

[6] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5022195/
[7] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4765973/
[8] https://www.ncbi.nlm.nih.gov/books/NBK402365/

Over-the-counter medication is an important benefit for enrollees, especially due to the low-income status of the expansion population. Over the counter medication is often an important element of managing chronic diseases. For example, aspirin therapy for those with Ischemic Vascular Disease (IVD) is a common treatment option. This is so common and important to managing this condition that the Health Resources Services Administration (HRSA) uses the percentage of patients 18 years of age and older with a diagnosis of IVD or AMI, CABG, or PCI procedure with aspirin or another antiplatelet as a metric for evaluating the clinical quality provided at community health centers. Over 1,000 patients at Nebraska health centers alone received aspirin therapy in 2018.[9] Lower quality of health due to the projected losses of these services must be evaluated before the proposed waiver is submitted.

Beneficiary Engagement Requirements

The proposed waiver not only includes a multitude of additional paperwork requirements for eligibility for Prime Coverage, but is anticipated to generate additional paperwork regarding eligibility. Exponentially increasing the paperwork burden is likely to result in confusion and coverage losses among enrollees. Reporting of work hours often leads to income verification check paperwork that can lead to disenrollment. While the waiver proposal no longer includes official six-month redetermination periods, the increased reporting requirements are likely to generate similar amounts of redetermination processes. In 2003, Washington State switched its CHIP population to six-month eligibility redeterminations. During the subsequent 12 months over 30,000 children lost coverage. These losses were then reversed when the program moved back to 12-month eligibility.[10] Anecdotally, under a similar waiver, individuals in New Hampshire found the system to be so confusing and onerous many were considering dropping coverage altogether.[11]

Moreover, documents are often not health literate and data errors lead to documents being sent in the wrong languages or to the wrong addresses in the current system. Organizations such as FQHCs who currently employ Certified Application Counselors or Navigators to aid in enrollment will likely see an increased burden with an overly complex system, placing an additional burden upon providers.

In order to qualify for Prime Coverage enrollees must comply with wellness and community engagement requirements (starting in 2021) unless they are determined medically frail or aged 19-20. According to the estimates in the proposed waiver, a significant portion of the population will be exempt from these requirements. Over 95,000 individuals are estimated to be exempt in year one, rising to 138,000 by year five. However, there remains a significant risk that those who are medically frail will fall through the cracks and lose coverage. The state has not identified significant protections to ensure that those who are medically frail are properly identified as such.

[9] https://bphc.hrsa.gov/uds/datacenter.aspx?q=t6b&year=2018&state=NE
[10] http://ccf.georgetown.edu/wp-content/uploads/2012/03/CE-program-snapshot.pdf
[11] https://www.nhpr.org/post/confusing-letters-frustrated-members-nhs-medicaid-work-requirement-takes-effect#stream/0

Demonstrating medical frailty can involve significant documentation hurdles for potential enrollees. Documentation hurdles, combined with likely low overall awareness, could lead to significant numbers of medically frail individuals not being enrolled in the medically frail program. Individuals in other states have had trouble navigating the system and obtaining the proper paperwork due to confusion among both providers and individuals.[12] As an example, individuals in New Hampshire received conflicting and confusing guidance as to their status.[13] A substantial number of individuals who should be considered medically frail are likely to be unaware of their need to document medical frailty or have issues completing the proper paperwork and will instead receive less comprehensive coverage. It is essential that the department implement strong protections for the medically frail population to prevent them from being locked out of needed services.

The proposed waiver outlines that, beginning in year two enrollees must meet Community Engagement Requirements, more commonly known as work requirements. According to data from the Kaiser Family Foundation, only 6% of individuals were not working at least part time and were unlikely to qualify for an exemption.[14] This is likely to be even lower in Nebraska due to the fact that Nebraska has the 2nd lowest proportion of families in poverty who are not working.[15] The vast majority of persons eligible for Medicaid are either working, ill or disabled, taking care of home or family, or going to school - 93% of enrollees fall in one of these categories.[16] Among family units, 78% are working at least part time.[17] Even among those who may average working 80 hours per month over a 12-month span, many work in jobs with variable hours, such as hospitality and seasonal agricultural work. One out of every four potentially eligible persons would not qualify in at least one month of a 12-month period.[18]

The experience with work requirements in other states has been fraught with issues. In Arkansas, 23% of those subject to work requirements lost coverage. Over 75% of persons subject to work requirements in Arkansas did not submit documentation of their work hours, mainly due to lack of awareness around documentation requirements.[19] Over 18,000 individuals in Arkansas lost coverage in 2018 alone and the data does not support that there was a significant positive impact on employment. Similarly, experience with work requirements in the TANF space demonstrates that a significant number of persons are likely to fall through the cracks. In Ohio, a report found that 32% of those subject to work requirements under TANF

[12] https://www.concordmonitor.com/Penacook-NH-medical-frailty-exemption-difficulties-26880774
[13] https://www.nhpr.org/post/confusing-letters-frustrated-members-nhs-medicaid-work-requirement-takes-effect#stream/0
[14] https://www.kff.org/medicaid/press-release/only-six-percent-of-adult-medicaid-enrollees-targeted-by-states-new-work-requirements-are-not-already-working-and-are-unlikely-to-qualify-for-an-exemption/
[15] https://www.openskypolicy.org/wp-content/uploads/2018/05/Demographic-Trends-for-Legislative-Forum-May-2018.pdf
[16] https://www.cbpp.org/research/health/medicaid-work-requirements-will-reduce-low-income-families-access-to-care-and-worsen
[17] https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work/
[18] https://www.cbpp.org/research/health/medicaid-work-requirements-will-reduce-low-income-families-access-to-care-and-worsen#_ftn15
[19] https://www.cbpp.org/health/commentary-as-predicted-arkansas-medicaid-waiver-is-taking-coverage-away-from-eligible-people#_ftn11

should have been exempted due to physical or behavioral health limitation.[20] Overall, this indicates that work requirements main effect is to cause persons to lose coverage for failure to complete paperwork. In fact, work requirements have been under intense legal scrutiny, having been struck down in three states for failure to demonstrate that the work requirements assist in administering the Medicaid program. In addition, two additional states have delayed implementation of work requirements because of the pending court cases. One additional lawsuit has been filed in an additional state, claiming work requirements violate the intent of Medicaid. Given the recent actions of other states and the pending litigation, it seems administratively and fiscally irresponsible for Nebraska to pursue community engagement requirements at this time. An amicus brief for over 40 health policy researchers put it succinctly when they noted "There is zero evidence to suggest that depriving people of Medicaid will lead to greater levels of employer insurance."

Similar to the community engagement requirements, the wellness and personal responsibility requirements proposed by the waiver are likely make the system harder to navigate for enrollees while exponentially increasing the amount of paperwork burden on both enrollees and providers. According to the Department's own estimates, over 50% of enrollees will not meet these requirements in the first year of implementation. Benefit losses due to these provisions must be considered when evaluating the desirability and legality of the waiver.

One of the wellness initiatives required by the proposed waiver is the selection of a Primary Care Provider (PCP). Currently, all Medicaid beneficiaries are assigned a PCP, either through patient choice or auto-assignment by the Enrollment Broker. From October to December 2015, 72.4% of patients were auto-enrolled into a Managed Care plan.[21] This indicates a large percentage of enrollees are likely automatically assigned a PCP. Current auto-assignment of a PCP takes into account prior patient physician relationships when making that assignment. Enrollee selected PCP choices can also be inaccurate. For example, when providers work at more than one organization, enrollees may select the correct provider but the wrong organization, placing them into the wrong care management systems. This may cause significant problems and lead persons to lose Prime Coverage due to documentation issues, which have little to no impact on their health. Since the majority of enrollees are currently assigned a PCP, and those with an existing relationship with a PCP are auto-assigned to that relationship, it is unclear what purpose conditioning receipt of benefits on this selection serves. Solutions to mismatches between assigned PCP and PCP providing care are better handled by better processes by providers and managed care companies.

The proposed waiver emphasizes that: "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." This is an admirable goal; however, an 1115 waiver is not necessary in order to implement these initiatives.

[20] http://admin.ohiofoodbanks.org/uploads/news/WEP-2013-2014-report.pdf
[21] http://das.nebraska.gov/materiel/purchasing/contracts/pdfs/71172(o4)awd.pdf p. 440

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As part of the care management requirements outlined in the proposed waiver, enrollees would be required to fill out a health risk and social determinants of health screening annually and upon enrollment. Like other requirements in this proposed waiver, this increases the paperwork burden upon the enrollee. These screenings are most effective when done by trusted primary care providers. Social determinants of health screenings in particular ask sensitive questions that many persons would be less likely to answer for an MCO or Medicaid agency as opposed to their doctor. For example, the PRAPARE tool used by many FQHCs nationwide to screen for social determinants of health involves questions related to domestic violence, which individuals would likely be more comfortable disclosing to a trusted medical professional than a government agency or contractor.[22] Moreover, much of the information contained is best assessed and utilized by the patient's primary care physician. Additionally, this requirement is duplicative of the annual health screening. For this reason, HCAN recommends that the Department aim to increase utilization of screening tools via contractual tools, e.g. incentive payments for providers to complete screening tools.

The final active case and care management activity is "for the beneficiary to fill medications routinely and have clinical labs drawn as ordered by their provider." Due to the general lack of knowledge about Medicaid program requirements among enrollees these requirements are unlikely to cause major changes in medication adherence. Moreover, the Department has not provided clear definitions of medication adherence, nor systems to track said issues. Specific definitions and systems are crucial for evaluating the potential effect of this requirement as well as ensuring that persons do not lose coverage due to data issues or due to minor issues.

The Department must take steps to ensure that the annual wellness visit does not cause undue barriers to accessing coverage. It is essential that beneficiaries know about this requirement, which will require significant outreach, especially to those with low health literacy, experiencing homelessness, or facing disabling conditions including mental illnesses. Moreover, the definition of an annual visit can cause confusion as the difference between a wellness visit and a doctor visit for another reason may not be clear to beneficiaries. As such, this creates possible administrative difficulties with the churning population, populations who moved, especially across state lines, and those who previously received care without insurance. Wellness visits not paid for through Medicaid are not currently tracked in a systemic fashion in the Department. A person with a wellness visit through private insurance, a different state's Medicaid program, charity care or with an FQHC on a sliding fee scale would not show up in Department systems and would create additional paperwork burden for enrollees. According to survey data nationally, 71% of adults enrolled in Medicaid have a visit with a primary care doctor in any given year.[23] This number is actually higher than the rate for those with employer sponsored insurance. While annual wellness visits are important, Medicaid must demonstrate that this requirement will in practice increase this rate by a substantial number rather than merely creating a hurdle to those trying to access care to services such as dental, vision and over the counter medication. Many of these same objectives could be achieved without causing losses in coverage through MCO value based contracts,

[22] http://www.nachc.org/wp-content/uploads/2018/05/PRAPARE_One_Pager_Sept_2016.pdf
[23] https://www.kff.org/medicaid/issue-brief/data-note-medicaids-role-in-providing-access-to-preventive-care-for-adults/

allowable under current Medicaid eligibility rules. Using provider networks to increase the number of enrollees with an annual visit through value based contracts is much more likely to be effective and have fewer negative effects on enrollees.

The Department proposes three "Personal Responsibility Activities". They are: "(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." These changes dramatically increase the reporting burden on enrollees and increase the number of individuals likely losing out on important benefits, while simultaneously being unlikely to cause any positive change to the health or wellbeing of individuals.

As providers, we recognize the importance of individuals attending their appointments, but have concerns with conditioning receipt of benefits upon not missing those appointments. Most facilities have policies and procedures in place to minimize the effect and incidence of missed appointments that are likely much more effective than any Medicaid agency action. Moreover, there is currently no system in place to track and report missing appointments to Medicaid. Any such system would lead to increased cost and burden on providers. For example, submitting a no-charge claim to indicate that a patient missed an appointment takes up staff time as well as requires payment to submit and process the claim. Medicaid enrollees tend to have barriers to accessing care which can lead to missed appointments, such as unreliable transportation, and variable work hours. Moreover, this provision places providers in a difficult position relative to their enrollees in determining what constitutes a missed appointment.

The second "personal responsibility requirement" is to maintain commercial coverage. Enrollees in the expansion population are, by definition, low income, and often work jobs with both low Employer Sponsored Insurance (ESI) offer rates as well as ESI that is unaffordable, not comprehensive and lacks important supports for low income populations. ESI premiums can easily total well over 10% of a person's income for those under the poverty line. The current waiver proposal does not include any affordability standards for either premiums or coinsurance. At a bare minimum the Department should adopt the ACA's definitions for affordability and minimum coverage to ensure that those with unaffordable coverage are not unfairly penalized. Employer sponsored plans are not designed with the Medicaid population in mind, as their high copays and deductibles can often be barrier to managing chronic conditions. For example, even among the insured the cost of insulin has been shown to decrease medication adherence and lead to negative health outcomes.[24] This likely will lead to worse outcomes among the chronically ill.

The final "personal responsibility" requirement is a 10-day timely notification requirement. Failure to report any change that could affect their status in Medicaid or Basic/Prime eligibility leads to a minimum of a 12-month lockout from Prime coverage. This requirement is plainly onerous on the enrollees and provides no health benefit or coverage benefit. Enrollees may be unaware of a change in status until after the 10-day period, for example with hospitality workers whose wages and shifts can be highly variable week to week and

[24] https://care.diabetesjournals.org/content/41/6/1299

month to month. This requirement only exacerbates the paperwork burden placed on individuals by placing an arbitrarily short deadline on notifications.

Demonstration waiver projects are intended to be experimental and test hypotheses, for this reason a robust evaluation plan is critical. The proposed waiver in its current form lacks an acceptable evaluation plan. An evaluation plan must include specific variables, controls, confounding factors and ways to prevent unobserved variables from marring the data. This is particularly important when evaluating Medicaid beneficiaries, some of whom have eligibility that is conditioned on having health problems. Causality can be bi-directional or run in opposite directions as anticipated. As an example, Medicaid beneficiaries can have worse health than the uninsured because those who enroll in Medicaid tend to be sicker. The listing of goals data and sources in the proposed waiver is not a robust evaluation plan. Without specific methodologies, variables and goals in place it is impossible to evaluate whether the data sources contain adequate information to properly detect differences and account for the non-experimental nature of the analysis. Additionally, the evaluation plan should address the health outcomes and impacts of those who do not obtain coverage, who otherwise would have, and the impacts of losing benefit coverage in basic relative to Prime Coverage. It is essential that the evaluation plan be able to address the self-selecting nature of Prime Coverage. The evaluation model must be able to differentiate between better health outcomes in highly engaged individuals because they are highly engaged in the first place and the changes brought about by incentives. Finally, the goal of ceasing Medicaid coverage is contrary to the purpose of the Medicaid program which is to provide Medical insurance to low income individuals. This measure would reward Medicaid for allowing members to fall through the cracks and become uninsured.

The proposed waiver's description of cost neutrality is insufficient. On a basic level, there is no comparison data. It is impossible to assess whether something is cost neutral without also providing the alternative scenario. The Department should provide a detailed breakdown of the differences between the waiver application and expansion of Medicaid using the benefit package available to the adults Parents and Caretaker Relatives eligibility group. Moreover, the Department should provide a detailed breakdown of where savings or additional expenditures are attributed, both to ensure transparency as well as to understand the effects of the waiver. This breakout should include costs by category, changes in member months and eligibility groups, administrative costs, costs related to administering job seeking activities in the state, costs due to churning between programs and within Basic/Prime coverage, costs related to the differing benefit tiers, the effects of retroactive eligibility changes on member month enrollment, costs per patient and potential savings due to better care management. This analysis must include a way of differentiating savings due to fewer needed services being provided to fewer individuals from increased efficiency in delivery of services. The current budgetary estimates lack this important specificity to be able to properly evaluate whether the waiver is beneficial or meets federal waiver standards. A recent General Accounting Office report found weaknesses in CMS oversight of administrative costs and recommended more detailed projections in state waiver proposals.[25]

[25] https://www.gao.gov/products/GAO-20-149?mobile_opt_out=1

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As providers who work directly with the individuals who will benefit from Medicaid expansion and be impacted by the requirements proposed in the proposed waiver, we have concerns about any program restrictions that hinder access to coverage, increase administrative burden, and increase the overall administrative cost of the program. We are committed to working with the Department to ensure that Medicaid expansion is implemented in a way that meets the intent of the ballot initiative and ensures all eligible individuals can enroll in and access these vital benefits.

Sincerely,

Amy R. Behnke
CEO
Health Center Association of Nebraska

November 26, 2019

Matthew Van Patton
Director, Division of Medicaid & Long-Term Care
State of Nebraska, Department of Health and Human Services
301 Centennial Mall South, 3rd Floor PO Box 95026
Lincoln, NE 68509-5026

Dear Mr. Van Patton:

The Cystic Fibrosis Foundation appreciates the opportunity to submit comments on Nebraska's Medicaid Section 1115 Heritage Health Adult Expansion Demonstration.

Cystic fibrosis is a rare, life-threatening genetic disease that affects approximately 270 people in Nebraska and roughly 14 percent of adults with CF rely on Medicaid for some or all of their health coverage. CF causes the body to produce thick, sticky mucus that clogs the lungs and digestive system, which can lead to life-threatening infections. Cystic fibrosis is both serious and progressive; lung damage caused by infection can be irreversible and have a lasting impact on length and quality of life. As a complex, multi-system condition, CF requires targeted, specialized treatment and medications.

People with cystic fibrosis need quality, affordable health coverage and Medicaid expansion can increase the number of Nebraskans living with CF who have adequate coverage. Medicaid expansion, as the voters approved in November, will expand coverage to 90,000 low-income Nebraskans. Medicaid is a critical program for patients with cystic fibrosis. For example, Medicaid helps people with CF afford medications and inpatient and outpatient care, ensuring access to life-saving services and allowing people with CF to maintain their health and well-being.

Unfortunately, this waiver lacks an evaluation plan and contains several problematic provisions, including onerous personal responsibility and work requirements, and the removal of retroactive eligibility. Additionally, this proposal will delay the implementation of Medicaid expansion until October of 2020, almost two years after the voters approved the measure. This is unacceptable and will delay access to quality and affordable for 90,000 Nebraskans. The CF Foundation urges Nebraska to implement Medicaid expansion as soon as possible, without the proposed delay, to follow the will of the voters.

<u>Tiered Benefit Structure</u>
The CF Foundation supports Nebraska's Medicaid expansion, but is worried that some provisions of the waiver proposal will limit the potential benefit of the program.

The Heritage Health Adult Expansion Demonstration waiver creates a two-tiered benefit structure. Initially, all expansion enrollees will have the "Basic" plan but can qualify for the "Prime" plan if they complete a set of wellness, personal responsibility, and work reporting requirements. The Prime plan

includes all of the benefits of the Basic plan plus vison, dental, and over-the-counter drugs—critical components of care for many people, including those with CF.

The requirements to receive the Prime benefit package are very onerous. Patients have to "actively participate" in care and case management, which includes completing a health risk screening, completing a "social determinants of health" assessment, routinely refilling prescriptions and having recommended labs performed. Additionally, beneficiaries will be required to have an annual visit with their primary care provider. Beneficiaries would also have to comply with a personal responsibility requirement, which includes not missing more than three appointments within six months, maintaining commercial coverage if available, and notifying the state within 10 days of any changes that may affect a beneficiary's eligibility for Medicaid or benefit tier.

Additionally, starting in Year Two of the demonstration, the expansion population between the ages of 21 and 59 would be required to prove that they work at least 80 hours per month or meet exemptions. One major consequence of this proposal will be to increase the administrative burden on individuals in the Medicaid program. Increasing administrative requirements will likely decrease the number of individuals with Medicaid Prime coverage, regardless of whether they are exempt or not. For example, Arkansas implemented a similar policy requiring Medicaid enrollees to report their hours worked or their exemption. During the first six months of implementation, the state terminated coverage for over 18,000 individuals and locked them out of coverage until January 2019.[1] In other states with similar policies, enrollees have found the reporting requirements confusing and added stress and anxiety to enrollees' lives.[2]

The state estimates that 40 percent of enrollees will not be able to comply with all the requirements and will receive the Basic benefit rather than Prime benefit. Each of these requirements adds additional red tape for Medicaid enrollees. Many of the requirements require significant access to transportation that can be a barrier for the low-income population. The Cystic Fibrosis Foundation encourages Nebraska to provide the Prime benefit to all Medicaid enrollees in the expansion population. This will eliminate confusion and additional paperwork for patients with CF.

<u>Removing Retroactive Coverage</u>

As part of the 1115 waiver, Nebraska is asking to waive retroactive eligibility and start coverage on the first day of the month of the application. Retroactive eligibility in Medicaid prevents gaps in coverage, by covering individuals for up to 90 days prior to the month of application, assuming the individual is eligible for Medicaid coverage during that time frame. It is common that individuals are unaware they are eligible for Medicaid until a medical event or diagnosis occurs. Retroactive eligibility allows patients who have been diagnosed with a serious illness, such as cystic fibrosis, to begin treatment without being burdened by medical debt prior to their official eligibility determination.

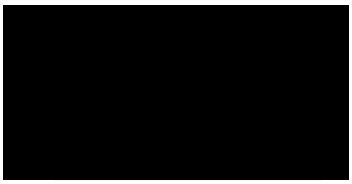
Medicaid paperwork can be burdensome and often times confusing. A Medicaid enrollee may not have understood or received a notice of Medicaid renewal and only discovered the coverage lapse when picking up a prescription or going to see their doctor. Without retroactive eligibility, Medicaid enrollees could then face substantial costs at their doctor's office or pharmacy. For example, when Ohio was considering a similar provision in 2016, a consulting firm advised the state that hospitals could accrue as much as $2.5 billion more in uncompensated care as a result of the waiver.[3] Nebraska estimates that over 29,000 adults will lose retroactive coverage as a result of the waiver. The CF Foundation urges Nebraska to remove this provision from the waiver application.

Lack of Evaluation Plan

The proposed 1115 waiver currently lacks an evaluation plan. While the state claims it will create a robust evaluation plan, there is nothing that is currently set up to evaluate the waiver. The CF Foundation encourages Nebraska to write and solicit feedback on an evaluation plan so the public can accurately comment on the proposal.

We urge Nebraska to expand Medicaid without delay to fulfill the will of the voters. However, this waiver should be modified to provide optimal care to all Medicaid enrollees by eliminating the tiered benefit approach and keeping retroactive coverage. Thank you for the opportunity to submit comments.

Sincerely,



Mary Dwight
Senior Vice President, Policy & Advocacy
Cystic Fibrosis Foundation

Lisa Feng, DrPH
Senior Director, Policy & Advocacy
Cystic Fibrosis Foundation

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[1] Robin Rudowitz, MaryBeth Musumeci, and Cornelia Hall, "A Look at November State Data for Medicaid Work Requirements in Arkansas," Kaiser Family Foundation, December 18, 2018. Available at: https://www.kff.org/medicaid/issue-brief/a-look-at-november-state-data-for-medicaid-work-requirements-in-arkansas/; Arkansas Department of Health and Human Services, Arkansas Works Program, December 2018. Available at: http://d31hzlhk6di2h5.cloudfront.net/20190115/88/f6/04/2d/3480592f7fbd6c891d9bacb6/011519_AWReport.pdf

[2] Musumeci, MaryBeth, Robin Rudowitz, Barbara Lyons. Medicaid Work Requirements in Arkansas: Experience and Perspectives of Enrollees. Kaiser Family Foundation. Dec 18, 2018. Available at: https://www.kff.org/medicaid/issue-brief/medicaid-work-requirements-in-arkansas-experience-and-perspectives-of-enrollees/

[3] Virgil Dickson, "Ohio Medicaid waiver could cost hospitals $2.5 billion", Modern Healthcare, April 22, 2016. (http://www.modernhealthcare.com/article/20160422/NEWS/160429965)

NAMI Nebraska
National Alliance on Mental Illness

Attachment 9

November 26, 2019

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

Re: Nebraska Section 1115 Heritage Health Adult Expansion Demonstration

Dear Dr. Van Patton:

NAMI Nebraska, the state chapter of the National Alliance on Mental Illness, appreciates the opportunity to comment on the Medicaid Section 1115 Waiver amendment, Heritage Health Adult Expansion Demonstration. NAMI is the nation's largest grassroots mental health organization dedicated to building better lives for the millions of Americans affected by mental illness.

Access to coverage and care is essential for people with mental illness to successfully manage their condition and get on a path of recovery. Medicaid is the lifeline for much of that care, as the nation's largest payer of behavioral health services,[i] which provides health coverage to 27 percent of adults with a serious mental illness.[ii]

Medicaid expansion in particular has provided substantial benefits to people with mental health conditions. It helps people access needed treatment, including screenings, medications, and therapy. In states that have expanded Medicaid, adults with serious mental illness (SMI) are 30 percent more likely to receive mental health treatment than their uninsured counterparts,[iii] and adults with serious psychological distress (SPD) are more likely to have health coverage and less likely to delay or forego necessary care.[iv] And when moms have Medicaid health coverage, their children are more likely to use behavioral health services,[v] underscoring the important benefit to families that Medicaid expansion brings.

NAMI Nebraska is grateful that the state is submitting an 1115 waiver to expand our Medicaid program, anticipated to cover an estimated 93,000 Nebraskans[vi] including those with mental illness. We fully support such an expansion and believe it will deliver critical health care services to eligible individuals in our state. At the same time however, we are concerned by multiple waiver elements that, if implemented, will create barriers to health care for people with mental illness, and further drive up costs to the state. Therefore, NAMI Nebraska offers the following comments on the state's proposal.

Retroactive Eligibility

Under the demonstration waiver, Nebraska proposes to waive the three-month retroactive eligibility period for beneficiaries while granting an exception for pregnant women, infants under age one, and those in nursing facilities. NAMI Nebraska discourages the state from pursuing this component. Retroactive coverage is important because many individuals are simply unaware that they are eligible for Medicaid until after they experience a traumatic event. For example, when a mental health crisis arises such as first episode psychosis, the initial focus often is on stabilizing the person's condition. If such a crisis event occurs toward the end of a calendar month, it may take several days or weeks for the individual and their family and providers to navigate complex medical issues before they turn to considering payment, including Medicaid eligibility. During this time, sizeable medical bills can accrue. Retroactive coverage protects patients like these by ensuring that medical bills are paid even if a Medicaid application is not filed until the calendar month following a traumatic event. Patients should not be left to choose between massive medical bills and treating their illness, and NAMI Nebraska urges the state to reconsider this waiver provision.

Plan Tiering, Wellness Activities, Personal Responsibility Activities, and Community Engagement Requirements

The Heritage Health Adult Program includes a number of elements intended to "incentivize personal responsibility."[vii] However, significant research demonstrates that imposing harsh elements like plan tiering, wellness and work requirements do not encourage appropriate use of health care among people with low incomes; rather, it discourages them from enrolling in coverage or seeking necessary care.

Plan Tiering

The proposal includes two levels of coverage – "Basic" and "Prime," wherein beneficiaries in the expansion population will begin with Basic Coverage, and receive Prime Coverage only if they are able to complete wellness initiatives, personal responsibility activities, and community engagement requirements. Those who are unable to do so will remain in the Basic. NAMI Nebraska worries that individuals will miss out on what are often standard benefits within other states' Medicaid programs, simply because beneficiaries did not understand, were unaware, or unable to complete the additional hurdles to improved coverage. In Indiana's Healthy Indiana Plan (HIP 2.0), which also includes two types of coverage, beneficiaries have found the tiered system confusing, according to a 2017 evaluation.[viii] Instead, NAMI Nebraska recommends a standard benefits package to improve access to care and reduce beneficiary confusion.

Wellness & Personal Responsibility Activities

The proposal requires that in order to gain or maintain Prime Coverage, beneficiaries must complete three wellness activities – such as selecting a primary care provider – and certain personal responsibility requirements, including not missing three or more appointments in a six-month period; maintaining commercial coverage; and providing timely notification to the state of changes in status. While well-intended, NAMI Nebraska is concerned about the lack of supporting evidence on these provisions in other states, and how these requirements will further reduce access to needed care.

In neighboring Iowa, recent research demonstrates that over 80 percent of Iowa's expansion population were unable to complete wellness requirements, and were therefore subject to paying premiums the following year.[ix] Of those subject to premiums, more than half were disenrolled because they were unable to pay.[x] Perhaps most strikingly, nine in 10 members were unaware that their premiums could be waived if they completed the healthy behavior requirement, and "stunted program's ability to achieve

significant participation.[xi] Conversely, research from Ohio, which expanded Medicaid without a waiver, shows an increase in the use of primary care services – calling into question whether these wellness requirements are needed in order to increase use of appropriate care.[xii] NAMI Nebraska instead recommends that the state forgo these barriers so that beneficiaries have access to critical health care services.

Community Engagement Requirements

Under the demonstration waiver, beneficiaries may receive Prime Coverage if they are able to complete workforce and community engagement requirements. While NAMI Nebraska is glad that inability to complete such requirements does not cause program disenrollment, we are nonetheless concerned about the implementation of this provision and its impact on people with mental illness, who are more likely to be subject to Medicaid work requirements than those without.[xiii] Moreover, we recognize that access to Medicaid often *supports* work and community engagement and reduces Supplemental Security Income (SSI) participation.[xiv] Consequently, such work requirements may undermine beneficiaries' employment and management of their health needs.

Employment offers many benefits to people with mental illness, and most people who live with mental health conditions want to work. However, work requirements can present unnecessary risks for people with mental illness. Serious mental illnesses are, by their very nature, chronic and recurring conditions that fluctuate in severity over time. This means that an individual could be in a state of recovery at the time they are assessed and face few obstacles to working at that time. However, the person's condition could change rapidly – without the knowledge of the Medicaid system. Work requirements, coupled with more frequent eligibility determinations as this proposal includes, would mean that an individual who is experiencing a crisis or decline in their condition could lose both their employment and Prime Coverage at the very time they need access to mental health care the most. NAMI Nebraska recognizes that Nebraska's proposal offers exemptions for serious mental illness, which may capture some individuals with mental health conditions. However, we are concerned that many people will still fall through the cracks, and may find it particularly burdensome to prove their eligibility for an exemption because of the nature of their condition.[xv]

If Nebraska is truly interested in helping support employment for beneficiaries with mental health conditions, we urge the state to fund other critical supports that will make employment more feasible. NAMI Nebraska urges the state to implement evidence-based supported employment programs, which have proven effective in helping vulnerable populations, such as people with mental illness recover and return to work.[xvi] This meets the intent of the demonstration proposal without the adverse consequences presented by a mandatory work requirement.

<u>Six Month Eligibility Determinations & Lockouts</u>

The state proposes to review the eligibility of beneficiaries every six months, and lock beneficiaries out of Prime coverage for a year if the beneficiary voluntarily drops commercial coverage for Medicaid coverage. NAMI Nebraska is concerned that this will further reduce access to health care, while driving up administrative costs to the state. When eligible people with mental health conditions go on and off of coverage – called "churn" – they are less likely to receive outpatient mental health services.[xvii]

Moreover, we worry that transfers to Medicaid from commercial coverage may not tell the full story, and therefore should not be discouraged. As health care costs increase and wages remain flat, working families in the private sector are increasingly turning to public coverage for their and their families' health care needs,[xviii] especially if they cannot afford critical – and costly - mental health services. For example, if an individual with mental illness receives coverage through their employer with an Association Health Plan, such plans can sharply limit coverage for essential health benefits like mental health care or substance use disorder treatment. If this individual is otherwise eligible for Medicaid coverage, we should be encouraging – not discouraging – the use of services that will best treat their mental health condition and put them on a path of wellness. NAMI Nebraska recommends that the state instead maintain annual eligibility determinations, and refrain from lockout periods that discourage regular use of care.

Administrative Costs

NAMI Nebraska is also concerned about the financial costs of implementing this proposal. States such as Michigan, Pennsylvania, Kentucky and Tennessee have estimated that setting up the administrative systems to track and verify exemptions and work activities will cost tens of millions of dollars,[xix] and Kentucky alone saw administrative costs increase by 40 percent after implementing work requirements in 2018.[xx] These policies – coupled with the churn of six-month eligibility determinations – will not only increase administrative costs of enrollment and re-enrollment, but increase health care costs when people with mental illness are unable to regularly see their providers or fill prescriptions. Altogether, these costs would divert resources from Medicaid's core goal – providing health coverage to those without access to care.

Conclusion

NAMI Nebraska urges the state to move forward Medicaid expansion, while cautioning against additional program barriers that will reduce access to care for people with mental health conditions. An 1115 waiver should not leave beneficiaries worse off than if they received coverage through a traditional Medicaid expansion.

Rather than imposing new barriers or incurring additional costs, NAMI Nebraska encourages the state to consider other innovative approaches that encourage appropriate use of care that will help individuals with mental illness access needed services and supports. Thank you for the opportunity to provide comments.

Sincerely,

[redacted]

Denise Stuart

Board President
NAMI Nebraska

[i] Medicaid and CHIP Payment and Access Commission, "Behavioral Health in the Medicaid Program—People, Use, and Expenditures," June 2015, https://www.macpac.gov/publication/behavioral-health-in-the-medicaid-program%E2%80%95people-use-and-expenditures/.

[ii] Rebecca Ahrnsbrak et al., "Key Substance Use and Mental Health Indicators in the United States: Results from the 2016 National Survey on Drug Use and Health," Substance Abuse and Mental Health Services Administration, September 2017, https://www.samhsa.gov/data/sites/default/files/NSDUH-FFR1-2016/NSDUH-FFR1-2016.pdf.

[iii] Beth Han et al., "Medicaid Expansion Under the Affordable Care Act: Potential Changes in Receipt of Mental Health Treatment Among Low-Income Nonelderly Adults With Serious Mental Illness", *American Journal of Public Health* 105, no. 10 (October 2015): pp. 1982-1989, https://ajph.aphapublications.org/doi/full/10.2105/AJPH.2014.302521.

[iv] Priscilla Novak, Andrew C. Anderson, and Jie Chen. Changes in Health Insurance Coverage and Barriers to Health Care Access Among Individuals with Serious Psychological Distress Following the Affordable Care Act. *Administration and Policy in Mental Health and Mental Health Services Research* 45, no. 6 (November 2018): pp. 924-932, https://link.springer.com/article/10.1007%2Fs10488-018-0875-9.

[vvv] M. Ali et al. The Implications of the Affordable Care Act for Behavioral Health Services Utilization. *Administration and Policy in Mental Health and Mental Health Services Research* 43, no. 11 (January 2016): pp. 11-22, https://doi.org/10.1007/s10488-014-0615-8.

[vi] Nebraska Department of Health and Human Services, "Frequently Asked Questions about Medicaid Expansion in Nebraska," Updated October 2019, http://dhhs.ne.gov/Documents/MedicaidExpansionFAQ.pdf.

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[ix] Brad Wright et al., "Completion of Requirements in Iowa's Medicaid Expansion Premium Disincentive Program, 2014-2015," *American Journal of Public Health.* Published online January 10, 2018, doi: 10.2105/AJPH.2017.304178.

[x] Iowa Wellness Plan Quarterly Report: 1115 Demonstrative Waiver: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ia/Wellness-Plan/ia-wellness-plan-qtrly-rpt-jul-sep-2017.pdf.

[xi] Health Behaviors Incentive Program Evaluation: Interim Report, University of Iowa Public Policy Center, University of Iowa College of Public Health, March 2016: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ia/Wellness-Plan/ia-wellness-plan-bhvrs-int-rpt-mar-2016.pdf.

[xii] Ohio Department of Medicaid, "Ohio Medicaid Group VIII Assessment: A Report to the Ohio General Assembly," https://medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Assessment.pdf.

[xiii] Hefei Wen, Brendan Saloner, and Janet R. Cummings. Conditions Among Medicaid Enrollees: Implications for Work Requirements. *Health Affairs* 38, no. 4 (April 2019), https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.05059.

[xiv] Aparna Soni et al., "Medicaid Expansion and State Trends in Supplemental Security Income Program Participation," *Health Affairs,* August 2017, https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2016.1632.

[xv] Richard Frank, "Medicaid work requirements will reduce care for mentally ill," The Hill, February 3, 2018, http://thehill.com/opinion/healthcare/372181-medicaid-work-requirements-will-reduce-care-for-mentally-ill.

[xvi] Examples of successful evidence-based programs include IPS Supported Employment (which places people with mental illness in competitive jobs in the community) and the comprehensive service array in First Episode Psychosis programs (FEP) that includes supported employment. Both these interventions have been shown to improve the employment outcomes of people with mental illness at rates far higher than the national average.

[xvii] Xu Ji et al. Effect of Medicaid Disenrollment on Health Care Utilization Among Adults With Mental Health Disorders. *Medical Care* 57, no. 8 (August 2019), https://journals.lww.com/lww-medicalcare/Abstract/2019/08000/Effect_of_Medicaid_Disenrollment_on_Health_Care.2.aspx.

[xviii] Douglas Strane et al. Growth of Public Coverage Among Working Families in the Private Sector. *Health Affairs* 38, no. 7 (July 2019) https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2018.05286?utm_campaign=HAT&utm_medium=email&utm

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National
Multiple Sclerosis
Society

November 26, 2019

Matthew Van Patton
Director, Division of Medicaid & Long-Term Care
State of Nebraska, Department of Health and Human Services
301 Centennial Mall South, 3rd Floor PO Box 95026
Lincoln, NE 68509-5026

Dear Mr. Van Patton:

The National MS Society (Society) appreciates the opportunity to submit comments on Nebraska's Medicaid Section 1115 Heritage Health Adult Expansion Demonstration.

Nearly one million people are living with multiple sclerosis (MS) in the United States, more than twice the original estimate. MS is an unpredictable, often disabling disease of the central nervous system that disrupts the flow of information within the brain, and between the brain and body. Symptoms vary from person to person and range from numbness and tingling, to walking difficulties, fatigue, dizziness, pain, depression, blindness and paralysis. The progress, severity and specific symptoms of MS in any one person cannot yet be predicted but advances in research and treatment are leading to better understanding and moving us closer to a world free of MS.

The Society believes everyone, including Medicaid enrollees, should have access to quality and affordable health coverage. Medicaid expansion, as the voters approved in November, will expand coverage to 90,000 low-income Nebraskans. This will provide individuals with prevention, early detection and diagnostic services as well as disease management and treatment for their conditions. Medicaid expansion is critical for patients with MS. Access to affordable, quality health care is vital for all of us, but especially for people living with MS. Accessing consistent treatment can reduce the number of new lesions and exacerbations, slow progression of disability, and may reduce future disease activity. Benefit package design and eligibility standards must address the health needs of people living with MS.

Unfortunately, this waiver proposal will delay the implementation of Medicaid expansion until October of 2020, almost two years after the voters approved the measure. This is unacceptable and will delay access to quality and affordable for 90,000 Nebraskans. The Society urges Nebraska to implement Medicaid expansion as soon as possible, without the proposed delay, to follow the will of the voters.

<u>Tiered Benefit Structure</u>
The Society supports Nebraska's Medicaid expansion, but is worried that some provisions of the waiver proposal will limit the potential benefit of the program.

The Heritage Health Adult Expansion Demonstration waiver creates a two-tiered benefit structure. Initially, all expansion enrollees will have the "Basic" plan but can qualify for the "Prime" plan if they complete a set of wellness, personal responsibility and work reporting requirements. The Prime plan includes all of the benefits of the Basic plan plus vison, dental and over-the-counter drugs. A vision problem is the first symptom of MS for many people. A common visual symptom of MS is optic neuritis

National Multiple Sclerosis Society

— inflammation of the optic (vision) nerve that can cause eye pain and blurred vision. Some people living with MS may also experience nystagmus, involuntary and uncontrolled movement of the eye that is usually rapid and can be up and down, side to side or rotating. Others may experience blurred or double-vision. These vision issues may occur as a relapse symptom or as a chronic symptom of MS, but all require care and treatment provided by low-vision specialists, ophthalmologists, or neuro-ophthalmologists.

The requirements to receive the Prime benefit package are very onerous. Patients have to "actively participate" in care and case management, which includes completing a health risk screening, completing a "social determinants of health" assessment, routinely refilling prescriptions and having recommended labs performed. Additionally, beneficiaries will be required to have an annual visit with their primary care provider. Beneficiaries would also have to comply with a personal responsibility requirement, which includes not missing more than three appointments within six months, maintaining commercial coverage if available, and notifying the state within 10 days of any changes that may affect a beneficiary's eligibility for Medicaid or benefit tier. MS is known to cause problems with cognitive functions; in fact, 65% of people with MS will experience some changes in cognitive functioning, most commonly related to speed of information processing, memory and attention. Adding barriers and complicated administrative processes will result in people with MS losing - not gaining - health care.

Additionally, starting in Year Two of the demonstration, the expansion population between the ages of 21 and 59 would be required to prove that they work at least 80 hours per month or meet exemptions. One major consequence of this proposal will be to increase the administrative burden on individuals in the Medicaid program. Increasing administrative requirements will likely decrease the number of individuals with Medicaid Prime coverage, regardless of whether they are exempt or not. For example, Arkansas implemented a similar policy requiring Medicaid enrollees to report their hours worked or their exemption. During the first six months of implementation, the state terminated coverage for over 18,000 individuals and locked them out of coverage until January 2019.[1] In other states with similar policies, enrollees have found the reporting requirements confusing and added stress and anxiety to enrollees' lives.[2] People living with MS should not be penalized if their health condition prevents them from working, particularly in a manner that reduces health coverage and access to needed treatments and services. People with MS may experience significant MS symptoms or exacerbations that temporarily interfere with their ability to work, but they may not meet some stringent definitions of "medically frail" or "disabled." The Society therefore opposes work requirements that penalize people with MS who are unable to work due to their MS or fail to meet burdensome administrative requirements.

The state estimates that 40 percent of enrollees will not be able to comply with all the requirements and will receive the Basic benefit rather than Prime benefit. Each of these requirements adds additional red tape for Medicaid enrollees. Many of the requirements require significant access to transportation that can be a barrier for the low-income population. The Society encourages Nebraska to provide the Prime benefit to all Medicaid enrollees in the expansion population. This will eliminate confusion and additional paperwork for people living with MS.

National
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Removing Retroactive Coverage

As part of the 1115 waiver, Nebraska is asking to waive retroactive eligibility and start coverage on the first day of the month of the application. Retroactive eligibility in Medicaid prevents gaps in coverage, by covering individuals for up to 90 days prior to the month of application, assuming the individual is eligible for Medicaid coverage during that time frame. It is common that individuals are unaware they are eligible for Medicaid until a medical event or diagnosis occurs. Retroactive eligibility allows patients who have been diagnosed with a serious illness, such as[insert condition], to begin treatment without being burdened by medical debt prior to their official eligibility determination.

Medicaid paperwork can be burdensome and often times confusing. A Medicaid enrollee may not have understood or received a notice of Medicaid renewal and only discovered the coverage lapse when picking up a prescription or going to see their doctor. Without retroactive eligibility, Medicaid enrollees could then face substantial costs at their doctor's office or pharmacy. For example, when Ohio was considering a similar provision in 2016, a consulting firm advised the state that hospitals could accrue as much as $2.5 billion more in uncompensated care as a result of the waiver.[3] Nebraska estimates that over 29,000 adults will lose retroactive coverage as a result of the waiver. The Society urges Nebraska to remove this provision from the waiver application.

Lack of Evaluation Plan

The proposed 1115 waiver currently lacks an evaluation plan. While the state claims it will create a robust evaluation plan, there is nothing that is currently set up to evaluate the waiver. The Society encourages Nebraska to write and solicit feedback on an evaluation plan so the public can accurately comment on the proposal.

The National MS Society urges Nebraska to expand Medicaid without delay to fulfill the will of the voters. However, this waiver should be modified to provide optimal care to all Medicaid enrollees by eliminating the tiered benefit approach and keeping retroactive coverage. Thank you for the opportunity to submit comments.

Sincerely,

[redacted]

Jenna Neher
National MS Society
President, Mid America Chapter

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[1] Robin Rudowitz, MaryBeth Musumeci, and Cornelia Hall, "A Look at November State Data for Medicaid Work Requirements in Arkansas," Kaiser Family Foundation, December 18, 2018. Available at: https://www.kff.org/medicaid/issue-brief/a-look-at-november-state-data-for-medicaid-work-requirements-in-arkansas/; Arkansas Department of Health and Human Services, Arkansas Works Program, December 2018. Available at: http://d31hzlhk6di2h5.cloudfront.net/20190115/88/f6/04/2d/3480592f7fbd6c891d9bacb6/011519_AWReport.pdf

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Society

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Attachment 9

JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

November 26, 2019

Department of Health and Human Services
Nebraska Medicaid
ATTN: HHA Waiver
301 Centennial Mall South
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Submitted via e-mail: DHHS.HHAWaiver@Nebraska.gov

Re: Section 1115 Heritage Health Adult Plan Expansion Demonstration

Justice in Aging appreciates the opportunity to comment on the Department of Health and Human Services (DHHS) proposed Section 1115 Heritage Health Adult Plan Expansion Demonstration. For the reasons discussed below, we oppose the proposals to create a tiered benefit system that requires individuals to meet work reporting requirements in order to be eligible for dental, vision, and over-the-counter medication coverage and the proposal to eliminate retroactive coverage.

Justice in Aging is an advocacy organization with the mission of improving the lives of low-income older Nebraskans and older adults nationwide. We use the power of law to fight senior poverty by securing access to affordable health care, economic security and the courts for older adults with limited resources, particularly populations that have traditionally lacked legal protection such as women, people of color, LGBTQ individuals, and people with limited English proficiency. We have decades of experience with Medicare and Medicaid and have worked extensively with advocates who represent low-income older Nebraskans. Justice in Aging conducts trainings and engages in advocacy regarding Medicare and Medicaid, provides technical assistance to attorneys in Nebraska and across the country on how to address problems that arise under these programs, and advocates for strong consumer protections at both the state and federal level.

Work Requirements Will Limit Coverage for Many Older Adults, People with Serious Health Conditions & Family Caregivers

DHHS is proposing to implement a tiered benefit system that will withhold dental, vision, and over the counter drug coverage from an estimated one-third of Nebraskans eligible for Medicaid expansion. In order to receive these benefits, Heritage Health enrollees under age 60 would have to qualify for Prime coverage by meeting nine requirements including reporting 80 hours of work. Withholding important benefits from people who fail to meet work reporting requirements will be particularly harmful to older adults, persons with serious health conditions and functional limitations, and family caregivers

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because they face additional challenges in meeting such requirements and the health consequences of losing or being denied access to full Medicaid coverage are likely to be especially severe.

Although Medicaid eligibility rules classify a person as "disabled" or "aged", disability and health challenges that accompany age are a continuum. A Heritage Health enrollee may not be "disabled" under Medicaid law or over age 65, but nonetheless face significant health-related challenges. Data from the National Center for Health Statistics shows that approximately 40% of working-age Medicaid beneficiaries "have broadly defined disabilities, most of whom are not readily identified as such through administrative records."[1] Similarly, data from the March 2017 Current Population Survey (reflecting 2016 health insurance coverage) show that, among Nebraska's non-elderly Medicaid population not receiving Supplemental Security Income due to disability, 40% cited being ill or disabled as the reason for not being employed.[2] Moreover, prevalence of chronic conditions, including both physical and mental health conditions, increases significantly with age. For example, a study by AARP analyzed data for the age 50–64 population, finding that 72.5% have at least one chronic condition, and almost 20% suffer from a mental illness.[3]

All these data demonstrate how older low-income Nebraskans who qualify for Medicaid—along with younger low-income beneficiaries with chronic conditions or functional limitations —are at risk of not being eligible for the full scope of coverage under the proposal. Although DHHS proposes to exempt individuals from the work requirements who are 60 and older, medically frail, or who have a serious mental illness or chronic substance use disorder, these exemptions will certainly not reach all individuals with health-related challenges and functional limitations that limit their ability to work and comply with reporting requirements. Moreover, people eligible for health-related exemptions may not know they are exempt to begin with.

Furthermore, these individuals' health will be seriously compromised by lack of coverage for the benefits that would be withheld from enrollees who do not meet the reporting or exemption requirements. For example, as of 2015, 13% of nonelderly adults in Nebraska reported poor condition of mouth/teeth.[4] In 2017, nationwide over 1 in 4 Medicare beneficiaries with disabilities under age 65 went without needed dental care due to costs.[5] Without access to oral health care, these individuals' health and the health of many other low-income Nebraskans who do not currently have poor oral

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[1] H. Stephen Kaye, Community Living Policy Ctr., How Do Disability and Poor Health Impact Proposed Medicaid Work Requirements? 2 (Feb. 2018), https://clpc.ucsf.edu/sites/clpc.ucsf.edu/files/reports/Disability%20%26%20Medicaid%20Work%20Requirements.pdf.

[2] Rachel Garfield, *et al.*, Kaiser Family Foundation, Understanding the Intersection of Medicaid and Work 10 (Appendix Table 2) (Jan. 2018), http://files.kff.org/attachment/Issue-Brief-Understanding-the-Intersection-of-Medicaid-and-Work.

[3] AARP Public Policy Institute, Chronic Care: A Call to Action for Health Reform 11–12, 16 (March 2009), www.aarp.org/health/medicare-insurance/info-03-2009/beyond_50_hcr.html.

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[5] Meredith Freed *et al*., Kaiser Family Foundation, Drilling Down on Dental Coverage and Costs for Medicare Beneficiaries (Mar. 2019), http://files.kff.org/attachment/Issue-Brief-Drilling-Down-on-Dental-Coverage-and-Costs-for-Medicare-Beneficiaries.

health will be harmed as they age because of compounding effects. According to the CDC, over 13% of Nebraska seniors age 65+ have lost all of their natural teeth due to decay or gum disease. Providing access to routine oral health care to all non-elderly adults on Medicaid holds the potential to greatly decrease this statistic by preventing and treating decay and gum disease.[6]

Work reporting requirements would also jeopardize the health of many Medicaid beneficiaries who care for family members or other individuals who cannot live independently. Many family caregivers leave the workforce or reduce their hours to provide informal care to seniors and others who need it. Therefore, these caregivers are likely to be Medicaid eligible because they are low-income and unlikely to have access to health insurance through a job or spouse. Nationwide, 30% of non-elderly Medicaid enrollees not receiving SSI cite caretaking as their reason for not engaging in the type of work activities the state is proposing to require of them.[7]

While Nebraska proposes to credit hours spent caregiving for "an elderly or disabled relative" or "a dependent child," many types of caregiving responsibilities don't fall neatly into those categories. Importantly, this approach provides no flexibility for caring for people who are not "relatives" nor shared caregiving responsibilities. Frequently, caregiving is round-the-clock and so necessitate shared responsibility.[8] Shared caregiving is also often necessary for individuals who do not have family to care for them.[9] Finally, imposing a work requirement puts an enormous and unnecessary burden on family caregivers to track their hours, maintain documentation, and understand and comply with reporting requirements in the midst of their caregiving and other responsibilities.[10] Given these realities, many family caregivers who qualify for Medicaid would be forced to compromise their own health because they would not be eligible for Prime coverage.[11]

Finally, this policy would also be counterproductive, as limiting coverage to low-income Nebraskans for not reporting work could cause their health to deteriorate, which in turn will make it harder for them to become or remain employed.[12] In addition, nearly 30% of adults eligible for Medicaid expansion

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[6]CDC, Oral Health Data by Topic, https://nccd.cdc.gov/oralhealthdata/rdPage.aspx?rdReport=DOH_DATA.ExploreByTopic&islYear=2016&islTopic=ADT&go=GO.

[7] Rachel Garfield, *et al.*, Kaiser Family Foundation, Understanding the Intersection of Medicaid and Work 10 (Appendix Table 2) (Jan. 2018), http://files.kff.org/attachment/Issue-Brief-Understanding-the-Intersection-of-Medicaid-and-Work.

[8] Justice in Aging, Medicaid Work Requirements: The Impact on Family Caregivers and Older Adults (Nov. 2018), *available at* http://www.justiceinaging.org/wp-content/uploads/2018/11/JusticeInAging-Medicaid-IssueBrief-November19-11am-2018.pdf.

[9] *See id.*; *see also* AARP New Hampshire, Testimony on SB 313 (Feb. 20, 2018), *available at* https://states.aarp.org/aarp-testifies-new-hampshire-granite-advantage-program/.

[10] Paperwork requirements have been shown to reduce Medicaid enrollment across populations. *See* Margot Sanger-Katz, "Hate Paperwork? Medicaid Recipients Will Be Drowning in It," The New York Times, January 18, 2018, www.nytimes.com/2018/01/18/upshot/medicaid-enrollment-obstacles-kentucky-work-requirement.html.

[11] *See* Justice in Aging, *supra* note 7.

[12] Coverage interruptions could lead to increased emergency room visits and hospitalizations, admissions to mental health facilities, and health care costs, research has shown. Leighton Ku & Erika Steinmetz, Assn. for Community Affiliated Plans, "Bridging the Gap: Continuity and Quality of Coverage in Medicaid," (Sept. 10, 2013), *available at* www.communityplans.net/Portals/0/Policy/Medicaid/GW%20Continuity%20Report%209-10-13.pdf.

report that the appearance of their mouth and teeth affects their ability to interview for a job.[13] These issues are even more profound for older adults in a volatile job market[14] who also face employment discrimination based on their age.[15] Take for example a 55-year old woman living in rural Nebraska who is caring for an aging friend who lives several miles away. As her caregiving obligations grew, she was laid off her paid job because she could not work the consistent hours her employer asked her to. She is not yet eligible for Medicare and will have a difficult time finding employment given her age and constraints on her time. She is at risk of being denied full Medicaid coverage if work requirements are implemented.

Eliminating Retroactive Coverage Will Deprive Low-Income Nebraskans of Needed Coverage.

We oppose DHHS's proposal to limit retroactive coverage to the first day of the month of application for all Medicaid populations except pregnant women, children under 18, beneficiaries dually eligible for Medicare and beneficiaries residing in nursing facilities. In many instances, a person who needs health care cannot be expected to apply for Medicaid coverage at the exact moment they become eligible: they may be hospitalized after an accident or unforeseen medical emergency; they may be struggling to cope with the shock of a diagnosis or sudden decline in functional ability; they may also be unfamiliar with Medicaid, or unsure about when their declining financial resources might fall within the Medicaid eligibility threshold.

Medicaid's three-month retroactivity window is a rational and humane response to these concerns. We emphasize that retroactive eligibility is only available to persons who would have met the Medicaid eligibility standards for the month[s] in question had they applied sooner.[16] This vital protection not only enables access to necessary care and treatment by giving providers assurance that Medicaid will reimburse them, it can be the difference between financial ruin and being able to recover from an unexpected health emergency. Under DHHS's proposal, however, a person could be hit by an uninsured driver on the evening of November 29 and be liable for thousands of dollars of hospital expenses due to the "failure" to file a Medicaid application within 36 hours, when November becomes December. This is a bad policy not only because it can prevent access to necessary care and exposes people who, by definition, cannot afford and are not eligible for other health coverage to crushing debt, but also because it is costlier for providers and the state.[17] Eliminating retroactive coverage

[13] American Dental Association, Oral Health and Well-Being in the United States (2015), https://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/OralHealthWell-Being-StateFacts/US-Oral-Health-Well-Being.pdf?la=en; *see also* Austin Frakt, New York Times, How Dental Inequality Hurts Americans (Feb. 19, 2018), https://www.nytimes.com/2018/02/19/upshot/how-dental-inequality-hurts-americans.html.

[14] *See* Brynne Keith-Jennings, Center on Budget & Policy Priorities, Policy Brief: Labor Market Facing SNAP and Medicaid Participants Offers Low-Paying, Volatile Jobs (July 24, 2018), *available at* https://www.cbpp.org/research/poverty-and-inequality/policy-brief-labor-market-facing-snap-and-medicaid-participants.

[15] *See* Julia Angwin, "Dozens of Companies Are Using Facebook to Exclude Older Workers from Job Ads," (Dec. 20, 2017), www.propublica.org/article/facebook-ads-age-discrimination-targeting.

[16] 42 U.S.C. § 1396a(a)(34).

[17] Justice in Aging, Medicaid Retroactive Coverage: What's at Stake for Older Adults When States Eliminate this Protection? (Sept. 2019), https://www.justiceinaging.org/wp-content/uploads/2019/09/Medicaid-Retroactive-Coverage-Issue-Brief.pdf?eType=EmailBlastContent&eId=a7bb9cdd-1ce1-4012-b154-7981533a4875.

increases uncompensated care, jeopardizing the ability of providers, especially rural hospitals, to continue to serve their communities.[18] In turn, this decreases access to care for all Medicaid enrollees and, in the case of medically underserved areas, all Nebraskans, leading to poorer health and necessitating costlier care.

DHHS's stated reason for eliminating retroactive coverage is "To allow for consistency with the commercial market and federal Marketplace policies." However, this rationale makes little sense, given the substantial differences between Medicaid and commercial insurance. A principal difference is the fact that commercial insurance relies on premium payments, while Medicaid coverage is based upon a determination that a person has limited financial resources and thus cannot afford private coverage. Retroactive coverage is not allowed in commercial insurance because the program's financing relies on premium payments in advance, before a person knows the medical services that they may require in any particular month. The same is not true in Medicaid. This rationale is even less applicable to people eligible for home- and community-based services (HCBS) because commercial health insurance does not cover HCBS. Additionally, an individual is only eligible for Medicaid HCBS if they meet the functional eligibility criteria, which generally means they require an institutional level of care. In other words, it is impossible to enroll in Medicaid HCBS coverage before needing it. Thus, denying retroactive coverage to people eligible for HCBS is effectively cutting the HCBS benefit.

Thank you for consideration of our comments. We urge DHHS to withdraw this proposal and fully expand Medicaid without barriers to coverage. If any questions arise concerning this submission, please contact Natalie Kean, Senior Staff Attorney, at nkean@justiceinaging.org.

Sincerely,

[redacted]

Jennifer Goldberg
Deputy Director

[18] *Id.*

FAMILIESUSA
THE VOICE FOR HEALTH CARE CONSUMERS

November 26, 2019

Department of Health and Human Services
Nebraska Medicaid
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P.O. Box 95026
Lincoln, Nebraska 68509-5026

Dear Dr. Van Patton:

Families USA appreciates the opportunity to provide comments on Nebraska's proposed Heritage Health Adult Expansion Section 1115 Demonstration Waiver. Please note I am submitting these comments both on behalf of the organization as well as an a national Medicaid expert, having been in Senior leadership roles at the Centers for Medicare and Medicaid Services, Centers for Medicaid Services.
Families USA is a national, non-partisan health care policy and advocacy organization that supports policies and programs at the state and federal levels to ensure the best health and health care are equally accessible and affordable to all, with a particular focus on actions that affect lower-income individuals.

In my expert opinion, multiple elements of this proposed 1115 waiver are both legally problematic and poor policy choices for the state. We support Nebraska's decision to cover dental, vision, and over-the-counter medication benefits, but these vital benefits should not be contingent on burdensome administrative requirements or other provisions that limit access to coverage. The specific provisions of this proposal are discussed in greater detail below.

Comments on Specific Provisions in the Amendment Request

1. Work and Wellness Requirements

The waiver proposes to provide "Prime" benefits – that is dental, vision, and over-the-counter medication – only to beneficiaries who comply with a multitude of reporting requirements related to "Wellness Activities," "Personal Responsibility," and "Community Engagement."[1] These work and wellness requirements are confusing and onerous for beneficiaries, administratively burdensome and costly for the state, and potentially illegal.

"Community Engagement"

Following in the misguided footsteps of other states, the proposed waiver requires non-exempt beneficiaries to report their participation in qualifying "community engagement" activities.[2]

[1] http://dhhs.ne.gov/Documents/HHAWaiverDraftApp.pdf, page 12.
[2] http://dhhs.ne.gov/Documents/HHAWaiverDraftApp.pdf, page 15.

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The state emphasizes that beneficiaries will not lose eligibility if they do not report participation in "community engagement" and other required activities. However, under the proposed two-tiered benefits system, beneficiaries will still lose benefits if they do not report.[3] Therefore, this provision of the waiver still conditions benefits on a work reporting requirement.

A work reporting requirement is contrary to Medicaid law.

Section 1115 of the Social Security Act gives the Secretary the authority to "waive compliance with any of the requirements of section […] 1902" of the Social Security Act for any experimental, pilot, or demonstration project which, in the judgment of the Secretary, "is likely to assist in promoting the objectives of title […] XIX."[4]

Medicaid's objectives or purpose is outlined in Section 1901 of the Social Security Act. It states that federal Medicaid dollars are for the purpose of enabling states "to furnish (1) medical assistance on behalf of [statutorily eligible individuals], and (2) rehabilitation and other services to help such [individuals] attain or retain capability for independence or self-care…."[5] In the context of the statute, it is absolutely clear that "independence or self-care" refers to federal funding enabling states to provide care that can help individuals attain or retain physical independence.

While HHS has updated its Medicaid.gov website to redefine the objectives of the Medicaid program, that has no legal import. Statutory language has precedence over any website language, no matter how official the website.

- A work reporting requirement is unrelated to Medicaid's objectives as defined in statute. The language in the statute is clear. Federal Medicaid dollars are to be used to *furnish* medical, rehabilitation, and long-term services. Requiring work or community service as a condition of receipt of benefits is not in any way related to the *state furnishing* medical services or to the *state furnishing* rehabilitative or other services—indeed it achieves the opposite goal by withdrawing medical services from otherwise eligible low-income people if they do not meet the work reporting requirement. It is therefore outside of CMS's authority to approve under section 1115 authority.

  In his recent ruling to vacate the approval of Arkansas' work reporting requirement, Judge Boasberg affirmed that a work reporting requirement is unrelated to Medicaid's objectives. Boasberg ruled that, "the Secretary's approval of the Arkansas Works Amendments is arbitrary and capricious because it did not address – despite receiving substantial comments on the matter—whether and how the project would implicate the "core" objective of Medicaid: the provision of medical coverage to the needy."[6]

  Similarly, Judge Boasberg ruled in his decision to vacate the approval of New Hampshire's work reporting requirement, ""Medicaid, both as enacted and as later expanded by the ACA, reflects Congress's desire to "mak[e] healthcare more affordable" for "needy populations." […] Congress

[3] http://dhhs.ne.gov/Documents/HHAWaiverDraftApp.pdf, page 4.
[4] Social Security Act, section 1115 [42 U.S.C. 1315].
[5] Social Security Act Sec. 1901. [42 U.S.C. 1396].
[6] https://ecf.dcd.uscourts.gov/cgi-bin/show_public_doc?2018cv1900-58, page 26.

therefore designed a scheme "to address not health generally but the provision of care to needy populations."[7]

- Adding a work reporting requirement is beyond the Secretary's authority to "waive" requirements in section 1902. Section 1115 gives HHS the authority to waive requirements in Section 1902. It does not allow states to add new program requirements that are not mentioned in 1902 and that are unrelated to the program's statutory purpose of furnishing medical or rehabilitative services.[8] Section 1902 does not mention engaging in work or community service. States do not have the authority to add new requirements unrelated to the program's objective of *furnishing* medical care.

- A mere nexus between an activity and health is not a sufficient basis for the Secretary to use 1115 authority to make Medicaid eligibility conditional upon participation in that activity. In its proposal, Nebraska states that its goal for adding a work reporting requirement is to improve beneficiaries' health and self-management.[9] However, the mere connection between an activity and health status is not a basis for making receipt of Medicaid benefits conditional upon an individual's participation in that activity. There are numerous activities that have been shown to improve physical and mental health. Diet[10], exercise[11], marital status[12], and social engagement[13] are only a few of the nearly endless activities that can impact individual health. It is gross regulatory overreach and a misuse of federal and state funds to add extra-statutory conditions that are not within the program's objectives simply because one or more of those activities have been shown to be related to individual health.

  Medicaid is a program to furnish medical assistance: it is a health *insurance* program. Health insurance protects people from financial loss associated with medical costs. That is not synonymous with health. That distinction holds true for Medicaid, Medicare, employer sponsored coverage, and any health insurance program. Following a path of adding reporting requirements to Medicaid simply because they arguably promote health is far beyond the program's objectives and could turn the program into a virtual a la carte menu of extra-statutory

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[7] https://ecf.dcd.uscourts.gov/cgi-bin/show_public_doc?2019cv0773-47, page 24.
[8] Social Security Act, section 1115 [42 U.S.C. 1315].
[9] http://dhhs.ne.gov/Documents/HHAWaiverDraftApp.pdf, page 5.
[10] See the U.S. Dietary Guidelines, Office of Disease Prevention and Health Promotion, Department of Health and Human Services, for an overview of the near endless number of studies looking at the relationship between diet and health, at https://health.gov/dietaryguidelines/2015/guidelines/introduction/nutrition-and-health-are-closelyrelated/.
[11] See the U.S. Physical Activity Guidelines, Office of Disease Prevention and Health Promotion, Department of Health and Human Services, for an overview of the near endless number of studies looking at the relationship between physical activity and health, at https://health.gov/paguidelines/
[12] For a summary of the copious data on this topic, see the Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, The Effects of Marriage on Health: A Synthesis of Recent Research Evidence. Research Brief, 7/01/2007 online at https://aspe.hhs.gov/report/effects-marriagehealth-synthesis-recent-research-evidence-research-brief.
[13] For a summary of the data on the connection between social relationships and health see Debora Umberson, et al., "Social Relationships and Health: A Flashpoint for Health Policy," Journal of Health and Social Behavior, 2010; 51 (Suppl): S55-S66, online at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3150158/.

requirements approved at any administration's whim. It sets up a dynamic that could lead to near unending government micromanagement of the lives of Medicaid enrollees.

Judge Boasberg affirmed that promoting health is not a freestanding objective of Medicaid in his ruling to vacate the approval of Kentucky's work reporting requirement waiver. In his decision, Boasberg notes that, were health to be considered a freestanding objective of Medicaid, "nothing would prevent the Secretary from conditioning coverage on a special diet or certain exercise regime."[14] He also notes that, "Even if health were such an objective, approving Kentucky HEALTH on this basis would still be arbitrary and capricious."[15] If approved, the same could be said for Nebraska's proposal to add a work reporting requirement.

- Like the work requirement waivers in other states, if approved, this waiver will be vulnerable to legal challenges. To date, the four states (KY, AR, NH, and IN) that have implemented work reporting requirement waivers have had the approval of these waivers challenged in court or have lawsuits pending. In three of those states (KY[16], AR[17], and NH[18]) the court has ruled to vacate their approval, and in the fourth state (IN[19]), the case has yet to be heard. Most recently, Michigan is also facing a lawsuit challenging its work reporting requirement, which has not yet been implemented.[20]

A work reporting requirement will cost millions of dollars to implement.

Last month, the United States Government Accountability Office (GAO) released a report that included five states' estimates of the administrative costs associated with implementing their approved work reporting requirement waivers.[21] Estimated costs varied from $6 million to $271 million for IT systems changes, beneficiary outreach, contracting and other administrative costs.[22] Much of these costs do not appear to be allowable for enhanced federal match and would therefore require significant state spending.

Nebraska's administrative costs will likely exceed those of the states the GAO analyzed, since the Nebraska is proposing to implement several reporting requirements, not just "community engagement." Determining compliance with these requirements will require a myriad of systems and entities. In particular, there will be significant administrative costs and burdens associated with determining which Medicaid beneficiaries are eligible for Employer-Sponsored Insurance (ESI) coverage and tracking their enrollment in that coverage, especially since ESI falls outside the Medicaid program. Implementation of this provision will require substantial and costly data matching and interagency collaboration.

Despite the astronomical costs associated with implementing these waivers, the GAO found that states were not required to provide projections of administrative costs when requesting approval of these

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[14] https://www.courtlistener.com/recap/gov.uscourts.dcd.192935/gov.uscourts.dcd.192935.132.0_2.pdf, page 27.
[15] *Idem*, page 28.
[16] https://ecf.dcd.uscourts.gov/cgi-bin/show_public_doc?2018cv0152-74
[17] https://ecf.dcd.uscourts.gov/cgi-bin/show_public_doc?2018cv1900-58
[18] https://ecf.dcd.uscourts.gov/cgi-bin/show_public_doc?2019cv0773-47
[19] https://9kqpw4dcaw91s37kozm5jx17-wpengine.netdna-ssl.com/wp-content/uploads/2019/09/Complaint_Rose-v-Azar-REDACTED.pdf
[20] https://healthlaw.org/wp-content/uploads/2019/11/Michigan-1115-Complaint-Redacted.pdf
[21] https://www.gao.gov/assets/710/701885.pdf
[22] *Id.*

waivers.[23] Therefore, in the interest of transparency with regards to state and federal spending, we request that the state include projections of administrative costs associated with implementing this waiver.

Historically, beneficiaries have had low awareness and understanding of work reporting requirements.

Earlier this year, New Hampshire halted implementation of its work reporting requirement due to lack of awareness among thousands of beneficiaries. Despite extensive efforts to inform beneficiaries of the work reporting requirement, the state failed to obtain compliance information for nearly 17,000 beneficiaries who were subject to the work reporting requirement and are therefore at risk of losing coverage.[24] Other states like Indiana[25] and Arizona have followed suit and suspended implementation of their work reporting requirements.[26] Nebraska will likely face these same challenges, resulting in thousands losing access to vital benefits.

"Wellness Initiatives"

In addition to the "community engagement" work reporting requirements, Nebraskans enrolled in the Heritage Health waiver must also participate in "Case and Care Management," attend an annual health visit, and select a primary care provider (PCP) as part of the state's "wellness initiatives."[27] There is evidence to suggest that beneficiaries often have limited understanding and awareness of these requirements and completion of these requirements depends largely on providers and managed care organizations[28, 29]

As part of "Case and Care Management," enrollees must complete a health risk screening and social determinants of health assessment annually to receive "Prime" benefits.[30] While beneficiaries may be willing to complete these assessments, whether or not they are completed is ultimately determined by their provider and their managed care plan. A Mathematica report notes that in Iowa, a state that incentivizes its Medicaid beneficiaries to complete annual wellness visits and Health Risk Assessments (HRAs), beneficiaries' completion of HRAs depends on the actions of their primary care provider. [31] Even if a beneficiary makes an appointment with their PCP to complete an HRA, the PCP may not complete the questionnaire. The report notes that "providers are unwilling to use visit time to complete HRAs,

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[23] *Id.*
[24] https://www.dhhs.nh.gov/medicaid/granite/documents/ga-ce-findings.pdf
[25] https://www.in.gov/fssa/files/Gateway_to_Work_suspension_announcement.pdf
[26] https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/az/Health-Care-Cost-Containment-System/az-hccc-postponement-ltr-ahcccs-works-10172019.pdf
[27] http://dhhs.ne.gov/Documents/HHAWaiverDraftApp.pdf, pages 13 and 14.
[28] https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/beneficiaries-understanding-incentives.pdf
[29] https://www.mathematica.org/our-publications-and-findings/publications/incentives-to-change-health-behaviors-beneficiary-engagement-strategies-in-indiana-iowa-and-michigan
[30] http://dhhs.ne.gov/Documents/HHAWaiverDraftApp.pdf, page 13.
[31] https://www.mathematica.org/our-publications-and-findings/publications/incentives-to-change-health-behaviors-beneficiary-engagement-strategies-in-indiana-iowa-and-michigan

even for financial rewards, because they do not consider the assessments clinically relevant."[32] Even if a beneficiary completes an HRA with their PCP, the PCP's office may not notify the managed care plan, and/or the managed care plan may not notify the State.

If, as stated in the application, managed care plans are indeed "responsible for providing Case and Care Management services to Heritage Health beneficiaries,"[33] then these managed care plans should be held accountable for completion of these assessments, not beneficiaries who risk losing benefits due to administrative issues beyond their control.

The proposed waiver lacks detail on requirements related to selecting a primary care provider (PCP) and attending annual visits and is sure to result in lack of awareness and participation among beneficiaries. According to another report from Mathematica, less than a third of beneficiaries in Iowa's similar Medicaid waiver were aware of the state's incentives to complete annual wellness visits in 2014 and 2015. In 2015, only 31% of beneficiaries in that state were aware of the state's tiered dental benefit.[34] In Nebraska, this likely lack of awareness among beneficiaries will prevent them from accessing vital benefits.

"Personal Responsibility Activities"

The "personal responsibility activities," along with the reporting requirements related to "community engagement" and "wellness initiatives," places additional burden on beneficiaries. Beneficiaries who are unable to attend three scheduled appointments in six months lose access to "Prime" benefits for a full 12 months.[35]

Many Nebraskans enrolled in Medicaid work jobs with irregular schedules and may be unable to keep their medical appointments. Given that beneficiaries are required to log 80 hours of "community engagement" each month and can only miss three appointments, those who work irregular schedules that conflict with medical appointments are put in a no-win situation where they cannot keep their benefits. They must decide between missing medical appointments to comply with the "community engagement" requirement, and missing work to comply with the "personal responsibility" requirements. In both cases, they can only comply with one requirement and risk losing their benefits for failing to complete the other.

As part of the proposed "Personal Responsibility Activities," beneficiaries who elect to receive Medicaid instead of their employer-sponsored insurance (ESI) will also be locked out of "Prime" benefits for 12 months.[36] We are concerned with the potential administrative costs and burdens associated with determining who is eligible for ESI coverage and tracking enrollment in that coverage, especially since ESI falls outside the Medicaid program. Implementation of this provision will require substantial data matching and interagency collaboration. Failure to properly implement this provision could have devastating consequences for beneficiaries. If the state erroneously determines that an individual

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[32] https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/beneficiaries-understanding-incentives.pdf
[33] http://dhhs.ne.gov/Documents/HHAWaiverDraftApp.pdf, page 13.
[34] https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/beneficiaries-understanding-incentives.pdf
[35] http://dhhs.ne.gov/Documents/HHAWaiverDraftApp.pdf, page 15.
[36] *Id.*

qualifies for ESI and locks them out of "Prime" benefits, that individual will lose access to vital health care.

Beneficiaries will also be locked out of "Prime" benefits for 12 months if they do not notify Medicaid within 10 days of a change of status that impacts their eligibility.[37] Other states have given beneficiaries 10 days to verify a change in status, and many beneficiaries have been unable to provide necessary information to the state within that short time frame. For example, in Texas, the state Medicaid agency routinely checks state income data to determine Medicaid eligibility and gives beneficiaries only 10 days to verify that eligibility determination. As a result, thousands of beneficiaries have lost eligibility for failing to verify eligibility in time.[38] Similarly, in Nebraska, the state plans to use electronic data sources like the state wage index to ensure timely reporting of eligibility.[39] Beneficiaries who cannot verify their eligibility against the state's data within 10 days risk losing vital benefits.

2. Dental, Vision, and Over-the-Counter Medication Benefits

We support the state's decision to expand dental, vision, and OTC medication benefits to beneficiaries. These benefits are vital for ensuring overall health. Many medications used to treat serious and chronic medical conditions are available over-the-counter. Medicaid coverage of OTC medications makes them accessible for Nebraskans who would otherwise be unable to afford them. Serious and chronic conditions can negatively impact oral and ophthalmic health. At the same time, untreated dental and vision issues can contribute to more serious health issues.[40, 41] Access to dental and vision benefits help patients and their providers to prevent, identify, and treat those serious conditions.

However, because these benefits are so vital, Nebraskans who qualify for Medicaid coverage should not have to jump through hoops and navigate red tape to receive them. Instead of creating a two-tiered system that forces beneficiaries to comply with onerous reporting requirements to access these "Prime" benefits, the state should make these benefits available to all beneficiaries automatically upon enrollment. The state can do this by simply amending its state plan, without submitting a complicated and time-consuming 1115 waiver that adds work and wellness reporting requirements.

3. Waiver of Retroactive Eligibility

The proposal to waive retroactive eligibility limits coverage for new beneficiaries who are made responsible for the entire cost of their care prior to enrollment, even if they could have been determined eligible during their care visit or retroactively after receiving care.[42] Retroactive coverage keeps individuals from incurring high medical bills and medical debt by covering the medical bills they incurred in the three months before being determined eligible for Medicaid. Retroactive coverage also encourages doctors and hospitals to treat uninsured Medicaid eligible patients, because they will be compensated for the services they provided once the individual is enrolled.

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[37] *Id.*
[38] https://familiesusa.org/wp-content/uploads/2019/09/Return_of_Churn_Analysis.pdf
[39] http://dhhs.ne.gov/Documents/HHAWaiverDraftApp.pdf, page 15.
[40] https://www.ahajournals.org/doi/pdf/10.1161/JAHA.113.000657
[41] https://jamanetwork.com/journals/jamaophthalmology/fullarticle/1897292
[42] http://dhhs.ne.gov/Documents/HHAWaiverDraftApp.pdf, page 8.

4. Limited Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Benefits

Medicaid coverage of EPSDT services is required because low-income children and young adults have a distinct need for comprehensive care in order to lead healthy lives. EPSDT covers items such as vision and hearing screening and treatment (e.g., glasses or hearing aids), basic dental, medical, mental health, and developmental services for children and young adults. Congress designed Medicaid with the EPSDT requirement because low-income children and young adults have a distinct need for comprehensive care in order to lead healthy lives.[43] These services cannot and should not be waived.

It is unclear whether 19 and 20 year olds will continue to receive EPSDT benefits during their initial benefit tier period. According to the draft waiver application, "All beneficiaries newly eligible for Medicaid under the HHA program will receive the Basic benefits package for the initial six month benefit tier period."[44] This means that medically frail, pregnant women, and 19 and 20 year olds who are newly eligible must receive the Basic benefits package for 6 months prior to qualifying for the Prime package based on their exempted status. The Basic benefits package does not include EPSDT meaning 19 and 20 year olds effectively have to go without EPSDT for the first six months of their coverage.

On the other hand, the Nebraska Department of Health and Human Services' September 2019 Expansion Report notes that, "existing beneficiaries who will join expansion will receive Prime benefits for their first benefit tier review period."[45] It is unclear whether 19 and 20 year olds are considered "existing beneficiaries who will join expansion."

Conclusion

Overall, the state's proposal lacks a coherent, data supported rationale for its proposal, showing how approval of the waiver will further the objectives of the Medicaid program. Instead of seeking approval of this legally questionable waiver request that creates barriers to coverage for eligible beneficiaries, the state should fully expand its Medicaid program as soon as possible, regardless of whether or when this waiver is approved. Hard-working Nebraskans voted for Medicaid expansion over a year ago, they cannot and should not wait any longer. This proposed 1115 waiver is holding up expansion and if approved, will create additional barriers to coverage. Medicaid expansion and access to vital benefits should not be contingent on this waiver.

Thank you for your consideration of these comments. If you have any questions, please contact Emmett Ruff at ERuff@familiesusa.org or 202-628-3030.

Respectfully submitted,

Eliot Fishman
Senior Director of Health Policy at Families USA

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[43] https://www.macpac.gov/subtopic/epsdt-in-medicaid/
[44] http://dhhs.ne.gov/Documents/HHAWaiverDraftApp.pdf, page 4.
[45] https://nebraskalegislature.gov/FloorDocs/106/PDF/Agencies/Health_and_Human_Services__Department_of/696_20191031-080313.pdf

American Heart Association.

November 26, 2019

Matthew Van Patton
Director, Division of Medicaid & Long-Term Care
State of Nebraska, Department of Health and Human Services
301 Centennial Mall South, 3rd Floor PO Box 95026
Lincoln, NE 68509-5026

Re: Nebraska – 1115 Heritage Health Adult Expansion

Dear Mr. Van Patton,

The American Heart Association (AHA) appreciates the opportunity to submit comments on Nebraska's Medicaid Section 1115 Heritage Health Adult Expansion Demonstration. While the AHA supports Nebraska's Medicaid expansion, as noted with the meeting with Deputy Director Nate Watson on October 1, we are concerned that some provisions of the waiver proposal will limit the potential benefit of the program.

The AHA believes everyone, including Medicaid enrollees, should have access to quality and affordable health coverage. Medicaid expansion, as the voters approved in November, will expand coverage to 90,000 low-income Nebraskans. This will provide individuals with prevention, early detection and diagnostic services as well as disease management and treatment for their conditions. Medicaid expansion is critical for patients with heart disease and stroke.

As the nation's oldest and largest organization dedicated to fighting heart disease and stroke, the AHA represents over 100 million patients with cardiovascular disease (CVD) including many who rely on Medicaid as their primary source of care. Nationally, twenty-eight percent of adults with Medicaid coverage have a history of cardiovascular disease. Medicaid provides critical access to prevention, treatment, disease management, and care coordination services for these individuals. Because low-income populations are disproportionately affected by CVD – with these adults reporting higher rates of heart disease, hypertension, and stroke – Medicaid serves as the coverage backbone for the healthcare services these individuals need.

Unfortunately, this waiver proposal will delay the implementation of Medicaid expansion until October of 2020, almost two years after the voters approved the measure. This is unacceptable and will delay access to quality and affordable care for 90,000 Nebraskans. The American Heart Association

urges Nebraska to implement Medicaid expansion as soon as possible, without the proposed delay, to follow the will of the voters.

To effectively treat and prevent heart disease and stroke, it is important to ensure that *everyone* in Nebraska has access to affordable, quality healthcare. The intent of the Medicaid program is to provide healthcare coverage for low-income individuals and families. As written, the provisions of the waiver proposal are limiting and impose multiple hurdles that need to be addressed sufficiently and timely. They include:

- Tiered Benefit Structure and Work Requirement
- Removing Retroactive Coverage
- Need for a Comprehensive Evaluation Plan

Tiered Benefit Structure

The Heritage Health Adult Expansion Demonstration waiver creates a two-tiered benefit structure. Initially, all expansion enrollees will have the "Basic" plan but can qualify for the "Prime" plan if they complete a set of wellness, personal responsibility and work reporting requirements. The Prime plan includes all of the benefits of the Basic plan plus vison, dental and over-the-counter drugs.

The requirements to receive the Prime benefit package are very onerous. Patients will have to "actively participate" in care and case management, which includes completing a health risk screening, completing a "social determinants of health" assessment, routinely refilling prescriptions and having recommended labs performed. Additionally, beneficiaries will be required to have an annual visit with their primary care provider. Beneficiaries would also have to comply with a personal responsibility requirement, which includes not missing more than three appointments within six months, maintaining commercial coverage if available, and notifying the state within 10 days of any changes that may affect a beneficiary's eligibility for Medicaid or benefit tier. Also, by having two levels of coverage, different requirements and frequent redeterminations, this will likely lead to ongoing movement between the programs at the same time additions are being made to the implementation of work requirements. This movement will create interruptions and lock out periods in coverage of work requirements. Lock out periods for beneficiaries with serious health needs, including those with cardiovascular disease, would have particularly harsh consequences.

Additionally, starting in Year Two of the demonstration, the expansion population between the ages of 21 and 59 would be required to prove that they work at least 80 hours per month or meet exemptions. One major consequence of this proposal will be to increase the administrative burden on individuals in the Medicaid program. Increasing administrative requirements will likely decrease the number of individuals with Medicaid Prime coverage, regardless of whether they are exempt or not. For example, Arkansas implemented a similar policy requiring Medicaid enrollees to report their hours worked or their exemption. During the first six months of implementation, the state terminated coverage for over 18,000 individuals and locked them out of coverage until January 2019.[i] In other states with similar policies, enrollees have found the reporting requirements confusing and added stress and anxiety to enrollees' lives.[ii]

The state estimates that 40 percent of enrollees will not be able to comply with all the requirements and will receive the Basic benefit rather than Prime benefit. Each of these requirements adds additional red tape for Medicaid enrollees. Many of the requirements

require significant access to transportation that can be a barrier for the low-income population. The AHA encourages Nebraska to provide the Prime benefit to all Medicaid enrollees in the expansion population. This will eliminate confusion and additional paperwork for patients suffering from cardiovascular disease and stroke.

Removing Retroactive Coverage

As part of the 1115 waiver, Nebraska is asking to waive retroactive eligibility and start coverage on the first day of the month of the application. Retroactive eligibility in Medicaid prevents gaps in coverage, by covering individuals for up to 90 days prior to the month of application, assuming the individual is eligible for Medicaid coverage during that time frame. It is common that individuals are unaware they are eligible for Medicaid until a medical event or diagnosis occurs. Retroactive eligibility allows patients who have been diagnosed with a serious illness, such as cardiovascular disease, to begin treatment without being burdened by medical debt prior to their official eligibility determination.

Medicaid paperwork can be burdensome and often times confusing. A Medicaid enrollee may not have understood or received a notice of Medicaid renewal and only discovered the coverage lapse when picking up a prescription or going to see their doctor. Without retroactive eligibility, Medicaid enrollees could then face substantial costs at their doctor's office or pharmacy. For example, when Ohio was considering a similar provision in 2016, a consulting firm advised the state that hospitals could accrue as much as $2.5 billion more in uncompensated care as a result of the waiver.[iii] Nebraska estimates that over 29,000 adults will lose retroactive coverage as a result of the waiver. The AHA urges Nebraska to remove this provision from the waiver application.

Need for Evaluation Plan

The proposed 1115 waiver currently lacks a comprehensive evaluation plan. While the state claims it will create a robust evaluation plan, there is nothing that is currently set up to evaluate the waiver. The AHA encourages Nebraska to write and solicit feedback on an evaluation plan so the public can accurately comment on the proposal.

The American Heart Association urges Nebraska to expand Medicaid without delay to fulfill the will of the voters. However, this waiver should be modified to provide optimal care to all Medicaid enrollees by eliminating the tiered benefit approach and keeping retroactive coverage. Thank you for the opportunity to share our thoughts with you as you work to address this issue. If you have any questions or would like to discuss these comments further, please contact Brian Krannawitter, Government Relations Director for the American Heart Association at Brian.Krannawitter@heart.org or 402.560.8921.

Sincerely,

[redacted]

Brian Krannawitter
Government Relations Director - Nebraska
American Heart Association

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November 26, 2019

Dr. Matthew Van Patton
Director, Division of Medicaid & Long-Term Care
Department of Health and Human Services
Nebraska Medicaid
301 Centennial Mall South
P.O. Box 95026
Lincoln, Nebraska 68509-5026

Re: HHA Waiver

Dear Dr. Van Patton:

On behalf of the more than 30 million Americans living with diabetes and the 84 million more with prediabetes, the American Diabetes Association (ADA) provides the following comments to Nebraska's Department of Health and Human Services (Department) on the Section 1115 Health Outcomes and Encouraging Life Successes for Adult Medicaid Beneficiaries Waiver (HHA Waiver).

As the global authority on diabetes, the ADA funds research to better understand, prevent and manage diabetes and its complications; publishes the world's two most respected scientific journals in the field, Diabetes and Diabetes Care; sets the standards for diabetes care; holds the world's most respected diabetes scientific and educational conferences; advocates to increase research funding, improve health care, enact public policies to stop diabetes, and end discrimination against those denied their rights because of the disease; and supports individuals and communities by connecting them with the resources they need to prevent diabetes and better manage the disease and its devastating complications.

According to the Centers for Disease Control and Prevention (CDC), over 8% of adults in Nebraska have diagnosed diabetes.[1] Access to affordable, adequate health coverage is critically important for all people with, and at risk for, diabetes. Adults with diabetes are disproportionally covered by Medicaid.[2] For low-income individuals, access to Medicaid coverage is essential to managing their health. As a result of inconsistent access to Medicaid across the nation, these low-income populations experience great disparities in access to care and health status, which is reflected in geographic, race and ethnic differences in morbidity and mortality from preventable and treatable conditions.

Expanding Medicaid Eligibility

Medicaid expansion made available through the Affordable Care Act (ACA) offers promise of significantly reducing disparities in access to care and health status. Specifically, in Medicaid expansion states, more individuals are being screened for and diagnosed with diabetes than

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states that haven't expanded.[3] Additionally, a new study found expansion states have a higher rate of prescription fills for diabetes medications than non-expansion states.[4] Regular medication use with no gap in health insurance coverage leads to fewer hospitalizations and less use of acute care facilities.[5,6] **The ADA supports Nebraska's action to expand Medicaid and ensure all low-income individuals in Nebraska have access to adequate, affordable healthcare coverage.**

Work Requirements

Despite the state's work to expand Medicaid coverage to all low-income Nebraskans, the ADA is deeply concerned by the Department's waiver to limit or revoke certain Medicaid beneficiaries' enrollment if they do not meet proposed requirements for documentation of community engagement. This type of coverage limit is in direct conflict with the Medicaid program's objective to offer health coverage to those without access to care. Most people with Medicaid who can work, do so. Nearly 8 in 10 non-disabled adults with Medicaid coverage live in working families, and nearly 60% are working themselves. Of those not working, more than one-third reported that illness or disability was the primary reason; 28% reported they were taking care of home or family; and 18% were in school.[7] For people who face major obstacles to employment, harsh Medicaid requirements will not help to overcome them. In addition, research shows work requirements are not likely to have a positive impact on long-term employment.[8] In a recent study of the Arkansas Medicaid work requirements, researchers found that 95% of the target population appeared to meet the requirements or qualified for an exemption, and yet there was still significant loss in coverage due to lack of awareness and confusion about the reporting requirements.[9] Instituting a work requirement could lead to higher uninsured rates and higher emergency room visits by uninsured individuals who would have been eligible for Medicaid coverage, and increase the administrative burden for the state and its Medicaid managed care plans.[10,11]

A study by the National Bureau of Economic Research concluded Medicaid coverage increases utilization of primary and preventive services, lowers out-of-pocket medical spending and medical debt, and results in better self-reported physical and mental health.[12] The CDC data show prevention programs and early detection can prevent the onset of type 2 diabetes and reduce state spending.[13] Nebraska's proposal to limit access to Medicaid services through the implementation of work requirements will decrease access to care for low-income Nebraska residents with diabetes and increase state health care costs. **The Department should retract its request to tie Medicaid eligibility to documentation of community engagement.**

Administrative Burden

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Under this proposed waiver, individuals will need to either prove they meet certain exemptions or provide evidence of the number of hours they have worked which significantly increases the administrative burden of health care. It is highly likely that increasing the administrative requirements to maintain eligibility will result in fewer individuals with Medicaid coverage, even for those who meet the requirements or qualify for an exemption. An analysis of expected Medicaid disenrollment rates after implementation of work requirements shows most disenrollment would be due to administrative burdens or red tape.[14,15] Medicaid enrollees who are working may experience difficulty obtaining the required documentation from their employer on a timely basis.

Diabetes is a complex, chronic illness that requires continuous medical care,[16] so Medicaid enrollees with diabetes cannot afford a sudden gap in health insurance coverage. A recent study found that patients with type 1 diabetes who experience a gap or interruption in coverage, are five times more likely than those with continuous coverage to use acute care services (i.e. urgent care facilities or emergency departments).[17] Adding administrative barriers and burdens will impede access to health services that Nebraska residents with diabetes need.

Retroactive Coverage

The ADA asks the Department to retract its request to waive the Medicaid requirement to provide 90 days of retroactive eligibility and instead only provide retroactive eligibility on the first day of the month of enrollment. Retroactive eligibility in Medicaid prevents gaps in coverage, allowing individuals who have been diagnosed with serious conditions, to maintain coverage and treatment. The federal Medicaid law allows up to 90 days for retroactive eligibility to help protect individuals from severe medical debt for treatments they need.

Conclusion

Research shows work requirements are not likely to have a positive impact on long-term employment.[18] Instead, instituting a work requirement would lead to higher uninsured rates and higher emergency room visits by uninsured individuals who would have been eligible for Medicaid coverage, and increase the administrative burden for the state and its Medicaid managed care plans. **We strongly urge the Department to retract the HHA Waiver as it creates barriers to accessible, affordable, and adequate healthcare for low-income Nebraskans with diabetes who rely on the program.**

The ADA appreciates the opportunity to comment on Nebraska's HHA Waiver. Our comments include numerous citations to supporting research, including direct links to the research for the benefit of the Department in reviewing our comments. We direct the Department to each of the studies cited – made available through active hyperlinks – and we request that the full text of each of the studies cited, along with the full text of our comments, be considered part of the administrative record in this matter for purposes of the Administrative Procedure Act. If you have any questions, please contact

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DHHS HHA Waiver

From: Kathleen Uhrmacher <Kathleen.Uhrmacher.253338970@p2a.co>
Sent: Wednesday, November 13, 2019 2:50 PM
To: DHHS HHA Waiver
Subject: Implement Medicaid expansion without barriers.

Dear Nebraska DHHS Nebraska Medicaid Waiver,

When the majority of voters in Nebraska wanted to have Medicaid Expansion, there was nothing in the wording of that ballot initiative that asked for complications or barriers to accessing those benefits. The proposed "Heritage Adult Plan" is a direct affront to the voters of Nebraska and those who Medicaid can help. Implement Medicaid Expansion immediately and without hurdles!

Regards,
Kathleen Uhrmacher

Attachment 10

Response to Public Comments

General

Comment. Many commenters expressed concern that the demonstration application process is delaying implementation of Medicaid expansion.

Response. Expanding Medicaid to cover approximately 90,000 able-bodied adults of working age is a significant undertaking. MLTC has an obligation to ensure that expansion delivers high-quality care, is cost-effective, and is done right for Nebraska. Heritage Health managed care plans need sufficient time to build out provider networks to accommodate a new and distinct population. MLTC must hire and train staff to implement expansion and assist these new applicants and beneficiaries. MLTC must also engage in discussions with the Centers for Medicare and Medicaid Services (CMS) and draft required federal documents, amend its contracts and capitation rates with existing Heritage Health managed care plans and obtain CMS approval of those amendments, amend its state regulations, and make changes to its information technology systems.

Comment. Many commenters indicated that they believed that the proposed demonstration application is not consistent with the Medicaid expansion approved by voters via Initiative 427.

Response. The proposed demonstration complies with Initiative 427, codified at Nebraska Revised Statute § 68-992. The necessary three (3) state plan amendments to elect the expansion option were timely submitted on April 1, 2019. All beneficiaries similarly situated will be treated similarly. The enhanced federal match rate applicable to expansion is fully sought. All beneficiaries newly eligible under expansion will have access to at least the Basic benefits package, which includes comprehensive medical, behavioral health, and prescription drug coverage, even if they choose not to earn the additional Prime benefits package by completing the wellness, personal responsibility, and community engagement activities.

Comment. Several commenters expressed confusion regarding whether the proposed demonstration is applicable to the existing Medicaid program and non-expansion population.

Response. The tiered benefit model and its wellness, community engagement, and personal responsibility activities are not applicable to the existing Medicaid program. Those provisions of the demonstration will only apply to individuals in the Medicaid expansion adult group (able-bodied Nebraskans ages 19 through 64 who are under 138% of the federal poverty level (FPL) and not eligible for Medicaid through another eligibility group). The waiver of retroactive eligibility will apply to everyone covered by Nebraska's Medicaid plan, except for pregnant women, children ages 0 to 18, beneficiaries dually eligible in Medicare and Medicaid, and recipients who are residing in a nursing facility.

Comment. A number of commenters discussed concerns about the costs associated with MLTC's pursuit of the demonstration and implementing the demonstration proposals.

Response. MLTC will implement the program in a cost-effective manner. To secure CMS approval of the demonstration, MLTC establishes that the Medicaid service costs of the demonstration will be budget neutral to the federal government, compared to what the costs would be without the demonstration.

Comment. A few commenters expressed concern that the proposed demonstration does not currently provide for a comprehensive evaluation plan.

Response. MLTC is working with CMS to develop a comprehensive evaluation plan for this demonstration. Federal law does not require that the plan be completed at this stage of the demonstration application process.

Comment. One commenter questioned the budget neutrality of the proposed demonstration.

Response. The budget neutrality section of the demonstration application illustrates compliance with federal law and policy. MLTC engaged an outside actuarial advisor with considerable experience in Medicaid financing to assist in assessing the budget neutrality of the proposed demonstration.

Tiered Benefits System

Comment. Many commenters expressed concern that the tiered benefits model will cause administrative burdens for providers in assessing if and when a beneficiary has coverage for different services.

Response. For most providers, it will not matter whether the beneficiary has the Basic benefits package or the Prime benefits package. The providers impacted will be those who offer vision or dental and pharmacies that distribute over-the-counter medications. With respect to these providers, MLTC plans to take this feedback into consideration in the final development of the operational components to minimize any burdens on providers.

Comment. A number of commenters opposed a tiered benefit model in which dental, vision and over-the-counter medications were not provided in the Basic benefits package. Some commenters stated that dental and vision should be considered essential health services. Some of these commenters noted that individuals who lack coverage of dental, vision, and over-the-counter medications would rely on emergency rooms for that care.

Response. Federal law requires that the expansion population receive an "alternative benefit plan" that includes, at a minimum, ten Essential Health Benefits – which does not include adult vision and dental. All beneficiaries newly eligible under expansion and enrolled through the demonstration – both those receiving the Basic benefits package and those receiving the Prime benefits package – will have access to alternative benefit plan coverage that includes Essential Health Benefits. MLTC is not seeking a waiver of the Essential Health Benefits requirements. Emergency services will be included within both the Basic benefits package and the Prime benefits package.

Comment. Many commenters opposed the tiered benefits model because of concerns regarding access to prescription drug coverage.

Response. Both the Basic benefits package and the Prime benefits package include prescription drugs. Over-the-counter medications are included in the Prime benefits package, but not the Basic benefits package.

Comment. One commenter was concerned that because over-the-counter medications are not covered under the Basic benefits package, beneficiaries assigned to the Basic benefits package will not have access to over-the-counter smoking cessation assistance.

Response. Beneficiaries receiving the Basic benefits package will have access to prescription smoking cessation assistance, and beneficiaries receiving the Prime benefits package will have access to both prescription and over-the-counter smoking cessation products.

Comment. Several commenters identified vision and dental needs associated with various chronic illness and expressed concern that vision and dental services would not be covered for such individuals assigned to the Basic benefits package.

Response. Emergency vision and dental issues will be included within the medical assistance benefits available under the Basic benefits package, too. Additionally, the benefit tiers contained within this demonstration application only apply to individuals eligible for Medicaid through the expansion group, that is, individuals who are not eligible for Medicaid on the basis of a disability or health condition, and within the expansion group many individuals with chronic illnesses will qualify as medically frail and therefore be eligible for the full array of vision and dental services included within the Prime benefits package.

Comment. Several commenters were concerned that the tiered benefit model meant children would not have access to dental and vision services important to their physical and educational development.

Response. Vision, dental, and over-the-counter medications will be available to all individuals under age 21. First, these benefits will be maintained in the traditional Medicaid program available to children. Second, vision, dental and over-the-counter medications will be available to all individuals in the expansion group who are 19- or 20-years-old, even if they choose not to participate in the wellness, community engagement, and personal responsibility activities.

Comment. Two commenters were concerned that the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit was only available in the Prime benefits package. These commenters requested that EPSDT benefits be provided to all children under age 21 who are enrolled in Medicaid.

Response. The EPSDT benefit will be available to all individuals under age 21. First, EPSDT will be maintained in the traditional Medicaid program available to children. Second, EPSDT will be available to all individuals in the expansion group who are 19- or 20-years-old, even if they choose not to participate in wellness, community engagement, and personal responsibility activities.

Comment. One commenter suggested that all newly eligible enrollees be automatically enrolled in the Prime benefits package as opposed to the Basic benefits package for the initial six months of enrollment.

Response. Only non-exempt beneficiaries will receive the Basic benefits package for the first six months of enrollment. Individuals who are medically frail, ages 19 or 20, or pregnant will receive the Prime benefits package. The tiered benefits structure, with the ability for beneficiaries to earn the Prime benefits package, encourages beneficiaries to engage in positive activities that will lead to improved health outcomes and life successes.

Comment. A number of commenters expressed concerns that the wellness, personal responsibility and community engagement activities will serve as a barrier to obtaining coverage or result in significant reductions in benefits.

Response. The wellness, personal responsibility and community engagement activities are voluntary incentives that encourage beneficiaries to earn extra benefits, in addition to the comprehensive baseline benefits package available to all Medicaid enrollees newly eligible under expansion through the Basic benefits package. The Basic benefits package includes all federally-mandated Essential Health Benefits. No one will lose access to or be prevented from enrolling in Medicaid because he or she does not participate in the wellness, personal responsibility, and community engagement activities.

Comment. One commenter suggested that MLTC discontinue community engagement activities if a certain threshold of enrollees lose coverage.

Response. No one will lose Medicaid coverage for failure to participate in community engagement activities. These activities apply solely to the expansion population and this group will receive the comprehensive array of

medical benefits and services available through the Basic benefits package or Prime benefits package. Adult expansion beneficiaries who are not exempt from wellness, personal responsibility, and community engagement activities will at a minimum receive the Basic benefits package.

Comment. Many commenters expressed concern that the wellness, personal responsibility, and community engagement activities will be administratively and financially burdensome for the State.

Response. MLTC will ensure that implementation of the program is cost-effective. While there are costs associated with administering the program – including with respect to the wellness, personal responsibility, and community engagement activities – those costs pay for increased engagement with beneficiaries who want to improve their health and lives in general. Over time this will lead to better and more cost-effective health outcomes and life success. It is important to help as many able-bodied adults of working age as possible achieve better health and reach a point in their lives where they no longer need public assistance. It is equally important to put expansion on a sustainable path that will allow it to continue to be able to serve Nebraskans in need into the future.

Comment. One commenter suggested that MLTC adopt a comprehensive, evidence-based participatory wellness initiative based on incentives that provide adequate and comprehensive coverage of preventive services and that emphasizes evidence-based interventions to educate, promote, and encourage patients to participate in prevention, early detection, and wellness.

Response. The wellness activities described in the proposed demonstration will provide beneficiaries with access to comprehensive and evidence-based interventions. Active participation in case and care management will promote wellness and empower beneficiaries to participate in their own care. Case and care management use evidence-based guidelines and best practice standards to achieve these goals.

Comment. Some commenters indicated that it will be challenging for beneficiaries to report compliance with or exemption from the wellness, community engagement, and personal responsibility activities. Commenters worried that individuals who are in compliance may lose coverage if they cannot understand the process for reporting.

Response. MLTC will conduct outreach and education to ensure that beneficiaries understand compliance, exemptions, and reporting. No one will lose coverage under the proposed demonstration. Every expansion beneficiary will receive at least the Basic benefits package, which includes comprehensive medical, behavioral health, and prescription drug coverage.

Comment. One commenter indicated that community engagement activities do not replace the need for a comprehensive workforce development program.

Response. This demonstration is not intended to be a comprehensive workforce development program. While the demonstration is designed for people to develop skills and practices that will help them (among other things) gain employment, this is only one of many programs offered by the State to assist individuals with obtaining employment. Through the demonstration, MLTC will also work with its contracted managed care plans to help improve beneficiary connectivity to additional government and community supports.

Comment. A few commenters raised concerns about beneficiaries being locked out of the Prime benefits package because of the administrative complexity of reporting compliance with the wellness, personal responsibility, and community engagement activities.

Response. The availability of the "good cause" process will address this concern. In addition, when a beneficiary receives the Basic benefits package due to nonparticipation with wellness, personal responsibility, and community engagement activities, he or she will have the opportunity to appeal.

Comment. One commenter requested that MLTC take into account unexpected challenges in participating in the beneficiary engagement activities due to unreliable transportation, inflexible work hours, and unavailability of childcare as MLTC develops its definition of a "reasonable notice of cancellation." One commenter identified similar challenges that beneficiaries may face in seeking to participate fully in all the beneficiary engagement activities.

Response. MLTC will take this feedback into consideration when it operationalizes the wellness, personal responsibility, and community engagement activities. In addition, the demonstration application identifies a number of exemptions to the community engagement requirements, and the "good cause" process is another way in which the demonstration will address specific challenges such as those identified.

Comment. One commenter expressed concern that primary care providers will not consistently assist beneficiaries in completing wellness and personal responsibility activities, and may not be willing to complete the screenings and assessments identified as part of the case and care management component of the wellness initiatives. The commenter suggested that managed care plans be held accountable for their completion of these assessments.

Response. MLTC will take this feedback into consideration when it operationalizes these aspects of the wellness and personal responsibility activities. MLTC will ensure providers are educated on these activities and will collaborate with the managed care plans to assist beneficiaries in meeting the wellness activities of the demonstration.

Comment. A few commenters requested that MLTC clarify the wellness and personal responsibility activities related to the selection of a primary care practitioner and attendance of an annual health visit.

Response. MLTC articulated the beneficiary requirements for PCP selection (Section 4.1.3) and attendance of an annual health visit (Section 4.1.2) within the demonstration application. Additional education on the wellness initiatives will be provided to beneficiaries and providers as part of MLTC outreach efforts prior to start of the demonstration program.

Comment. One commenter expressed concerns that Deaf, DeafBlind, and Hard of Hearing beneficiaries will face additional challenges in fully participating in the beneficiary engagement activities due to limited availability of auxiliary aids and services.

Response. MLTC will ensure that these beneficiaries have every opportunity to fully participate in the wellness, personal responsibility, and community engagement activities by facilitating access to needed accommodations and supports. When appropriate, those individuals who meet medical frailty requirements will be exempt from these activities. Additionally, the "good cause" process will ensure that any beneficiary who experiences difficulty in fully participating has the opportunity to raise these specific barriers.

Comment. Commenters requested additional information regarding MLTC's process for assessing compliance with the wellness, personal responsibility, and community engagement activities.

Response. MLTC will implement innovative approaches to improving beneficiaries' engagement with their care and encouraging self-sufficiency. MLTC will use a combination of claims information, new data exchanges, and

enhanced eligibility system capabilities to monitor beneficiary participation with the wellness, personal responsibility, and community engagement activities.

Comment. One commenter requested that MLTC consider exempting cancer survivors and cancer patients in active treatment from participating in the beneficiary engagement activities.

Response. MLTC appreciates that cancer patients and some recent cancer survivors may be limited in their ability to fully participate in the wellness, personal responsibility, and community engagement activities. These concerns will be addressed through the medical frailty exemption and "good cause" processes.

Comment. Several commenters shared personal information and requested clarification regarding the definition of "medically frail." One commenter requested that MLTC specifically identify people living with HIV as qualifying for the medical frailty exemption.

Response. Federal regulations at 42 C.F.R. § 440.315 define "medically frail" as an individual with special medical needs and must include the following: (1) individuals with disabling mental disorders, (2) individuals with chronic substance use disorders, (3) individuals with serious and complex medical conditions, and (4) individuals with a physical, intellectual, or developmental disability. MLTC is not seeking to waive any aspects of the federal definition of medically frail.

To ensure that medically frail individuals are appropriately exempted from the wellness, personal responsibility, and community engagement activities, MLTC is developing a medical frailty determination process. Nebraska will work with the federal government, providers, and other stakeholders to ensure adequate communication about and training on the process of identifying medically frail beneficiaries.

Comment. Several commenters expressed concern about 19- and 20-year old beneficiaries being subject to wellness, personal responsibility and community engagement activities.

Response. Individuals who are 19 or 20 years old are exempt from the wellness, personal responsibility, and community engagement activities.

Comment. One commenter recommended that the State consider exempting from the community engagement activity component people who live in areas of great economic distress or poverty.

Response. The demonstration exempts from the community engagement activities beneficiaries who reside in an area that has been granted a federal waiver of the work requirements in the Supplemental Nutrition Assistance Program due to insufficient jobs to provide employment.

Comment. Several commenters asked how individuals who work in fields dominated by unique seasonal and fluctuating schedules, such as construction, agriculture, food service, education, and manufacturing, can be expected to fully participate in community engagement activities.

Response. MLTC will have policies to address seasonal employment. The demonstration application also provides for specific exemptions to address situations such as job loss or lack of access to employment. For example, individuals who are receiving or have applied for unemployment compensation are exempt from the community engagement requirements, as are those experiencing chronic homelessness.

Comment. Several commenters asked how the caregiver role will be defined for the purposes of activities that satisfy the community engagement component.

Response. MLTC will establish rules that will govern the circumstances in which an individual will be considered a caretaker exempt from the community engagement activities.

Comment. Several commenters requested clarification regarding the goals of wellness, personal responsibility, and community engagement activities. They noted that many Nebraskans eligible under expansion are already employed, and that many unemployed eligible individuals experience significant barriers to employment such as chronic illness or family caregiving responsibilities.

Response. In providing the Prime benefits package to beneficiaries who engage in wellness, personal responsibility, and community engagement activities, MLTC is seeking to promote the goals of the Quadruple Aim (which are to improve the patient experience of care, improve the provider experience of care, improve the health of the population, and reduce the per capita cost of care) and to better achieve the federal statutory purpose of the Medicaid program in the provision of medical assistance for eligible persons of limited means by encouraging better health outcomes and life success both for the sake of each individual beneficiary as well as the sake of the long term financial sustainability of Nebraska's Medicaid program.

Additionally, the demonstration has a number of specific exemptions that reflect the experience and needs of Nebraskans. For example, community engagement exemptions are provided for individuals with mental illness or chronic substance use disorder and for individuals participating in substance use disorder or mental health treatment programs. The demonstration also provides for a variety of different activities that qualify as community engagement. For example, participation in volunteer activities with a public charity, participating in SNAP- and TANF-recognized job search activities, and being a relative, kinship, or licensed foster parent are all qualifying activities for participation in the community engagement component of the demonstration.

Comment. Several commenters expressed concern with the employer sponsored insurance (ESI) components of the personal responsibility activities. These commenters argued that the out-of-pocket contributions required by ESI prevents low income enrollees from accessing preventive and necessary care and suggested that the demonstration include an affordability standard for premiums and coinsurance.

Response. MLTC currently has a premium assistance program, known as the Health Insurance Premium Payment (HIPP) program, for some beneficiaries dually enrolled in ESI and Medicaid. This program will continue as currently structured for the expansion population.

Comment. Several commenters raised questions about whether the community engagement activities comply with federal law.

Response. MLTC is aware of a number of recent court opinions about community engagement activities in Medicaid waivers approved by CMS. The proposed community engagement activities and the tiered benefits structure of Nebraska's demonstration application are very different than the requirements in other states, including the other states that have been the subject of these court opinions. Unlike these other states, for example, Nebraska's proposal does not eliminate Medicaid eligibility if a beneficiary does not participate in wellness, personal responsibility, and community engagement activities. Instead, in Nebraska, participating in these activities that promote better health and more cost-effective outcomes allows a beneficiary to earn the additional services available through the Prime benefits package. The community engagement activities set forth in this proposed demonstration comply with federal law. In providing the Prime benefits package to beneficiaries who engage in wellness, personal responsibility, and community engagement activities, MLTC is seeking to promote the goals of the Quadruple Aim (which are to improve the patient experience of care, improve the provider experience of care, improve the health of the population, and reduce the per capita cost of care) and to better achieve the federal statutory purpose of the Medicaid program in the provision of medical assistance for

eligible persons of limited means by encouraging better health outcomes and life success both for the sake of each individual beneficiary as well as the sake of the long term financial sustainability of Nebraska's Medicaid program.

Waiver of Retroactive Eligibility

Comment. Some commenters raised concerns with the proposed waiver of retroactive eligibility. These commenters objected to the retroactivity waiver due to medical debt, gaps in coverage, and increased uncompensated care costs.

Response. The purpose of this part of the proposed demonstration is to encourage beneficiaries to obtain and maintain health coverage as soon as they are eligible, rather than to wait until they are sick. MLTC believes this will improve access to preventive care. MLTC acknowledges that some individuals may incur some medical expenses if they choose not to enroll in Medicaid as soon as they are eligible, but believes that this is outweighed by the benefits of waiving retroactive eligibility (for example, increasing continuity of care by reducing gaps in coverage).

Comment. Several commenters noted that the retroactivity waiver would be disproportionately burdensome for individuals experiencing a life event such as a cancer or disability diagnosis that triggers both significant medical expenses as well as coverage eligibility.

Response. If an individual experiences a major life event, such as a cancer or disability diagnosis, he or she can immediately apply for Medicaid and, if he or she is eligible, will be enrolled in Medicaid as of the first day of the month of application. This is so even if that application is not processed for some time. The waiver of retroactive eligibility will apply to everyone covered by Nebraska's Medicaid plan, except for pregnant women, children ages 0 to 18, beneficiaries dually eligible in Medicare and Medicaid, and recipients who are residing in a nursing facility.

Comment. A few commenters raised questions about whether the waiver of retroactivity complies with federal law and cited recent district court cases that have rejected other states' applications to waive this requirement.

Response. MLTC's requested waiver of retroactivity is fully compliant with federal law and consistent with the purpose of the Medicaid program. Furthermore, many states have received federal approval of the waiver of retroactive eligibility.

NEBRASKA
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Pete Ricketts, Governor

October 10, 2019

To: Omaha Tribe of Nebraska, Ponca Tribe of Nebraska, Santee Sioux Nation, Winnebago Tribe of Nebraska, Carl T. Curtis Health Center, Fred LeRoy Health & Wellness Center, Santee Sioux Clinic, Winnebago Tribal Health Department, Winnebago Indian Hospital, Nebraska Urban Indian Health Coalition, Aberdeen Area Indian Health Service, Great Plains Tribal Chairmen's Health Board, Oglala Sioux Tribe, Oglala Sioux Lakota Nursing Home

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

Improving Health Outcomes and Encouraging Life Successes for Adult Medicaid Beneficiaries.
October 10, 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 plans to request a Section 1115 demonstration project that will implement Medicaid expansion through a program that will be known as "Heritage Health Adult" (HHA). 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;
- Age 19 or 20; or
- Beginning in Demonstration Year (DY) 1, they engage in the wellness initiatives and personal responsibility activities. Beginning in DY2, HHS beneficiaries must also participate in community engagement activities, including but not limited to, employment, job-seeking activities, and educational activities.
- HHA beneficiaries who do not engage in these activities will be assigned to the Basic benefits package. Beneficiaries will not lose their Medicaid eligibility if they chose to not engage in these activities.

In addition to the tiered benefit structure, MLTC will encourage timely enrollment and promote increased continuity of care through a waiver of retroactive eligibility for HHA and other select Medicaid groups consisting of non-pregnant adults.

Finally, MLTC plans to facilitate and encourage more widespread enrollment in private health insurance through a future amendment to the demonstration.

The provisions of the demonstration projection will apply to all tribal members enrolled in Medicaid eligibility groups that are subject to the provisions of the demonstration, except that individuals in the ACA expansion group enrolled in a federally recognized tribe will not be subject to the community engagement requirements. Thus, tribal members need only comply with the wellness initiatives and personal responsibility activities to access Prime benefits. Tribal members that are medically frail or under age 21 will also receive Prime benefits.

Tribal governments and the public are invited to review and comment on the State's demonstration request.

Comments from Tribes will be accepted from now until 30 days following the date when the State gives notice to the general public, which the State expects to be October 25, 2019. Thus, the State will accept comments until 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

Email: DHHS.HHAWaiver@Nebraska.gov

Starting October 25, 2019, a full public notice document describing the demonstration application in more detail will be available at http://dhhs.ne.gov/Pages/Heritage-Health-Adult-Demonstration.aspx, and a draft of the demonstration application itself will be found at http://dhhs.ne.gov/Pages/Heritage-Health-Adult-Demonstration.aspx. Please note, this website will not go live until October 25, 2019. Appointments may be made to view a hard copy of the full public notice document and a draft of the amendment application by calling 402-471-9718. Appointments may be made during regular business hours, Monday through Friday. Appointments to view the documents will take place at the Nebraska State Office Building, 301 Centennial Mall South, Lincoln NE.

Public hearings are scheduled at the following times/locations:

Date	Time	Location	Room Capacity
Tuesday, October 29, 2019	7 pm - 8:30 pm MDT	Board Room Scottsbluff High School 313 E 27th St, Scottsbluff, NE 69361	125
Wednesday, October 30, 2019	6:45 pm - 8:15 pm CDT	South Platte Room Kearney Public Library 2020 1st Ave, Kearney, NE 68847	100
Thursday, November 7, 2019	6 pm - 7:30 pm CST	Meeting Room A Norfolk Public Library 308 W Prospect Ave, Norfolk, NE 68701	100
Tuesday, November 12, 2019	7 pm - 8:30 pm CST	Room 132 UNO College of Public Affairs & Community Service University of Nebraska Omaha 6320 Maverick Plaza, Omaha, NE 68182	110

If any Tribal Government would like an additional in-person meeting to discuss the demonstration application, please contact Catherine Gekas Steeby, Administrator of Policy & Regulations, Division of Medicaid and Long-Term Care, at Catherine.GekasSteeby@nebraska.gov or

Catherine Gekas Steeby
Administrator II Policy & Regulations
Nebraska Department of Health and Human Services
301 Centennial Mall South
P.O. Box 95026
Lincoln, NE 68509

Thank you in advance for your cooperation.

Respectfully,

Catherine Gekas Steeby
Administrator II Policy & Regulations
Nebraska Department of Health and Human Services

HERITAGE HEALTH ADULT EXPANSION

Nebraska's Section 1115 Demonstration Application

Catherine Gekas Steeby

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Helping People Live Better Lives.

Attachment 12

Medicaid Expansion

HERITAGE HEALTH ADULT EXPANSION

- Initiative 427: Nebraska voters elected 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)

- “Heritage Health Adult” will be the program through which Initiative 427 is implemented

- Heritage Health Adult beneficiaries will be enrolled in managed care plans operated by Nebraska's existing Heritage Health program

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Attachment 12

Who is covered by the expansion?

HERITAGE HEALTH ADULT EXPANSION

Who is eligible for Heritage Health Adult? Individuals under 138% of the federal poverty level who are not otherwise eligible for Medicaid

Family Size	138% of the federal poverty level
1	$16,753
2	$22,715
3	$28,676
4	$34,638
5	$40,600
6	$46,561

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Attachment 12

Heritage Health Adult expansion: Goals

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

How does the Heritage Health Adult expansion accomplish these goals?

HERITAGE HEALTH ADULT EXPANSION

- The Heritage Health Adult program has innovative features designed to improve health through beneficiary engagement and enhanced care and case management

- These features require federal approval through a section 1115 demonstration project

- When does Nebraska intend to submit the expansion program to the federal government for review?

  December 2019

- When will the Heritage Health Adult expansion program be implemented?

  October 1, 2020

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Two Levels of Benefits

Attachment 12

HERITAGE HEALTH ADULT EXPANSION

Basic

- Ambulatory
- Emergency
- Maternity and Newborn
- Mental Health and Substance Abuse Disorder Services
- Prescription Drugs
- Rehabilitative Services
- Laboratory Services
- Preventive, wellness, and chronic disease management

Prime

- Basic +
- Dental
- Dentures
- Optometrist
- Eyeglasses
- Over the counter medication

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Attachment 12

Who gets Basic benefits?

All beneficiaries newly eligible for Medicaid under the Heritage Health Adult program, except those eligible for Prime benefits

Who gets Prime benefits?

Attachment 12

HERITAGE HEALTH ADULT EXPANSION

A. “Medically frail”; or

B. Aged 19 or 20; or

C. Participation in

(1) wellness initiatives,

(2) personal responsibility activities, and

(3) beginning in 2nd year of the program, community engagement

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Helping People Live Better Lives.

What does “medically frail” mean?

HERITAGE HEALTH ADULT EXPANSION

“Medically frail” is determined based on complex health needs

Federal rules define “medically frail” as an individual with special medical needs and must include at least the following:

- Individuals with disabling mental disorders,
- Individuals with chronic substance use disorders,
- Individuals with serious and complex medical conditions,
- Individuals with a physical, intellectual or developmental disability

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What are Wellness Initiatives?

- Case and care management
- Annual Health Visit
- Primary Care Provider Selection

What are Personal Responsibility Activities?

HERITAGE HEALTH ADULT EXPANSION

- Not missing scheduled appointments
- Not voluntarily discontinuing commercial health coverage
- Notifying Medicaid of a change in status

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Why is Nebraska adding wellness and personal responsibility requirements?

- Case and care management services are an important part of Heritage Health's existing managed care plan

- Case and care management improves health outcomes, promotes wellness, and empowers beneficiaries to participate in the management of their own care

- Beneficiaries will gain support in fulfilling the Wellness Initiative and the Personal Responsibility Activity requirements through case and care management

Attachment 12

What is Community Engagement?

HERITAGE HEALTH ADULT EXPANSION

- Employed or self-employed
- Volunteer activities
- Enrolled in college, university, trade school, training program
- Caregiver of dependent child or elderly or disabled relative
- SNAP Employment and Training program
- TANF/AFDC Employment First program
- SNAP and TANF recognized job search activities

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Community Engagement Exceptions

HERITAGE HEALTH ADULT EXPANSION

- Medically frail
- 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
- Victims of domestic violence, when participation would make it harder to escape, penalize the individual, or put them at further risk of domestic violence
- Residing in an area that has been granted a federal ABAWD waiver due to insufficient jobs
- Individuals experiencing chronic homelessness
- Pregnant or in a post-partum period
- In high-school at least half time
- Age 60 or older

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Is this like other states' work requirements?

HERITAGE HEALTH ADULT EXPANSION

No

- Other states are terminating Medicaid enrollment if a beneficiary is unable to satisfy work requirements
- Nebraska is not terminating Medicaid if you are unable to meet all of the requirements
- Participating in community engagement only affect access to the additional services available through the Prime package

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Other Changes to Heritage Health

HERITAGE HEALTH ADULT EXPANSION

In addition to the Heritage Health Adult expansion program, Nebraska is making some other changes to the broader Heritage Health program

- No “retroactive” Medicaid coverage
  - Coverage and benefits will begin on the first day of the application month

- Exceptions: pregnant women, children ages 0 to 18 years old, beneficiaries enrolled in both Medicare and Medicaid, and nursing facility residents
  - For these individuals, eligibility will be effective up to three months prior to the date of application

Why is Nebraska making these changes?

HERITAGE HEALTH ADULT EXPANSION

Changing retroactive eligibility will promote

- Early and continuous coverage
- Enrollment of eligible people when they are healthy
- Consistency with commercial and federal markets

Will the program be monitored and evaluated?

HERITAGE HEALTH ADULT EXPANSION

Yes

- The Heritage Health Adult expansion program will be evaluated according to applicable federal requirements

- Additionally, Nebraska will also be ensuring the program is continuously evaluated

Attachment 12

Questions and Comments

HERITAGE HEALTH ADULT EXPANSION

Catherine Gekas Steeby

Administrator II, Policy and Regulations

Catherine.gekassteeby@Nebraska.gov

Attachment 13

From:	DHHS Medicaid SPA
To:	Preston, Drew
Subject:	FW: 1115 Demonstration Waiver Tribal Notice
Date:	Thursday, December 5, 2019 2:26:08 PM
Attachments:	1115 Demonstration Waiver Tribal Notice.docx.pdf

From: DHHS Medicaid SPA
Sent: Friday, October 25, 2019 9:01 AM
To: Audrey Parker <audrey.parker@ihs.gov>; Barbara Cotterman <Barbara.Cotterman@cms.hhs.gov>; Crystal Appleton <crystal.appleton@ihs.gov>; Danelle Smith <danelle.smith@winnebagotribe.com>; Donna Polk-Prim <dpolk-primm@nuihc.com>; Frank White <frank.white@winnebagotribe.com>; Jena Free <jena.free@ihs.gov>; Julian Bear Runner - President Oglala Sioux <president.bearrunner@oglala.org>; Karen Hatcher - CMS <karen.hatcher@cms.hhs.gov>; Kathaleen Bad Moccasin <kathaleen.badmoccasin@ihs.gov>; Kim Friloux <kim.friloux@winnebagotribe.com>; Larry Voegele <lvoegele@poncatribe-ne.org>; Larry Wright <ldwrightjr@gmail.com>; LaVonne Jones <pwjones57@yahoo.com>; Lisa Miller CTC <lisa.miller4@ihs.gov>; Michael Wolfe <mike.wolfe@omahatribe.com>; Mona Zuffante <Mona.zuffante@ihs.gov>; Nancy Mackey <nancy.mackey@ihs.gov>; Oglala Sioux Lakota Nursing Home <assistant@oslnh.com>; Rebecca Tamayo <rtamayo@poncatribe-ne.org>; Roger Trudell <rtrudell@santeedakota.org>; Roth, Jessica <Jessica.Roth@nebraska.gov>; Sarah Rowland CTC acting CEO <sarah.rowland@omahatribe.com>; Schenk, Stacy <Stacy.Schenk@nebraska.gov>; Taria Wolfe <taria.wolfe@ihs.gov>; Tashina Provost <tashina.provost@ihs.gov>; Taylor Housman <taylor.housman@ihs.gov>; Vietta Swalley <vietta.swalley@ihs.gov>; Yolanda Faausuusu CTC Admin. Of. <yolanda.faausuusu@ihs.gov>
Cc: DHHS Medicaid SPA <DHHS.MedicaidSPA@nebraska.gov>; Preston, Drew <Drew.Preston@nebraska.gov>; Gekas Steeby, Catherine <Catherine.GekasSteeby@nebraska.gov>; Baustert, Todd <Todd.Baustert@nebraska.gov>; Georgiana, Crystal <Crystal.Georgiana@nebraska.gov>; Zemlicka, Wendy <Wendy.Zemlicka@nebraska.gov>; Brunssen, Jeremy <Jeremy.Brunssen@nebraska.gov>; Watson, Nate <Nate.Watson@nebraska.gov>; Heng, Karen <Karen.Heng@nebraska.gov>; Petersen-Lukenda, Larra <Larra.Petersen-Lukenda@nebraska.gov>; Schweitzer Masek, Carisa <Carisa.SchweitzerMasek@nebraska.gov>; Van Patton, Matthew <Matthew.VanPatton@nebraska.gov>; Litt, Matt <Matt.Litt@nebraska.gov>
Subject: 1115 Demonstration Waiver Tribal Notice

Attached for your review is a summary of Nebraska Medicaid's plan to request a Section 1115 demonstration project that will implement Medicaid expansion through a program to be known as "Heritage Health Adult" (HHA). Comments will be accepted from now until November 26, 2019.

Dawn Kastens | *DHHS Program Specialist*
MEDICAID & LONG-TERM CARE
Nebraska Department of Health and Human Services
OFFICE: 402-471-9530

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

October 25, 2019

To: Omaha Tribe of Nebraska, Ponca Tribe of Nebraska, Santee Sioux Nation, Winnebago Tribe of Nebraska, Carl T. Curtis Health Center, Fred LeRoy Health & Wellness Center, Santee Sioux Clinic, Winnebago Tribal Health Department, Winnebago Indian Hospital, Nebraska Urban Indian Health Coalition, Aberdeen Area Indian Health Service, Great Plains Tribal Chairmen's Health Board, Oglala Sioux Tribe, Oglala Sioux Lakota Nursing Home

Tribal 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 plans to request a Section 1115 demonstration project that will implement Medicaid expansion through a program that will be known as "Heritage Health Adult" (HHA). 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;
- Age 19 or 20;
- Pregnant Women; or
- Beginning in Demonstration Year (DY) 1, they engage in the wellness initiatives and personal responsibility activities. Beginning in DY2, HHS beneficiaries must also participate in community engagement activities, including but not limited to, employment, job-seeking activities, and educational activities.

- HHA beneficiaries who do not engage in these activities will be assigned to the Basic benefits package. Beneficiaries will not lose their Medicaid eligibility if they chose to not engage in these activities.

In addition to the tiered benefit structure, MLTC will encourage timely enrollment and promote increased continuity of care through a waiver of retroactive eligibility for HHA and other select Medicaid groups consisting of non-pregnant adults.

Finally, MLTC plans to facilitate and encourage more widespread enrollment in private health insurance through a future amendment to the demonstration.

The provisions of the demonstration projection will apply to all tribal members enrolled in Medicaid eligibility groups that are subject to the provisions of the demonstration, except that individuals in the ACA expansion group enrolled in a federally recognized tribe will not be subject to the community engagement requirements. Thus, tribal members need only comply with the wellness initiatives and personal responsibility activities to access Prime benefits. Tribal members that are medically frail, pregnant, or under age 21 will also receive Prime benefits. The anticipated effective date of the 1115 demonstration waiver is October 1, 2020.

Tribal governments and the public are invited to review and comment on the State's demonstration request.

Attached is the full public notice document describing the demonstration application in more detail, this document is also available at http://dhhs.ne.gov/Pages/Heritage-Health-Adult-Demonstration.aspx, and a draft of the demonstration application itself can be found at http://dhhs.ne.gov/Pages/Heritage-Health-Adult-Demonstration.aspx.

Comments from Tribes will be accepted 30 days from this notice. Thus, the State will accept comments until November 26, 2019. If any Tribal Government would like an in-person meeting to discuss the demonstration application, please contact the Medicaid tribal liaison: Catherine Gekas Steeby, Administrator of Policy & Regulations, Division of Medicaid and Long-Term Care at:

Catherine Gekas Steeby
Administrator II Policy & Regulations
Nebraska Department of Health and Human Services
301 Centennial Mall South
P.O. Box 95026
Lincoln, NE 68509-5026

Email: Catherine.gekassteeby@nebraska.gov
Phone: 402-471-9058

Comments from the general public 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

Email: DHHS.HHAWaiver@Nebraska.gov

Public hearings are scheduled at the following times/locations:

Date	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 & Community Service University of Nebraska Omaha 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.

Thank you in advance for your cooperation.

Respectfully,

Catherine Gekas Steeby
Administrator II Policy & Regulations
Nebraska Department of Health and Human Services

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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.
-

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.

[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.