Nebraska’s Department of Health and Human Services and Medicaid Reform

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Mr. Capretta’s articles and essays have appeared in a large number of prominent print and online publications, including the *Wall Street Journal* and *Politico*. He has been asked to provide expert testimony at congressional hearings and appears regularly as a commentator on television and radio programs.
The Nebraska Department of Health and Human Services (DHHS), like its federal counterpart, is a large and diverse agency providing an array of services to the state’s lower income households and medically vulnerable populations. And, also like its federal counterpart, the agency’s budget is dominated by large health entitlement expenditures—specifically for the Medicaid program. Any effort to improve DHHS operations will necessarily involve an intensive examination of Medicaid.

On some measures, Nebraska’s Medicaid program is in better shape than it is in other states. For instance, while payments to providers of medical services are notoriously low in Medicaid, and thus also an impediment to securing appropriate access to care in many instances, fees for physician services in Nebraska’s Medicaid program are higher, when measured as a percentage of Medicare’s rates, than in all but ten other states. Further, while program enrollment has surged nationwide and in Nebraska too, Nebraska’s Medicaid enrollment, when compared to the size of the entire state population, remains low compared to the rest of the country.

Still, even in Nebraska, the program is far from what it should be, both in terms of the services it provides to its participants and the costs it imposes on taxpayers.

Nebraska and other states are hampered by the tangle of federal rules and regulations governing the program, and the perverse incentives embedded in the existing federal matching system for covering Medicaid’s costs. With these incentives and rules, the path of least resistance for both federal and state policymakers has been steady program expansion, with costs only cosmetically controlled with payment rate restrictions and inferior access to care for program participants.

Nebraska should chart a new and better course for the Medicaid program by proceeding with reforms on two tracks.

First, the state should examine what other states have done in recent years, learn from those efforts, and pursue a traditional, but aggressive, reform agenda. These reforms should include:

• proceeding with already planned expansions of enrollment in capitated managed care programs;
• placing a heavier emphasis on beneficiary choice and responsibility in the program;
• making aggressive use of all available data systems to ensure program integrity and the disenrollment of ineligible participants; and
• initiating a careful review of optional services to determine if any might be eliminated from future program costs.

In addition to this agenda, which can be pursued in the near-term, Nebraska should begin planning to use existing waiver authority to fundamentally transform the program into a fully consumer-driven model of insurance and service provision. A transformative reform effort of this kind would need approval from the federal government, which is unlikely under the current administration. Nonetheless, it is important to begin planning for such an effort now.
because the next window of opportunity for consideration of a reform plan of this kind could occur in early 2017, when a new administration is taking office. To be ready to take advantage of that potential opportunity, the state would need to begin developing a workable plan in the very near future. Moreover, regardless of the posture of the federal government, it is important for states like Nebraska to provide a vision for Medicaid and health care reform that demonstrates to citizens in the state and the rest of the country that there is a viable alternative to ever more federal control over the health system.

A fundamental transformation of Nebraska’s Medicaid program should be built on the following framework:

• Pursuit of a combined waiver under section 1115 of the Social Security Act and section 1332 of the Affordable Care Act (ACA). This combined waiver would give Nebraska much more flexibility to build a true, market-driven reform plan within a fixed budget.

• Integration of Medicaid insurance (for the non-disabled and non-elderly) with the broader health insurance marketplace in Nebraska. Instead of separating Medicaid participants from everyone else, they would select from the same competitive insurance plans offered to other working age people and their dependents. Added emphasis should be placed on giving Medicaid participants the option to enroll in Health Savings Accounts and higher deductible insurance options.

• Expansion of the idea that the disabled and the elderly, together with their families and caregivers, are in the best position to use Medicaid’s limited resources to buy the services that they need and desire the most. This approach would enhance budgetary control and enlist the program’s participants in eliminating lower value services.

Beyond Medicaid, DHHS’ portfolio is dominated by economic assistance efforts for lower income households. The agency also administers a number of other programs, including traditional public health efforts, mental health and substance abuse prevention and treatment initiatives, residential and day services for persons with developmental disabilities, and four homes for needy veterans. Compared to Medicaid and economic assistance efforts, these programs are relatively small and are substantially funded and governed by rules issued from federal agencies.

Nebraska, like other states, faces challenges in promoting economic independence among lower income and disadvantaged households, but the challenges are more manageable in Nebraska than elsewhere because of the state’s strong economy—including a very low unemployment rate as well as relatively low rates of poverty.

The state already emphasizes work and program integrity in its administration of these programs, but additional steps can be taken. Among other things, Nebraska could implement even more aggressive contractor incentives to improve job placement results for needy families. In addition, the agency should establish work expectations for able-bodied participants in the Supplemental Nutrition Assistance Program (SNAP). Finally, DHHS should aggressively use all available data matches to ensure program integrity in SNAP.
Introduction

The Department of Health and Human Services (DHHS) is Nebraska’s largest state agency. DHHS administers the significant human service and health care programs for the state, including Medicaid, the Supplemental Nutrition Assistance Program (SNAP), economic assistance for families, public health programs, behavioral health efforts, child welfare services, veterans’ services, and much else.

Health and human service programs have grown rapidly in many state budgets in recent years, and Nebraska is no exception. Driven primarily by growth in Medicaid expenditures, DHHS’ budget has overtaken education as the most expensive line item in Nebraska’s state budget.

The looming presence of the federal government complicates efforts to reform DHHS operations and programs generally and Medicaid specifically. Medicaid was enacted by Congress in 1965, and although the states administer Medicaid, it is fundamentally a federal program. The federal government has established an extensive web of regulatory requirements for Medicaid the states must follow unless they specifically seek and are granted a waiver by the federal government, which generally only occurs after much effort and protracted negotiations. Further, the federal government pays for more than half of all Medicaid expenditures, including in Nebraska. As a result, when a state implements measures to reduce Medicaid spending, most of the savings goes back to the federal, not the state, treasury. This makes it difficult for state leaders to secure the necessary political support to pursue what are inevitably controversial steps.

Far-reaching reform of DHHS programs is also difficult because of the importance of the assistance provided to many economically vulnerable households in Nebraska. Nebraskans, like citizens in other states, expect their government leaders to use taxpayer funds wisely and to aggressively root out any fraud and abuse of government funds; however, they are also generally supportive of an effective safety net. They prefer reforms that make programs work better and more efficiently to changes that simply reduce the levels of support for disadvantaged households. The Medicaid program represents an opportunity in this regard because, despite its significant expense, there is a large amount of evidence that the program’s expenditures are not matched by high levels of services or improvements in the health status of those enrolled in the program. There is thus ample room for improvement without the need to devote more taxpayer funds to the program.

The challenge for policymakers in Nebraska and elsewhere is to craft reforms in Medicaid and other health and human service programs that open up new possibilities and opportunities for those participating in the programs rather than just giving them less support. There is no single or simple answer to how this might be done. But an important part of the answer is to rely more on the enrollees themselves to make choices and steer limited resources in ways that assist them in their efforts to improve their lives and achieve greater independence.

Brief Overview of the Nebraska DHHS

Nebraska’s DHHS has evolved over the years, with new services and programs created or moved within its purview on a regular basis. The result is a sprawling department, not unlike the federal Department of Health and Human Services, with responsibilities for a wide variety of activities, including public health promotion, health insurance administration, economic assistance, child support enforcement, disability assistance, and much else.

As shown in Figure 1, the result of a long series of federal and state decisions to expand assistance and services in these areas is a DHHS budget that is now the largest single line item in Nebraska’s general fund account, surpassing state educational aid to localities. In the newly completed FY 2016 budget, total general fund appropriations were $4.3 billion, with nearly $1.6 billion allocated to DHHS services and operations, approximately 37 percent of the entire state budget.1

These figures for the state’s general fund budget reflect state-only resources; however, DHHS’s budget is considerably larger than these figures indicate due to the large amount of federal funding also flowing through it.

The full DHHS budget for FY 2014, including both state and federal funds, is shown in Figure 2. Total expenditures were about $3.0 billion, and one-half of that spending was financed with federal funds, including federal
matching funds for the Medicaid program, the welfare assistance block grant, and full federal funding of the benefits provided through SNAP. The rest of the funding came from appropriations from the state’s general fund or cash reserves.

Figure 2 also shows the uses of those combined federal and state funds in FY 2014. Nearly 80 percent of DHHS resources were spent on direct aid to program beneficiaries, including cash support payments, SNAP benefits, and Medicaid coverage for medical expenses. About 6 percent of the DHHS budget was spent on state-operated service agencies, such as veterans’ homes and centers for the developmentally disabled. Three percent of funds were spent on public health efforts, and the remaining 12 percent was spent on DHHS administrative costs. The department employs about 5,500 state workers.

The department divides its programmatic responsibilities into six divisions, as shown in the agency’s official organizational chart, replicated in Figure 3: behavioral health; children and family services; developmental disabilities; Medicaid and long-term care; public health; and veterans’ homes. These divisions are sensible as they reflect the varied programmatic responsibilities within the department.

**DHHS and Nebraska’s Medicaid Program**

Medicaid and the Children’s Health Insurance Program (CHIP) are the dominant programs within DHHS. In FY 2014, DHHS’ total expenditures were about $3.0 billion, of which a little more than $1.8 billion, or 60 percent, was devoted to Medicaid and CHIP benefits. If SNAP benefits, which are entirely financed with federal funds, are removed from the DHHS total, then the amount associated with Medicaid and CHIP is even higher—about two-thirds of DHHS’ remaining budget. Although Medicaid is appropriately handled by its own division within DHHS, it is important to recognize there are also very different program beneficiaries within Medicaid, with very different service needs. Specifically, Medicaid provides insurance to lower income households needing access to traditional medical services, and it provides assistance to the severely disabled and to the frail elderly in need of nursing home care or other support services to help them with their activities of daily living.

As shown in Figure 4, Medicaid and CHIP eligibility in Nebraska is dominated by children and non-disabled adults, including pregnant women. These groups make up more than three-fourths of all persons enrolled in
Nebraska’s Medicaid or CHIP programs. The elderly and the disabled comprise just 24 percent of all enrollees in these programs.

However, the distribution of expenditures is not reflective of program enrollment. In FY 2014, two-thirds of all Medicaid and CHIP spending went toward services used by the elderly or the disabled and just one-third of all spending went to services used by children and non-disabled adults. The higher concentration of spending on the elderly and disabled in Nebraska’s Medicaid program is due to the much more expensive and intensive services needed for these populations. In FY 2014, Nebraska Medicaid spent nearly $22,000 per elderly and disabled enrollee, compared to just $3,500 per child or non-disabled adult.
Medicaid Eligibility in Nebraska

Medicaid’s enrollment profile in Nebraska is a function of the program’s patchwork of mandatory coverage provisions and state options. In the Affordable Care Act (ACA), Congress attempted to establish more uniform national standards for Medicaid eligibility by setting 133 percent of the federal poverty line (FPL) as the threshold below which all adults, including those without dependent children, would be eligible for enrollment in the program. States that did not adopt this new eligibility standard were to face a severe penalty—the loss of all federal Medicaid funds in the state. The Supreme Court intervened, however, and ruled that this heavy penalty was an unconstitutional infringement on state authority. The court’s decision effectively converted the ACA provision from what was supposed to be a new mandatory coverage requirement into an option that states could elect to implement under their Medicaid programs.

As of mid-2015, thirty-one states plus the District of Columbia had adopted the ACA’s Medicaid expansion, but Nebraska is not one of them. As a result, eligibility for the program in the state is still governed by a combination of previously established federal requirements and state decisions to optionally expand coverage to various populations.

As originally conceived, Medicaid was to provide health insurance to the same families needing welfare support under the old Aid to Families with Dependent Children (AFDC), replaced by Temporary Assistance to Needy Families (TANF) in 1996. States were also allowed to extend Medicaid coverage to low-income blind, disabled, and elderly persons eligible for Supplemental Security Income (SSI), or a state-financed supplement to that program. For many years, these were the populations that dominated Medicaid enrollment. The major expansions of the program, mainly for children and pregnant women, came in the mid-1980’s and later. Up until passage of the ACA in 2010, Medicaid generally had not provided coverage to able-bodied adults without dependent children. Nebraska’s program continues to adhere to that traditional model.

In general, and as summarized in Figure 5, the populations who are eligible for Medicaid coverage in Nebraska fall into five groups:

**Figure 5: Mandatory and Optional Coverage in Nebraska**

<table>
<thead>
<tr>
<th>Eligibility Group</th>
<th>Federal Requirements</th>
<th>State Options</th>
</tr>
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<tbody>
<tr>
<td><strong>Children</strong></td>
<td>• Dependents in AFDC-eligible households (up to about 33% of FPL)</td>
<td>• Children in “medically needy” households</td>
</tr>
<tr>
<td></td>
<td>• CHIP Age 1-5: Up to 133% of FPL</td>
<td>• CHIP Up Thru Age 18: Up to 200% of FPL</td>
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<tr>
<td></td>
<td>• CHIP Age 6-18: Up to 100% of FPL</td>
<td></td>
</tr>
<tr>
<td><strong>Pregnant Women &amp; Newborns (Up to 1)</strong></td>
<td>• Up to 133% of FPL</td>
<td>• Up to 185% of FPL</td>
</tr>
<tr>
<td><strong>Parents/Caretakers of Eligible Children</strong></td>
<td>• Up to the old AFDC eligibility threshold (about 33% of FPL)</td>
<td>• “Medically needy” adults in households with dependent children</td>
</tr>
<tr>
<td><strong>Blind and Disabled</strong></td>
<td>• Coverage of premium and cost-sharing Medicare costs below 100% FPL, premiums between 100% and 135% of FPL</td>
<td>• Full Medicaid below 100% of FPL</td>
</tr>
<tr>
<td></td>
<td>• Persons eligible for federal SSI or state supplement</td>
<td>• “Medically needy”</td>
</tr>
<tr>
<td></td>
<td>• “Medically needy”</td>
<td></td>
</tr>
<tr>
<td><strong>Poor Elderly</strong></td>
<td>• Coverage of premium and cost-sharing Medicare costs below 100% FPL, premiums between 100% and 135% of FPL</td>
<td>• Full Medicaid below 100% of FPL</td>
</tr>
<tr>
<td></td>
<td>• Persons eligible for federal SSI or state supplement</td>
<td>• “Medically needy”</td>
</tr>
<tr>
<td></td>
<td>• “Medically needy”</td>
<td>• Spousal impoverishment coverage</td>
</tr>
</tbody>
</table>

Sources: Nebraska Department of Health and Human Services and “2014 Fact Sheet, Nebraska CHIP,” National Academy for State Health Policy.
• **Children:** Under Medicaid and CHIP (which Nebraska has chosen to administer as an extension of Medicaid), the state is covering all children in low-income households up to 200 percent of FPL; federal law requires coverage of young children (1 to 5) up to 133 percent of FPL, and older children (6 to 18) up to 100 percent of FPL;

• **Pregnant Women and Newborns:** Over a number of years in the 1980’s, Congress steadily expanded Medicaid coverage to low-income pregnant women and their young children. The law now requires coverage to 133 percent of the FPL for pregnant women and their newborn children; Nebraska has taken up the option to raise the income threshold to 185 percent of FPL for this population;

• **Parents/Caretakers of Low-Income Children:** Some parents of low-income children, or their caretakers, can be eligible for Medicaid in Nebraska if their incomes are very low (around 33 percent of the FPL or lower) and thus would make them eligible for assistance on the old AFDC program, now converted to TANF. In addition, Medicaid allows the state programs, as an optional expansion, to count very high medical expenses as effectively a reduction in income. Thus, some “medically needy” parents also qualify for Medicaid coverage.

• **Blind and Disabled Citizens:** Federal Medicaid law requires states to provide coverage of premiums and cost-sharing obligations for blind and disabled persons who are on the Medicare program and have low incomes. Nebraska, like most states, has also elected to provide full Medicaid coverage to those who are on the federal Supplemental Security Income (SSI) program, which provides monthly income-tested cash benefits to very low income blind and disabled persons, and the state provides full Medicaid coverage—beyond filling in Medicare’s cost-sharing—to any blind or disabled person with an income below 100% of FPL. In addition, the state has elected to provide “medically needy” coverage to this population as well.

• **Poor Elderly:** Nebraska’s coverage for the poor elderly generally mirrors what the state provides to the blind and disabled. Federal law requires coverage of premiums and cost-sharing for some low-income seniors, but Nebraska has chosen to go beyond that requirement and provide full Medicaid to all seniors with incomes below 100 percent of the FPL, as well as to “medically needy” seniors. It is this coverage that allows many frail elderly to have their nursing home expenses paid for by the Medicaid program.

### Medicaid’s Steady Enrollment Growth

Medicaid enrollment has risen steadily in Nebraska from the program’s inception in 1965. As shown in Figure 6, in 1977, there were 54,000 Nebraskans on the program. Today, there are about 250,000 people enrolled in the program on a monthly basis.

The steady rise in program enrollment is partly due to the series of program liberalizations enacted by Congress in the 1980’s and 1990’s. These changes to Medicaid, and then also the enactment of CHIP, extended public insurance coverage to tens of millions of people nationwide, and tens of thousands of Nebraskans.

But it wasn’t just federal action that expanded these pro-
grams. The pressures that pushed Congress to amend Medicaid to broaden its reach also pushed states to adopt some of the optional coverage expansions provided in federal law. As noted, Nebraska has gone beyond required federal coverage for all of the major eligibility categories.

Still, Nebraska is a relatively low enrollment state compared to the rest of the country. As shown in Figure 7, Nebraska’s enrollment, as a percentage of the total state population, has gone up significantly over the years, from 4 percent in 1980 to 13 percent in 2013. But that level of enrollment is still well below what has been taking place elsewhere. In 1980, national Medicaid enrollment was 9 percent of the total U.S. population, and by 2013, it had risen to 18 percent.

**Covered Services in Nebraska’s Medicaid Program**

Another important aspect of Medicaid administration is required and optional covered services. Federal Medicaid law specifies a number of services that every state Medicaid program must cover as part of its medical assistance to enrollees. The law also specifies a number of services that states are permitted, but not required, to cover.

As shown in Figure 8, the list of required federal services is lengthy and covers many of the items one would expect to see provided by a traditional health insurance plan, including hospital services, physician care, diagnostic tests, and outpatient services. Importantly, Medicaid law requires coverage of “nursing facility services” which is the hook by which the program has become the largest purchaser of nursing home care for frail seniors.

Some services not required by federal law really are not optional, in a practical sense. For instance, prescription drugs are not a required covered service under Medicaid, but it is hard to fathom an effective health insurance plan for low income households which provides no assistance in paying for the medicines that are necessary to stay well. Consequently, Nebraska—and every other state, for that matter—covers prescription medications in its Medicaid program.

Nebraska also pays for many institutional and community-based services for the disabled that are not required by federal law but are viewed as effective mechanisms for keeping patients out of even more expensive care settings.

Although much of what Nebraska pays for in its program is either required or impractical to exclude from coverage, the state has elected to take up some options that are somewhat more discretionary. For instance, the state covers the cost of school-based administration of services for lower income students in conjunction with their education. The rationale is that some services might be best delivered in a school setting (such as speech therapy). States have also found it advantageous to secure federal funding for a portion of local school expenses.

**Providers of Medicaid Services**

Nebraska's Medicaid program has been steadily moving away from the traditional fee-for-service (FFS) insurance model to a managed care approach to providing services to the enrolled population. Under FFS, the Medicaid program makes direct payments to physicians, hospitals, clinics, and other providers when they render a covered service to a Medicaid enrollee. Under managed care, the Medicaid plan
Nebraska’s Department of Health and Human Services and Medicaid Reform

Figure 8: Required and Optional Medicaid Services in Nebraska

<table>
<thead>
<tr>
<th>Federally-Mandated Services</th>
<th>Optional Services Covered by Nebraska Medicaid</th>
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<tr>
<td>• Inpatient and outpatient hospital services</td>
<td>• Prescribed drugs</td>
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<tr>
<td>• Laboratory and x-ray services</td>
<td>• Intermediate care facilities for the developmentally disabled (ICF/DD)</td>
</tr>
<tr>
<td>• Nursing facility services</td>
<td>• Home and community-based services for aged persons and persons with disabilities</td>
</tr>
<tr>
<td>• Home health services</td>
<td>• Dental services</td>
</tr>
<tr>
<td>• Nursing services</td>
<td>• Rehabilitation services</td>
</tr>
<tr>
<td>• Clinic services</td>
<td>• Personal care services</td>
</tr>
<tr>
<td>• Physician services</td>
<td>• Durable medical equipment</td>
</tr>
<tr>
<td>• Medical and surgical services of a dentist</td>
<td>• Medical transportation services</td>
</tr>
<tr>
<td>• Nurse practitioner services</td>
<td>• Vision-related services</td>
</tr>
<tr>
<td>• Nurse midwife services</td>
<td>• Speech therapy services</td>
</tr>
<tr>
<td>• Pregnancy-related services</td>
<td>• Physical therapy services</td>
</tr>
<tr>
<td>• Medical supplies</td>
<td>• Chiropractic services</td>
</tr>
<tr>
<td>• Early and periodic screening and diagnostic treatment services for children (EPSDT)</td>
<td>• Occupational therapy services</td>
</tr>
<tr>
<td></td>
<td>• Optometric services</td>
</tr>
<tr>
<td></td>
<td>• Podiatric services</td>
</tr>
<tr>
<td></td>
<td>• Hospice services</td>
</tr>
<tr>
<td></td>
<td>• Mental health and substance use disorder services</td>
</tr>
<tr>
<td></td>
<td>• Hearing screening services for newborn and infant children</td>
</tr>
<tr>
<td></td>
<td>• School-based administrative services</td>
</tr>
</tbody>
</table>

Source: “Nebraska Medicaid Reform Annual Report,” Division of Medicaid and Long-Term Care, Nebraska Department of Health and Human Services, December 1, 2014.

pays a fixed monthly amount per person enrolled in a managed care insurance plan—the “capitation” rate. The managed care plan is then responsible for making payments out of its total available funds to the various medical services providers who take care of the patients enrolled in the plan.

The steady shift away from FFS in Nebraska has taken place over two decades and has pushed the managed care insurance plans to the top of the list of vendors receiving payments from Nebraska’s Medicaid program. As shown in Figure 9, the managed care plans received a total of $556 million in FY 2014, or about 30 percent of all Medicaid payments in Nebraska to service providers. The next largest recipients of Medicaid payments were the facilities and community-based providers that take care of the elderly and disabled—populations not covered to date by Nebraska’s managed care initiative. In 2014, these facilities and providers received a combined $626 million—or 34 percent of all Medicaid payments in 2014.

Medicaid’s Low Payment Rates, Access Problems, and Poor Quality of Care

Nationally, the Medicaid program has been characterized for many years with restricted access to care. To cut costs, states have often reduced their payment rates to hospitals and physicians to levels that are well below what private insurers and the Medicare program pay for the same services. As a consequence, the program has struggled with maintaining an adequate network of hospitals, clinics, and physicians willing to provide services to large numbers of Medicaid patients. And without adequate networks of care, the program’s participants sometime struggle getting the medical attention they need or getting it from the best and most qualified practitioners.

Several academic studies have documented the problems that occur when access to care is inadequate. A 2003
A recent study published in the *New England Journal of Medicine* looked strictly at access to specialist physician services among children and found that those on Medicaid faced significant barriers to scheduling appointments with private practice clinics. More than half of the specialist physician practices contacted in an audit required disclosure by the caller of the patient’s insurance status before indicating if an appointment could be scheduled.

Although other factors, such as language proficiency barriers, can certainly play a role in the reduced access to care for some Medicaid enrollees, the most significant factor is almost certainly the program’s notoriously low payment rates for services. According to the Office of the Actuary in the Centers for Medicare and Medicaid Services (and shown in Figure 10), Medicaid’s payments for hospital care were just 61 percent of what private insurers paid for the same services. Medicaid’s payments for physician services were even lower, at just 58 percent of what private insurers paid for the same services. Physicians and other service providers respond to these low payment rates by explicitly limiting the number of Medicaid patients they will see or by employing other business practices, such as the location of their offices and facilities, which cater to patients with higher-paying commercial insurance.

Like other states, Nebraska’s Medicaid program pays low rates for physician services compared to private insurance, but, in relative terms, Nebraska has not gone as low with its physician fees in Medicaid as other states have gone. As shown in Figure 11, on average across the U.S., states have set fees for all physician services at about 66 percent of the comparable Medicare rate. In Nebraska, however, Medicaid’s fees for physician care have been set at about 87 percent of the comparable Medicare rates. That puts Nebraska above all but ten states in terms of the percentage of physician fees paid through Medicaid relative to what Medicare pays for the same services in the state. For primary care services, the average Medicaid program pays 59 percent of what Medicare pays, while Nebraska pays 76 percent.

These figures are not an indication that Nebraska has no problem with access to care in Medicaid. Setting physician fees at 87 percent of Medicare’s rates implies that Nebraska’s Medicaid program only pays 68 percent of what private insurers pay for the same services—a gap that is significant enough to cause the same access problems in

### Table: FY 2014 Nebraska Medicaid Payments by Service Provider

<table>
<thead>
<tr>
<th>Service Provider or Product</th>
<th>Millions</th>
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<tr>
<td>Managed Care Organizations</td>
<td>$555.6</td>
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<tr>
<td>Nursing Facilities</td>
<td>$326.6</td>
</tr>
<tr>
<td>Developmentally Disabled Waiver Services</td>
<td>$239.7</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>$174.8</td>
</tr>
<tr>
<td>Inpatient Hospital Services</td>
<td>$134.4</td>
</tr>
<tr>
<td>Intermediate Care Facility – Developmentally Disabled</td>
<td>$77.4</td>
</tr>
<tr>
<td>Aged and Disabled Waiver Services</td>
<td>$74.3</td>
</tr>
<tr>
<td>Physicians, Practitioners, and EPSDT</td>
<td>$64.0</td>
</tr>
<tr>
<td>Outpatient Hospital Services</td>
<td>$50.7</td>
</tr>
<tr>
<td>Dental Services</td>
<td>$42.2</td>
</tr>
<tr>
<td>Home Health Services</td>
<td>$32.3</td>
</tr>
<tr>
<td>Other Services</td>
<td>$38.2</td>
</tr>
<tr>
<td>Outpatient Mental Health Services (non-hospital)</td>
<td>$19.3</td>
</tr>
</tbody>
</table>

Source: “Nebraska Medicaid Reform Annual Report,” Division of Medicaid and Long-Term Care, Nebraska Department of Health and Human Services, December 1, 2014

A 2010 study published in the *Annals of Surgery* found that Medicaid patients fared much worse, after controlling for important demographic and risk factors, than their counterparts in private insurance in terms of outcomes from major surgical interventions. The study examined nearly 900,000 cases from a large patient-care database compiled from hospitals from all over the country. The authors found that patients with Medicaid coverage were much more likely to die from surgical interventions than the privately insured, and that Medicaid patients even had higher mortality rates than those who were uninsured.
Nebraska’s Department of Health and Human Services and Medicaid Reform

Estimates of Medicaid’s payments relative to Medicare and private insurance are based on examinations of what state Medicaid programs pay for services covered under the program’s traditional fee-for-service insurance arrangements. But most states have moved aggressively away from the fee-for-service model toward managed care (as discussed below), and in those managed care arrangements, the private insurers have more freedom to set provider reimbursement levels in the contracts they negotiate with doctors and hospitals. So, in theory, the move to managed care could improve access to care within Medicaid. And, in fact, some states have reported improved use of important preventive services by patients enrolled in their managed care plans.\textsuperscript{14}

But it is also true that the payments made to the managed care plans are generally built on the assumption that these plans will pay for services at rates comparable to what the Medicaid program pays under fee-for-service arrangements. Consequently, the overall capitation rates paid to the managed care plans serve as a constraint on fees for physician and other services too.

A recent study from the Office of Inspector General of the federal Department of Health and Human Services looked at access to physician services within Medicaid managed care plans. It found that more than half of the physicians listed as participating in these plans were not available to take appointments. Moreover, of those willing to take appointments, more than 10 percent had wait times exceeding two months.\textsuperscript{15}

### Medicaid Managed Care in Nebraska

As noted previously, Nebraska has moved steadily away from the traditional FFS approach to providing Medicaid-covered services through a managed care model. Many other states have followed a similar path, and for good reason. Extensive use of managed care has been shown to help states better manage their Medicaid costs by reducing use of unnecessary or inappropriate care.
At the same, the best state managed care efforts have also improved measures of use of important preventive services.

The central feature of the managed care approach is a fully capitated payment to the managed care plan in lieu of individual payments to the physicians and other service providers. The managed care plan is then fully “at risk” and must provide all necessary medical services to its Medicaid managed care enrollees within the total amount of monthly capitated payments it receives from the state.

As summarized in Figure 12, Nebraska’s managed care effort began in 1996, and focused initially on just a few counties. The program grew in the ensuing years and went statewide to all counties in 2012. Currently, about 80 percent of Nebraska’s Medicaid participants are enrolled in a managed care plan.

At the moment, Nebraska’s managed care effort is focused only on the non-disabled and non-elderly—in other words, mainly single mothers and their children. Further, the capitated payments to the plans so far have excluded prescription drugs, which have been covered separately by the state.

The state has used an actuarial consultant to establish the monthly capitated payments the state was willing to make to managed care plans. It then selected three national insurance carriers to offer coverage. One plan is offered statewide, one is offered just in the eastern region, and the other is offered in just the western region. Thus, Medicaid participants may select from two competing plans, although there is no cost consequence to them for their choice. The state has contracted with an enrollment broker to assist Medicaid beneficiaries in making a selection, but about half never do. Instead, they are enrolled automatically in one of the insurance plans.

Although there are no definitive cost estimates for Nebraska’s program, other states with similar initiatives have experienced cost reductions ranging from 5 to 10 percent.

Nebraska is already well along in developing its next phase of managed care in Medicaid, dubbed Managed Care 2.0, planned for rollout in January 2017. The current 2.0 plan would fold behavioral health needs and prescription drugs into the capitated payments to the managed care plans. In addition, the managed care plans would provide Medicaid-covered services for the aged and disabled too, excluding, however, their long-term care needs, which will continue to be paid on a fee-for-service basis.

### Figure 12: Medicaid Managed Care in Nebraska

| **History** | • Program began in 1996 in selected counties  
• Based on capitated payments for physical health  
• Expanded statewide in 2012  
• Penetration now at about 80% among non-disabled and non-elderly |
| **Program Design** | • State contracts with three national insurers  
• Participants can choose between two plans: a statewide plan (Aetna) and United Healthcare (in the eastern region) or Arbor Health Plan (in the west)  
• Rates are set based on actuarial assessment (state contract with Optumas)  
• Enrollment broker assists in beneficiary choice  
• Approximately 50% of enrollees choose their plan; others are auto-enrolled in a plan |
| **Managed Care 2.0** | • New RFP released in late summer 2015 for implementation Jan 2017  
• Require statewide plans  
• Include behavioral health and pharmacy in capitation program  
• Fold into the program the aged and disabled for their services excluding long-term care needs  
• Emphasis on improved metrics of beneficiary health  
• Separate process launched for redesign of long-term care services and supports that are outside of capitation program |
Nebraska’s Department of Health and Human Services and Medicaid Reform

The state plans to issue an RFP for this expanded managed care initiative in mid-2015 and solicit bids from insurers willing to provide their services statewide. State officials hope to attract strong competition to the program, and to leverage that competition into better services and performance for the beneficiaries in the coming years.

State officials are also launching a new effort to redesign how Nebraska provides long-term care services and supports. The effort will begin with a concept paper developed within DHHS and used as a starting point for community discussions. The plan is to rethink every aspect of the program, from what is covered to who decides what services will be purchased. The redesign effort will run parallel to the implementation of Managed Care 2.0.

A Review of Selected State Medicaid Reforms

Because Medicaid is administered by the states, it is possible for state policymakers to observe and learn from the efforts of their counterparts around the country. The list of interesting and innovative state efforts is too extensive to summarize here but a review of the experience of four states (summarized in Figure 12) is nonetheless instructive:

- **Florida:** In 2005, then-Gov. Jeb Bush proposed a sweeping reform of the state’s Medicaid program in the form of a section 1115 waiver request. He sought to inject competition and consumer choice into the program for the non-elderly and non-disabled. The program contracted with competing private managed care plans, and allowed the beneficiaries to choose among them based on the quality of the services they provided. The competing plans were allowed to adjust their benefit offerings, within certain boundaries. Consumers were also enrolled in an account program and were given credits for engaging in healthy behaviors. The accounts can be used to pay for health-related services not covered by the insurance plans. The program was rolled out in 2006 in two counties, and then expanded to three more in 2007. An independent evaluation found that consumers were actively engaged in the program (about 70 percent have proactively selected their insurance plan), and Medicaid costs in the counties testing this new approach rose just 1.4 percent annually from 2006 to 2009.

- **Illinois:** Newly elected Gov. Bruce Rauner is pursuing aggressive reductions in Medicaid costs to improve the state’s difficult budgetary outlook. He has accelerated and deepened an initiative to screen the Medicaid program in the state using privately-built databases to ensure enrollees are in fact eligible for benefits. An initial review of the data, in 2012, revealed that some 250,000 persons were not eligible for the program. Ultimately, the state removed about 234,000 persons from the program. Gov. Rauner is planning further reviews, as well as aggressive auditing of provider payments to detect abusive billing practices, that promise to save many millions of dollars for the program in the coming years. He has also moved to trim optional benefits from the program, including adult dental services and podiatry, among other things.

- **Louisiana:** Gov. Bobby Jindal introduced Bayou Health, an aggressive managed care initiative, in February 2012 to reduce Medicaid costs while improving health outcomes for program enrollees. The program is based on moving away from the traditional fee-for-service model. A competitive procurement was used to select three plans offering coverage statewide. These plans receive a monthly capitated payment throughout the state and are fully at risk for providing Medicaid-covered services to the enrollees. Two other private plans provide primary care coordination services for a monthly fee from the state. Since introduction, Louisiana has moved more than one million people enrolled in Medicaid and CHIP from fee-for-service to a managed care model. The state estimates that the initiative has cut costs by about 8.7 percent, even as key metrics of health have improved, including an 11 percent increase in use of prenatal care by pregnant women.

- **Pennsylvania:** Former Gov. Tom Corbett and his Secretary of the Department of Public Welfare started the “Enterprise Program Integrity” effort in 2011. The initiative was aimed at using all available sources of information across welfare and health care programs to identify and eliminate ineligible program participants and prevent improper payments for services. The effort created a new office of program integrity and examined cases of overlap between providers of services, such as a day care, and income reporting for eligibility purposes. In addition, management practices were used to ensure backlogs were reduced and cases were handled according to federal and state law. Almost immediately, the
Considerations for Reform

Any reform of Nebraska’s DHHS and its Medicaid program must take several important realities into consideration.

First, the DHHS portfolio of programs is very diverse and reflects the historic approach of combining health programs with various efforts to help disadvantaged households. This is the model at the federal level and has been followed in many states, including Nebraska. However, there is no particular reason to expect the competencies associated with running a major health insurance benefit program like Medicaid are also useful in managing other programs, such as helping children in foster care or assisting households juggling child care and work, even when some of the beneficiaries are assisted by both Medicaid and income support. Further, even within Medicaid, the vast array of services provided, such as those for disabled children and the frail elderly, are entirely different from...
the benefits provided to an otherwise healthy family that uses the program to help pay for routine health services.

Second, many states have moved forward with what might be described as efforts to better manage the Medicaid program as it is traditionally known and administered. These state efforts are important because they provide some examples of what Nebraska might do to improve the management of its current program, much of which can be accomplished without the need of federal approval.

Third, although it is possible to better manage today’s Medicaid program, the fundamental problem with the program is structural and cannot be fixed with better management. To really fix Medicaid, in Nebraska and elsewhere, it will be necessary to reform the financial relationship between the states and the federal government. Beginning October 1, 2015, Nebraska’s federal matching rate will be 51.16 percent, meaning when the state spends $1.00 on Medicaid, the federal government will pay about 51 cents, and the state will cover the other 49 cents.23

The federal matching system for Medicaid financing directly influences state policymakers’ decisions regarding program expenditures. For example, state policymakers wanting to increase Medicaid expenditures must ask state taxpayers for only one-half of the cost of the increased spending. Because a substantial portion of this cost is shifted from state to federal taxpayers, this reduces the incentive to control program expenditures. Further, because the federal treasury pays for more than half of all Medicaid spending increases in Nebraska, it is very difficult to implement large spending reductions, because most of the savings are realized by federal, not state, taxpayers. For example, in order for Nebraska policymakers to save $1 of the state’s general fund contribution, they must cut $2 of Medicaid program expenditures. In effect, Medicaid’s federal matching system provides strong incentives to operate a more expensive program than if the states were responsible for 100 percent of the program costs, including any increases in spending.

The federal matching system for Medicaid also distorts political accountability. The federal government pays for more than half of program costs (about 57 percent nationally), and in theory, states are given authority under the law to make most of the decisions about program benefits and eligibility. But because of its large financial role in the program, the federal government has felt more than free to impose extensive regulatory control over the states. Indeed, the web of federal regulation of Medicaid is so pervasive that states often protest they do not have sufficient discretion to really manage the program. The result is bifurcated political responsibility, with neither federal policymakers nor state officials taking full responsibility for effectively managing program resources.

The final important consideration is the ongoing implementation of the Affordable Care Act (ACA). The ACA authorized a large expansion of the Medicaid program, financed for three years entirely with federal funds and thereafter with a 90 percent federal matching rate. In addition, the ACA established a new system of health insurance premium credits for persons without access to employer coverage and with incomes above Medicaid eligibility but below four times the federal poverty line. In Nebraska and thirty-six other states, the federal government has built, and is running, the exchange that is the administrative vehicle for determining eligibility for the subsidies and for informing consumers of their insurance options.

Although there are many reasons to oppose the ACA and work to replace it with an alternative program, it is not practical to embark on a Medicaid reform program at this time with any assumption other than the continued implementation of the ACA.

Near-Term Reforms of Nebraska’s Medicaid Program

Managing the Medicaid program is difficult for states because they do not have unilateral authority to make major modifications to the program based on changing circumstances and evolving policy preferences. Rather, the states must work with the federal government to run the program, and, depending on the point of view of the administration in power in Washington, that can mean a more or less deferential approach to state preferences. At the moment, the Obama administration has looked unfavorably on most changes proposed by the states that would move the program in what might be described as a more market-oriented direction, with the exception that such changes might be considered in the context of a large expansion of the program.

This is not to suggest that the states have no authority to make any changes in Medicaid; they do. It is just
that more meaningful changes almost always involve, at a minimum, some level of consultation with the federal government, and very often a formal request for federal approval. State policymakers must weigh the benefits of making the change against the time and effort necessary to secure approval for the change from the bureaucracy, and sometimes political leaders, in Washington, D.C.

With this in mind, the following is an outline of an agenda (summarized in Figure 14) for Medicaid reform based on current political and programmatic realities, as well as the experience of other states. The assumption is that current law and the policies of the Obama administration will remain unchanged through the end of 2016, but that some changes are still possible and should be pursued, including some that would require a waiver of Medicaid’s existing rules.

**• Continue the Move to Managed Care.**

Nebraska officials are already well along in planning for the next phase of managed care in the state. As previously noted, “Managed Care 2.0,” scheduled for implementation in January 2017, will incorporate coverage of behavioral health and prescription drugs into the capitated payment amounts. The state is planning to issue an RFP soon to solicit bids from insurance companies. The plan is to require insurance providers to offer coverage statewide, and to increase options for the enrollees beyond two plans. Nebraska should follow the lead of Louisiana and use this procurement process to drive even greater value for Medicaid enrollees, with specific health outcome goals and awards and penalties for achieving or missing them. This kind of procurement gives the state great leverage to address the actual health needs of the Medicaid population. For instance, the state could make it a priority of the winning bidders to make real progress in the management of diabetes, which is a growing problem in Nebraska just as it is in most other states.24

**• Increase Beneficiary Roles and Responsibilities.** A missing ingredient on Nebraska’s current plans for Medicaid reform is a genuine and important role for the consumer. In the managed care program, the beneficiaries are given the option to select a plan, but those who do not are auto-enrolled in one of the two competing options. It would be much better if Managed Care 2.0 allowed for greater differentiation among the competing insurance options, both in terms of the financial responsibilities of the enrollees and the services offered by the plans. For instance, a managed care plan might offer premium rebates to enrollees that cooperated in an aggressive health maintenance program. The rebates could be deposited into individually-owned accounts to be used at the discretion of the enrollee for qualified health-related services. This is similar to the approach taken in Florida, with success. Nebraska could take the concept a step further and incorporate directly into Managed Care 2.0 the possibility of using some of the Medicaid capitation rate to fund such accounts for persons willing to accept some level of cost-sharing (above what Medicaid allows today) for services. Admittedly, these changes would require preparation and submission of a section 1115 waiver request to the federal government, as was the case in Florida. But these policy changes would be well worth the effort because they are fundamental to bringing more personal responsibility into the administration of the program.

**• Make Department-Wide Program Integrity a Top Priority.** In 2011 and 2012, Pennsylvania demonstrated the value of making program integrity, broadly understood, a top priority for the management of the Medicaid program. And Illinois’ more recent efforts confirmed the large returns a state can achieve with an aggressive effort. There is no reason to believe, based on current information, that Nebraska is experiencing anything close to what other, more populous states have experienced in terms of improper enrollment or abusive billing practices. But Nebraska has not been entirely free of documented program integrity problems. In 2013, the state auditor identified significant lapses in the management of Nebraska’s premium payment program for enrollees electing to participate in an employer-sponsored plan. The state failed to ensure the program was cost effec-

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**Figure 14: Near-Term Medicaid Reforms**

1. **Continue the Move to Managed Care**
2. **Increase Beneficiary Roles and Responsibilities**
3. **Make Department-Wide Program Integrity a Top Priority**
4. **Emphasize Competitive and Selective Procurement of Products and Services**
Nebraska’s Department of Health and Human Services and Medicaid Reform

The Department of Health and Human Services and Medicaid Reform are critical for Nebraska’s taxpayers, as required by federal and state rules. There is no downside to making avoidance of a repeat of this kind of problem a top priority over the coming years. The state can do so by implementing the key features of the Pennsylvania effort: a department-wide program integrity office; cross-checking of existing state databases to match program beneficiaries with information about income and contracts; use of privately-built databases of Medicaid eligibility; and holding state employees accountable for continuous improvement in the timely and accurate resolution of all cases, focused especially on securing the return to the state treasury of any improperly obligated taxpayer funds.

- **Emphasize Competitive and Selective Procurement of Products and Services.** In future years, more and more of Nebraska’s Medicaid expenditures will be wrapped into capitated payments to managed care plans. However, there is, and always will be, a portion of the Medicaid budget that is spent on the direct procurement of services from various vendors. In Nebraska, as in other states, these payments are influenced by the history of open-ended fee-for-service payments. In general, qualified and licensed providers in the state can receive payments from Medicaid for providing a covered service to a program enrollee. That still is largely the case in Nebraska for services that fall outside of the capitated structure for managed care. The state should move aggressively to review this approach to provider reimbursement outside of managed care and convert payments, where possible, into more competitive procurements. For instance, this approach could be used to purchase selected services for use in community-based care for the disabled, and for purchasing products that are commonly used in nursing homes. Similarly, the state could use selective contracting to establish a preferred network of nursing facilities for those needing institutional care. Changes of this kind require federal approval under a section 1915(b) waiver, but that should not be a significant hurdle because selective contracting, based on value and performance, is a prominent feature of the Obama administration’s health agenda.

These changes, even if implemented aggressively, would not constitute a large-scale change in direction for Nebraska’s Medicaid program. But they have the potential to produce meaningful savings for state taxpayers and quality improvements in the program for the beneficiaries, as other states have demonstrated.

**A Framework for Major Structural Reform of the Medicaid Program**

Reform of a program as complex and sensitive as Medicaid will almost certainly proceed on a rather incremental basis to avoid unnecessary disruptions in services for vulnerable families. Still, it is worthwhile to consider a broad framework for reform that can guide discrete policy decisions over a number of years. This framework can help direct state policymaking not only with respect to DHHS governance of Medicaid but also with respect to the ongoing financial relationship of the state of Nebraska with the federal government.

1. **Pursue Fixed Federal Funding and State Flexibility with 1115 and 1332 Waiver Requests**

   Today, the federal government and the states point at each other for Medicaid’s shortcomings. Fixing the program requires straightening out political accountability, which can only be accomplished if states become more financially responsible for their decisions. This will require striking a new bargain with the federal government: the state accepts a fixed budget in return for greater flexibility to manage and run the program according to the needs and preferences of its citizens.

2. **Integrate Acute Care Medicaid Into a Larger Consumer and Market-Driven Health Insurance Reform Plan**

   Today, Medicaid is run as a health insurance system for the non-disabled and non-elderly that is entirely separate from the insurance system available to other residents in the state. A better approach would be to integrate Medicaid into a more fully functioning marketplace.

3. **Empower the Disabled and Frail Elderly (and Their Families and Caregivers) Within a Fixed Budget**

   Medicaid provides both health and long-term care assistance with activities of daily living to the severely disabled and to frail elderly with very low income.
and assets. The needs of this population are entirely different from the needs of those for whom Medicaid is strictly a health insurance program, and thus the policy solutions for this population are also very different. But, despite the differences, it is still important to build into this part of the Medicaid program more budgetary certainty along with much greater consumer control.

These concepts provide the structure for developing a specific reform plan that will lead to a more cost effective and higher quality Medicaid program.

Administering Medicaid’s Two Distinct Parts

When Medicaid was enacted by Congress in 1965, the program was thought to provide mainly assistance for accessing traditional medical care, meaning physician services and hospitalization. The target populations were families participating in the largest federal welfare assistance programs—mainly women and their dependent children. Over the years, the definitions and criteria of eligible households were loosened to the point that Medicaid has become a massive health insurance program for lower income Americans, whether or not they are eligible for cash welfare assistance. These households use Medicaid primarily as a means of financing the kinds of services typically covered by modern health insurance.

At the same time as Medicaid’s role as a health insurer grew, so too did its role in providing services beyond medical care. The lure of large, open-ended federal matching payments induced a vast expansion of the program into the financing of nursing home care for the elderly and, in
time, a vast array of non-institutional support programs and services for both the poor elderly and the severely disabled. This component of Medicaid, in Nebraska and elsewhere, is now, by a wide margin, the most expensive part of the program.

The result of Medicaid’s steady evolution in these areas over five decades is a massive program with two very different purposes. The program is the largest health insurance plan in the country, and in Nebraska, providing access to traditional medical services to some 180,000 people, even as it has also become the dominant payer of long-term care services and supports as well.

It should not be surprising the policy solutions for these very different components of the Medicaid program are different. This is particularly important in the context of reforming the health insurance role of Medicaid. For policy reasons and as discussed later, it would be better if Medicaid, in its capacity as health insurer for the poor, were more closely integrated with the health insurance offerings that are available to Nebraskans outside of the program. The same is not really true for Medicaid’s role in supporting the severely disabled and elderly, largely because there is less of a private system for these services.

Although the long-term policy solutions for the different Medicaid populations are very different, the expertise for implementing these changes is likely to reside within today’s Medicaid division of DHHS, or the outside expertise that the division regularly engages to support program administration. Consequently, it may be possible to effectively pursue these reforms discussed below within today’s organizational structure. Any changes in the structure of Medicaid administration could await further clarity on how much of reformed Medicaid, with an emphasis on patient choice, could be administered by traditional state agencies and how much might need to be outsourced to private sector firms.

The Mechanics of Using Waivers to Achieve Reform and Recent State Experience

The federal matching system of financing Medicaid and CHIP is the source of misaligned incentives and poorly structured political accountability. State-only decisions can increase obligations for federal taxpayers quite sub-
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stantially, which provides the political impetus for extensive federal control over the program. As matters currently stand, Nebraska and most other states are only notionally in control of Medicaid policy. The states have some discretion, but it is very circumscribed by a vast array of federal regulations and requirements. Further, the political incentives for pursuing difficult and far-reaching reforms at the state level are compromised by the heavy infusion of federal money for decisions that increase and sustain high levels of spending rather than decrease it. Many states, including Nebraska, have found it impossible to resist the temptation of folding programs previously financed with state funds into Medicaid to draw down additional federal matching funds.

The vast array of medical service providers are also heavily invested in Medicaid’s open-ended federal matching system because it provides, in some cases, a source of government revenue for their services that can be tapped without limit.

The most straightforward solution to the flaws within the current federal-state relationship concerning Medicaid would be to convert the program into a more flexible block grant. Under a block grant, the matching system would be repealed and the federal government would instead provide to the states a fixed amount of funding, perhaps adjusted for measures of the population eligible for enrollment. The state would then have much more flexibility to manage the program within the new fixed budget (presumably including the state’s previous “match” amount). Any spending beyond the block grant’s available funds would have to be financed entirely out of state resources. It is the great irony of the Medicaid program that states would be better off with a block grant rather than open-ended federal funding because a block grant would bring budget discipline to state decision-making too.

Of course, a block grant of this type is unlikely to replace Medicaid’s current financing structure anytime soon, as the Obama administration is strongly opposed to the concept and would veto any legislation that moved the program in that direction.28

Although a block grant is not possible in the near term, it may be possible for Nebraska to pursue far-reaching reform of Medicaid using two special “waiver” authorities under current law.

The first, section 1115 of the Social Security Act, allows states to apply for the “waiving” of selected Medicaid rules in order to pursue alternative approaches to managing the program. There is one important catch to this approach to reform: the federal Department of Health and Human Services (HHS). HHS must give its approval for 1115 waivers, and there is no fixed list of criteria for making approval or denial decisions. Consequently, the process of applying for and securing a federal waiver can be arbitrary and time-consuming. Moreover, the process of negotiating a waiver means the federal government can exert substantial control over the terms of waiver, seemingly undermining the purpose of the waiver authority.29

Nonetheless, a section 1115 waiver, assuming current law remains as it is, provides a route for Nebraska and other states to break out of the traditional Medicaid model and pursue reforms that can improve the program’s effectiveness and value. Many states have pursued waivers of this kind, with some success.

The goal should be to secure a predictable, steady stream of federal funding, based on historical expenditure patterns for the state. Section 1115 waivers are required to be “budget neutral,” meaning the amount of federal funding expended under the waiver cannot exceed the amount that would have spent by the federal government in the absence of the waiver. In order to get approval of the waiver, therefore, Nebraska must assemble and submit to the federal government a reform program with a realistic chance of meeting this test. Beyond budget neutrality, the federal government also assesses these waivers for other effects, including enrollment and insurance coverage rates.

In 2008, the federal government granted a waiver to Rhode Island to pursue reforms outside of Medicaid’s normal rules. In return, the state agreed to a hard cap on the federal government’s Medicaid spending in the state. In effect, Rhode Island accepted something akin to a block grant in return for much more flexibility in managing the program. Independent evaluations of the effort showed that the state was able to produce significant cost-savings during the years the waiver program was in place.30

A more aggressive 1115 waiver request could go even farther than Rhode Island did in moving toward a block grant-like structure. Instead of an overall federal cap on spending, which retains the federal matching system up to
the cap, a waiver could seek to get federal funding in fixed payments that are not dependent on the submission of claims of services provided to participants in the program.

In recent years, the most interesting development that has occurred in the waiver arena has been the use of the process to execute compromises between states and the federal government over the terms of expanding the Medicaid program, as called for in the ACA.

Not surprisingly, the Obama administration has been pushing states since the law’s enactment in 2010 to adopt straight expansions of the existing program. But many state political leaders, in states all across the United States, have resisted doing a straight expansion because of their deep concern that Medicaid is already a broken and dysfunctional program and that an expansion without reform would only make it more difficult to make the fundamental changes that are really necessary.

Recognizing the resistance it faced, the administration has been signaling to selected state leaders that it is open, under certain conditions, to using a section 1115 waiver process to achieve the expansion in a way state leaders find more acceptable. So far, six states have come to an agreement with the federal government to expand their Medicaid programs under painstakingly-negotiated section 1115 waiver programs: Arkansas, Indiana, Iowa, Michigan, New Hampshire, and Pennsylvania.

Of course, many state leaders, including in Nebraska, are rightfully concerned about a Medicaid expansion even if it could be achieved under terms more favorable than current Medicaid law. Their concerns go to the effect of the expansion on the state’s fiscal stability, work incentives for program participants, and the quality and flexibility of the overall health care system. Nonetheless, the experience of the states that have been willing to expand the program under the terms of a waiver is still instructive in that these waivers demonstrate the kinds of reforms that are possible when Medicaid’s rules are relaxed. In the future, under a new administration, it may be possible to pursue similar reforms without also agreeing to a large-scale expansion of the program.

The six states that have received waiver approval have all pursued changes, with varying degrees of emphasis, that differ from a straight expansion of traditional Medicaid. Three of these programs are described here and summarized in Figure 16:

- **Arkansas:** Former Democratic Gov. Don Beebe pushed the state legislature in Arkansas to approve a Medicaid expansion in the state that has been called the “Private Option.” After extensive negotiation with the Department of Health and Human Service, the Private Option plan was approved in September 2013. Instead of enrolling newly eligible adults in traditional Medicaid coverage, or even a Medicaid managed care plan, the state decided to vastly expand the reach of the ACA by enrolling all people with incomes between 50 percent and 133 percent of the Federal Poverty Level (FPL) into ACA-compliant plans being offered on the “exchange.” Participants in the program get Medicaid benefits that are not included in what is provided through the ACA-compliant plans directly from the state Medicaid program. All enrollees in the program are assigned an Individual Account, which is like a Health Savings Account (HSA). Participants in the program with an income between 50 percent and 100 percent of the FPL must contribute $5 per month to the account. Those with incomes between 100 percent and 133 percent of the FPL must contribute between $10 and $25 per month. This waiver program is expected to increase enrollment in the Medicaid program by approximately 205,000 people.

- **Indiana:** In 2007, former Indiana Gov. Mitch Daniels secured a section 1115 waiver from the federal government to implement the Healthy Indiana Plan, or HIP. This waiver program broke new ground in Medicaid as Indiana became the first state to use Medicaid funds to enroll program participants in higher deductible insurance plans combined with an individually-owned and controlled Health Savings Account—called a POWER account. The insurance plans were based on products found in the commercial marketplace. The POWER account is used to pay for services before the deductible limit—set initially at $1,100 annually—is reached, and to pay for services not covered by the insurance plan. HIP participants are not required to separately negotiate prices for services with physicians and hospitals. Instead, the program requires the use of Medicare’s payment rates for all services covered in the benefit plan. The state contracted with three private insurance plans to administer the POWER accounts and the insurance coverage. HIP 1.0 also provided each participant with $500 annually of preventive care. The original program enrolled approximately 38,000 people, includ-
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The waiver program also includes an option for premium assistance payments to employer-sponsored coverage, with POWER accounts attached. Enrollment in the program is expected to rise to 430,000 in 2017.34

**Iowa:** Gov. Terry Branstad moved quickly after the enactment of the ACA to seek approval of an 1115 waiver allowing Iowa to enroll persons in the targeted income category in private plans offered on the ACA exchange instead of traditional Medicaid. The program was approved by CMS in December 2013 and enrollment in the program began in 2014. Originally, the plan was to enroll all persons in the expansion population in plans offered on the exchange. The waiver program has since been modified such that only persons with incomes between 101 percent and 133 percent of the FPL may select from plans on the ACA exchange, and they may opt to get coverage from a Medicaid managed care plan instead; others, with lower incomes, will be enrolled in a Medicaid managed care option. All participants are required to make a monthly contribution to their accounts.

**Figure 16: Selected Section 1115 Waivers Related to the ACA**

<table>
<thead>
<tr>
<th>State</th>
<th>Description of Key Provisions</th>
</tr>
</thead>
</table>
| **Arkansas** | • “Private Option” Demonstration applies to persons with incomes between 50 and 133% of FPL  
• Enrolled into plans offered on ACA exchange  
• Combined with Individual Account funded by program and enrollee contributions (> 100% of FPL = $10-$25 per mo.; <100% of FPL = $5 per mo.)  
• Alternative Benefit Plan  
• Enrollment = ~205,000 |
| **Indiana** | • Healthy Indiana Plan (HIP) 2.0  
• POWER Accounts linked to higher deductible plans mandatory for person with incomes between 100% and 133% of FPL; benefits include enhanced vision and dental  
• Below 100% of FPL, persons are offered POWER as an option but are defaulted into a less generous benefit plan (HIP Basic)  
• Enrollment in employer plans is an option, with POWER accounts attached  
• Enrollment in 2015 = ~250,000, in 2017 = ~430,000 |
| **Iowa** | • Allows participants with incomes between 100% and 133% of FPL to use premium assistance to buy qualified coverage from a plan on the ACA exchange, or to enroll in a Medicaid managed care plan; they must pay a premium of $10 per mo.  
• Below 100% of FPL, participants are enrolled in a Medicaid managed care plan and pay $5 per mo.  
• Enrollment = ~190,000 |

Other states with similar waivers: Michigan, New Hampshire and Pennsylvania. Pennsylvania is transitioning away from its waiver program to a traditional expansion.

Source: Centers for Medicare and Medicaid Services and the Kaiser Family Foundation.
make monthly premiums payments ($10 for those with incomes between 101 percent and 133 percent of the FPL and $5 for those with lower incomes, but Medicaid eligibility cannot be terminated for nonpayment of premiums for persons with incomes below 100 percent of FPL). The waiver program is expected to increase enrollment in Iowa’s Medicaid program by approximately 190,000 people.

The policy flexibility that comes with a section 1115 waiver could be supplemented with a new tool made available under the Affordable Care Act (ACA)—a section 1332 waiver. This new waiver authority allow states to combine funding made available under the ACA, including premium credits and cost-sharing subsidies, with Medicaid funds available under a section 1115 waiver. The combined funding would give Nebraska a much larger pool of funding for pursuing reforms. Importantly, it is not necessary for a state to agree to expand Medicaid to pursue this approach to reform. Section 1332 waivers can be granted to states for changes in programs that begin January 1, 2017.

An important qualification is that the Obama administration has issued initial regulations governing 1332 waivers, and through those regulations has made it clear that it intends to approve them only with extensive restrictions. In other words, state programs that deviate substantially from the goals and philosophy of the ACA are likely to meet with significant resistance from this administration.

But the waiver authority is permanent, even as the current administration’s time in office winds down. Consequently, what may be impermissible now could be approved under a new administration.

Moreover, even under current political circumstances and current law, there is little doubt that a combined 1115/1332 waiver provides the most promising route for Nebraska and other states to pursue significant reforms to its Medicaid program and, for that matter, to the state’s approach to broadening health insurance coverage as an alternative to the ACA.

Indeed, a combined 1115/1332 waiver could give Nebraska and other states with political leaders that are generally opposed to the ACA’s reform program a way around the on-going and contentious issue of Medicaid expansion. At enactment in 2010, the ACA presumed every state would have no choice but to expand Medicaid eligibility up to 133 percent of the federal poverty line (FPL), as any state that refused to comply would be denied the entirety of its federal matching funds for the program. The Supreme Court ruled this mandate on the states was unconstitutional in NFIB v. Sebelius. Consequently, the Medicaid expansion is now optional for the states and not a requirement to obtain a special waiver authority.

Currently, thirty-one states plus the District of Columbia have expanded Medicaid, and nineteen states, including Nebraska, have chosen not to expand the program.

There are, of course, strong arguments against expanding Medicaid, the most important of which is that an expansion of the program, without any serious reforms, will make it that much harder to ever implement structural changes to address the program’s evident flaws. As noted previously, numerous studies have demonstrated that the program lags behind private insurance in delivering high quality access to care, due in large part to the program’s very low payments to providers of medical services compared to commercial insurance rates.

At the same time, the status quo is unstable programatically. In states that have not expanded Medicaid, the ACA’s new insurance subsidies are made available to households with incomes as low as 100 percent of FPL, but not lower. So many states, including Nebraska, now have coverage gaps for households with incomes above Medicaid eligibility but below 100 percent of FPL.

There’s nothing in law that would require a state to include in a combined section 1115/1332 waiver request the presumption of Medicaid expansion. Indeed, it would be entirely possible for a state to request the combined funding stream for a program that assumes Medicaid was not expanded. The more flexible funds could then be used to target subsidies in a rational, state-driven design, focusing first on lower-income households, including those households with incomes below the poverty line who are currently left out of any assistance in non-expansion states. A program of this kind would likely mean less heavy subsidization of higher income households. But the distribution of support for insurance coverage would also be much fairer than it is today.
Nebraska’s Department of Health and Human Services and Medicaid Reform

Medicaid, Health Insurance Reform, and the ACA

In recent years, Nebraska has pursued a number of sensible reforms within Medicaid, including much more substantial use of managed care insurance for its non-disabled and non-elderly participants. The idea, used by many other states, is to pay insurers fixed monthly amounts per enrollee as much as possible, and then require the insurer to finance all Medicaid-covered services within that fixed, per-person budget. The intention is to create an incentive to judiciously manage the funds and emphasize prevention over expensive hospital care.

This is a laudable effort that should be expanded and refined. But it is unlikely to change the basic dynamics of Medicaid or, for that matter, health care service delivery and health insurance coverage within the state.

Ironically, the enactment of the Affordable Care Act (ACA), with all of its many flaws and distortions, has created an environment in which states like Nebraska might begin to think about more fundamental and structural reform of its Medicaid program in the context of a larger effort to rework health insurance coverage more generally.

What’s needed in Nebraska, and elsewhere, is a better functioning marketplace for insurance and health care services. It is through a system built on competition and consumer choice that providers of services and products have a strong incentive to innovate, to keep their costs low, and to continuously improve the quality of what they are offering customers. That’s a virtuous cycle that is sorely lacking in health care throughout the United States.\(^38\)

By necessity, a marketplace of this kind will need to have special accommodations for lower income households, to ensure they have affordable access to care. But that does not mean they must be enrolled in a program that is completely set apart from the system that is available to everyone else.

And, in fact, that is precisely what is wrong with Nebraska’s Medicaid program. Participants in the program get insurance from a heavily regulated program that is not seamlessly coordinated with the rest of the system. Among other things, Medicaid pays much lower reimbursement rates than commercial insurance, and thus relies on a much narrower network of willing physicians and other suppliers of medical services. The result is a program that has a very uneven record in terms of quality of care for program participants.

Nebraska’s payments under Medicaid are typical. According to a recent evaluation by the Government Accountability Office (GAO), Nebraska’s Medicaid program pays 53 percent less under Medicaid compared to private insurance for a whole range of typical evaluation and management services covered by health insurance.\(^39\)

Separate insurance arrangements for those on Medicaid and for those more strongly attached to the workforce also creates discontinuity in coverage for those who move into higher paying jobs, and thus lose their Medicaid eligibility. It would be far better for Medicaid beneficiaries if they received subsidies for health insurance that allowed them to keep the same coverage when their incomes went up with better paying jobs. The subsidies would be withdrawn gradually as their ability to pay for premiums on their own increased. But they would not be forced to abruptly switch insurance plans, and potentially also doctors, simply because they moved up the wage scale.

Beginning with calendar year 2017, Nebraska should pursue a combined 1115/1332 waiver. With that waiver, the state could put in place a completely redesigned approach to providing health insurance options to lower income state residents that would simultaneously serve as a sweeping reform of Medicaid and an alternative to the ACA. The following should be the key features of such a program:

**Income-Tested, Defined Contribution Premium Assistance.** With an 1115/1332 waiver, Nebraska could pool Medicaid funding (for the non-disabled and non-elderly) with the ACA’s premium credit funds and cost-sharing subsidies into a large pool for a redesigned premium assistance program. The subsidies would be used by eligible participants to offset the cost of purchasing private insurance offerings in the state. The premium assistance would come in the form of defined contribution payments—meaning the amount an individual would be entitled to receive would be the same regardless of the insurance plan he selected. This design ensures the participants would be cost-conscious. If they chose ex-
pensive options, they would be required to pay more out of their own resources to cover the cost. If they selected less expensive options, they could potentially keep some of the defined contribution payment for future use in a Health Savings Account.

The defined contribution payments would be set based on a combination of household income and some measure of the premium necessary for an average cost plan. The very lowest income households would receive premium assistance covering most of the cost of a standard plan. The state could then design a schedule by which the subsidy was reduced gradually as incomes rose (the state could choose to phase out the subsidies differently than provided for in the ACA). In this system, the Medicaid participants and the population receiving subsidies under the ACA would be grouped together in the same program.

Using defined contribution payments as the means of delivering health insurance subsidies to eligible participants would give the state substantial budgetary control over the program. The total cost of the program would be a function of the defined contribution payments and the total number of eligible participants. If the state found that the total cost of the program would exceed its budget (the funding available from the combined 1115/1332 block grant, plus state Medicaid funds), it could accelerate the phase out of the subsidies by income, reduce the defined contribution payments for all participants by a fixed percentage, or change the definition of a standard coverage plan.

• State-Regulated Insurance Offerings. Under this reform approach, Nebraska, not the federal government, would set the terms of the insurance offerings made available to subsidy-eligible program participants. The state could choose to abandon the essential health benefits regulatory structure of the ACA in favor of a more flexible approach. This would allow insurers to tailor coverage to the preferences of consumers. A smart approach would be to combine catastrophic insurance protection with some level of up-front benefits (such as 3 low-cost physician office visits annually) so consumers would see the immediate value of the insurance plan.

Nebraska should also allow participants in this new subsidy structure to use their defined contribution payments to enroll in any insurance plan approved for sale in the individual insurance market. Under a section 1332 waiver, the rules for what would be allowed in that marketplace could be relaxed. Consequently, Nebraska could approve for sale in that market plans with much greater variation in coverage and cost-sharing than is allowed currently under the ACA.

• State-Determined Mechanism for Choosing Plans. Nebraska could choose to retain the ACA exchange as one mechanism for enrolling in coverage, but it could also allow subsidy-eligible participants to use other mechanisms to enroll in coverage. This could include privately-run insurance exchanges and traditional insurance brokers.

• Promotion and Use of HSA Options. A very important feature of a revised Medicaid program should be the promotion of consumer-directed care in the form of Health Savings Accounts (HSAs). HSAs allow consumers to accumulate resources in a tax-preferred account for later use in paying for their health care needs. HSAs are usually combined with high-deductible insurance products. The insurance enrollee, or their employer, makes contributions to the HSA that match or come close to matching the insurance plan deductible. The enrollee then uses funds out of the HSA to pay for services before reaching the deductible. Because balances in HSAs belong to the enrollees, they have strong financial incentives to use the funds judiciously. Many studies have shown that this approach to providing insurance coverage can cut costs and eliminate wasteful and unnecessary spending.

Indiana has pioneered the use of an HSA-like account in its Medicaid program, through an 1115 waiver. Even before the enactment of the ACA, Indiana moved forward with a program to expand Medicaid using a non-traditional approach. Instead of the full Medicaid benefit, participants in the new program got a high-deductible insurance plan and a HSA-like account. The state paid for the insurance and deposited funds in the account for use by the insurance enrollee. Participants in the program are also required to make their own contributions to the account. Independent evaluations of the program have shown that it has reduced costs, and that the participants in the program highly value the accounts they now own.40
Nebraska should feature a similar option in a reform of its Medicaid program. The HSA option need not be the only one made available. But a person receiving a defined contribution payment from the state should be allowed to use some of it to pay for the premium of a high-deductible plan, and then place the balance of the state’s financial support in the HSA to be used entirely at the discretion of its owner.

Pursuing a reform program of this kind is not the same thing as accepting the ACA’s Medicaid expansion, with minor adjustments to make it appear different. For starters and as previously noted, it is not necessary for Nebraska or any other state to agree to the expansion in order to pursue an 1115/1332 waiver. The only condition is that the state must not put in place changes that increase the number of uninsured, compared to current policy. In Nebraska, that would mean covering as many people as have been covered without an expansion of Medicaid.

But resistance to expanding Medicaid should not be equated with generalized opposition to doing anything to improving insurance enrollment. Rather, resistance to the expansion is best understood as opposition to the ACA’s heavy reliance on federal control and funding to achieve its ends. An 1115/1332 waiver, as described here, would allow Nebraska to retarget existing (not new) federal subsidies and spread them more rationally across income groups, design more flexible and sensible benefit packages, integrate subsidized populations into the mainstream insurance market, intensify competition among insurers, and require participants to become partners in controlling costs. In combination, these changes would allow Nebraska to demonstrate that it is possible to improve insurance coverage in the state, and the overall health system, while following a path that diverges substantially from the ACA.

Nebraska, along with many other states, has been pursuing reforms over the past decade to give disabled and elderly participants in Medicaid, and their families, more direct control over the allocation of resources to actual service delivery providers. These efforts, under the heading “Money Follows the Person,” or MFP, attempt to transition disabled and elderly Medicaid participants out of nursing homes and into their own homes or group homes by directing resources toward service providers promoting independently living.61

In addition to MFP, most states, including Nebraska, have made extensive use of Home and Community-Based waiver programs, which allow the states to contract directly with service providers on behalf of elderly and disabled citizens in an attempt to keep them out of nursing homes altogether.

These movements, and especially the “Money Follows the Person” effort, have been very important developments within Medicaid administration, but their reach is still too limited and the degree of true consumer direction too circumscribed.

A more aggressive approach could take the concept of consumer-driven services a step further. Using the combined 1115/section 1332 block grant as a starting point, Nebraska could provide a pre-determined level of financial support to the frail elderly and persons with disabilities. This financial support would be used, in turn, by the recipients to pay for the services they—and their family members or support network—decide they need, from providers of their own choosing.42

**Basic Design.** As shown in Figure 18, the process begins by calculating what might be considered the maximum defined contribution payment for someone needing significant daily support for their activities of daily living and no financial resources of their own to pay for them. The state would make this calculation based on an assessment of existing usage of services by the frail elderly and disabled population on the Medicaid program. The state would have the option of creating a single estimate that would apply to all ap-
Applicants, or multiple estimates based on several subcategories of beneficiaries (such as the elderly, non-elderly disabled adults, and disabled children).

Then, applicants for state Medicaid benefits would be assessed based on the acuity of their disabilities, relative to a person who would be entitled to a full defined contribution payment. This “disability acuity assessment” would need to be seen as an apolitical and objective process, conducted independently of budgetary or other pressures and based solely on the evidence of disability and functional impairment.

In addition to an acuity assessment, the state would then conduct an assessment of the applicant's financial resources and ability to pay for services on their own. As much as possible, this assessment should look at the resources of the applicant and the applicant’s family.

- **Accessing Services.** After a benefit determination was completed, the state would then make available to the beneficiaries a list of approved vendors for the various services, as shown in Figure 19. So, for instance, there would be vendors providing assistance with various activities of daily living, transportation, and other social services.

As much as possible, the state should not over-regulate the process of certifying vendors for approval. The idea is to foster quality and price competition among the vendors so that the program participants get the highest possible value with the resources made available to them. And to incentivize economizing behavior, the beneficiaries should be able to retain resources they do not use in one month for later use. Beneficiaries could thus “save” resources in their accounts (which are really an accounting tally) to provide additional protection should they need more services in the future.

- **The Nursing Home Exception.** If an applicant is found to need nursing home services, the defined contribution entitlement would need to be terminated, and the nursing home stay would be financed through the traditional Medicaid structure with a
greater emphasis on competitive bidding for nursing home beds by the program.

Excluding nursing home care from services covered by the defined contribution payment is necessary because of its high expense. The criteria for entering a nursing home should be strict. The presumption in nearly all cases should be that support in the community is the optimal option, given both overwhelming preference for community based care, as well as the significant cost considerations.

• **Maintaining Budgetary Control.** A primary benefit of this approach to financing long-term care services and supports is that it would allow for ongoing budgetary control in the context of block grant-like funding from the federal government.

To keep spending for these services in line with available funds, the maximum defined contribution amounts established by the state could be set to grow at the same rate as federal funds. This would provide a link between the aggregate funding levels budgeted for the program and the amounts actually provided to the beneficiaries.

But this linkage would not necessarily keep spending within the state’s budget. That’s because the number of applicants to the program might grow beyond what was expected, or the acuity of the disabilities might worsen over time and thus push average benefit payments. Moreover, the financing of the nursing home benefit could be a source of excessive spending.

In the event that expected Medicaid spending were to exceed the amount budgeted for the program by the state, this reform would allow for adjustments to other dimensions of the eligibility and state contributions level to bring spending in line with available resources. The state could apply a uniform benefit reduction factor to all defined contribution payments to bring overall spending back within the budgeted total. Alternatively, the state could choose to eliminate the lowest acuity beneficiaries from the program, or reduce benefits for those closest to the income eligibility cut-off. Of course, the state could also choose to increase the state contribution to the program, or pursue some combination of all of these options.

### DHHS’ Other Programs and Activities

DHHS administers a number of other social welfare and health-related programs, beyond Medicaid and CHIP. Figure 20 provides a summary of the major functions and responsibilities of DHHS’ programmatic divisions, excluding the Division on Medicare and Long-Term Care, along with the fiscal year 2015 funding total for activities in those divisions and the amount of federal funding associated with programs in that component of the DHHS budget.

All of these DHHS efforts are important and are replicated in various ways in every state budget in the country. However, relative to Medicaid, these programs in DHHS are much smaller. Moreover, their mission is driven heavily by federal law and grant funding, which largely set the terms for what the agency is seeking to accomplish with the funds. For instance, in the Division of Behavioral Health, DHHS is administering grant funds from the federal Substance Abuse and Mental Health Services Administration, and the Division of Public Health is performing a similar task for an array of programs funded in part from grants provided by the federal Centers for Disease Control and Prevention. Short of moving to a larger block grant for all of these funding streams (which would require a change in federal law), the state will continue to work mainly within the confines of the priorities of federal policy in these areas.

An exception to this general rule is the Children and Family Services Division. This is the part of DHHS that administers the TANF block grant, child support enforcement efforts, benefit payments under the federal SNAP program, child welfare services, and programs such as child care to assist in promoting family economic independence. Much of this area of DHHS is also heavily influenced by federal law and federal funding streams. But providing broad social welfare services is such a complex undertaking that states can play a significant role in setting expectations for those receiving assistance from taxpayers.

In some ways, Nebraska’s task in promoting economic independence among disadvantaged households is easier than it is elsewhere around the country. That’s due to the state’s historically strong labor market and relatively low levels of poverty. As shown in Figure 21, the unemployment rate in Nebraska has been well below the national
average every year going back to at least 1996, and the unemployment rate at the beginning of this year was a remarkably low 2.9 percent. Such a low level of unemployment is an indication of a very tight labor market, and high demand for workers. This makes the state’s job of seeking better employment opportunities for families on public assistance much easier than it would be if Nebraska were a high unemployment state.

This low level of unemployment contributes to a similarly favorable trend in the state’s poverty rate, compared to the national average. As shown in Figure 21, in 2013, Nebraska’s poverty rate was 13.2 percent, more than a percentage point below the national rate of 14.5 percent. Nebraska’s poverty has also been below the national rate every year going back at least two decades. These favorable economic conditions allowed Nebraska to move aggressively toward an emphasis on work and preparation for work in its economic assistance programs even before this kind of emphasis became official federal policy with the enactment of TANF in 1996. It is now widely understood, based on substantial research, that an emphasis on work is crucial for breaking welfare dependency.

Nebraska officials saw the need for this shift in emphasis early in the process of the nationwide movement toward welfare reform. Beginning in 1995, Nebraska received permission from the federal government for its “Employment First” initiative. The program conditions the payment of temporary economic assistance on the signing of a “self-sufficiency contract” by the recipient. The contract stipulates the steps the person will take to become self-sufficient, focused on skill enhancement and job search. Nebraska provides financial assistance for enrolling dependent children in child care for families with incomes below 185 percent of the FPL. The program involves

<table>
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<tr>
<th>DHHS Division</th>
<th>Major Functions and Programs</th>
<th>2015 Overall Budget</th>
<th>2015 Federal Funding</th>
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<tr>
<td>Behavioral Health</td>
<td>• Administration of the major mental health and substance abuse funding streams coming from the federal Substance Abuse and Mental Health Administration (SAMHSA) • Operation of three regional psychiatric hospitals</td>
<td>$143.7</td>
<td>$21.9</td>
</tr>
<tr>
<td>Children &amp; Family Services</td>
<td>• Administration of Temporary Assistance for Needy Families, Supplemental Nutrition Assistance Program, Child Support Enforcement, Child Welfare programs</td>
<td>$508.0</td>
<td>$189.4</td>
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<tr>
<td>Developmental Disabilities</td>
<td>• Administer programs for developmentally disabled, including three Home and Community-Based Waiver program providing services to Medicaid-eligible individuals • Operates direct service provision sites in two state locations with multiple facilities</td>
<td>$210.7</td>
<td>$37.1</td>
</tr>
<tr>
<td>Public Health</td>
<td>• Administers federal grant programs aimed at ensuring public health through surveillance, traditional public health tools, prevention efforts, and education</td>
<td>$140.8</td>
<td>$87.0</td>
</tr>
<tr>
<td>Veterans Homes</td>
<td>• Operates four veterans’ homes financed in part by the federal Department of Veterans Affairs</td>
<td>$57.4</td>
<td>$19.4</td>
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Figure 20: Major DHHS Programs and Functions (excluding Division of Medicaid and LTC)

Source: Fiscal Year 2014 Annual Report, Department of Health and Human Services, and Executive Budget, 2015-2017 Biennium, State Budget Division, Administrative Services, State of Nebraska
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benefit sanctions for persons who do not cooperate in the self-sufficiency program.45

Although TANF pushed all states to adopt a model for welfare assistance along the lines of Employment First, Nebraska is still a leader in pushing this agenda. In 2014, of the TANF funds devoted to things besides direct assistance to families, Nebraska used more than half for work-related activities. The national average was under 20 percent.46

Still, it is possible to do even more to promote independence and exercise care with taxpayer funds. In that regard, Nebraska should consider placing additional emphasis on a few selected areas of welfare administration:

- **Ensure Coordinated Program Integrity Efforts Across the Agency:** As demonstrated in Pennsylvania in 2011 and 2012, there are numerous potential areas for coordinated program integrity efforts across spending for Medicaid and welfare assistance. DHHS should place high emphasis on using all available data sources to cross-check income of applicants and existing beneficiaries. That should include using non-traditional data bases to verify incomes for SNAP recipients, many of whom also apply for and qualify for Medicaid and economic assistance benefits. Because SNAP benefits are 100 percent financed by the federal government, the state incentive for pursuing every lead can be minimal, even with federal incentives and penalties. But Nebraska and other states should recognize that added integrity in SNAP will provide benefits to state-funded efforts as well.

- **Be as Aggressive as Possible in Pushing Payment Incentives for Job Placement Vendors in TANF:** Nebraska carefully tracks how well job placement efforts are proceeding in the state’s four TANF regions.47 The state contracts with two vendors to assist in job placement for TANF client families. States are moving to include in such contracts explicit and significant pay-for-performance provisions. Nebraska should review its current practices to determine if additional incentives could be added to the contracts to improve job placements and improve the earnings of client families.

- **Set Expectations for Work and Self-Sufficiency among SNAP Participants:** A significant disconnect in current federal welfare policy is
the lack of an official work requirement in the SNAP program. Many families seeking temporary cash assistance through state TANF programs also apply for, and receive, SNAP support for food purchases each month. Those benefits are income-tested and therefore are reduced when a person secures new employment and increases his or her income. This can be a disincentive for some people to take a higher paying job because the loss of benefits is like a tax on their earnings. What’s needed is an approach that makes it clear that SNAP benefits, like TANF, are intended as temporary support until self-sufficiency is reached. That is difficult without a change in federal law, but Nebraska can build a culture of work in SNAP by including within its plans of self-sufficiency the goal of reaching an income level where these benefits would no longer be available from the federal government.

Conclusion

Nebraska’s DHHS is a crucial agency because it administers programs serving some of the most vulnerable citizens in the state. The challenges the agency faces are in part driven by the high expectations placed upon it by the state’s residents and their elected representatives.

Central to the agency’s on-going challenges is the Medicaid program. There’s a saying that “if you have seen one state’s Medicaid program, you have seen one state’s Medicaid program.” The implication is that Medicaid administration is so diverse across the country that it is hard to make generalizations about the program.

But that’s not really true.

Medicaid in Nebraska and elsewhere has structural problems that flow from current law and policy at the federal level. Costs are high, and quality is mixed at best, because of the program’s poorly structured financial incentives and excessive reliance on regulatory control. Fixing these problems requires fundamental reforms that substantially alter how the program operates. That’s the case in Nebraska and in every other state as well.

The key to a better Medicaid program, one with more predictable costs and better quality care, is a restructured relationship between the state and the federal government, and a greater reliance on consumer-direction of resources rather than federal or state regulatory control. These are the key pieces in both major parts of Medicaid—the one devoted to expanding health insurance coverage, and the one aimed at supporting the disabled and frail elderly—even as the application of these broad concepts differs for these different populations.

Reforming Nebraska’s Medicaid programs according to the concepts presented here would entail a fundamental change in direction, and substantial disruption of the status quo. But that should not be a deterrent to pursuit of reforms based on these concepts. It may be necessary to move in this direction in steps, and to provide a multi-year transition plan to ease program participants into new arrangements.

But it will not be possible to pursue even incremental steps in this direction without a clear understanding of the goals and objectives for the program. Medicaid has become a massive social safety net program, serving hundreds of thousands of Nebraskans and tens of millions of Americans. The program has grown so rapidly that it has become a heavy burden to both state and federal taxpayers. Medicaid in the future must still serve the vulnerable populations it serves today. With sensible reforms, the program can continue to fill this role, but with costs that are more predictable and affordable and services more tailored to the actual needs of the beneficiaries.

Beyond Medicaid, Nebraska’s DHHS administers a diverse portfolio of public services, led by economic assistance programs. The state has been a leader for two decades in emphasizing, above all else, the importance of work as the means for improving the prospects of disadvantaged households. The state should renew and deepen this commitment, even as it also redoubles efforts to ensure enrollment and payment integrity throughout DHHS’ various programs.
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Selected References


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Endnotes

1. Nebraska’s state government runs on a July to June fiscal year. FY 2016 refers to the period from July 1, 2015 to June 30, 2016.

2. CHIP is aimed at providing health insurance coverage for children in households with incomes above Medicaid eligibility. In Nebraska, as in many other states, the administration of CHIP has been folded into the Medicaid program. CHIP is heavily financed with federal funds (up to a maximum allotment per state), with matching rates that will be 23 percentage points above the matching rates in Medicaid for the years 2016 through 2019. See “Enhanced Federal Medical Assistance Percentage (FMAP) for CHIP,” The Henry J. Kaiser Family Foundation (http://kff.org/other/state-indicator/enhanced-federal-matching-rate-chip/).


12. These figures are from the Kaiser Family Foundation for 2012 and therefore differ slightly from the estimates of the CMS Office of the Actuary. See “Medicaid-to-Medicare Fee Index,” Kaiser Family Foundation (http://kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/).


14. Louisiana has reported a significant increase in immunization rates among children enrolled in Medicaid managed care plans compared to what had been occurring under the legacy fee-for-service Medicaid program. See Bayou Health Transparency Report, Calendar Year 2013 (Figure 12.4), Department of Health and Hospitals, State of Louisiana, January 2015 (http://dhhs.louisiana.gov/assets/docs/BayouHealth/2013Act212/2013BayouHealthTransparencyReport.pdf).


16. Nebraska was able to implement this program under what is known as a section 1915(b) waiver under the Medicaid law. The waiver allows the managed care plan to steer enrollees to a preferred network of plan providers.

17. This description is based on information provided to the author by the state Medicaid program as well as information available online at http://dhhs.ne.gov/medicaid/Pages/PhysicalHealthManagedCare.aspx.

18. Section 1115 waivers, if approved by the federal government, allow states to administer the Medicaid program outside of the requirements of the law.


27. CHIP funding is currently provided to the states in the form of a matching program, up to a maximum state allotment. In that sense, the program shares characteristics with a traditional block grant. However, CHIP funding could be even more valuable to the states if it were combined with Medicaid in a more flexible and larger block grant. In the rest of this section, references to Medicaid are intended to be references to combined funding of Medicaid and CHIP.


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31. Pennsylvania has signaled that it will transition away from its waiver program and begin enrolling eligible adults in a traditional Medicaid expansion later this year. See “Medicaid Expansion in Pennsylvania: Transition from Waiver to Traditional Coverage,” Kaiser Family Foundation, August 3, 2015 (http://kff.org/medicaid/fact-sheet/medicaid-expansion-in-pennsylvania/).


38. For a longer discussion of how to reform Medicaid and integrate it with the larger health insurance system, see “Reforming Medicaid,” James C. Capretta, in The Economics of Medicaid, Jason Fichtner, ed., Mercatus George Mason University, 2014 (http://mercatus.org/sites/default/files/Medicaid_Ch7.pdf).


42. For an in-depth presentation of this reform concept, see “Assuring a Future for Long-Term Care Services and Supports in Texas,” James C. Capretta, Andrew Croshaw, Michael Deily, and Laura Summers, Texas Public Policy Foundation, December 2012 (http://www.texaspolicy.com/library/docLib/2012-12-rr09-assuringfuturelongtermcareservices-chp-capretta.pdf).


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