Nebraska Department of Health and Human Services

Access Monitoring Review Plan

October 1, 2016

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1. STATEMENT OF PURPOSE

On November 2, 2015, the Centers for Medicare and Medicaid (CMS) issued its final rule with comment period for CMS-2328-FC (Access to Care Rule). This final rule requires that each state submit an initial access monitoring review plan (AMRP) by October 1, 2016, documenting the state's efforts to ensure adequate access to covered services for Medicaid-eligible individuals served through the state's fee-for-service (FFS) delivery system.

The State of Nebraska has developed this AMRP in accordance with the requirements detailed in 42 CFR §447.203, §447.204, and §447.205 as amended and based on additional technical assistance provided by CMS. This AMRP provides a description of the current Medicaid program, details changes underway to the Medicaid delivery system, documents the State's efforts to measure and monitor access to care, and describes the mechanisms the State of Nebraska will employ to assess how changes in FFS provider reimbursement rates will impact access to care for eligible individuals.

2. MEDICAID OVERVIEW

The State of Nebraska's Medicaid program is administered by the Department of Health and Human Services' (DHHS) Division of Medicaid and Long-Term Care (MLTC). Nebraska Medicaid provides health care services to eligible elderly and disabled individuals and eligible low-income pregnant women, children, and parents.

Approximately 230,000 Nebraskans receive medical coverage through Medicaid and the Children's Health Insurance Program (CHIP). For State Fiscal Year (SFY) 2015[1], Medicaid and CHIP expenditures totaled approximately $1.8 billion.

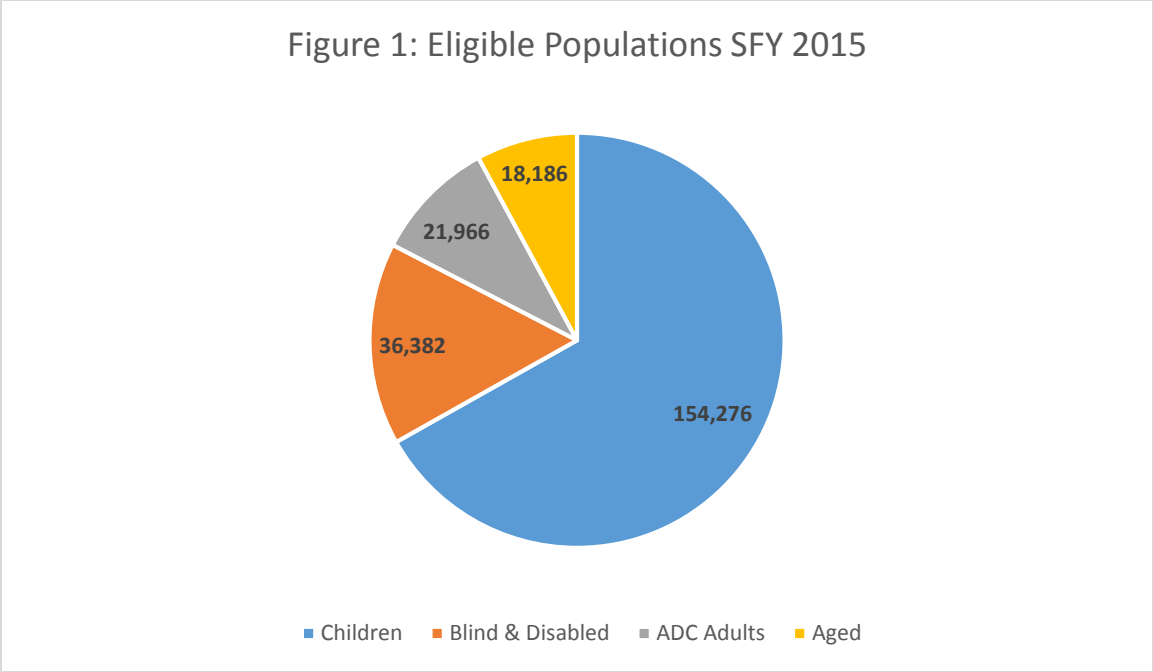
2.1 MEDICAID AND CHIP ELIGIBLE POPULATIONS

Nebraska Medicaid provides coverage for individuals in the following eligibility categories:

- Children,
- Former Foster Care Youth,
- Aged, Blind & Disabled (ABD),
- Pregnant Women, and
- Parent/Caretaker Relatives.

Eligibility factors vary by group and include income, resources, and employment status. Rules for Nebraska Medicaid eligibility are detailed in Nebraska Administrative Code (NAC) 477.

[1] The state fiscal year runs from July 1st to June 30th.



2.2 MEDICAID AND CHIP EXPENDITURES

Figure 2 shows the five largest categories of Medicaid and CHIP expenditures to vendors by vendor type. A comprehensive listing of expenditure categories is available in Attachment 1 – Nebraska Medicaid Reform Annual Report for State Fiscal Year 2015. Figure 3 shows SFY 2015 expenditures to vendors by eligibility category.

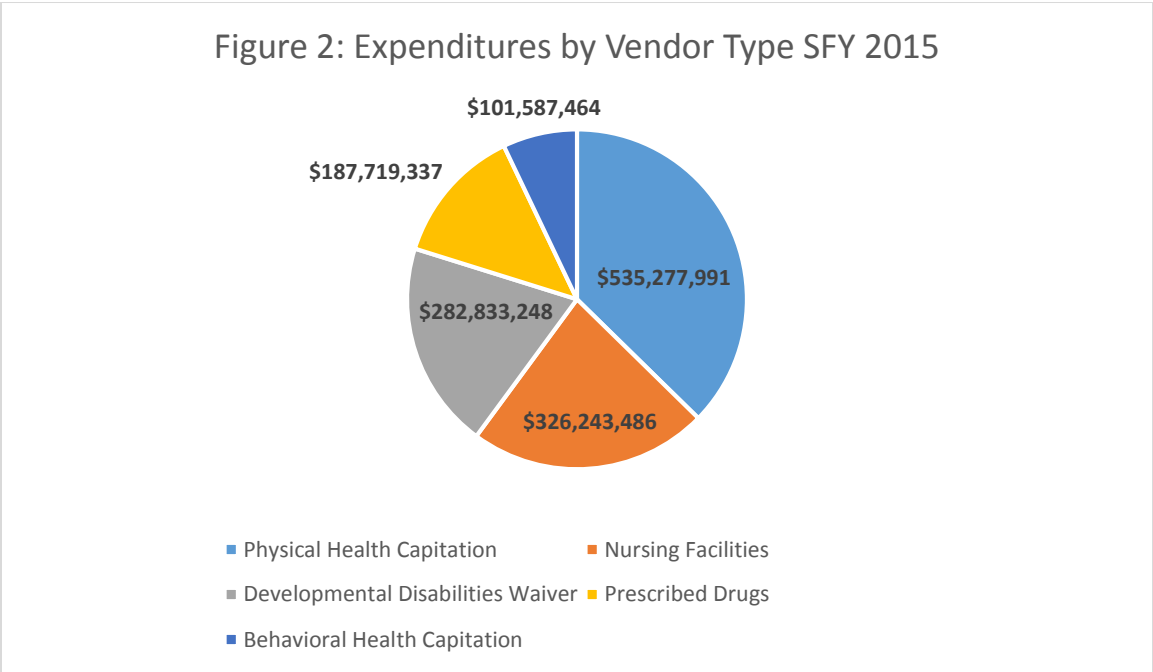
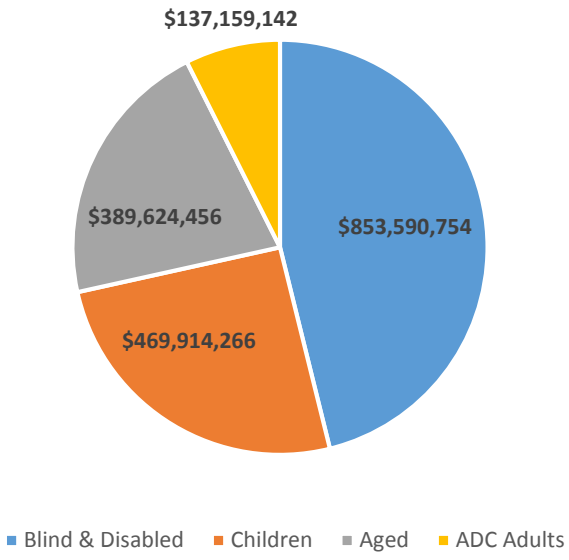


Figure 3: Expenditures by Eligibilty Category SFY 2015



2.3 MEDICAID DELIVERY SYSTEMS

2.3.1 CURRENT MANAGED CARE PROGRAM

Most Medicaid eligible individuals in Nebraska receive their health benefits through the managed care delivery system. The Nebraska Medicaid Managed Care Program (NMMCP), first implemented in July 1995, now includes approximately 189,000 individuals enrolled in physical health managed care and approximately 229,000 individuals enrolled in behavioral health managed care. Those individuals who are enrolled in behavioral health managed care, but not physical health managed care, receive their physical health services from Nebraska Medicaid under the FFS reimbursement model.

NMMCP is authorized under section 1932 of the Social Security Act, which permits a state to operate a managed care program through its Medicaid State Plan. Additionally, Nebraska operates a 1915(b) waiver requiring special needs children and Native Americans to participate in the managed care program. The 1915(b) waiver permits Nebraska Medicaid to operate the behavioral health managed care program.

NMMCP currently includes:

- Physical health managed care provided through risk-comprehensive contracts that are fully-capitated and require the contracted entity to be a managed care organization (MCO) or health insuring organization. “Comprehensive” means that the contracted entity is at financial risk to provide all the services in the core benefits package. The physical health managed care program was expanded from three (3) counties to all ninety-three (93) counties on July 1, 2012. The State of Nebraska currently contracts

with two MCO networks serving ten counties in the East-Central region of the state and two MCO networks serving the remaining eighty-three (83) counties.
- Behavioral health managed care provided through one, statewide prepaid inpatient health plan (PIHP) which is not comprehensive, but is fully-capitated. The current behavioral health managed care program was implemented on September 1, 2013.

2.3.2 IMPLEMENTATION OF HERITAGE HEALTH

On January 1, 2017, MLTC will launch the Heritage Health managed care program. The implementation of Heritage Health brings several changes to the State's managed care program including:

- Integration of physical and behavioral health managed care through three (3) MCO contracts operating in all ninety-three (93) counties in the state of Nebraska.
- Inclusion of pharmacy services in the core benefit package and the MCO capitation rate.
- Inclusion of the Aged, Blind and Disabled populations who are dually eligible for Medicaid and Medicare, in a home and community-based services (HCBS) waiver program, or living in an institution, for integrated physical health, behavioral health, and pharmacy services.

While individuals receiving long-term services and supports (LTSS) will be included in Heritage Health for their medical, behavioral health, and pharmacy services, their LTSS services, as detailed in Section 2.3.4, will continue to be administered through the legacy FFS delivery system.

With the implementation of Heritage Health, the only populations remaining in the legacy FFS program will be:

- Aliens who are eligible for Medicaid for an emergency condition only.
- Beneficiaries who have excess income or who are required to pay a premium, except those who are continuously eligible due to a share of cost obligation to a nursing facility or for HCBS Waiver services.
- Beneficiaries who have received a disenrollment or waiver of enrollment.
- Participants in the Program for All-Inclusive Care for the Elderly
- Beneficiaries with Medicare coverage where Medicaid only pays co-insurance and deductibles.
- Inmates of public institutions.

These remaining populations within the FFS program will constitute less than 2% of the Medicaid eligible population in Nebraska.

2.3.3 TRANSITION TO MANAGED DENTAL BENEFITS PROGRAM

MLTC is currently developing a request for proposals (RFP) to procure a dental benefits manager (DBM) that will administer the State's new Medicaid managed care dental

program. The DBM will be structured as a single, statewide, fully-capitated, prepaid ambulatory health plan (PAHP). MLTC is planning the release of the DBM RFP in late summer 2016 and anticipates that implementation of the program to start on July 1, 2017.

2.3.4 FEE-FOR-SERVICE PROGRAM

The following Medicaid services will continue to be administered through the FFS delivery system after the implementation of Heritage Health and the launch of the DBM:

- LTSS such as nursing facility custodial care, services provided in intermediate care facilities for persons with developmental disabilities (ICF/DD), HCBS waiver services, and personal assistance service (PAS).
- School-based services for Medicaid eligible children that provide speech therapy, occupational therapy, physical therapy, and personal assistance care based on the child's special education plan.
- Non-emergency medical transportation services which provide transportation for eligible individuals for medically-related appointments.

2.3.5 LONG-TERM CARE REDESIGN

MLTC has contracted with a consultant to develop recommendations for MLTC's future administration of long-term care services. The consultant is engaging stakeholders throughout the redesign process as it evaluates the needs of LTSS recipients, provider concerns, and the current LTSS program structure. A draft plan for long-term care redesign is scheduled to be released for stakeholder review and input in January 2017. MLTC anticipates the final redesign plan to be completed in May 2017.

Information about the long-term care redesign project is available at: http://dhhs.ne.gov/medicaid/Pages/medicaid_LTC.aspx

3. MEDICAID ACCESS TO CARE PROFILE

3.1 GENERAL ACCESS CHALLENGES

In Nebraska, challenges to accessing care for Medicaid eligible individuals are primarily driven by geographic factors. Nebraska ranks 45th in population density[2] with 23.8 persons per square mile. As illustrated in Attachment 2 – "Nebraska Counties Classified by Urban, Rural or Frontier Status", of the State's ninety-three (93) counties, forty-eight (48) are considered "rural" and thirty-one (31) are considered "frontier" for purposes of establishing managed care access standards.

The geographic challenges impeding access to care for Medicaid-eligible individuals are similar to challenges facing the general Nebraska patient population. Attachment 3 – "State-Designated Shortage Area – Medical and Mental Health", illustrates the shortage of practitioners by

[2] U.S. Census Bureau: 2010 Census

specialty type predominately in rural areas of the state. Access to behavioral health services in all areas other than the state's two largest metropolitan areas is limited as demonstrated in Attachment 4 – "State-Designated Shortage Areas Psychiatry & Mental Health".

3.2 ADDRESSING ACCESS THROUGH MANAGED CARE

MLTC views the ongoing transition to managed care as the State's primary mechanism for addressing Medicaid delivery challenges including ensuring adequate access to care for beneficiaries.

- Challenges in accessing behavioral health services, particularly in rural areas, were an important factor in the State's decision to launch its initial behavioral health managed care program in 2013. Improving access to behavioral health services is also an important element guiding the State's development of the Heritage Health integrated managed care program.
- Maintaining adequate access to primary care dentists and expanding access to dental specialists are key considerations in the decision to transition the State's FFS dental program to the MMDBP.

Managed care entities provide national-level expertise in the development of provider networks, along with more modern claims management systems and scalable prior authorization services for Medicaid providers. This expertise and infrastructure are important factors in encouraging and maintaining provider participation in the Medicaid program.

3.3 FEE-FOR-SERVICE POPULATION CHARACTERISTICS

Medicaid-eligibility for the populations remaining in the FFS delivery system is particularly volatile, which when combined with the small size of these populations, inhibits MLTC's ability to provide more exact projections for population size, composition, location, and service utilization. The estimates included in this section represent the State's best approximations based on analysis of those populations as they exist as of the submission date of this plan.

With the implementation of Heritage Health, MLTC projects that the Medicaid eligible populations remaining in the FFS delivery system, listed in Section 2.3.2, will constitute less than 2% of the overall Medicaid population. MLTC estimates that over the course of a calendar year, approximately 2,500 unique individuals will become Medicaid eligible within those remaining FFS population categories. Of those 2,500 eligible individuals, MLTC anticipates that approximately 50% are likely to be beneficiaries who have a share of cost obligation that must be met before that individual becomes Medicaid eligible.

4. MEASURING ACCESS TO CARE

4.1 ACCESS MEASUREMENT METHODOLOGY

MLTC utilized a ZIP Code Tabulation Area (ZCTA) analysis to evaluate access to care for the remaining FFS populations listed in Section 2.3.2. The analysis included Medicaid-enrolled providers for the required service categories listed in §§447.203(b)(5)(ii)(A-D). The geographic access standards used for the ZCTA analysis were based on the standards identified for the Heritage Health managed care program and included as Attachment 5 – "Heritage Health Access Standards".

4.2 ACCESS ASSESSMENT

MLTC's ZCTA-based analysis projects the following estimates of access for the access to care final rule's required service categories:

- 100% of the FFS population would have access to a primary care provider within MLTC standards.
- 100% of the FFS population would have access to some specialty services within MLTC standards.[3]
- Less than 1% of the FFS population may potentially lack access to a pre- and post-natal provider based on MLTC access standards.
- Less than 1% of the FFS population may potentially lack access to behavioral health services based on MLTC access standards.

4.2.1 HOME HEALTH SERVICES

In Nebraska, Home Health services for FFS populations are delivered primarily by Home Health agencies and private duty nurses. MLTC has not previously established geographic or timely services access standards for Home Health. The availability of these services are determined by the locations each provider chooses to serve and each providers' client capacity.

5. REIMBURSEMENT RATE ANALYSIS

5.1 RATE COMPARISON METHODOLOGY

MLTC chose services for its reimbursement rate comparison based on the list of services currently included in the State's enhanced primary care payments program (EPC). On December 31, 2014, the federal government ended funding for enhanced primary care reimbursement for certain primary care providers as required by final rule CMS-2370-F. The State of Nebraska

[3] The availability of specific specialty services will vary based on the location of the Medicaid FFS-eligible individual. As the Access to Care Final Rule did not include a list of specialists that states are required to analyze, MLTC included those Medicaid-enrolled Doctors of Medicine and Doctors of Osteopathic Medicine in this category who did not fall within the four other required service type categories.

chose to continue providing enhanced payments to qualifying providers for certain primary care services. These enhanced payments remain in effect as of the submission of this AMRP.

5.2 RATE COMPARISON

Attachment 6 – "Reimbursement Rate Comparison" details reimbursement rates for services included in the State's EPC payments program and non-EPC Nebraska Medicaid reimbursement rates for the same services included in the EPC list. The EPC and non-EPC rate lists are compared to the following rate schedules:

- Medicare reimbursement rates
- Iowa Medicaid reimbursement rates
- Colorado Medicaid reimbursement rates
- Texas Medicaid reimbursement rates

Attachment 6 – "Reimbursement Rate Comparison" includes a category code denoting which of the required services categories are impacted by each rate. A key for the category code is included in the attachment.

6. STAKEHOLDER OUTREACH

MLTC addresses the various stakeholder input requirements in the access to care final rule throughout this section. Section 6.1 summarizes the prior stakeholder input that guided the development of the AMRP. Section 6.2 details the AMRP public comment period as required by the amended §447.203(b).

6.1 INCORPORATING STAKEHOLDER INPUT

Prior to the release of the access to care final rule, MLTC did not employ a formal tracking process for capturing stakeholder access concerns for services provided through the FFS program. Notwithstanding the absence of a formal process, MLTC has received feedback through the Division's regular engagement with providers, recipients, advocacy organizations, and other stakeholders that includes concerns about the lack of access to certain covered services.

For purposes of analyzing access to services and reimbursement rates as required by the access to care final rule, MLTC determined that the service type categories included in §§447.203(b)(5)(ii)(A-E) sufficiently encompass those services that stakeholders have identified as areas where accessing care may have proven challenging in the past.

6.2 AMRP STAKEHOLDER FEEDBACK

On August 16, 2016, MLTC posted the draft AMRP for a thirty day public review and comment period on the State's Medicaid website at http://dhhs.ne.gov/medicaid/Pages/MedicaidPublicNotices.aspx

The State also issued a public notice alerting stakeholders and the general public to the AMRP release and the opportunity to comment on the draft. MLTC created a dedicated email address DHHS.AMRPComments@nebraska.gov for the submission of comments. The State did not receive any comments from the public.

7. ACCESS TO CARE MONITORING

7.1 INFORMATION REQUIREMENTS

As required by §447.204, prior to Nebraska Medicaid submitting a state plan amendment that proposes to reduce or restructure Medicaid service payment rates for services included in §§447.203(b)(5)(ii)(A-E), the Agency will consider the following:

- The data collected, and the analysis performed, under §447.203.
- Input from beneficiaries, providers and other affected stakeholders on beneficiary access to the affected services and the impact that the proposed rate change will have, if any, on continued service access.

7.2 WEBSITE REQUIREMENTS

As noted in Section 6.2, Nebraska Medicaid created a dedicated page for public review and comment on the State's proposed access monitoring review plan. That webpage or a similar dedicated page will be maintained and updated in accordance with the requirements in §447.205 which include:

- The site be clearly titled and easily reached from a hyperlink included on Web sites that provide general information to beneficiaries and providers, and included on the State specific page on the Federal Medicaid Web site.
- The site is updated for bulletins on a regular and known basis and the public notice is issued as part of the regular update.
- The site complies with national standards to ensure access to individuals with disabilities.
- Includes protections to ensure that the content of the issued notice is not modified after the initial publication and is maintained on the Web site for no less than a 3-year period.

Division of Medicaid & Long-Term Care

Nebraska Medicaid Reform Annual Report

December 1, 2015

Prepared in Accordance with Neb. Rev. Stat. § 68-908(4)

December 1, 2015

We are pleased to present the Medicaid Annual Report for State Fiscal Year 2015, which also includes the Children's Health Insurance Program (CHIP).

As outlined in this report, the Division of Medicaid and Long-Term Care continues its commitment to increase efficiency and manage costs of the Medicaid program in Nebraska. Many of our initiatives in SFY2015 resulted from new federal requirements and state legislation, most with the same target of better fiscal management and more efficient service provision. This report offers a review of the ongoing work of the Division, highlighting the year's major initiatives, describing the larger projects for the year ahead, and detailing the persons served and services provided through the program.

The Division is looking forward to working with the legislature and our community partners in the year ahead as we undertake major initiatives to improve the provision of services to our clients. We would like to highlight two initiatives. One will be the implementation of Heritage Health, Nebraska's new managed care program, which combines the delivery of physical, behavioral, and pharmacy services. Beginning January 1, 2017, each contracted managed care organization will provide a full range of services including physical health, behavioral health, and pharmacy services. The Division is also undertaking an effort to redesign its long-term services and supports (LTSS) system, an effort that will be ongoing over the next several years.

As we begin 2016, the Division is excited about the progress made and the work ahead. Please contact me if you have any questions about this report.

Sincerely,

Calder A. Lynch
Director
Division of Medicaid & Long-Term Care
Department of Health and Human Services

Nebraska Medicaid Annual Report
Neb. Rev. Stat. § 68-908(4)

I. INTRODUCTION

Medicaid is a public health insurance program that provides coverage for low-income individuals. Originally enacted in 1965 under Title XIX of the Social Security Act, Medicaid is an entitlement program (a program that guarantees benefits to anyone who meets the qualifications) covering a low-income population primarily including seniors, children and individuals with disabilities.

State Medicaid programs are administered by the states with oversight from the Centers for Medicare & Medicaid Services (CMS), part of the federal Department of Health and Human Services (HHS). Every state outlines the eligibility, benefits, provider payments, and service delivery systems of its specific Medicaid program within broad guidelines set by the federal government. Although there are numerous federal requirements, eligibility and benefit packages can vary widely from state to state.

The Children's Health Insurance Program (CHIP) was created in 1997 under Title XXI of the Social Security Act, and was designed to offer insurance coverage for low-income children with family income above Medicaid limits. States administer their CHIP programs in different ways. In Nebraska, CHIP is operated using the same delivery system, benefit package, and regulations as Medicaid.[1] Effective July 19, 2012, Nebraska implemented a separate CHIP program that adds prenatal and delivery services for the unborn children of certain women who do not meet Medicaid eligibility criteria. In 2014, another separate CHIP program (2101(f) CHIP) was implemented to cover those children who would otherwise have lost eligibility due to new eligibility rules created through the Patient Protection and Affordable Care Act (ACA). With both the CHIP expansion and stand-alone programs, Nebraska is now considered a CHIP combination state.

Medicaid and CHIP are financed jointly by the federal government and state governments, with the federal government matching state spending at a rate known as the Federal Medical Assistance Percentage (FMAP), which varies from state to state. FMAP is based on each state's per capita income relative to the national average and is highest in the poorest states, varying from 50% to 73%. Nebraska's FMAP in federal fiscal year (FFY) 2015[2] was 53.27% for Medicaid and 67.29% for CHIP.

[1] This is known as a "Medicaid expansion" unrelated to the Medicaid expansion in the Patient Protection and Affordable Care Act (ACA).

[2] October 1, 2014 to September 30, 2015

II. DISCUSSION

A. ELIGIBLE CLIENTS

Nebraska Medicaid provides coverage for individuals in the following eligibility categories:

- Children,
- Former Foster Care Youth,
- Aged, Blind & Disabled (ABD),
- Pregnant Women, and
- Parent/Caretaker Relatives.

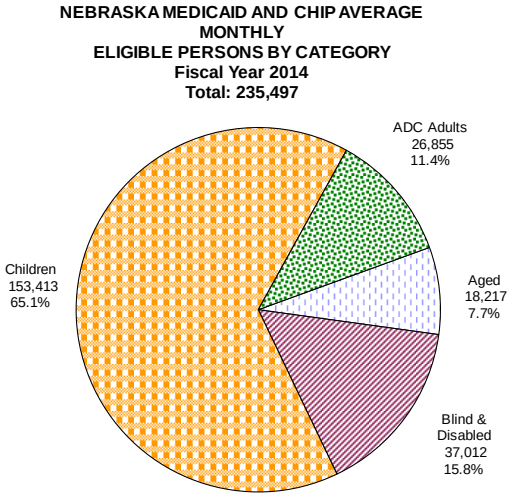
Eligibility factors vary by group and include income, resources, and employment status.

Nebraska's CHIP has operated since May 1998 and provides health coverage for eligible uninsured children if they have income at or below 213% of the federal poverty level (FPL) and are not eligible for Medicaid. As of July 2012, Nebraska implemented a separate CHIP program to provide coverage to the unborn children of women who are not otherwise eligible for Medicaid, have no creditable insurance, and meet financial requirements. The 2101(f) CHIP was implemented as a separate CHIP and expires on December 31, 2015.

The ACA requires the use of modified adjusted gross income (MAGI) as the income methodology for Medicaid and CHIP children, pregnant women and parents/caretaker relative groups. The ABD population is not subject to MAGI or other eligibility changes under the ACA.

ELIGIBLE POPULATIONS

FIGURE 1



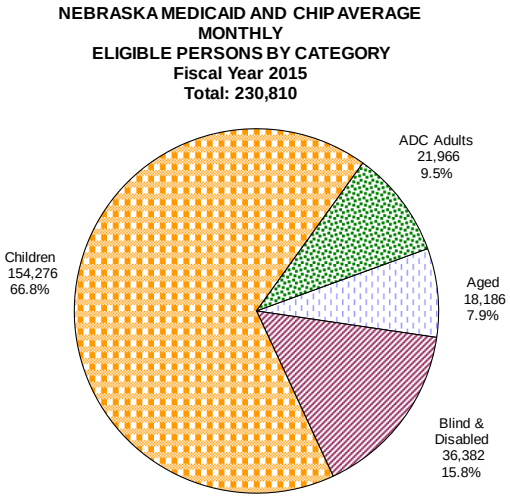
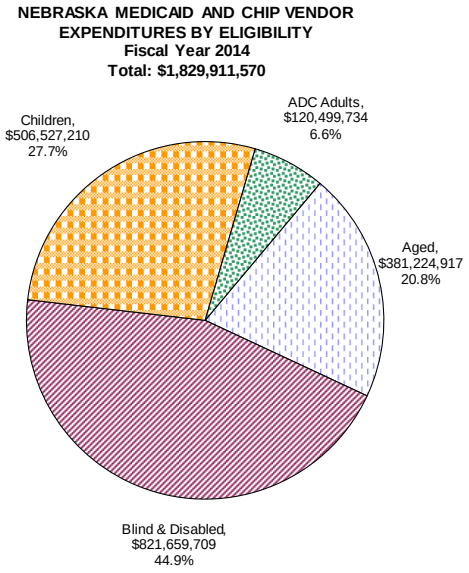


FIGURE 2



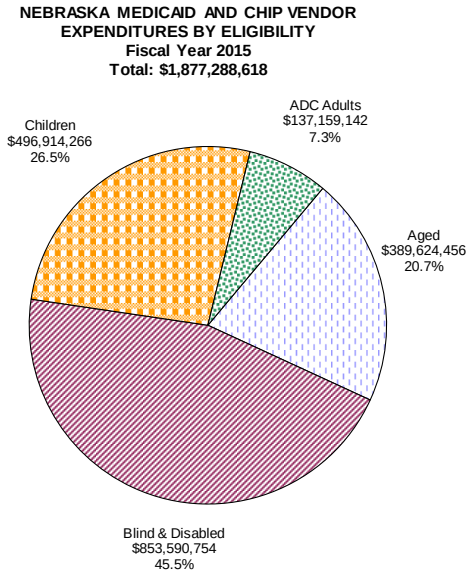


Figure 1 compares eligibility categories for state fiscal years[3] (SFYs) 2014 and 2015. The total decrease in average monthly eligibles from SFY 2014 to SFY 2015 was 2.0%. The largest percentage decrease was in the aid to dependent children (ADC) adults category, which was

[3] The state fiscal year runs from July 1st to June 30th.

reduced by 18.2%. Average monthly eligibles in the blind and disabled's category decreased by 1.7%. The children's category grew 0.6%, and the aged category decreased by 0.2%

Figure 2 compares vendor expenditures by eligibility category for SFYs 2014 and 2015. Viewing Figures 1 and 2 together provides insight into the cost differences of different eligibility categories. While the ABD category represents 23.7% of clients, they account for 66.2% of expenditures. This is almost the exact opposite of children, who account for 66.8% of clients but only 26.5% of expenditures.

Figure 2 does not account for all Medicaid and CHIP expenditures, in part because some payments and refunds are not specific to a recipient or eligibility category. Examples of transactions not included are drug rebates, payments made outside the Medicaid Management Information System (MMIS), and premium payments paid on behalf of persons eligible for Medicare. Client demographic data are not available for these expenditures. This means that some expenditures, particularly in the ABD categories, are understated.

Categories expected to decrease as a result of the transition to managed care did show a decrease. These categories are outpatient health, physician services, and inpatient hospital. The disabled category also experienced a substantial increase in home and community-based services (HCBS) for persons with developmental disabilities.

The aged category was the third largest growing eligibility category with expenditures increasing 2.2% from $381,224,917 in SFY 2014 to $389,624,456 in SFY 2015. The largest increase was in ADC Adults at 13.8% from $120,499,734 in SFY 2014 to $137,159,142 in SFY 2015. Children declined 1.9% in expenditures from $506,527,210 in SFY 2014 to $496,914,266 in SFY 2015.

B. COVERED SERVICES

Federal Medicaid statutes mandate states to provide certain services and allow states the option of providing other services. The Nebraska Medical Assistance Act (68-901 to 68-975) delineates the mandatory and optional services available to Medicaid and CHIP recipients in Nebraska.

Figure 3

Federal Medicaid Mandatory and Optional Services Covered in Nebraska
Neb. Rev. Stat. 68-911

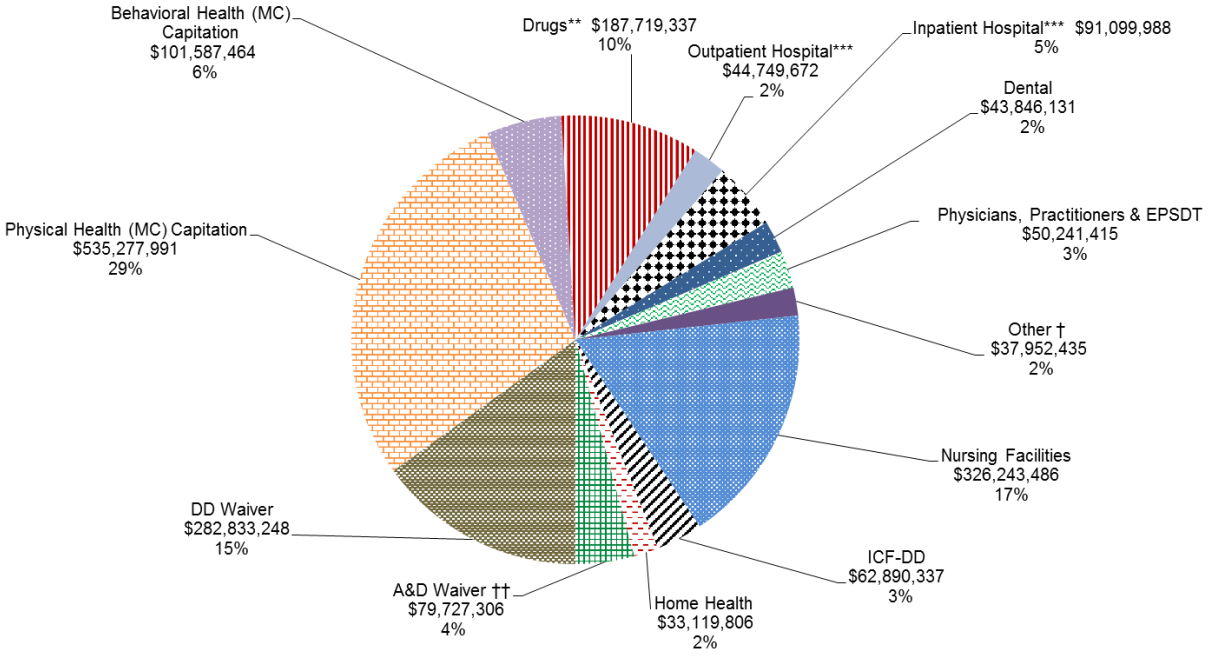
Mandatory Services	Nebraska Optional Services
• Inpatient and outpatient hospital services • Laboratory and x-ray services • Nursing facility services • Home health services • Nursing services • Clinic services • Physician services • Medical and surgical services of a dentist • Nurse practitioner services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

VENDOR EXPENDITURES

Figure 4 shows how the $1.88 billion in Medicaid/CHIP expenditures to vendors are distributed by vendor type. Total vendor payments increased $47,377,048 or 2.6% from SFY 2014 to SFY 2015. With the move to statewide managed care, there were service payments in SFY 2014 that became capitation payments in SFY 2015.

Figure 4

NEBRASKA MEDICAID AND CHIP VENDOR EXPENDITURES* BY SERVICE
FISCAL YEAR 2015
Total Vendor Payments $1,877,288,618



* Includes payments to vendors only, not adjustments, refunds or certain payments for premiums or services paid outside the Medicaid Payment System (MMIS) or NFOCUS.
** $106.7 million in offsetting drug rebates is not reflected in the drug expenditures of $187,719,337
*** DSH payments of $42.5 million are not reflected in Inpatient or Outpatient Hospital Expenditures
† Includes Speech/ Physical Therapy, Medical/Optical Supplies, Ambulance, and Lab/Radiology
†† A&D Waiver includes $678,185 of expenditures under the Traumatic Brain Injury waiver

A significant shift in the management and administration of Medicaid services has taken place over the past several years with the growth of managed care. Full risk managed care is a health care delivery system where managed care organizations (MCOs) are contracted to authorize, arrange, provide, and pay for the delivery of services to enrolled clients. Managed care facilitates access to a primary care provider, emphasizes preventive care and encourages the appropriate utilization of services in the most cost-effective setting. Nebraska Medicaid has utilized managed care in three urban counties since 1995, and added the seven surrounding counties in August 2010. As of July 1, 2012, Nebraska's managed care program was expanded statewide for physical health services. This move is projected to result in additional savings to Medicaid and CHIP over time. On September 1, 2013, Nebraska shifted its behavioral health program to an at-risk managed care model.

Figure 5 shows vendor expenditures from SFY 2014 and 2015 side by side. The expansion of physical health managed care to cover the remaining 83 counties explains the decrease in these services and the corresponding increase in managed care capitation payments.

Figure 5

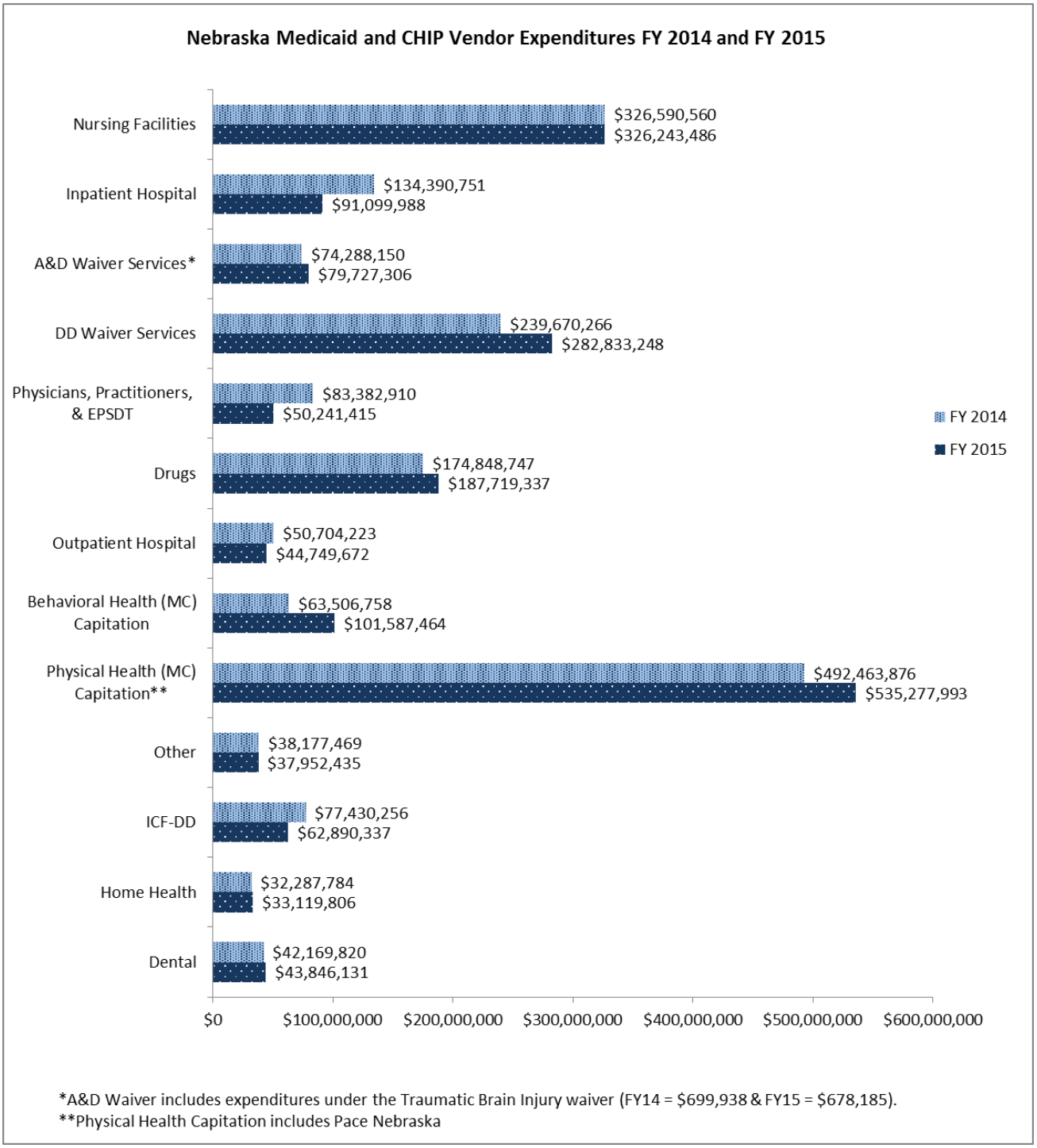
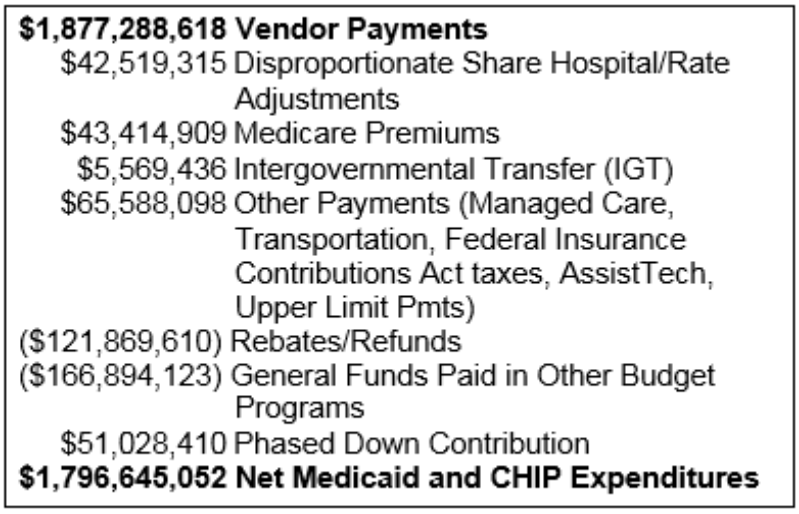


Figure 6



Not all Medicaid and CHIP expenditures are captured in Figure 4. Medicaid and CHIP vendor expenditures totaled $1,877,288,618 in SFY 2015. The net program expenditures for this same time period totaled $1,796,645,052. Several of these manual transactions are highlighted below.

Drug rebates are reimbursements made by pharmaceutical companies to Medicaid and CHIP that reduce individual drug costs to a more competitive or similar price that is being offered to other large drug payers, such as insurance companies. In SFY 2015, Medicaid received $106.7 million in drug rebates, an increase of 10.6% compared to the $96.5 million received in SFY 2014.

Disproportionate share hospital (DSH) payments are additional payments to hospitals that serve a high number of Medicaid and uninsured patients. In SFY 2015, Medicaid paid $42,519,315 through the DSH program, a 17.6% decrease compared to $51,614,426 paid in SFY 2014.

Medicaid pays the Medicare Part B premium for clients that are dually eligible for Medicare and Medicaid. In SFY 2015, Medicaid paid $43,414,909 for Medicare premiums, a 1.5% decrease from the $44,076,259 paid in SFY 2014. Part B premium amounts were $99.90 per month in calendar year (CY) 2012, $104.90 in CY 2013, CY 2014 and CY 2015. CY 2016 monthly premium amounts are estimated at $159.30.

Intergovernmental transfers (IGTs) are payments made to public providers that have 40% or higher Medicaid utilization and whose direct nursing or direct support costs have exceeded the Medicaid maximum allowable rate. In SFY 2015, Medicaid paid $5,569,436 for IGTs, an increase of 33.2% from the $4,182,764 paid in SFY 2014.

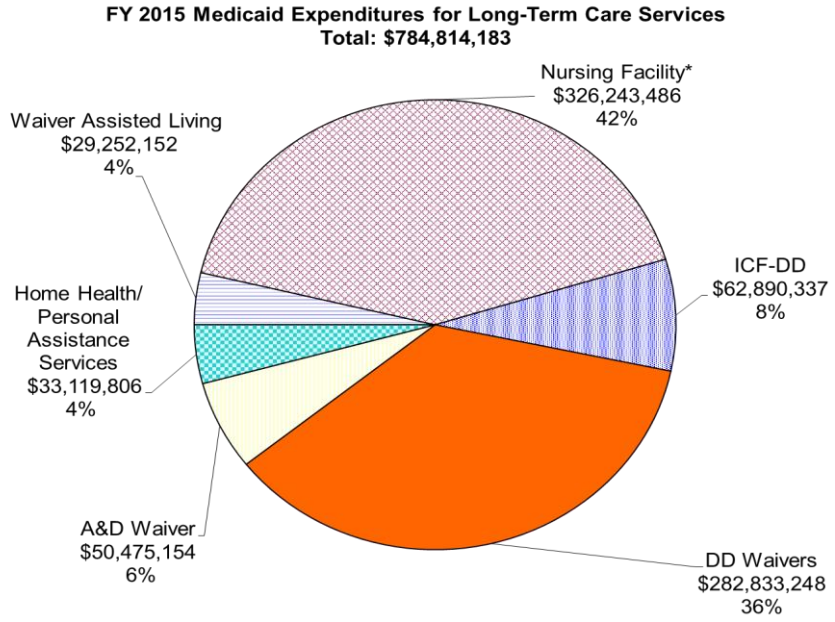
Part D clawback payments are made to CMS to cover the State's share of prescription drugs for persons dually eligible for both Medicare and Medicaid. In SFY 2015, Clawback payments totaled $51,028,410, a 1.4% decrease from the $51,740,416 paid in SFY 2014. The clawback payment

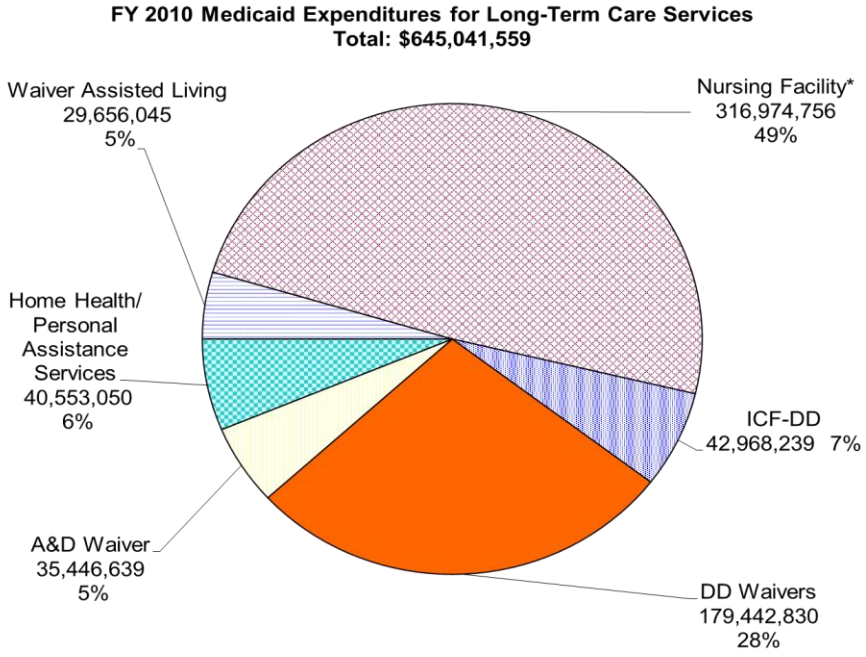
amount per person is based on a complex formula that takes into account the cost of drugs and the FMAP. Nebraska's FMAP has been steadily decreasing since FFY 2011.

LONG-TERM CARE SERVICES

Long-term care (LTC) services support individuals with chronic or ongoing health needs related to age or disability. Services are geared to multiple levels of client need ranging from limited assistance with activities of daily living to complex nursing interventions. Assistance can be offered in a variety of settings from care in an individual's home, to care in small group settings with community supports, to care in a nursing facility or intermediate care facility for persons with developmental disabilities. In general, home and community-based care is less expensive and offers greater independence for the consumer than facility-based care. For these reasons, state and federal initiatives encourage the development of care options in the community as an alternative to institutional care. Efforts to encourage home and community-based alternatives to facility based-care are resulting in a gradual rebalancing of LTC expenditures.

Figure 7





*Includes rate increase associated with LB600 implementation.
†A&D Waiver includes expenditures under the Traumatic Brain Injury waiver (FY10 = $505,112 & FY15 = $678,185).

C. PROVIDER REIMBURSEMENT

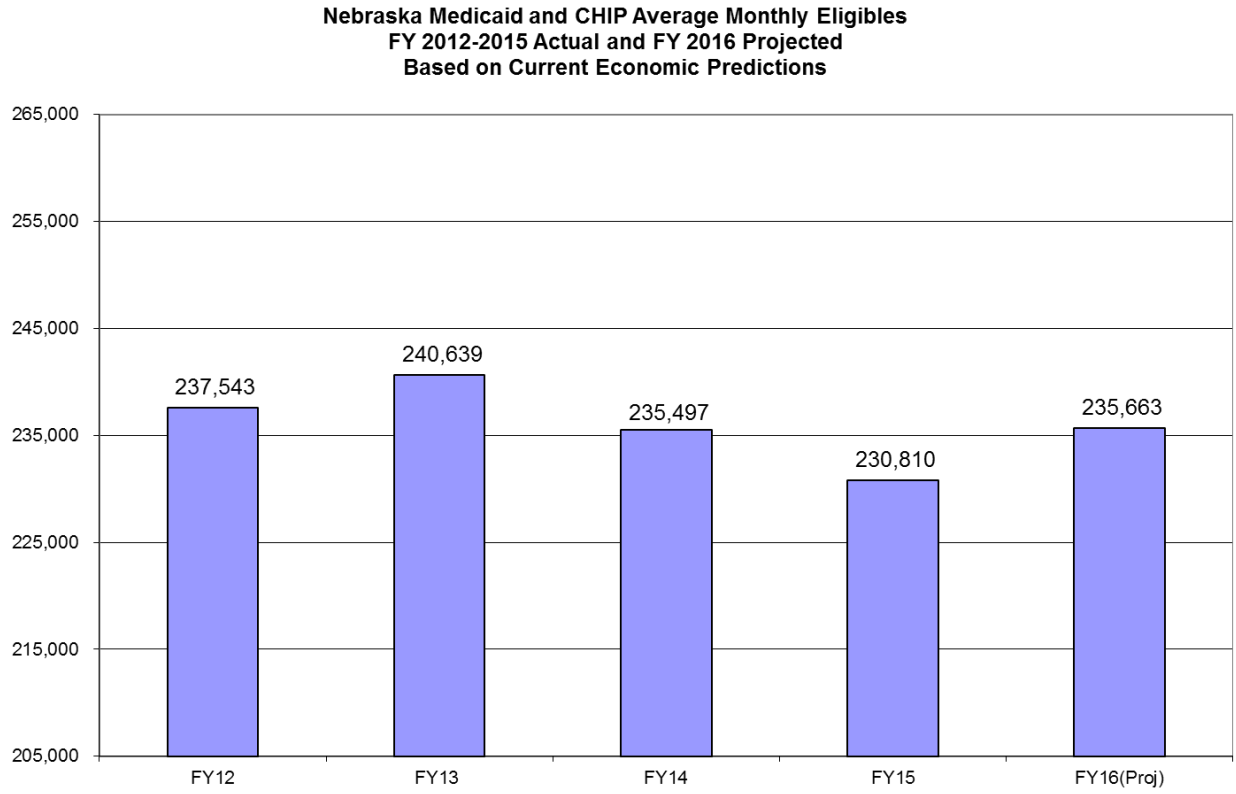
Medicaid purchases health services for clients on a fee-for-service (FFS) basis or, increasingly, by paying premiums to MCOs that coordinate provider networks and provider reimbursements.

The Nebraska Medicaid program uses different methodologies to reimburse different Medicaid FFS services. Practitioner, laboratory, and radiology services are reimbursed according to a fee schedule. Prescription drugs are reimbursed according to a discounted product cost calculation plus a pharmacy dispensing fee. Inpatient hospital services are reimbursed based on a prospective system using either a diagnosis related group (DRG) or per diem rate. Critical access hospitals (CAH) are reimbursed a per diem based on a reasonable cost of providing the services. Federally qualified health centers (FQHCs) are reimbursed on a prospective payment system. Rural health clinics (RHCs) are reimbursed their cost or a prospective rate depending on whether they are independent or provider-based. Outpatient hospital reimbursement is based on a percentage of the submitted charges. Nursing facilities are reimbursed a daily rate based on facility cost and client level of care. Intermediate care facilities for persons with developmental disabilities (ICF/DDs) are reimbursed on a per diem rate based on a cost model. HCBSs, including assisted living costs, are reimbursed at reasonable fees as determined by Medicaid.

In many states, budget and enrollment pressures on Medicaid have led to cuts in provider rates. Nebraska Medicaid providers have received rate increases every year from 2005 through 2015. Effective July 1, 2011 rates for all provider types, excepting primary care services, were decreased by 2.5%. Effective July 1, 2012, the rates that were decreased were increased 1.54%. Effective July 1, 2013, Medicaid rates were increased up to 2.25% to a maximum of 100% of Medicare rates as of January 1, 2013. This did not include primary care services which were increased as a result of implementation of the ACA. Effective July 1, 2014, rates were increased by up to 2.25% to a maximum of 100% of Medicare rates as of January 1, 2014. Effective July 1, 2015, the rates were again increased up to 2.25% to a maximum of 100% of Medicare rates for behavioral health, nursing facilities, assisted living and ICF-DD providers. Other Medicaid services rates were increased up to 2.00% to a maximum of 100% of Medicare rates. This rate increase did not include primary care service rates which were increased as a result of implementation of the ACA. FQHCs, RHCs are increased by Medicare economic index (MEI) as required by federal law. Indian Health Services (IHS) rates are established by CMS.

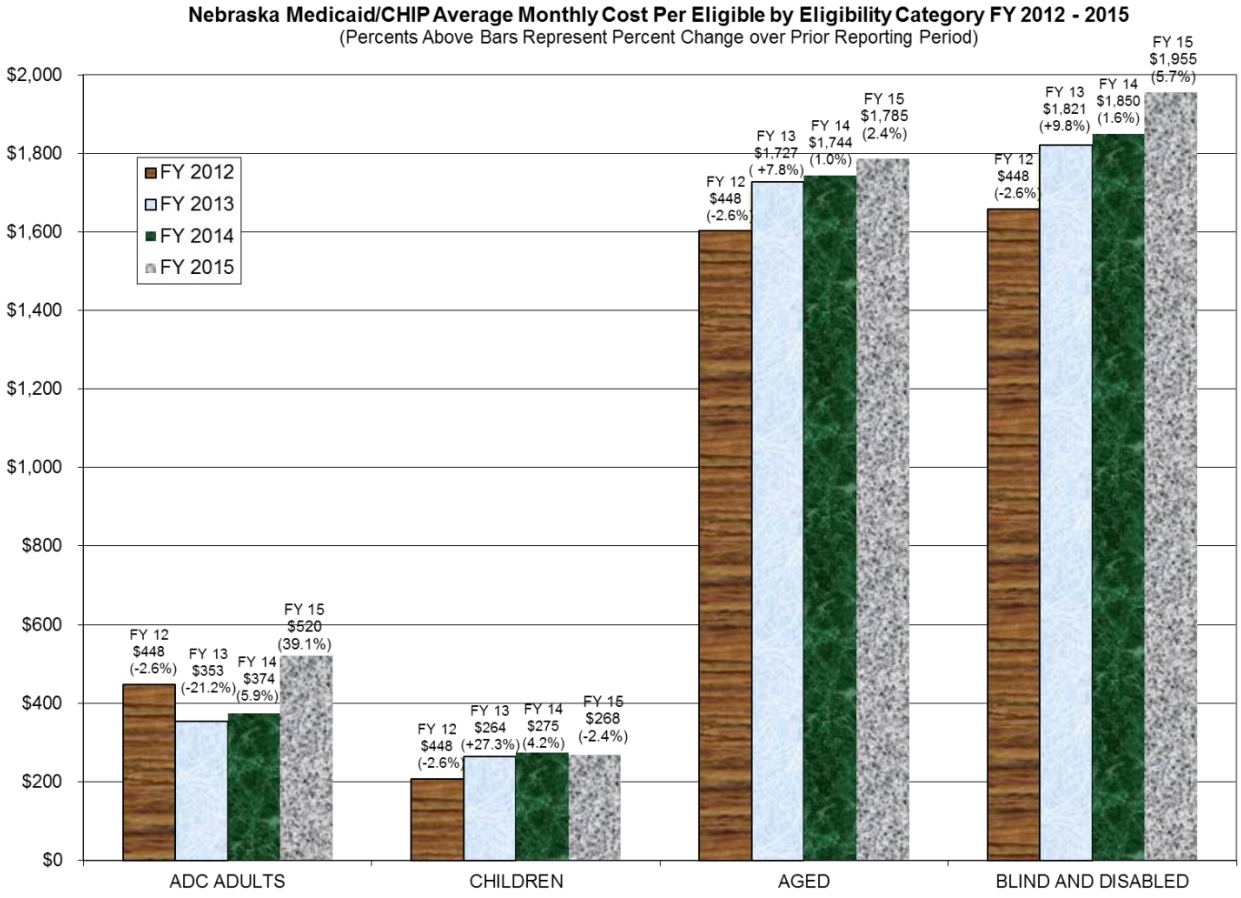
D. PROGRAM TRENDS AND PROJECTIONS

Figure 8



The increase in enrollment from SFY 2011 to SFY 2012 was a modest 0.9%, attributed in part to the statutory expansion of CHIP eligibility to 200% FPL and to the national economy. The number of eligibles increased 1.3% from SFY 2012 to SFY 2013 and then decreased 2.1% from SFY 2013 to SFY 2014. Based on historical trends, the average monthly eligibles in SFY 2016 are expected to increase by 2.1%.

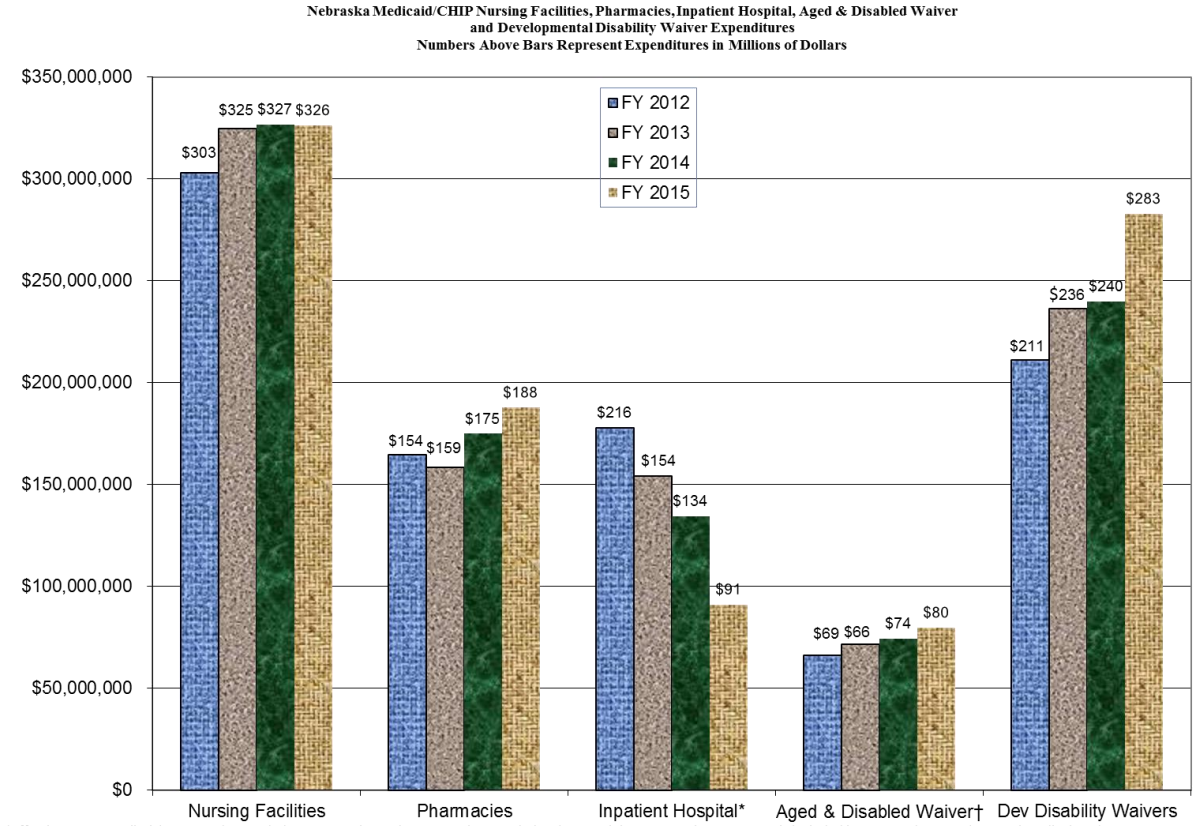
Figure 9



The average monthly cost per eligible (Figure 9) increased 4.7 % overall from SFY 2014 to SFY 2015. The largest cost per eligible increase was in the ADC Adults category, which increased by 39.1%. The Aged category increased by 2.4%. The Children category decreased by 2.4% and the Blind & Disabled category increased by 5.7%. As noted previously, decreases in expenditures in the Adult categories appear to be related, in large part, to the increasing inclusion of those clients in managed care.

The top four vendor expenditure categories in Medicaid and CHIP (excluding managed care capitation payments) are nursing facilities, pharmacies, inpatient hospital, and home and community services. The home and community service category consists of home health, personal assistance services and waiver services, including assisted living. Figure 10 reflects the trends in these categories from SFY 2012 through SFY 2015. The drop in inpatient hospital expenditures reflects inclusion in managed care.

Figure 10



*Effective 8-1-11, Full-Risk Managed expanded to 10 counties and on 7-1-12 it expandedto the remaining 83 counties. Inpt Hosp is included in Managed Care, other services displayed are not.
†A&D Waiver includes expenditures under the Traumatic Brain Injury Waiver (FY12 = $638,782, FY13 = $681,800, FY14 = $699,938, FY15 = $678,185).

E. SFY 2015 INITIATIVES

Highlighted below are some of the major projects during SFY 2015.

Enhanced Provider Enrollment and Screening Requirement

The ACA includes enhanced provider screening and enrollment requirements for all Medicaid service-rendering providers and those that order, refer, and prescribe services. Nebraska Medicaid implemented many of these requirements and is working with Maximus, Inc. to conduct provider screening and enrollment activities, including providing a web portal to simplify the application process, application and fee collection, database screening, and site visits. The implementation for the provider screening and enrollment web portal and other activities occurred December 1, 2015. CMS recently issued guidance about the ACA requirement to complete fingerprint based criminal background checks on providers (and the owners of those providers) determined to be high risk to commit Medicaid fraud. Implementation of the background checks is mandated by May of 2016.

ICD-10 – International Classification of Diseases Version 10

The federal DHHS mandated transition from the International Classification of Diseases version 9 (ICD-9) to ICD-10 for all Health Insurance Portability and Accountability Act of 1996 (HIPAA) covered entities (health care providers, clearinghouses and payers). Working in collaboration with the DHHS Information & Technology (IS&T) unit, MMIS requirements were developed; coding was completed and policies, forms and contracts were revised. External interface testing with trading partners started in April 2014, and significant systems changes were implemented on October 1, 2014. CMS delayed ICD-10 implementation until October 1, 2015. Because of this delay, providers will not be submitting claims with the ICD-10 codes until after that date. Additional testing and development along with communication and provider outreach activities continue. ICD-10 was implemented on October 1, 2015 without significant complications.

MITA 3.0 -- Medicaid Information and Technical Architecture (MITA)

The Medicaid IT Architecture (MITA) is a CMS initiative to establish national guidelines for technologies and processes that improve program administration for the State Medicaid Enterprise. CMS requires each state to complete a MITA 3.0 State Self-Assessment (SS-A) to obtain enhanced federal funding for its Medicaid program. All technology-related funding requests from the state Medicaid agency to CMS must now reference MITA status and explain how MITA maturity will be enhanced through the funded work. The Division completed the SS-A in December 2014.

Administrative Simplification

All HIPAA covered entities, including providers, clearinghouses and payers, are required to comply with the ACA requirements to implement the Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange® (CORE). The CORE Operating Rules are further standardization of the HIPAA Standard Electronic Transactions version 5010, implemented on January 1, 2012. Planning and implementation of the first two CORE phases began in 2013; these phases affect health plan eligibility (270/271) and health care

claim status (276/277) transactions. This project is known as Medicaid AS-ECS (Administrative Simplification – Eligibility and Claim Status). A RFP was issued to procure a solution to the real-time requirements. Edifecs was awarded the contract in November 2013. The AS-ECS project was implemented on March 9, 2015.

The CORE Operating Rule Phase III affected the Electronic Funds Transfer (EFT) and Health Care Payment and Remittance Advice (ERA or 835) transactions. This project is known as the AS-EFT/ERA (Administrative Simplification – Electronic Fund Transfer and Electronic Remittance Advice). This phase facilitated delivery of the 835, format changes of EFT to national banking standards, and standardized use of reason codes. Edifecs was awarded the contract to extend the enhanced web connectivity to these transactions in December 2014. The AS-EFT/ERA Project was implemented May 1, 2015.

The CORE Operating Rule Phase IV final federal regulations are expected in late 2015.

The Health Plan Identifier (HPID) final federal regulations have not yet been published. The Division of Medicaid and Long-Term Care has applied for and received an HPID for use in Medicaid standard HIPAA transactions when required.

Medicaid Upper Payment Limit

Starting in 2013, CMS required states to submit upper payment limit (UPL) demonstrations on an annual basis. Previously, this information was collected or updated only when a state was proposing an amendment to a reimbursement methodology in its Medicaid state plan. Starting in 2014, and annually thereafter, states are required to submit annual UPL demonstrations for inpatient hospital services, outpatient hospital services, clinics, physician services (for states that reimburse targeted physician supplemental payments), ICF/DD, private residential treatment facilities and institutes for mental diseases. This information must be submitted by the state prior to the start of each SFY. An RFP was issued to solicit proposals for qualified vendors to assist with these new requirements. The contract was awarded to Navigant. Nebraska complied with this requirement by submitting the UPL demonstrations to CMS in June 2015.

Primary Care Services at Medicare Rates

Effective January 1, 2013, Medicaid payment rates for primary care services furnished by certain physicians in CYs 2013 and 2014 cannot be less than the Medicare rates. This minimum payment level applies to specified primary care services furnished by a physician with a specialty designation of family medicine, general internal medicine, or pediatric medicine. The methodology for FFS payments and for managed care capitation rates was approved by CMS. Although the federal rule to pay certain physicians no less than the Medicare rates ends December 2014. The Department continues to reimburse these providers at the Medicare rates. The Department submitted a state plan amendment (NE SPA 15-003) to continue the Enhanced Primary Care Payment Program. The SPA was approved by CMS on June 18, 2015 for effective date of January 1, 2015.

Expanded Services in Physical Health Managed Care

Effective July 1, 2015, Nebraska Medicaid carved in the hospice (when provided in the home) and non-emergency transportation when provided by an ambulance services into the physical health managed care delivery system. In addition, clients eligible for Medicaid through the subsidized adoption and Women with Cancer programs became mandatory for enrollment into managed care for July 2015.

Nebraska Casemix System Web (NCSWeb)

In July 2014, Nebraska Medicaid implemented a live, secure web-based system for a small group nursing home providers. This case mix system allows providers to generate level of care reports as well as weighted days reports. It also enables them to see the status of their resident assessments in terms of timeliness, errors, reimbursement, accurate billing, resident data, and not having their claims rejected. This change eliminates the monthly and yearly mailing of reports to facilities. DHHS collaborated with the nursing facility associations to instruct providers on the use of the system. The use of this system was rolled out statewide in July 2015.

Health Information Exchange (HIE)

The Nebraska Health Information Initiative (NeHII) is the lead health information exchange (HIE) in Nebraska and has the capability to serve any health care provider. The main purpose of an HIE is to exchange laboratory, radiology, medication history, clinical documentation, public health information and other medical data among Nebraska providers and hospitals. Nebraska Medicaid submitted a funding request to CMS on behalf of NeHII in July 2013. This was approved in October 2014, and a contract between NeHII and MLTC was signed. This will allow NeHII to assist Medicaid providers in achieving meaningful use of their electronic health record (EHR) technology, which is one of the qualifications for the EHR Incentive Program. Several of the meaningful use measures relate to the exchange of key medical information.

Electronic Health Record (EHR) Incentive Payment Program

A new computer system was implemented on October 6, 2014 to support the electronic health record (EHR) incentive program. The new system is able to create dashboard reporting and other statistics on the EHR incentive program. It also created a provider portal for submitting and viewing the attestations as well as automating many of the functions performed by EHR incentive program staff. The EHR incentive program has paid over $64 million to Nebraska Medicaid providers since the program launched on May 7, 2012.

Eligibility and Enrollment System

The (ACA) requires significant changes to state Medicaid eligibility and enrollment (E&E) systems. Nebraska's current Medicaid eligibility system cannot meet the ACA requirements without significant modification and investment. As a result, Nebraska is implementing a new Medicaid E&E system. RFPs were issued for a new Medicaid eligibility solution and independent verification and validation (IV&V) activities associated with implementing a new Medicaid

eligibility solution. WIPRO was awarded the contract for the E&E on March 19, 2014 and the project began on August 28, 2014. First Data was awarded the IV&V contract. Through SFY14 the state and WIPRO solidified a project approach and continued to finalize business requirements. In October 2014 CMS announced the permanent extension of 90/10 enhanced funding for systems. Due to the extended funding opportunity the state and WIPRO have revised the approach and timeline. The updated go-live date is now the first quarter of 2017. The revision will ensure the state is able to fully test and successfully implement the new system.

Transformed-Medicaid Statistical Information System (T-MSIS)

The T-MSIS project, started in January 2013, is the expansion of federal reporting measures from the states' MMISs. The new report will be submitted to CMS monthly instead of quarterly as is the current practice. Report data has been expanded to include: eligibility information, health care quality measures, and managed care measures in addition to medical services claims and frequency reporting. Implementation and submission of T-MSIS reporting will begin in January 2016.

F. SFY2016 PROJECTS

Many of the SFY 2015 projects detailed above will continue in SFY 2016. In addition, new projects will be implemented.

MMIS Replacement Project

The current MMIS has served the state well for over 35 years, but has become complex as the Medicaid program has evolved. The planning effort to replace the existing system with a solution that will meet the long-term goals of DHHS has continued with completion of a strategic analysis. This analysis included reviewing numerous replacement options, conducting cost benefit analysis, analyzing the marketplace for solution support and developing a phased-in/modular approach leveraging current vendor contracts and proposed program changes.

A primary focus will be procuring data management and analytics tools to improve access to quality and timely data and enhance capabilities to ensure quality, medically necessary and cost-effective services are being provided. As more individuals with Medicaid have their healthcare covered through a risk-based MCO, there will be less need for a traditional MMIS to process claims. The costs associated with building and operating a new system for small volumes of fee-for-service claims does not make financial sense. The approach that best supports the future Medicaid program is to leverage existing technical infrastructure through a Claims Broker Services arrangement with an MCO. This innovative solution is projected to cost less than a traditional MMIS and also take less time to implement.

Managed Care Enrollment Broker

Nebraska Medicaid is expanding services available from the Managed Care Enrollment Broker. A RFP will be released in early 2016 for these services. The Enrollment Broker contract will provide choice counseling and education to Medicaid members enrolling in a managed care plan. The broker will provide services on an enrollment web portal and will offer a call center to assist m members in plan selection and primary care provider selection and assists members with changing of managed care plans. The Enrollment Broker provides information and counselling regarding the managed care plans and service providers enrolled with Nebraska Medicaid. The information assists members in health care management. The Enrollment Broker will provide real time data exchange with the Medicaid eligibility system and the managed care companies. This allows for immediate communication between parties to better serve the members. The Enrollment Broker is responsible for providing choice counseling services to members, auto-enrolling members if a plan is not selected, capitation payment calculation, and providing information on managed care plans and healthcare providers. The Enrollment Broker services are targeted for implementation September 2016.

Heritage Health

In October 2015, the Department released a request for proposal (RFP) to procure three statewide Managed Care Organizations (MCOs) who will provide integrated physical health, behavioral health, and the pharmacy benefits into the managed care delivery system. In addition, clients who receive LTSS will be carved into the integrated managed care delivery system for their physical,

behavioral, and pharmacy services. The LTSS services will continue to be carved out of managed care and will continue to be reimbursed Fee-For-Service. Contract awards are expected in spring 2016 and this program, Heritage Health, will launch January 1, 2017.

Long-Term Services and Supports (LTSS) Redesign

In light of the CMS Home and Community Based Services new regulations and the Department of Labor Home Care Rule, work has begun to examine the current delivery of long-term services and supports, the appropriate authorities for LTSS, examine if duplication exists, and where gaps may exist with existing services. Examples of long-term care services are Home and Community Based waiver services, nursing facility, the personal assistance service, the home health service, and the Private Duty Nursing service. MLTC will seek input into the design of the current services, and redesign of the LTSS services from a broad group of stakeholders.

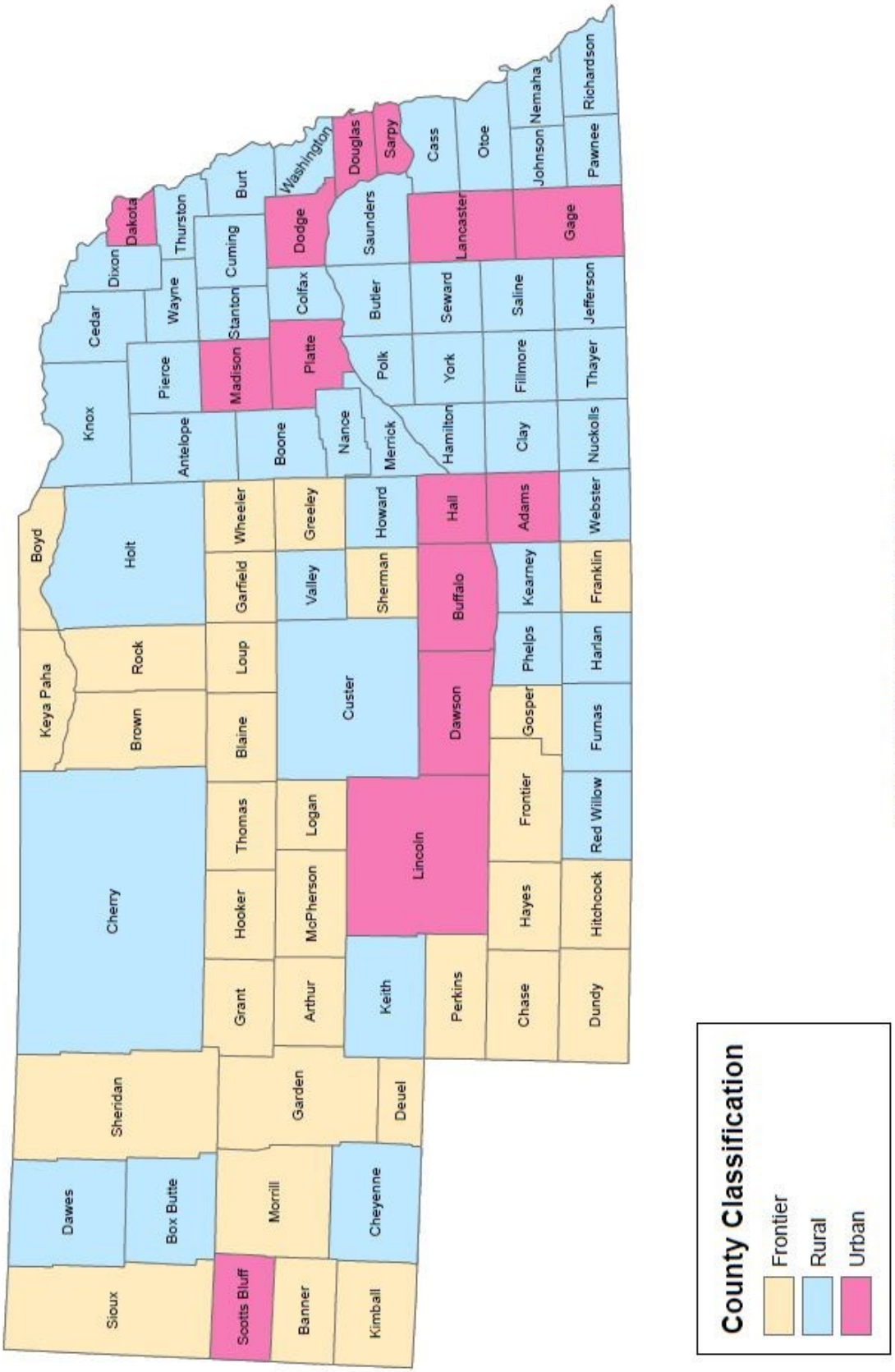
III. CONCLUSION

MLTC strives to operate a Medicaid program which addresses the health care needs of eligible low-income Nebraska residents in a cost-effective and deliberately planned manner. While the number of Medicaid-eligible clients has increased in recent years due to economic conditions, the program and policies referenced in this report have moderated the growth of Medicaid expenditures. These policies and initiatives slow the growth of the Medicaid program and further fiscal sustainability by making the program more efficient and cost-effective through careful management of services, better delivery of care, more appropriate services and improved program administration.

The Division looks forward to continuing to work with the Governor, the Legislature, the Medicaid Reform Council, and stakeholders to improve and sustain Medicaid for current and future generations.

Attachment 2

Nebraska Counties Classified by Urban/Rural/Frontier Status



Source: 2010 Census, US Census Bureau

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1	ADAMS	*	X			X	X
2	ANTELOPE	X	X	X	X		X
3	ARTHUR	X	X	X	X	X	X
4	BANNER	X	X	X	X	X	X
5	BLAINE	X	X	X	X	X	X
6	BOONE		X		X	X	X
7	BOX BUTTE	X	X	X	X	X	X
8	BOYD			X	X	X	X
9	BROWN	X		X	X	X	X
10	BUFFALO	*	X			X	X
11	BURT	X	X	X	X	X	X
12	BUTLER		X**	X**	X**		X**
13	CASS	*	X**	X**	X**	X**	X**
14	CEDAR	X	X	X	X	X	X
15	CHASE	X (9/1/13)	X	X	X	X	X
16	CHERRY	X	X	X	X		X
17	CHEYENNE	X	X	X	X		X
18	CLAY	X	X	X	X	X	X
19	COLFAX	X	X	X	X	X	X
20	CUMING	X	X	X	X		X
21	CUSTER	X (12/1/2013)	X	X	X	X	X
22	DAKOTA	*	X	X	X	X	X
23	DAWES	X	X	X	X		X
24	DAWSON	*	X	X	X	X	X
25	DEUEL	X	X	X	X	X	X
26	DIXON	X	X	X	X	X	X
27	DODGE	*	X			X	X
29	DUNDY	X	X	X	X		X
30	FILLMORE		X	X	X		
31	FRANKLIN	X	X	X	X	X	X
32	FRONTIER	X	X	X	X	X	X
33	FURNAS	X	X	X	X	X	X
34	GAGE	*	X**	X**	X**	X**	X**
35	GARDEN	X	X	X	X	X	X
36	GARFIELD	X	X	X	X	X	X
37	GOSPER	X	X	X	X	X	X
38	GRANT	X	X	X	X	X	X
39	GREELEY	X	X	X	X	X	X
40	HALL	*	X	X	X	X	X
41	HAMILTON		X	X	X		X

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42	HARLAN	X	X	X	X	X	X
43	HAYES	X	X	X	X	X	X
44	HITCHCOCK	X	X	X	X	X	X
45	HOLT	X	X	X	X	X	X
46	HOOKER		X	X	X	X	X
47	HOWARD		X	X	X		X
48	JEFFERSON	X	X	X	X		X
49	JOHNSON	X	X	X	X	X	X
50	KEARNEY	X	X	X	X	X	X
51	KEITH	X	X	X	X		X
52	KEYA PAHA	X	X	X	X	X	X
53	KIMBALL	X	X	X	X	X	X
54	KNOX	X	X	X		X	X
56	LINCOLN	*	X	X	X		X
57	LOGAN	X	X	X	X	X	X
58	LOUP	X	X	X	X	X	X
59	MCPHERSON	X	X	X	X	X	X
60	MADISON	*	X	X		X	X
61	MERRICK	X	X	X	X		X
62	MORRILL	X	X	X	X	X	X
63	NANCE	X	X	X	X	X	X
64	NEMAHA		X	X	X		X
65	NUCKOLLS		X	X	X	X	X
66	OTOE	*	X**	X**	X**	X**	X**
67	PAWNEE		X	X	X	X	X
68	PERKINS		X	X	X		X
69	PHELPS	X	X	X	X		X
70	PIERCE	X	X	X	X		X
71	PLATTE	*	X	X	X	X	X
72	POLK	X	X	X	X	X	X
73	RED WILLOW		X	X	X		X
74	RICHARDSON	X	X	X	X	X	X
75	ROCK	X (9/1/2013)	X	X	X	X	X
76	SALINE		X**	X**	X**	X**	X**
78	SAUNDERS	*	X**	X**	X**	X**	X**
79	SCOTTS BLUFF	*	X	X			X
80	SEWARD	*	X**	X**	X**	X**	X**
81	SHERIDAN	X	X	X	X		X
82	SHERMAN	X	X	X	X	X	X
83	SIOUX	X	X	X	X	X	X

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84	STANTON	**X**	**X**	**X**	**X**	**X**	**X**
85	THAYER	**X**	**X**	**X**	**X**	**X**	**X**
86	THOMAS	**X**	**X**	**X**	**X**	**X**	**X**
87	THURSTON	**X**	**X**	**X**	**X**	**X**	
88	VALLEY	**X**	**X**	**X**	**X**		**X**
89	WASHINGTON	*	**X****	**X****	**X****	**X****	**X****
90	WAYNE	**X**	**X**	**X**	**X**	**X**	**X**
91	WEBSTER	**X (12/1/2014)**	**X**	**X**	**X**	**X**	**X**
92	WHEELER	**X**	**X**	**X**	**X**	**X**	**X**
93	YORK	**X (1/1/2014)**	**X**	**X**	**X**		**X**
	One World Community Health Center (Omaha)	**X**	*	*	*	*	*
	Charles Drew Health Center (Omaha)	**X (8/1/2013)**	*	*	*	*	*
	Good Neighbor Community Health Center (Columbus)	**X**	*	*	*	*	*
	Norfolk Community Health Care Clinic	**X**	*	*	*	*	*
	Community Action Partnership of Western Nebraska (CAPWN) (Gering)	**X**	*	*	*	*	*
	People's Health Center (Lincoln)	**X**	*	*	*	*	*
	Ponca Tribe of Nebraska - Fred LeRoy Health & Wellness Center (Omaha)		*	*	*	*	*

State of Nebraska employees are NOT eligible for the rural incentive programs.

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X** indicates only part of the county is a shortage area for that specialty
Numbered footnotes are on page 4

COUNTY NUMBER	COUNTY NAME	FAMILY PRACTICE see footnote (1)	GENERAL INTERNAL MEDICINE see footnote (2)	GENERAL PEDIATRICS see footnote (3)	OB/GYN see footnote (4)	GENERAL SURGERY see footnote (5)	PSYCHIATRY & MENTAL HEALTH see footnote (6)

STATE DESIGNATED MEDICAL AND MENTAL HEALTH
SHORTAGE AREAS - Statewide Review 2013
FOOTNOTES

(1) For purposes of the financial incentive programs under the Rural Health Systems and Professional Incentive Act (the Act), a physician must be board eligible or board certified in and practice "Family Medicine" in one of the state-designated family medicine shortage areas. A physician assistant must be practicing under the supervision of a physician who is board eligible or board certified in family medicine in one of the family medicine shortage areas to be eligible for financial incentives under the Act.

(2) For purposes of the financial incentive programs under the Rural Health Systems and Professional Incentive Act (the Act), a physician must be board eligible or board certified in and practice "general internal medicine" in one of the state-designated general internal medicine shortage areas. A physician assistant must be practicing under the supervision of a physician who is board eligible or board certified in general internal medicine in one of the general internal medicine shortage areas to be eligible for financial incentives under the Act.

(3) For purposes of the financial incentive programs under the Rural Health Systems and Professional Incentive Act (the Act), a physician must be board eligible or board certified in and practice "general pediatrics" in one of the state-designated general pediatric shortage areas. A physician assistant must be practicing under the supervision of a physician who is board eligible or board certified in general pediatrics in one of the general pediatric shortage areas to be eligible for financial incentives under the Act.

(4) For purposes of the financial incentive programs under the Rural Health Systems and Professional Incentive Act (the Act), a physician must be board eligible or board certified in and practice "Obstetrics & Gynecology" in one of the state-designated OB/GYN medicine shortage areas. A physician assistant must be practicing under the supervision of a physician who is board eligible or board certified in OB/GYN in one of the OB/GYN shortage areas to be eligible for financial incentives under the Act.

(5) For purposes of the financial incentive programs under the Rural Health Systems and Professional Incentive Act (the Act), a physician must be board eligible or board certified in and practice "general surgery" in one of the state-designated general surgery shortage areas. A physician assistant must be practicing under the supervision of a physician who is board eligible or board certified in general surgery in one of the general surgery shortage areas to be eligible for financial incentives under the Act.

(6) For purposes of the financial incentive programs under the Rural Health Systems and Professional Incentive Act (the Act), a physician must be board eligible or board certified in and practice "psychiatry" in one of the state-designated psychiatry shortage areas. A physician assistant must be practicing under the supervision of a physician who is board eligible or board certified in psychiatry in one of the psychiatry shortage areas to be eligible for financial incentives under the Act.

(7) For purposes of the financial incentive programs under the Rural Health Systems and Professional Incentive Act (the Act), a nurse practitioner's training and supervision will be taken into consideration to determine the appropriate shortage area. The Rural Health Advisory Commission will review individual cases.

Nebraska Office of Rural Health
(402) 471-2337
12/02/2014

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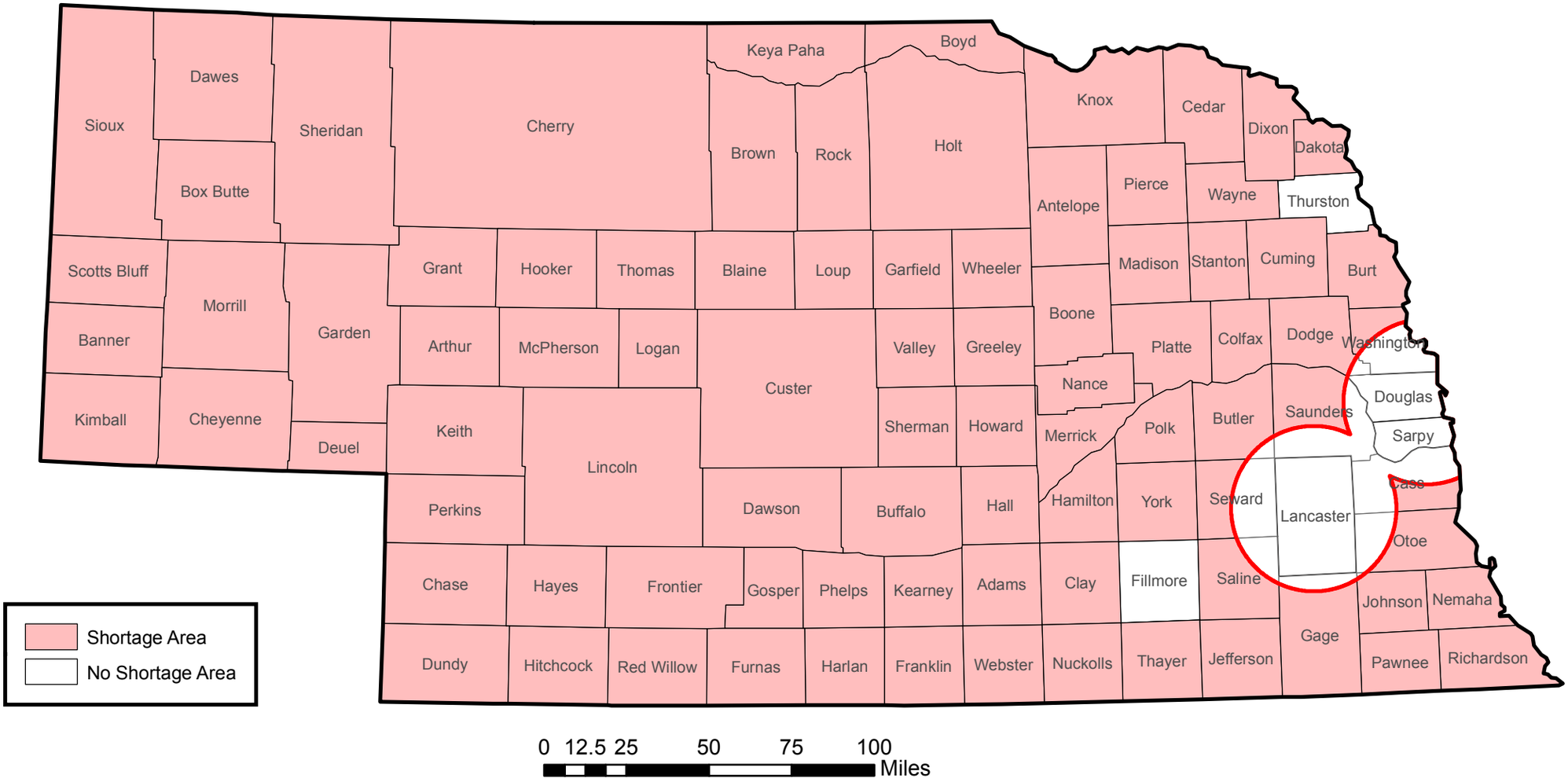
State-Designated Shortage Areas
Psychiatry & Mental Health

Nebraska



Source: Rural Health Advisory Commission
DHHS - Nebraska Office of Rural Health
Statewide Review: 2013
Last Updated: July 2013

Cartography: Clark Sintek | Community & Regional Planning Intern | DHHS
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Attachment 5
Heritage Health Access Standards

Appointment Availability Access Standards

1. Emergency services must be available immediately upon presentation at the service delivery site, 24 hours a day, seven days a week. Members with emergent behavioral health needs must be referred to services within one hour generally and within two hours in designated rural areas.

2. Urgent care must be available the same day and be provided by the PCP or as arranged by the MCO.

3. Non-urgent sick care must be available within 72 hours, or sooner if the member's medical condition(s) deteriorate into an urgent or emergent situation.

4. Family planning services must be available within seven calendar days.

5. Non-urgent, preventive care must be available within 4 weeks.

6. PCPs who have a one-physician practice must have office hours of at least 20 hours per week. Practices with two or more physicians must have office hours of at least 30 hours per week.

7. For high volume specialty care, routine appointments must be available within 30 calendar days of referral. High volume specialists include cardiologists, neurologists, hematologists/oncologists, OB/GYNs, and orthopedic physicians. For other specialty care, consultation must be available within one month of referral or as clinically indicated.

8. Laboratory and x-ray services must be available within three weeks for routine appointments and 48 hours (or as clinically indicated) for urgent care.

9. Maternity care must be available within 14 calendar days of request during the first trimester, within seven calendar days of request during the second trimester, and within three calendar days of request during the third trimester. For high-risk pregnancies, the member must be seen within three calendar days of identification of high risk by the MCO or maternity care provider, or immediately if an emergency exists.

Geographic Access Standards

1. The MCO must, at a minimum, contract with two PCPs within 30 miles of the personal residences of members in urban counties; one PCP within 45 miles of the personal residences of members in rural counties; and one PCP within 60 miles of the personal residences of members in frontier counties.

2. The MCO must, at a minimum, contract with one high volume specialist within 90 miles of personal residences of members. High volume specialties include cardiology, neurology, hematology/oncology, obstetrics/gynecology, and orthopedics.

3. The MCO must secure participation in its pharmacy network of a sufficient number of pharmacies that dispense drugs directly to members (other than by mail order) to ensure convenient access to covered drugs.

    a. In urban counties, a network retail pharmacy must be available within five miles of 90% of members' personal residences.

    b. In rural counties, a network retail pharmacy must be available within 15 miles of 70% of members' personal residences.

    c. In frontier counties, a network retail pharmacy must be available within 60 miles of 70% of members' personal residences.

4. The MCO must, at a minimum, contract with behavioral health inpatient and residential service providers with sufficient locations to allow members to travel by car or other transit provider and return home within a single day in rural and frontier areas. If it is determined by MLTC that no inpatient providers are available within the access requirements, the MCO must develop alternative plans for accessing comparable levels of care, instead of these services, subject to approval by MLTC.

5. The MCO must, at a minimum, contract with an adequate number of behavioral health outpatient assessment and treatment providers to meet the needs of its members and offer a choice of providers. The MCO must provide adequate choice within 30 miles of members' personal residences in urban areas; a minimum of two providers within 45 miles of members' personal residences in rural counties, and a minimum of two providers within 60 miles of members' personal residences in frontier counties. If the rural or frontier requirements cannot be met because of a lack of behavioral health providers in those counties, the MCO must utilize telehealth options.

6. The classification of counties according to urban, rural, and frontier status is included as Attachment 3, with classifications based upon data from the most recent U.S. Census.

7. The MCO must contract with a sufficient number of hospitals to ensure that transport time will be the usual and customary, not to exceed 30 minutes, except in rural areas where access time may be greater. If greater, the standard needs to be the community standard for accessing care, and exceptions must be justified and documented to the State on the basis of community standards.

Attachment 6 - Reimbursement Rate Comparison

Procedure Code	Modifier	Category Code	2016 NE EPC Fee Schedule	2016 Non-EPC NE Medicaid Rate	2016 Medicare Rate	EPC Comparison	2016 IA Medicaid Rate	EPC Comparison	2016 CO Medicaid Rate	EPC Comparison	2016 TX Medicaid Rate	EPC Comparison
90471			$23.46	$5.80	$23.46	0.00%	$5.09	-360.90%	$21.68	-8.21%	$7.84	-199.23%
90472			$11.74	$5.80	$11.68	-0.51%	$5.09	-130.65%	$12.59	6.75%	$7.84	-49.74%
90473			$23.46	$5.80	$23.46	0.00%	$12.88	-82.14%	$21.68	-8.21%	$7.84	-199.23%
90474			$11.74	$5.80	$11.68	-0.51%	$6.86	-71.14%	$12.59	6.75%	$7.84	-49.74%
90633	SL		$19.82	$10.71	N/A	N/A	$30.35	34.70%	N/A	N/A	$30.73	35.50%
90647	SL		$19.82	$10.71	N/A	N/A	$20.91	5.21%	N/A	N/A	N/A	N/A
90648	SL		$19.82	$10.71	N/A	N/A	$22.52	11.99%	N/A	N/A	$24.39	18.74%
90649	SL		$19.82	$10.71	N/A	N/A	$145.36	86.36%	$163.98	87.91%	$158.07	87.46%
90650	SL		$19.82	$10.71	N/A	N/A	MP	N/A	$163.98	87.91%	$138.14	85.65%
90655	SL		$19.82	$10.71	N/A	N/A	$14.30	-38.60%	N/A	N/A	N/A	N/A
90656	SL		$19.82	$10.71	N/A	N/A	$12.91	-53.52%	$18.24	-8.66%	$13.28	-49.25%
90657	SL		$19.82	$10.71	N/A	N/A	$5.27	-276.09%	N/A	N/A	N/A	N/A
90658	SL		$19.82	$10.71	N/A	N/A	NA	N/A	$14.36	-38.02%	$16.16	-22.65%
90660	SL		$19.82	$10.71	N/A	N/A	$28.91	31.44%	$21.09	6.02%	$22.10	10.32%
90670	SL		$19.82	$10.71	N/A	N/A	$112.56	82.39%	N/A	N/A	$163.13	87.85%
90680	SL		$19.82	$10.71	N/A	N/A	$80.07	75.25%	N/A	N/A	$80.63	75.42%
90681	SL		$19.82	$10.71	N/A	N/A	$37.90	47.70%	N/A	N/A	$114.32	82.66%
90696	SL		$19.82	$10.71	N/A	N/A	$102.33	80.63%	N/A	N/A	N/A	N/A
90698	SL		$19.82	$10.71	N/A	N/A	$77.71	74.49%	N/A	N/A	N/A	N/A
90700	SL		$19.82	$10.71	N/A	N/A	$17.14	-15.64%	N/A	N/A	N/A	N/A
90707	SL		$19.82	$10.71	N/A	N/A	$50.50	60.75%	N/A	N/A	$63.94	69.00%
90710	SL		$19.82	$10.71	N/A	N/A	$33.65	41.10%	N/A	N/A	$180.40	89.01%
90713	SL		$19.82	$10.71	N/A	N/A	$29.12	31.94%	$65.08	69.55%	$30.77	35.59%
90714	SL		$19.82	NA	N/A	N/A	$40.24	50.75%	$52.57	62.30%	$17.85	-11.04%
90715	SL		$19.82	$10.71	N/A	N/A	$40.24	50.75%	$99.21	80.02%	$27.17	27.05%
90716	SL		$19.82	$10.71	N/A	N/A	$87.87	77.44%	$104.52	81.04%	$113.28	82.50%
90723	SL		$19.82	$10.71	N/A	N/A	$76.37	74.05%	N/A	N/A	$75.29	73.68%
90734	SL		$19.82	$10.71	N/A	N/A	$120.32	83.53%	MP	N/A	$121.15	83.64%
90744	SL		$19.82	$10.71	N/A	N/A	$52.78	62.45%	N/A	N/A	$22.82	13.15%
90746	SL		$19.82	$10.71	N/A	N/A	$52.78	62.45%	MP	N/A	$56.25	64.76%
90748	SL		$19.82	$10.71	N/A	N/A	$52.82	62.48%	N/A	N/A	$46.51	57.39%
99201		a,b,d	$40.94	$32.30	$40.94	0.00%	$36.82	-11.19%	$43.52	5.93%	$28.87	-41.81%
99202		a,b,d	$70.14	$47.21	$70.14	0.00%	$57.82	-21.31%	$74.77	6.19%	$45.36	-54.63%
99203		a,b,d	$100.97	$69.58	$100.97	0.00%	$81.37	-24.09%	$108.53	6.97%	$61.56	-64.02%
99204		a,b,d	$155.38	$104.21	$154.65	-0.47%	$117.82	-31.88%	$166.65	6.76%	$90.07	-72.51%
99205		a,b,d	$194.33	$131.18	$194.11	-0.11%	$146.89	-32.30%	$207.55	6.37%	$111.98	-73.54%

Category Codes for Procedures

a) Primary care
b) Physican speciality
c) Behavioral health
d) Pre- and post-natal obstetrics
e) Home health

Attachment 6 - Reimbursement Rate Comparison

Procedure Code	Modifier	Category Code	2016 NE EPC Fee Schedule	2016 Non-EPC NE Medicaid Rate	2016 Medicare Rate	EPC Comparison	2016 IA Medicaid Rate	EPC Comparison	2016 CO Medicaid Rate	EPC Comparison	2016 TX Medicaid Rate	EPC Comparison
99211		a,b,c,d	$18.71	$17.39	$18.62	-0.48%	$18.10	-3.37%	$20.17	7.24%	$14.96	-25.07%
99212		a,b,c,d	$40.81	$29.82	$40.81	0.00%	$31.36	-30.13%	$43.89	7.02%	$25.04	-62.98%
99213		a,b,c,d	$68.52	$45.07	$68.52	0.00%	$43.23	-58.50%	$73.32	6.55%	$37.64	-82.04%
99214		a,b,c,d	$101.41	$67.78	$101.23	-0.18%	$66.80	-51.81%	$108.17	6.25%	$52.86	-91.85%
99215		a,b,c,d	$136.42	$96.91	$136.42	0.00%	$99.95	-36.49%	$144.80	5.79%	$81.38	-67.63%
99217		a,b,d	$69.15	$36.18	$69.15	0.00%	$62.06	-11.42%	$72.85	5.08%	N/A	N/A
99218		a,b,d	$95.11	$48.24	$94.81	-0.32%	$64.96	-46.41%	$99.74	4.64%	$58.24	-63.31%
99219		a,b,d	$129.73	$86.43	$128.99	-0.57%	$106.69	-21.60%	$136.52	4.97%	$90.59	-43.21%
99220		a,b,d	$177.31	$108.54	$176.86	-0.25%	$143.59	-23.48%	$186.54	4.95%	$122.95	-44.21%
99221		a,b,c,d	$96.18	$50.25	$95.65	-0.55%	$64.96	-48.06%	$102.20	5.89%	N/A	N/A
99222		a,b,c,d	$131.03	$88.44	$130.07	-0.74%	$107.01	-22.45%	$138.80	5.60%	N/A	N/A
99223		a,b,c,d	$193.65	$114.57	$192.48	-0.61%	$143.59	-34.86%	$204.45	5.28%	N/A	N/A
99224		a,b,d	$37.95	$22.51	$37.77	-0.48%	$25.49	-48.88%	$40.18	5.55%	N/A	N/A
99225		a,b,d	$69.62	$39.39	$69.51	-0.16%	$45.40	-53.35%	$72.85	4.43%	N/A	N/A
99226		a,b,d	$100.28	$59.09	$100.02	-0.26%	$67.89	-47.71%	$105.13	4.61%	N/A	N/A
99231		a,b,c,d	$37.50	$30.15	$37.44	-0.16%	$33.16	-13.09%	$39.45	4.94%	N/A	N/A
99232		a,b,c,d	$69.09	$48.24	$68.86	-0.33%	$51.88	-33.17%	$72.46	4.65%	N/A	N/A
99233		a,b,c,d	$99.63	$80.40	$99.17	-0.46%	$72.99	-36.50%	$104.40	4.57%	N/A	N/A
99234		a,b,d	$128.25	$92.46	$126.85	-1.10%	$117.99	-8.70%	$135.93	5.65%	N/A	N/A
99235		a,b,d	$161.60	$130.65	$161.03	-0.35%	$159.49	-1.32%	$170.02	4.95%	N/A	N/A
99236		a,b,d	$208.52	$156.78	$207.59	-0.45%	$196.15	-6.31%	$219.52	5.01%	N/A	N/A
99238		a,b,d	$72.36	$72.36	$69.02	-4.84%	$61.82	-17.05%	$72.87	0.70%	N/A	N/A
99239		a,b,d	$120.60	$120.60	$102.16	-18.05%	$81.30	-48.34%	$107.67	-12.01%	N/A	N/A
99241		a,b,c,d	$48.24	$48.24	N/A	N/A	$50.37	4.23%	N/A	N/A	$44.87	-7.51%
99242		a,b,c,d	$85.88	$68.34	N/A	N/A	$83.40	-2.97%	N/A	N/A	$70.25	-22.25%
99243		a,b,c,d	$117.61	$88.44	N/A	N/A	$106.73	-10.19%	N/A	N/A	$90.77	-29.57%
99244		a,b,c,d	$175.56	$112.56	N/A	N/A	$148.57	-18.17%	N/A	N/A	$127.28	-37.93%
99245		a,b,c,d	$214.58	$152.76	N/A	N/A	$193.18	-11.08%	$196.36	-9.28%	$169.01	-26.96%
99251		a,b,c,d	$52.26	$52.26	N/A	N/A	$40.46	-29.16%	N/A	N/A	N/A	N/A
99252		a,b,c,d	$72.45	$72.36	N/A	N/A	$70.29	-3.07%	N/A	N/A	N/A	N/A
99253		a,b,c,d	$111.05	$92.46	N/A	N/A	$94.45	-17.58%	N/A	N/A	N/A	N/A
99254		a,b,c,d	$160.95	$120.60	N/A	N/A	$132.63	-21.35%	N/A	N/A	N/A	N/A
99255		a,b,c,d	$194.16	$160.80	N/A	N/A	$181.14	-7.19%	N/A	N/A	N/A	N/A
99281		a,b,d	$21.30	$21.30	$20.22	-5.34%	$18.45	-15.45%	$21.15	-0.71%	N/A	N/A
99282		a,b,d	$39.46	$36.18	$39.40	-0.15%	$28.97	-36.21%	$41.57	5.08%	N/A	N/A

Category Codes for Procedures

a) Primary care
b) Physican speciality
c) Behavioral health
d) Pre- and post-natal obstetrics
e) Home health

Attachment 6 - Reimbursement Rate Comparison

Procedure Code	Modifier	Category Code	2016 NE EPC Fee Schedule	2016 Non-EPC NE Medicaid Rate	2016 Medicare Rate	EPC Comparison	2016 IA Medicaid Rate	EPC Comparison	2016 CO Medicaid Rate	EPC Comparison	2016 TX Medicaid Rate	EPC Comparison
99283		a,b,d	$59.04	$54.27	$59.00	-0.07%	$59.12	0.14%	$61.99	4.76%	N/A	N/A
99284		a,b,d	$112.24	$64.32	$111.94	-0.27%	$91.03	-23.30%	$118.21	5.05%	N/A	N/A
99285		a,b,d	$165.46	$104.52	$165.08	-0.23%	$143.10	-15.63%	$173.76	4.78%	N/A	N/A
99291		a,b,d	$259.17	$168.84	$259.00	-0.07%	$176.58	-46.77%	$275.35	5.88%	N/A	N/A
99292		a,b,d	$116.58	$84.42	$116.26	-0.28%	$88.05	-32.40%	$123.40	5.53%	N/A	N/A
99304		a,b,d	$88.20	$58.62	$87.19	-1.16%	$57.41	-53.63%	$93.66	5.83%	$49.73	-77.36%
99305		a,b,d	$125.66	$81.69	$124.20	-1.18%	$57.41	-118.88%	$133.47	5.85%	$59.47	-111.30%
99306		a,b,d	$159.80	$104.75	$158.62	-0.74%	$57.41	-178.35%	$168.99	5.44%	$80.68	-98.07%
99307		a,b,d	$42.61	$29.82	$42.52	-0.21%	$30.80	-38.34%	$44.89	5.08%	$30.96	-37.63%
99308		a,b,d	$65.57	$47.21	$65.37	-0.31%	$30.80	-112.89%	$69.30	5.38%	$37.02	-77.12%
99309		a,b,d	$86.63	$64.61	$86.43	-0.23%	$66.63	-30.02%	$91.21	5.02%	$55.64	-55.70%
99310		a,b,d	$128.89	$86.83	$128.89	0.00%	$30.80	-318.47%	$135.68	5.00%	$55.64	-131.65%
99315		a,b,d	$69.70	$69.58	$69.34	-0.52%	$55.28	-26.09%	$73.57	5.26%	$45.82	-52.12%
99316		a,b,d	$100.66	$79.52	$100.66	0.00%	$70.72	-42.34%	$105.52	4.61%	$71.29	-41.20%
99318		a,b,d	$91.66	$61.39	$91.32	-0.37%	$30.18	-203.71%	$96.56	5.07%	$49.73	-84.32%
99324		a,b,d,e	$52.98	$40.41	$52.71	-0.51%	$38.74	-36.76%	$55.97	5.34%	$31.64	-67.45%
99325		a,b,d,e	$77.29	$58.82	$76.90	-0.51%	$38.74	-99.51%	$81.44	5.10%	$58.08	-33.08%
99326		a,b,d,e	$133.63	$96.09	$132.87	-0.57%	$38.74	-244.94%	$140.28	4.74%	$76.51	-74.66%
99327		a,b,d,e	$178.03	$124.85	$176.92	-0.63%	$38.74	-359.55%	$187.29	4.94%	$60.01	-196.67%
99328		a,b,d,e	$206.88	$147.53	$206.84	-0.02%	$38.74	-434.02%	$217.06	4.69%	$60.01	-244.74%
99334		a,b,d,e	$57.75	$40.76	$57.46	-0.50%	$33.37	-73.06%	$61.02	5.36%	$41.73	-38.39%
99335		a,b,d,e	$90.72	$62.86	$90.38	-0.38%	$33.37	-171.86%	$95.47	4.98%	$63.65	-42.53%
99336		a,b,d,e	$128.27	$89.20	$128.27	0.00%	$33.37	-284.39%	$134.59	4.70%	$93.20	-37.63%
99337		a,b,d,e	$184.44	$127.93	$183.30	-0.62%	$33.37	-452.71%	$194.10	4.98%	$73.10	-152.31%
99341		a,b,d,e	$52.71	$49.70	$52.71	0.00%	$54.00	2.39%	$55.60	5.20%	$53.81	2.04%
99342		a,b,d,e	$76.11	$62.12	$75.93	-0.24%	$77.78	2.15%	$80.35	5.28%	$69.55	-9.43%
99343		a,b,d,e	$124.71	$93.59	$124.08	-0.51%	$114.47	-8.95%	$131.27	5.00%	$90.07	-38.46%
99344		a,b,d,e	$174.16	$109.34	$173.20	-0.55%	$147.00	-18.48%	$183.36	5.02%	$138.07	-26.14%
99345		a,b,d,e	$210.07	$144.13	$209.83	-0.11%	$178.24	-17.86%	$221.02	4.95%	$164.50	-27.70%
99347		a,b,d,e	$53.00	$39.76	$53.00	0.00%	$42.44	-24.88%	$55.97	5.31%	$43.48	-21.90%
99348		a,b,d,e	$80.42	$58.28	$80.42	0.00%	$65.31	-23.14%	$84.68	5.03%	$63.65	-26.35%
99349		a,b,d,e	$121.91	$85.23	$121.99	0.07%	$99.05	-23.08%	$128.12	4.85%	$93.20	-30.80%
99350		a,b,d,e	$169.58	$124.25	$168.97	-0.36%	$143.45	-18.22%	$178.67	5.09%	$134.24	-26.33%
99354		a,b,d	$95.26	$80.40	$95.03	-0.24%	$97.16	1.96%	$100.50	5.21%	$60.51	-57.43%
99355		a,b,d	$93.30	$40.20	$92.62	-0.73%	$94.89	1.68%	$98.32	5.11%	$27.48	-239.52%

Category Codes for Procedures

a) Primary care
b) Physican speciality
c) Behavioral health
d) Pre- and post-natal obstetrics
e) Home health

Attachment 6 - Reimbursement Rate Comparison

Procedure Code	Modifier	Category Code	2016 NE EPC Fee Schedule	2016 Non-EPC NE Medicaid Rate	2016 Medicare Rate	EPC Comparison	2016 IA Medicaid Rate	EPC Comparison	2016 CO Medicaid Rate	EPC Comparison	2016 TX Medicaid Rate	EPC Comparison
99356		a,b,d	$88.44	$88.44	$87.42	-1.17%	$85.38	-3.58%	$92.57	4.46%	N/A	N/A
99357		a,b,d	$87.21	$44.22	$87.09	-0.14%	$85.94	-1.48%	$91.85	5.05%	N/A	N/A
99360		a,b,d	$60.30	$60.30	N/A	N/A	$40.69	-48.19%	$62.83	4.03%	N/A	N/A
99381	EP	a,b	$104.35	$95.16	N/A	N/A	$88.72	-17.62%	$112.16	6.96%	N/A	N/A
99382	EP	a,b	$109.14	$100.17	N/A	N/A	$95.22	-14.62%	$116.87	6.61%	N/A	N/A
99383	EP	a,b,d	$113.85	$110.18	N/A	N/A	$94.57	-20.39%	$121.92	6.62%	N/A	N/A
99384	EP	a,b,d	$128.84	$120.20	N/A	N/A	$105.26	-22.40%	$137.83	6.52%	N/A	N/A
99385	EP	a,b,d	$130.22	$130.22	N/A	N/A	$102.04	-27.62%	$133.84	2.70%	$80.46	-61.84%
99385		a,b,d	$130.22	$130.22	N/A	N/A	$102.04	-27.62%	$133.84	2.70%	$80.46	-61.84%
99386		a,b,d	$144.58	$135.23	N/A	N/A	$122.89	-17.65%	$154.43	6.38%	$94.10	-53.65%
99387		a,b	$156.84	$95.16	N/A	N/A	$134.02	-17.03%	$167.82	6.54%	$103.10	-52.12%
99391	EP	a,b	$93.98	$80.13	N/A	N/A	$72.40	-29.81%	$100.94	6.90%	N/A	N/A
99392	EP	a,b	$100.43	$85.14	N/A	N/A	$79.93	-25.65%	$107.81	6.85%	N/A	N/A
99393	EP	a,b,d	$100.10	$90.15	N/A	N/A	$79.60	-25.75%	$107.44	6.83%	N/A	N/A
99394	EP	a,b,d	$109.93	$95.16	N/A	N/A	$90.07	-22.05%	$117.57	6.50%	N/A	N/A
99395	EP	a,b,d	$112.38	$100.17	N/A	N/A	$87.80	-28.00%	$120.11	6.44%	$69.83	-60.93%
99395		a,b,d	$112.38	$100.17	N/A	N/A	$87.80	-28.00%	$120.11	6.44%	$69.83	-60.93%
99396		a,b,d	$119.88	$105.18	N/A	N/A	$97.86	-22.50%	$128.03	6.37%	$76.37	-56.97%
99397		a,b	$128.84	$110.18	N/A	N/A	$108.34	-18.92%	$137.83	6.52%	$86.65	-48.69%
99401	EP	a,b,d	$34.35	N/A	N/A	N/A	N/A	N/A	$36.91	6.94%	N/A	N/A
99402	EP	a,b,d	$59.08	N/A	N/A	N/A	$19.96	-195.99%	$63.28	6.64%	N/A	N/A
99406		a,b,d	$14.07	$14.07	$13.41	-4.92%	N/A	N/A	MP	N/A	$11.74	-19.85%
99407		a,b,d	$26.25	$24.12	$26.24	-0.04%	$66.02	60.24%	MP	N/A	$22.91	-14.58%
99460		a,b,d	$109.34	$109.34	$92.47	-18.24%	$69.24	-57.91%	$95.06	-15.02%	$80.36	-36.06%
99461		a,b,d	$93.35	$89.46	$93.35	0.00%	$79.48	-17.45%	$98.85	5.56%	$49.56	-88.36%
99462		a,b,d	$49.70	$49.70	$40.18	-23.69%	$36.97	-34.43%	$42.32	-17.44%	N/A	N/A
99463		a,b,d	$126.73	$126.73	$113.59	-11.57%	$88.75	-42.79%	$115.20	-10.01%	$109.55	-15.68%
99464		a,b,d	$102.51	$102.51	$68.51	-49.63%	$88.11	-16.34%	$71.37	-43.63%	$109.55	6.43%
99465		a,b,d	$146.15	$112.56	$146.15	0.00%	$173.24	15.64%	$148.46	1.56%	N/A	N/A
99466		a,b,d	$237.46	$160.80	$220.27	-7.80%	$207.12	-14.65%	$264.16	10.11%	N/A	N/A
99467		a,b,d	$118.23	$80.40	$112.07	-5.50%	$106.14	-11.39%	$123.76	4.47%	N/A	N/A
99468		a,b,d	$905.45	$663.30	$905.45	0.00%	$741.17	-22.16%	$937.94	3.46%	N/A	N/A
99469		a,b,d	$381.37	$353.76	$381.37	0.00%	$370.53	-2.93%	$397.77	4.12%	N/A	N/A
99471		a,b,d	$825.10	$574.86	$825.10	0.00%	$741.17	-11.32%	$859.07	3.95%	N/A	N/A
99472		a,b,d	$390.47	$287.43	$390.47	0.00%	$370.53	-5.38%	$404.22	3.40%	N/A	N/A

Category Codes for Procedures

a) Primary care
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d) Pre- and post-natal obstetrics
e) Home health

Attachment 6 - Reimbursement Rate Comparison

Procedure Code	Modifier	Category Code	2016 NE EPC Fee Schedule	2016 Non-EPC NE Medicaid Rate	2016 Medicare Rate	EPC Comparison	2016 IA Medicaid Rate	EPC Comparison	2016 CO Medicaid Rate	EPC Comparison	2016 TX Medicaid Rate	EPC Comparison
99475		a,b,d	$549.68	$381.90	$549.68	0.00%	$486.37	-13.02%	$579.51	5.15%	N/A	N/A
99476		a,b,d	$331.96	$233.16	$330.04	-0.58%	$290.47	-14.28%	$350.37	5.25%	N/A	N/A
99477		a,b,d	$342.97	$270.16	$342.97	0.00%	$263.22	-30.30%	$349.00	1.73%	N/A	N/A
99478		a,b,d	$141.54	$141.54	$131.12	-7.95%	$134.19	-5.48%	$138.44	-2.24%	N/A	N/A
99479		a,b,d	$119.79	$97.28	$119.30	-0.41%	$122.56	2.26%	$125.52	4.57%	N/A	N/A
99480		a,b,d	$115.20	$97.28	$114.61	-0.51%	$118.05	2.41%	$120.86	4.68%	N/A	N/A
99485		na	$80.95	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
99486		na	$69.39	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

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