



Ninety-Ninth Legislature - Second Session - 2006
Revised Committee Statement
LB 1248

Hearing Date: February 8, 2006
Committee On: Health and Human Services

Introducer(s): (Jensen, Erdman)
Title: Adopt the Medical Assistance Act

Roll Call Vote – Final Committee Action:

- Advanced to General File
 - X Advanced to General File with Amendments
 - Indefinitely Postponed
-

Vote Results:

6	Yes	Senator Jensen, Byars, Cunningham, Erdman, Johnson and Stuthman
	No	
1	Present, not voting	Senator Howard
	Absent	

Proponents:

Senator Jensen
Jeff Santema
Senator Pederson
Dick Nelson
Dr. Ron Klutman
Dr. Eric Hodges
Ron Jensen

Representing:

Introducer
Jim Jensen
District 42
Nebraska Health and Human Services System
Nebraska Medical Association
Nebraska Dental Association
Nebraska Association for Homes and Services for Aging

Opponents:

Kathy Hoell
Deborah Weston
Brad Meurrens
Simone Rock
Patricia McGill Smith
Tim Kolb
Cortni Krusemark
Rebecca Gould

Mike Schafer
Laurie Ackerman

Representing:

Statewide Independent Living Council
The Arc of Nebraska
Nebraska Advocacy Services, Inc.
Self
Self
Self
The Nebraska Occupational Therapy Association
Nebraska Appleseed Center for the Law and Public Interest
League of Human Dignity
The Arc of Omaha

Jeff Kuhr
Annie Anderson
Mary McHale
Roger Keetle
Sarah Ann Lewis
Jim Cunningham
Philip Webb
Marlene Chirnside

Public Health Association of Nebraska
The Arc of Omaha
Omaha Down Syndrome Parents Network
Nebraska Hospital Association
Voices for Children in Nebraska
Nebraska Catholic Charities
Statewide Independent Living Council
Self

Neutral:
Bruce Dart

Representing:
Lincoln/Lancaster County Health Department

Summary of purpose and/or changes: LB 1248 is introduced by Senator Jensen as chair of the Health and Human Services Committee pursuant to LB 709 (2005) (the Medicaid Reform Act, sections 68-1087 to 68-1094). The bill is intended to facilitate implementation of the Medicaid Reform Plan prepared pursuant to the act, but does not contain all provisions or recommendations of the plan that do not require legislation for their implementation.

The bill recodifies statutes relating to the Medicaid program and names a new act (the Medical Assistance Act).

Section 1 names the new act. Section 2 makes technical changes to section 68-1018, which establishes the medical assistance program (MAP), known as Medicaid.

Section 3 adds new provisions relating to Medicaid public policy: “(1) It is the public policy of the State of Nebraska to provide a program of medical assistance on behalf of eligible low-income Nebraska residents that (a) cooperates with public and private sector entities to promote the public health of Nebraska residents; (b) assists eligible recipients to access appropriate and necessary health care and related services; (c) encourages personal responsibility and accountability for the appropriate utilization of health care and related services; (d) cooperates with public and private employers and private sector insurers in providing access to health care and related services for Nebraska residents, (e) is appropriately managed and fiscally sustainable; and (f) qualifies for federal matching funds under Title XIX and Title XXI of the federal Social Security Act.”

Section 4 defines terms.

Section 5 makes technical changes to section 68-1021 and incorporates provisions of section 68-1021.01. Incorporation of federal law by reference is made effective as such law existed on July 1, 2006, the operative date of the bill.

Section 6 adds new provisions relating to duties of the Department of Health and Human Services Finance and Support (department). The bill: (1) requires the department to administer the medical assistance program (MAP or Medicaid) and comply with all applicable provisions of state and federal law relating to the program,

(2) permits the department to (a) enter into contracts and interagency agreements, (b) adopt and promulgate rules and regulations, (c) adopt fee schedules, and (d) perform other activities as necessary and appropriate to carry out its duties under the Medical Assistance Act;

(3) preserves existing contracts, agreements, and rules and regulations relating to the MAP,

(4) requires the department to maintain the confidentiality of information regarding applicants for or recipients of medical assistance,

(5) requires the department to administer the MAP in a manner consistent with the public policy in section 3 and “designed to achieve effective cost containment and moderation in the growth of medical assistance expenditures, including, but not limited to, the development and implementation of waivers and managed care plans for recipients of medical assistance,”

(6) requires the department to prepare a biennial budget and program review and analysis of the MAP and submit a report of such review and analysis to the Governor and the Legislature by December 1 of every even-numbered year, and

(7) requires the department, in consultation with the Health and Human Services Committee of the Legislature, to “develop recommendations for further modification or replacement of the defined benefit structure of the medical assistance program.” The study must be consistent with the public policy in section 3 of the bill, “consider the needs and resources of low-income Nebraska residents who are eligible or may become eligible for medical assistance,” and “consider the experience and outcomes of other states that have developed and implemented such changes.” Recommendations must be reported by the Governor and the Legislature by December 1, 2008.

Section 7 relates to funding for the MAP and medical assistance payments, makes technical changes to section 68-1022, requires that medical assistance funding be based on an assessment of General Fund revenue and the competing needs of other state-funded programs, permits greater flexibility in the payment of medical assistance, codifies Medicaid “disproportionate share” payments, and prohibits the payment of medical assistance directly to eligible recipients.

Section 8 relates to Medicaid-covered services, makes technical changes to section 68-1019, and incorporates provisions of 68-1071 and 68-1072 (payments to schools and ESUs for Medicaid administrative activities). The bill requires the MAP to cover federally mandated services (but deletes the current list of mandatory services) and permits coverage for “optional” services. The bill requires that Medicaid-covered services be “generally reflective of and commensurate with group health insurance coverage provided by public and private employers and private sector insurers in this state as determined by the director [of the Department of Health and Human Services Finance and Support] and the Director of Insurance, with due consideration given to the needs and resources of eligible recipients.”

Section 9 relates to limitations on Medicaid-covered services, makes technical changes, and incorporates and deletes various provisions of sections 68-1019 to 68-1019.09. The bill permits the department to establish a schedule of premiums, copayments, and deductibles for goods and services provided under the MAP and to provide limits on the amount, duration, and scope of goods and services recipients may receive under the program. In addition, the bill permits the department to “establish requirements for recipients of medical assistance as a necessary condition for the continued receipt of such assistance, including, but not limited to, active participation in care coordination or appropriate disease management programs and activities.” The bill continues to require reporting prior to the adoption and promulgation of rules and regulations to establish limitations on covered services. The report must summarize the content of proposed rules and regulations and analyze their projected impact on recipients of medical assistance and medical assistance expenditures. The department is required to monitor and report to the Governor and the Legislature on the effect of limitations on eligible recipients and medical assistance expenditures, and activities of the department to enforce such limitations.

Section 10 relates to eligibility for medical assistance and makes technical changes to section 68-1020. The bill permits the department to establish a separate children’s health

insurance program as allowed under Title XXI of the federal Social Security Act for children under 19 years of age with family income of 150% to 185% of the federal poverty level.

Section 11 relates to application for medical assistance and eligibility determinations under the MAP, and contains provisions transferred from section 68-1020. The bill requires that applications for medical assistance be filed with the department. Applicants for medical assistance are entitled to notice of denial or discontinuation of eligibility and denial or modification of medical assistance benefits. Decisions of the department may be appealed in accordance with the Administrative Procedure Act.

Sections 12 to 21 transfer and make technical changes to sections 68-1026 to 68-1028 (assignment of rights), 68-1036.02 (estate recovery), 68-1036.03 (garnishment), and 68-1038 to 68-1043 (spousal impoverishment).

Sections 20-29 transfer and make technical changes to sections 68-10,100 to 68-10,107 relating to coordination of benefits (LB 589, 2005).

Sections 30-43 transfer and make technical changes to the Medicaid False Claims Act, sections 68-1073 to 68-1086 (LB 1084, 2004).

Sections 44 to 80 make harmonizing changes to other Medicaid-related statutes.

Section 81 provides for an operative date of July 1, 2006. Section 82 repeals the original sections.

Section 83 outright repeals the following sections: 68-1019.02 to 68-1019.09, 68-1021.01, 68-1024, 68-1025, 68-1025.01, 68-1029 to 68-1036, 68-1037, 68-1048 to 68-1069, 68-1071, 68-1072, 68-1087 to 68-1099, and 83-1214.

Section 84 contains an emergency clause.

Explanation of amendments, if any: The committee amendment (AM 2831) rewrites the first eleven sections of LB 1248 as introduced, and adds six new sections. The changes are intended to address four primary objections to LB 1248 as introduced: (1) too much discretion being given to the department, (2) insufficient legislative oversight and policy direction, (3) the Medicaid Reform Plan is not adequately reflected, and (4) certain repealed or stricken provisions should be reinstated.

Section 1 incorporates new sections into the Medical Assistance Act.

Section 2 provides purposes for the Medical Assistance Act: to “(1) reorganize and recodify statutes relating to the medical assistance program; (2) provide for implementation of the Medicaid Reform Plan; (3) clarify public policy relating to the medical assistance program; (4) provide for administration of the medical assistance program within the department; and (5) provide for legislative oversight and public comment regarding the medical assistance program.”

Section 3 establishes the medical assistance program, known as Medicaid. This section is unchanged from LB 1248 as introduced.

Section 4 adds the following legislative findings: “(1) many low-income Nebraska residents have health care and related needs and are unable, without assistance, to meet such needs, (2) publicly funded medical assistance provides essential coverage for necessary health care and related services for low-income Nebraska children, pregnant women and families, aged persons, and persons with disabilities, (3) publicly funded medical assistance cannot meet the health care and related needs of all low-income Nebraska residents, (4) the State of Nebraska cannot sustain a rate of growth in medical assistance expenditures that exceeds the rate of growth of General Fund revenues, (5) policies and priorities must be established for the medical assistance program that will effectively address the health care and related needs of eligible recipients and effectively moderate the growth of medical assistance expenditures, and (6)

publicly funded medical assistance must be integrated with other public and private health care and related initiatives providing access to health care and related services for Nebraska residents.”

Section 5 revises public policy provisions to emphasize (1) prevention, early intervention, and the provision of health care and related services in the least restrictive environment consistent with the health care and related needs of the recipients of such services, (2) personal independence, self-sufficiency, and freedom of choice, (3) personal responsibility and accountability for the payment of health care and related expenses and the appropriate utilization of health care and related services; and (4) cooperation with providers of health care and related services, public and private employers, and private sector insurers in encouraging and supporting the development and utilization of alternatives to publicly funded medical assistance.

Section 6 provides assent to applicable provisions of federal law, and incorporates federal law by reference as it existed on April 1, 2006.

Section 7 adds new definitions for (1) council (i.e. Medicaid Reform Council), (2) Medicaid Reform Plan, (3) provider, (4) medicaid state plan, and (5) waiver.

Section 8 revises duties of the department in administering the medical assistance program. Provisions relating to the preservation of existing rules and regulations are transferred to section 9 of the amendment. Provisions relating to mandated biennial summary and analysis of the medical assistance program are revised and expanded. A draft report of such summary and analysis is due no later than October 1 of each even-numbered year. The Medicaid Reform Council (council) is required to conduct a public meeting and provide recommendations regarding the draft report. The final report is due no later than December 1 of each even-numbered year. Provisions relating to a study and recommendations for modification or replacement of the current defined benefit structure of Medicaid are transferred to section 49 of the amendment.

Section 9 adds new provisions. All existing rules and regulations, Medicaid state plan amendments, and waivers are preserved. Prior to the adoption of new rules and regulations under section 12 of the amendment, or relating to a Medicaid plan amendment or waiver, the department is required to provide a report of proposed changes to the Health and Human Services Committee (committee) and the council, summarizing the purpose and content of the rules and regulations and their projected effect on Medicaid recipients and medical assistance expenditures.

The committee of the council, no later than thirty days after receiving such a report, may conduct a public meeting to receive public comment regarding the report. The committee or the council must provide any comments and recommendations regarding the report in writing to the department. Such comments and recommendations are advisory only, but the department must promptly provide a written response to the committee or council.

The committee, by a majority vote of its members and no later than thirty days after the date of receipt of such a report, may request in writing that the department delay the final adoption or implementation of a proposed rule and regulation summarized in the report for a sufficient period of time to permit additional legislative consideration of the proposal. The request is not binding on the department, but the department must promptly provide a written response to the request.

The department is required to monitor and periodically as necessary, but no less than annually, report to the Governor, the Legislature, and the council on the implementation of rules and regulations, Medicaid state plan amendments, and waivers adopted under the Medical

Assistance Act and their effect on eligible recipients of medical assistance and medical assistance expenditures.

Section 10, relating to payment for medical assistance, is revised.

Section 11 revises provisions relating to mandatory and optional services under the medical assistance program. The amendment adds a list of mandatory and optional services taken from current federal law and reflecting optional services currently being offered under the medical assistance program. Provisions are removed relating to “benchmarking” medical assistance coverage to currently available group health insurance coverage.

Section 12 changes provisions relating to limits on Medicaid-covered services. The department is required to establish copayments, premiums, and deductibles for the medical assistance program, and limits on the amount, scope, and duration of Medicaid-covered services, and to establish requirements for Medicaid recipients such as active participation in care coordination or appropriate disease management activities.

In establishing, prioritizing, and limiting coverage for services under the medical assistance program, the department must consider (1) the effect of such coverage or limitations on recipients of medical assistance and medical assistance expenditures, (2) the public policy in section 5 of the amendment, (3) the experience and outcomes of other states, (4) the nature and scope of benchmark or benchmark equivalent health insurance coverage as recognized under federal law, and (5) other relevant factors as determined by the department.

Existing coverage for mandatory and eligible services is preserved. Any proposed reduction or expansion of services or limitations of covered services by the department is subject to the review and reporting requirements of section 9 of the amendment.

Section 13 inserts and modifies provisions of section 68-1025.01 regarding public awareness activities relating to the Medicaid children’s health insurance program.

Section 14 contains provisions of section 11 of LB 1248 as introduced, relating to application for medical assistance, with technical revisions.

Section 15 contains provisions of section 10 of LB 1248 as introduced, relating to eligibility for medical assistance. Authorization for the department to establish a separate children’s health insurance program for children with family income of 150% to 185% of the federal poverty level is removed. Other provisions are essentially unchanged with the exception of technical corrections.

Section 48 is a new section that establishes the Medicaid Reform Council (council). The council consists of ten persons appointed by the chairperson of the committee, in consultation with the Governor and the Director of HHS Finance and Support, including, but not limited to, at least one representative from each of the following: health care providers, recipients of medical assistance and advocates for such recipients, business representatives, insurers, and elected officials. The chairperson of the committee appoints the chairperson of the council. Members of the council may be reimbursed for their actual and necessary expenses.

The council is required to “(a) oversee and support implementation of the reforms to the medical assistance program, including but not limited to, reforms such as those contained in the Medicaid Reform Plan; (b) conduct at least two public meetings annually and other meetings at the call of the chairperson of the council, in consultation with the director and the chairperson of the committee; and (c) provide comments and recommendations to the department regarding the administration of the medical assistance program and any proposed changes to the program.” The Medicaid Reform Council terminates on June 30, 2010.

Section 49 provides legislative intent to implement program reforms such as those contained in the Medicaid Reform Plan, including but not limited to “(a) an incremental

expansion of home and community-based services for aged persons and persons with disabilities consistent with the plan, (b) an increase in care coordination or disease management initiatives to better manage medical assistance expenditures on behalf of high-cost recipients with multiple or chronic medical conditions, and (c) other reforms as deemed necessary and appropriate by the department, in consultation with the committee and the Medicaid Reform Council.”

The department is required to develop recommendations relating to the provision of health care and related services for Medicaid-eligible children under the state children’s health insurance program. A draft report of such recommendations is due to the committee and the Medicaid Reform Council no later than October 1, 2007. The council is required to conduct a public meeting and provide any comments and recommendations regarding such report to the department by November 1, 2007. The department must submit a final report to the committee and the council no later than December 1, 2007.

The department is required to develop recommendations regarding the modification or replacement of the defined benefit structure of the medical assistance program. A draft report of such recommendations is due to the committee and the Medicaid Reform Council no later than October 1, 2008. The council is required to conduct a public meeting and provide any comments and recommendations regarding such report to the department by November 1, 2008. The department must submit a final report to the committee and the council no later than December 1, 2008.

Senator Jim Jensen, Chairperson