LEGISLATURE OF NEBRASKA

ONE HUNDRED THIRD LEGISLATURE

SECOND SESSION

LEGISLATIVE BILL 887

Introduced by Campbell, 25; Crawford, 45; Howard, 9; Nordquist, 7.
Read first time January 14, 2014

Committee: Health and Human Services

A BILL

FOR AN ACT relating to medical assistance; to adopt the Wellness in Nebraska Act; and to declare an emergency.

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

Section 1. This act shall be known and may be cited as the Wellness in Nebraska Act.

Sec. 2. The Legislature finds:

(1) It is necessary to improve the health of and health care coverage for uninsured adults in Nebraska in a manner that strengthens Nebraska's health care system in accordance with the Institute of Healthcare Improvement's aims of improving health consumer and patient experience of care, including, but not limited to, quality and satisfaction, improving the health of populations in Nebraska, and reducing the per capita cost of health care;

(2) Improving access to affordable health care for low-income Nebraska citizens is essential to improving the health of the state's population and strengthening the state's economy;

(3) Health benefits for the newly eligible population under the Affordable Care Act should be provided in a manner that encourages personal responsibility, leverages insurance offered by employers and private insurance companies, and improves the health outcomes and financial security of those receiving benefits; and

(4) The Wellness in Nebraska Act will expand access to health coverage for individuals who are defined as newly eligible for medical assistance, as specified in section 1905(y) of the federal Social Security Act, as amended, 42 U.S.C. 1396d(y), in a manner that assures fiscal responsibility, safeguards the interests of Nebraska taxpayers, and provides accountability and oversight.

Sec. 3. The Legislature specifically intends to foster

and promote:

(1) Access to affordable and quality health care coverage for uninsured and underinsured individuals in Nebraska by innovative models of care towards a patient-centered, integrated health care system;

(2) Continuity of coverage for vulnerable individuals, by phasing in a premium assistance program that will substantially reduce the number of newly eligible individuals who would lose coverage as a result of income fluctuations that cause their eligibility to change from year to year or multiple times throughout a year;

(3) Coordination of health care delivery for newly eligible individuals to address the entire spectrum of physical and behavioral health, by focusing on prevention and wellness, health promotion, and chronic disease management;

(4) Incentives to encourage personal responsibility, cost-conscious utilization of health care, and adoption of preventive practices and healthy behaviors;

(5) Competition, consumer choice, and cost reduction within the private marketplace by implementing a premium assistance program that will enable newly eligible individuals with household incomes between one hundred percent and one hundred thirty-three percent of the federal poverty level to obtain coverage through the private marketplace;

(6) Maximizing Nebraska's access to federal funding

during the period the federal government will pay one hundred percent of the cost of the benefits provided to newly eligible individuals;

(7) Improving health care coverage to eliminate cost shifting and to substantially reduce the burden of uncompensated care for medical providers and the state; and

(8) Health care cost containment, high-value coordinated services, and minimization of administrative costs for services provided to newly eligible individuals who are medically frail or have exceptional medical conditions and have household incomes that are under one hundred thirty-three percent of the federal poverty level.

Sec. 4. For purposes of the Wellness in Nebraska Act, the definitions found in sections 5 through 35 of this act apply.

Sec. 5. Accountable care organization means a risk-bearing, integrated health care organization characterized by a payment and care delivery model that ties provider reimbursement to quality metrics, thereby reducing the total cost of care for an attributed population of patients.

Sec. 6. Affordable Care Act means the federal Patient Protection and Affordable Care Act, Public Law 111-148, as amended by the federal Health Care and Education Reconciliation Act of 2010, Public Law 111-152.

Sec. 7. Centers for Medicare and Medicaid Services means the federal agency responsible for overseeing the implementation of health coverage for newly eligible individuals across the United

States and for approval of state plan amendments and waivers under the federal Social Security Act, as amended.

Sec. 8. Chief executive officer means the head of the Department of Health and Human Services appointed by the Governor pursuant to section 81-3114.

Sec. 9. Department means the Department of Health and Human Services created pursuant to section 81-3113.

Sec. 10. Director means the Director of Medicaid and Long-Term Care of the Division of Medicaid and Long-Term Care of the department.

Sec. 11. Employer-sponsored insurance means group health care coverage that is offered by a public or private employer to its employees.

Sec. 12. Essential health benefits means essential health benefits as defined in 42 U.S.C. 18022(b).

Sec. 13. Federal approval means approval by the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services.

Sec. 14. Federal funding means the federal medical assistance percentage for a state, including newly eligible individuals as provided under section 1905(y)(1) of the federal Social Security Act, as amended, 42 U.S.C. 1396d(y)(1).

Sec. 15. Federal poverty level means the most recently revised poverty income guidelines published by the United States Department of Health and Human Services.

Sec. 16. Health benefit exchange or marketplace means the health benefit exchange established for the state under 42 U.S.C. 18031.

Sec. 17. Health insurance premium program means the program established by the department pursuant to section 1906 of the federal Social Security Act, as amended, 42 U.S.C. 1396e, to purchase employer-sponsored group health care coverage.

Sec. 18. Health home means a designated medical provider, including a medical provider that operates in coordination with a team of health care professionals, or a health care team selected by an eligible individual with chronic conditions to provide health home services.

Sec. 19. Health home services means comprehensive and timely high-quality health care services, including, but not limited to, comprehensive care management, care coordination and health promotion, comprehensive transitional care, including appropriate follow-up from inpatient to other settings, patient and family support, referral to community and social support services, if relevant, and use of health information technology to link services as feasible and appropriate.

Sec. 20. Household income means household income as determined using the modified adjusted gross income methodology pursuant to section 2002 of the Affordable Care Act, 42 U.S.C. 1396a(e)(14).

Sec. 21. Managed care plan means a health benefit plan,

including closed plans and open plans, that either (1) requires a covered person to use health care providers managed, owned, under contract with, or employed by the carrier offering the plan or (2) creates financial incentives to use health care providers managed, owned, under contract with, or employed by the carrier offering the plan by providing a more favorable deductible, coinsurance, or copayment level for a covered person.

Sec. 22. Managed care organization means a medical provider or a group or organization of medical providers who or which offers managed care plans and that is under contract with the department.

Sec. 23. Medicaid means the program paying all or part of the costs of care and services provided to an individual pursuant to Title XIX of the federal Social Security Act.

Sec. 24. Medically frail or exceptional medical condition means a disabling mental disorder, a serious and complex medical condition, and physical or mental disabilities that significantly impair an individual's ability to perform one or more activities of daily living. Medically frail or exceptional medical condition includes at least two chronic conditions, or one chronic condition and the risk of a second chronic condition, or a serious and persistent mental health condition. For purposes of this subdivision, chronic condition includes, but is not limited to, a mental health condition, substance use disorder, asthma, diabetes, heart disease, or being obese.

Sec. 25. Member means an eligible individual who is enrolled in the Wellness in Nebraska plan.

Sec. 26. Newly eligible or newly eligible individual means an individual who:

(1) Is defined under section 1902(a)(10)(A)(i)(VIII) of the federal Social Security Act, as amended, 42 U.S.C. 1396a(a)(10)(A)(i)(VIII), for whom increased federal funding is provided for under section 1905(y)(2)(A) of the federal Social Security Act, as amended, 42 U.S.C. 1396d(y)(2)(A);

(2) Is a resident of Nebraska; and

(3) Satisfies all applicable federal income, citizenship, and immigration requirements.

Sec. 27. Participating accountable care organization means an accountable care organization approved by the department to participate in the Wellness in Nebraska plan provider network.

Sec. 28. Patient-centered medical home means a health care delivery model in which the patient establishes an ongoing relationship with a physician-directed team to provide comprehensive, accessible, and continuous evidence-based primary and preventive care services and to coordinate the patient's health care needs across the health care system to improve quality, safety, access, and health outcomes in a cost-effective manner.

Sec. 29. Physician-directed team means a physician and other health care professionals licensed, certified, or registered to perform specified health services, designated by the patient-centered

medical home to supervise, coordinate, or provide initial care or continuing care to a covered person and who may be required by the patient-centered medical home to initiate a referral for specialty care and maintain supervision of health care services rendered to the covered person.

Sec. 30. Preventive care services means services provided to an individual to promote health, prevent disease, or diagnose disease.

Sec. 31. Primary care provider means a physician or advanced care practitioner licensed, certified, or registered to perform primary care services chosen by a member or to whom a member is assigned under the Wellness in Nebraska plan.

Sec. 32. Qualified health plan means a qualified health plan as defined in 42 U.S.C. 18021 that is available for purchase on the health benefit exchange.

Sec. 33. Value-based reimbursement means a payment methodology that links provider reimbursement to improved performance by health care providers by holding health care providers accountable for both the cost and quality of care provided.

Sec. 34. Wellness in Nebraska plan means: (1) WIN Marketplace Coverage which is the plan established under the Wellness in Nebraska Act to provide health care coverage through a medicaid expansion demonstration waiver to newly eligible individuals through health insurance premiums paid by the department to purchase qualified health plans on the health benefit exchange or employer-

sponsored insurance; and (2) WIN Medicaid Coverage which is health care coverage provided through a medicaid expansion demonstration waiver pursuant to the medical assistance program for newly eligible individuals with incomes (a) at or below one hundred percent of the federal poverty level or (b) at or below one hundred thirty-three percent federal poverty level who are medically frail or have exceptional medical conditions.

Sec. 35. Wrap-around benefits means benefits that are required to be provided by the medical assistance program established under the Medical Assistance Act pursuant to the terms of a state plan amendment or waiver but are not covered by a qualified health plan or employer-sponsored insurance.

Sec. 36. (1)(a) Not later than thirty days after the effective date of this act, the department shall apply for a state plan amendment for newly eligible individuals in accordance with section 1902(a)(10)(A)(i)(VIII) of the federal Social Security Act, as amended, 42 U.S.C. 1396a(a)(10)(A)(i)(VIII), for individuals who:

(i) Are nineteen years of age or older and under sixty-five years of age;

(ii) Are not pregnant;

(iii) Are not entitled to or enrolled in Medicare benefits under part A or enrolled in Medicare benefits under part B of Title XVIII of the federal Social Security Act, as amended, 42 U.S.C. 1395c et seq.;

(iv) Are not otherwise described in section 1902(a)(10)

(A)(i) of the federal Social Security Act, as amended, 42 U.S.C. 1396a(a)(10)(A)(i);

(v) Are not exempt pursuant to section 1902(k)(3) of the federal Social Security Act, as amended, 42 U.S.C. 1396a(k)(3); and

(vi) Have household income as determined under 1902(e)(14) of the federal Social Security Act, as amended, 42 U.S.C. 1396a(e)(14), that is between zero and one hundred thirty-three percent of the federal poverty level, as defined in section 2110(c)(5) of the federal Social Security Act, as amended, 42 U.S.C. 1397jj(c)(5), for the applicable family size.

The state plan amendment under this subsection shall be in effect until the enactment of waivers implementing the Wellness in Nebraska Act by the Centers for Medicare and Medicaid Services.

(b) Newly eligible individuals pursuant to the state plan amendment shall be covered by a benchmark benefit package as defined in section 1937(b)(1) of the federal Social Security Act, 42 U.S.C. 1396u-7(b)(1), for Secretary-approved coverage. The state plan amendment shall include for newly eligible adults in Secretary-approved coverage: (i) All mandatory and optional coverage under section 68-911 for health care and related services in the amount, duration, and scope in effect on January 1, 2014; and (ii) any additional benefits as wrap-around benefits required by the Affordable Care Act not included under section 68-911.

(c) The federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. 300gg-5,

shall apply to state plan amendment under subdivision (1)(a) of this section and the Wellness in Nebraska plan.

(2) The department, with oversight by the Wellness in Nebraska Oversight Committee, shall apply to the Centers for Medicare and Medicaid Services for any waivers or state plan amendments necessary to implement the Wellness in Nebraska plan beginning on January 1, 2015, or as soon after that date that the waivers are enacted. Discussion with the Centers for Medicare and Medicaid Services regarding the waiver application shall begin immediately after the effective date of this act. The Wellness in Nebraska plan shall:

(a) Implement a premium assistance program to be known as WIN Marketplace Coverage, with coverage beginning January 1, 2015, or as soon after such date as waivers are enacted, to allow all newly eligible individuals with household incomes between one hundred and one hundred thirty-three percent of the federal poverty level who (i) do not have access to cost-effective employer-sponsored insurance, (ii) who are not determined to be medically frail in accordance with 42 C.F.R. section 440.315(f), and (iii) who do not have exceptional medical conditions as determined by the department, according to criteria developed by the department and the Wellness in Nebraska Oversight Committee, to enroll in a qualified health plan offered on the health benefit exchange;

(b) Allow all newly eligible who have access to employer-sponsored insurance to participate in the Wellness in Nebraska

employer-sponsored insurance premium program if the department determines such participation to be cost effective to the state; and

(c) Implement WIN Medicaid Coverage to provide health care coverage through the medical assistance program established under the Medical Assistance Act for newly eligible individuals with household incomes below one hundred percent of the federal poverty level and medically frail individuals with household incomes at or under one hundred thirty-three percent of the federal poverty level.

(3) A newly eligible individual may enroll and receive coverage under the Wellness in Nebraska plan if the individual: (a) Provides all information regarding residence, financial eligibility, citizenship immigration status, and eligibility for and access to employer-sponsored health insurance and any other public or private health insurance as required by the department; and (b) is determined by the department to be eligible for participation in the Wellness in Nebraska plan.

Sec. 37. (a) Newly eligible individuals who do not have access to employer-sponsored insurance or for whom employer-sponsored insurance is not determined to be cost effective by the department shall be eligible for WIN Marketplace Coverage with coverage beginning January 1, 2015, or as soon thereafter as waivers are approved and implemented. WIN Marketplace Coverage shall allow all newly eligible individuals with household incomes between one hundred and one hundred thirty-three percent of the federal poverty level, who are not determined to be medically frail in accordance with 42

C.F.R. section 440.315(f), and who do not have exceptional medical conditions as determined by the department, according to criteria developed by the department and the Wellness in Nebraska Oversight Committee in accordance with guidelines of the Centers for Medicaid and Medicare Services, to enroll in a qualified health plan offered on the health benefit exchange created pursuant to the Affordable Care Act. For newly eligible individuals participating in WIN Marketplace Coverage, the department shall pay the full cost of the premium for purchase of a qualified health plan on the health benefit exchange, plus any co-payments, co-insurance, deductible and wrap-around benefits, as necessary. The department shall pay premiums on behalf of such individuals directly to the qualified health plan issuer.

(b) The qualified health plan shall be a high-value, one hundred percent actuarial value silver plan. All participating carriers in the health benefit exchange shall offer coverage conforming to the requirements of this section. The Department of Insurance shall promote a regulatory environment where price-competitive choices exist in health plans offered in the state and, where possible, work with insurers to promote at least two qualified health plans from which newly eligible individuals may choose coverage.

(c) Coverage for a newly eligible individual determined to be eligible for coverage under WIN Marketplace Coverage is effective the first day of the month following the month of

application for enrollment. If the individual is eligible for medicaid, the department shall provide coverage through fee-for-service medicaid from the date an individual applies until the enrollment in the qualified health plan becomes effective. The department shall provide for wrap-around benefits that are not covered by the qualified health plan. Such benefits include non-emergency transportation, early preventive screening, diagnosis, and treatment services for individuals under twenty-one years of age, and fee-for-service dental plan. WIN Marketplace Coverage provider networks shall include federally qualified health centers and rural health clinics as essential community providers required pursuant to 42 U.S.C. 18031(c)(1)(c). WIN Marketplace Coverage beneficiaries shall have access to the same networks as other individuals.

(d) The department and the Wellness in Nebraska Oversight Committee shall develop policies for the purposes of minimizing the disruption of care and ensuring uninterrupted access to medically necessary services, providing continuous care for individuals moving between health insurance products, plans, and provisions and medicaid, and minimize churning between provider networks to provide seamless coverage transitions for enrollees. Policies may include requirements that when new medicaid managed care contracts are negotiated or medicaid contracts come up for renewal, contractors shall be required to participate as a carrier in the health insurance marketplace.

(e) On January 1, 2015, or as soon thereafter as waivers

are enacted by the Centers for Medicare and Medicaid Services, any qualified health plan that provides benefits under the WIN Marketplace Coverage shall ensure that all newly eligible individuals enrolled in the plan have access to a qualified, licensed primary care provider and, where available, are enrolled in a patient-centered medical home. All newly eligible individuals enrolled in the plan shall receive information on wellness activities that qualify an individual for exemption from monthly contributions, including the requirement that enrollees be scheduled within sixty days after enrollment for an initial appointment with a qualified licensed primary care provider.

(f) The department, with oversight by the Wellness in Nebraska Oversight Committee, shall develop measures to determine clinical outcomes to be attained by patient-centered medical home providers and quality health benchmarks that meet specified health improvement goals for newly eligible individuals. The department, with oversight by the committee, shall work with qualified health plan carriers to create value-based reimbursement that utilize fee-for-service or capitalization and a paid care coordination fee on a per-member per-month basis until an alternative reimbursement methodology is determined according to section 42 of this act.

Sec. 38. Newly eligible individuals who have access to private employer-sponsored insurance on or after the effective date of this act, either directly as an employee or through another individual such as a spouse, dependent, or parent who is eligible,

which employer-sponsored insurance meets the definition of minimum essential coverage under the 26 U.S.C. 5000A(f), and any regulation adopted thereunder, and for which the employer pays no less than fifty percent of the total cost of the employee's coverage for such employer-sponsored insurance which the department has determined to be cost-effective, shall be eligible for the employer-sponsored insurance premium program. Premium payments shall be made by the department for the continued purchase of employer-sponsored insurance through the employer, including the employee's share of an employer-sponsored insurance premium plus any required cost-sharing, copayments, co-insurance, deductible and wrap-around benefits, if the department determines the employer-sponsored insurance is cost effective to the state in accordance with any waiver or state plan amendment approved by Centers for Medicare and Medicaid Services. For newly eligible individuals who have access to employer-sponsored insurance and participate in the employer-sponsored insurance program, the department shall provide for wrap-around benefits that are not covered by the employer-sponsored insurance.

Sec. 39. (1) Newly eligible individuals whose household income is below one hundred percent of the federal poverty level shall be covered under WIN Medicaid Coverage with a benchmark benefit package as defined in the section 1937(b)(1)(D) federal Social Security Act, as amended, 42 U.S.C. 1396u-7(b)(1)(D), for Secretary-approved coverage. The waiver application shall include: (a) All mandatory and optional coverage under section 68-911 for health care

and related services in the amount, duration, and scope in effect on January 1, 2014; and (b) any additional benefits as wrap-around benefits required by the Affordable Care Act not included in section 68-911. The Paul Wellstone and Pete Dominici Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. 300gg-5, shall apply to WIN Medicaid Coverage.

(2) Any private managed care organization that provides health benefits under the WIN Medicaid Coverage shall ensure that all newly eligible individuals have access to a qualified licensed primary care provider and, where available, are enrolled in a patient-centered medical home. The department shall require that all newly eligible individuals who enroll with a private managed care organization shall be scheduled within sixty days after enrollment by the managed care organization for an initial appointment with a qualified licensed primary care provider. The department, with oversight by the Wellness in Nebraska Oversight Committee, shall work with contracting private managed care organizations to create financial incentives for providers that meet health improvement goals for newly eligible individuals.

Sec. 40. (1) A goal of the Wellness in Nebraska Act is to engage newly eligible participants and leverage the corresponding financial resources made available through the Affordable Care Act to assist in the transformation of Nebraska's health care system to quality patient-centered wellness, coordinated appropriate levels of care, and value-based reimbursement. Accordingly the Wellness in

Nebraska plan waiver applications to the Centers for Medicare and Medicaid Services shall include health care innovations and integrated care models. The innovations and integrated care models shall deliver health care to newly eligible individuals through WIN Marketplace Coverage and WIN Medicaid Coverage with an emphasis on whole-person orientation and incorporating primary care systems. A foundational component of such innovations and integrated care models shall be participation in patient-centered medical homes. The Wellness in Nebraska plan shall include care delivery models that: (a) Integrate providers and incorporate financial incentives to improve patient health outcomes, improve care, and reduce costs; (b) integrate both clinical services and nonclinical community and social supports utilizing patient-centered medical homes and community care teams as basic components; and (c) incorporate into the integrated system safety net providers, including, but not limited to, federally qualified health centers, rural health clinics, community mental health centers, public hospitals, and other nonprofit and public providers, that have experience in caring for vulnerable populations.

(2) On January 1, 2015, or as soon thereafter as plan waivers are approved by Centers for Medicare and Medicaid Services and implemented, the department under the Wellness in Nebraska plan shall ensure that all newly eligible individuals have access to a qualified, licensed primary care provider and, where available, are enrolled in a patient-centered medical home. Upon enrollment, a member shall choose a primary care provider and where available, a

patient-centered medical home. If the member does not choose a primary care provider or a patient-centered medical home, the department shall assign the member to a primary care provider and where available, a patient-centered medical home.

(3)(a) Beginning January 1, 2016, all newly eligible individuals enrolled in the Wellness in Nebraska plan shall be enrolled in a patient-centered medical home, where available.

(b) If patient-centered medical homes are not available for all WIN Marketplace Coverage and WIN Medicaid Coverage enrollees by January 1, 2016, the department, with oversight by the Wellness in Nebraska Oversight Committee, shall develop plans for increasing patient-centered medical homes or alternative integrated care models and pilot projects that may include accountable care organizations, health homes, community homes, community care organizations, physician-hospital organizations, accountable care communities, or other innovative, integrated care models that include coordinated, team-based patient-centered care.

(c) The plans shall include health homes, including, but not be limited to, the health home pilot programs described in section 41 of this act. In developing the plans, the department and the Wellness in Nebraska Oversight Committee shall engage Nebraska health care entities, stakeholders, providers, managed care organizations, health insurance carriers, and other interested parties. The plans shall take into consideration existing patient-centered medical home programs currently operating or under

development.

(4) By January 1, 2016, patient-centered medical homes shall have attained patient-centered medical home certification or have a plan to attain such certification, by the National Committee for Quality Assurance, the Joint Committee on Accreditation of Health Care, or Utilization Review Accreditation Commission or a successor certifying body.

(5) Accountable care organization shall incorporate patient-centered medical homes as a foundation and shall emphasize whole-person orientation and coordination and integration of both clinical services and nonclinical community and social supports that address social determinants of health. A participating accountable care organization shall enter into a contract with the department directly or with a plan provider or through a managed care organization under contract with the department, to ensure the coordination and management of the health of its members, to produce quality health care outcomes, and to control overall costs.

(6) The department shall work with participating managed care organizations or other health care entities providing patient-centered medical homes to create value-based reimbursements as described in subsection (3) of section 39 of this act.

Sec. 41. (1) The waiver application required pursuant to the Wellness in Nebraska Plan shall include a plan developed by the department, with oversight by the Wellness in Nebraska Oversight Committee, for a pilot program for each managed care organization

contracting with the department to develop at least three health homes for newly eligible individuals who are medically frail or have exceptional medical conditions. Such health homes shall provide intensive care management and patient navigation services for such individuals. Health homes shall have designated providers operating under a whole-person approach to care within a culture of continuous quality improvement. Health homes shall use a multidisciplinary team of medical, mental health, and substance abuse treatment providers, social workers, nurses, and other care providers led by a dedicated care manager who assures that participating members receive needed medical, behavioral, and social services through a single integrated care entity. Such entity shall be headed by a primary care provider who shall lead such multidisciplinary team which shall collectively take responsibility for the ongoing health care and health-related needs of patients. The primary care provider shall be responsible for providing for all of a patient's health-related needs or shall take responsibility for appropriately arranging for health-related services provided by other qualified health care professionals and providers of medical and nonmedical health-related services. This responsibility includes, but is not limited to, health-related care at all stages of life, including, but not limited to, preventive care services, acute care, chronic care, long-term care, transitional care between providers and settings, and end-of-life care. The responsibility includes whole-person care consisting of physical health care, including but not limited to oral, vision, and specialty

care, pharmacy management, and behavioral health care. Care shall be coordinated and integrated across all elements of the health care system and the participant's community.

(2) Health homes which are part of the pilot program shall provide comprehensive care coordination and health promotion; access to primary and specialty services coordinated with physical health, behavioral health services, substance-abuse services, HIV/AIDS treatment, housing, social services, comprehensive transitional care from hospital or prison to the community, patient and family support, referral to community and social support services, and use of health information technology to link services. A health home shall: (a) Connect under a single point of accountability; (b) have a referral relationship with one or more hospital systems; (c) cover physical and behavioral health; and (d) utilize community-based organizations for care and housing providers.

(3) The department will work with participating managed care organizations or other health care entities participating in the pilot program to create value-based reimbursements.

Sec. 42. (1) By January 1, 2016, the department, in conjunction with the Wellness in Nebraska Oversight Committee, shall recommend a reimbursement methodology and incentives for participation in the patient-centered medical home and health home systems to ensure that providers enter into and continue participating in the system. In developing the recommendations for incentives, the department shall consider, at a minimum, providing

incentives to promote wellness, prevention, chronic care management, immunizations, health care management, and the use of electronic health records. In developing the recommendations for the reimbursement system, the department shall analyze, at a minimum, the feasibility of all of the following:

(a) Reimbursement to promote wellness and prevention and to provide care coordination and chronic care management;

(b) Increasing reimbursement to Medicare levels for certain wellness and prevention services, chronic care management, and immunizations;

(c) Providing reimbursement for primary care services by addressing the disparities between reimbursement for specialty services and for primary care services;

(d) Increasing funding for efforts to transform medical practices into certified patient-centered medical homes, including emphasizing the use of electronic health records;

(e) Targeting reimbursement to providers linked to health care quality improvement measures established by the department;

(f) Reimbursement for specified ancillary support services, such as transportation for medical appointments and other similar types of services;

(g) Reimbursement for medication reconciliation and medication therapy management service, where appropriate; and

(h) Developing quality performance standards. In developing such standards, the department and the committee shall

consider various standards, including, but not limited to, the quality index score, the Medicare shared savings program quality reporting metrics, and the uniform data set.

(2) The department, in conjunction with the Wellness in Nebraska Oversight Committee, shall also recommend payment models for accountable care organizations by January 1, 2016, that include, but are not limited to, risk sharing, including both shared savings and shared costs, between the state and the participating accountable care organization and bonus payments for improved quality. Contract terms may require that a participating accountable care organization be subject to shared savings beginning in the initial year of the contract, have quality metrics in place within three years after the initial year of the contract, and participate in risk sharing within five years after the initial year of the contract.

Sec. 43. (1) The waiver applications required pursuant to the Wellness in Nebraska Act shall include provisions for incentives to encourage development of cost-conscious consumer behavior in consumption of health care services and to improve the use of preventive care services. The Legislature finds that monthly payments provide members with (a) financial predictability and certainty, (b) an incentive to actively seek preventive care services and engage in healthy behaviors that may earn an exemption from monthly contributions, and (c) consistent program policies to prepare them to transition to coverage on the exchange if their income increases above one hundred thirty-three percent of the federal poverty level.

(2)(a) Beginning January 1, 2016, members with incomes at or about fifty percent of the federal poverty level who are enrolled in WIN Marketplace Coverage or WIN Medicaid Coverage shall contribute two percent of their monthly income to the program under which they receive coverage. If a member completes required preventive care services and wellness activities described in subsection (3) of this section during the initial year of membership, the monthly contributions shall be waived during each subsequent year until the member fails to complete such required preventive care services and wellness activities specified during the prior annual membership period.

(b) To remove barriers to health care, newly eligible participants shall have no copays other than those imposed for inappropriate utilization of a hospital emergency department. The department and Wellness in Nebraska Oversight Committee, in accordance with guidance from the Centers for Medicare and Medicaid Services, shall develop a policy regarding what constitutes inappropriate utilization of a hospital emergency department and any cost sharing required by enrollees as a result of such policy.

(c) The total of monthly contributions plus cost sharing each quarter shall be limited to one quarter of five percent of the yearly income of the member. The policy shall include guidelines for hardship exemptions from monthly contributions and cost sharing by members.

(3) Preventive care services and wellness activities

shall include, but are not limited to, an annual physical and completion of an approved health risk assessment to identify unhealthy characteristics, including chronic disease, alcohol use, substance use disorders, tobacco use, and obesity and immunization status. Future requirements may include additional preventive care services, health promotion, and disease management as determined by the department and the committee. As a part of the health risk assessment, members receive information on and discuss with their primary care provider advance directives and shall complete an advance directive on a form developed by the department that includes an option to decline with assurances that declining does not impact potential exemption from monthly contributions.

Sec. 44. Eligibility for coverage under the Wellness in Nebraska Act is a qualifying event under the federal Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191. Services that are otherwise covered through the Wellness in Nebraska plan shall not be excluded from coverage because they are ordered by a court or required as a condition of probation or parole. Following initial enrollment, a member is eligible for covered benefits for twelve months, subject to program termination and other limitations specified by the department. The department shall review each member’s eligibility annually. Every newly eligible individual who applies for coverage under the Wellness in Nebraska Act shall at the time of enrollment acknowledge in writing that he or she has received written information stating that coverage under the Wellness in

Nebraska Act is subject to cancellation pursuant to section 50 of this act upon notice thereof to the enrollee.

Sec. 45. The department shall include in its applications for waivers required by the Wellness in Nebraska Act a plan for evaluating whether:

(1) WIN Marketplace Coverage participants will have greater access to health care providers than WIN Medicaid Coverage participants due to increased reimbursement provided by a qualified health plan;

(2) WIN Marketplace Coverage participants have greater access to health care providers than persons insured by private qualified health plans, due to the increased focus on primary care delivery through patient-centered medical homes;

(3) The WIN Marketplace Coverage option for newly eligible individuals with higher incomes will result in lower administrative costs attributable to the medical assistance program;

(4) The focus pursuant to WIN Marketplace Coverage on primary care and patient-centered medical homes results in improved outcomes and cost containment compared to other private qualified health plan participants;

(5) WIN Marketplace Coverage members will experience fewer gaps in insurance coverage and maintain continuous access to the same qualified health plan and providers than persons covered by medicaid;

(6) Provision of premium assistance for qualified health

plans on the health benefit exchange, resulting in more medicaid recipients in the health benefit exchange will increase competition in the private market, resulting in lower costs for all Nebraskans participating in the health benefit exchange;

(7) The incentive program that reduces cost sharing in subsequent years results in increased preventive care services and other disease prevention and health promotion activities;

(8) The incentive program that reduces cost sharing results in lower health care costs and improved health outcomes for participants under the Wellness in Nebraska Act;

(9) The copayment requirement for overutilization of hospital emergency departments decreases the non-emergency use of the emergency department;

(10) Limiting WIN Marketplace Coverage and WIN Medicaid Coverage participation to only individuals without access to employer-sponsored insurance keeps people on their private employer-sponsored insurance;

(11) Offering newly-eligible individuals coverage under the Wellness in Nebraska plan offers low-income newly eligible individuals an opportunity to assure access to a primary care provider, emphasizes preventive care services, and encourages the appropriate utilization of services in the most cost-effective manner;

(12) Increased financing available through the Affordable Care Act allows for innovation and implementation of new health care

delivery systems to promote coordinated care, managed care, and the development of accountable care organizations, resulting in higher quality and lower premium costs;

(13) The health care delivery systems provided to the newly eligible individuals through the innovative and integrated care plans increase positive health outcomes and translate to improved value and health;

(14) Value-based payment models developed pursuant to the Wellness in Nebraska Act are effective in promoting increased quality and controlling costs in comparison to fee-for-service reimbursement and capitation payment models;

(15) Financial participation through monthly contributions for WIN Marketplace Coverage and WIN Medicaid Coverage rather than copayments results in more consistent financial responsibility and compliance; and

(16) There is any difference between newly eligible individuals who receive incentives for exemption from monthly contributions compared to traditional medicaid beneficiaries who make copayments when participants move from medicaid to private qualified health plans with respect to members fulfilling their financial responsibilities and cooperating in healthy behaviors.

Sec. 46. (1) The Wellness in Nebraska Oversight Committee is created as a special legislative committee. The committee shall consist of nine members of the Legislature appointed by the Executive Board of the Legislative Council as follows: (a) The chairperson of

the Health and Human Services Committee of the Legislature who shall serve as chairperson of the Wellness in Nebraska Oversight Committee; (b) two members of the Health and Human Services Committee of the Legislature, (b) two members of the Appropriations Committee of the Legislature, (c) two members of the Banking, Commerce and Insurance Committee of the Legislature, and (d) two members of the Legislature who are not members of such committees. The executive board shall appoint members of the Wellness in Nebraska Oversight Committee no later than thirty days after the effective date of this act.

(2) The Wellness in Nebraska Oversight Committee shall oversee and monitor the Wellness in Nebraska Act, including, but not limited to, reviewing information from the department, participating with the department in negotiations with Centers for Medicare and Medicaid Services regarding medicaid waiver applications, and providing recommendations to the department to implement the act.

(3) The committee shall meet at least quarterly with representatives of the department, including, but not limited to, the Director of Medicaid and Long-Term Care of the Division of Medicaid and Long-term Care of the department, with the Director of Insurance, and other interested parties. The committee may meet at other times at the call of the chairperson.

(4) The committee may hire a consultant with training and expertise in health care system innovation and medicaid, preferably including specialized knowledge and experience in the process of applying and negotiating medicaid waivers.

(5) The committee may utilize individuals and organize work groups who or which may include stakeholders, health care providers, public and private insurers, health care delivery organizations, specialty societies, professional and higher education entities, and consumers to provide information, expertise, and recommendations on Nebraska's health care system to the committee in furtherance of its duties.

(6) The Department of Health and Human Services and the Department of Insurance shall provide the committee with any reports, data, analysis, including actuarial data and reports, or other information upon which the departments utilize for implementing the act.

Sec. 47. If federal funding under the Affordable Care Act falls below ninety percent, the Legislature in the first regular legislative session following such reduction in federal funding shall review the Wellness in Nebraska Act to determine how to mitigate the impact on state expenditures and review health coverage options available for persons receiving coverage under the Wellness in Nebraska Act.

Sec. 48. The department shall adopt and promulgate rules and regulations to carry out the Wellness in Nebraska Act.

Sec. 49. Since an emergency exists, this act takes effect when passed and approved according to law.