



OPEN MINDS

Nebraska Health & Human Services System Market Profile



Nebraska Health & Human Services Market Profile Overview

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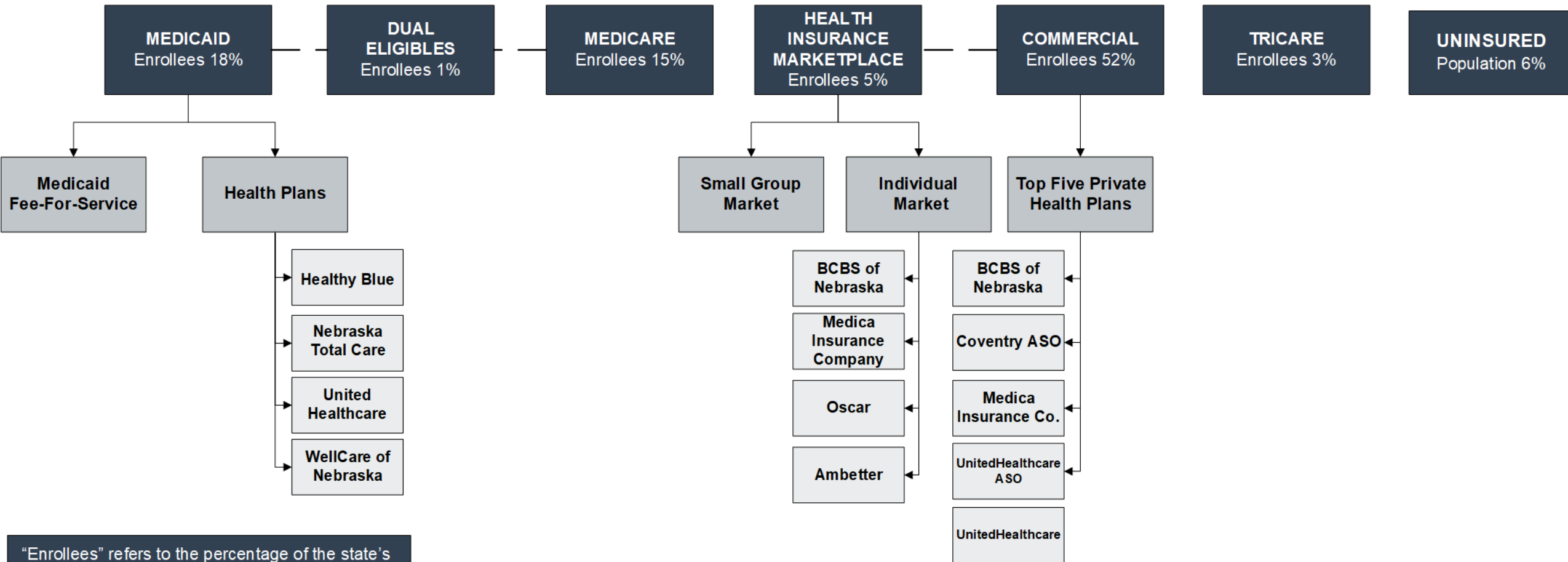
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A. Executive Summary

A.1. Nebraska Physical Health Care Coverage by Payer

Total Nebraska Population- 1,963,692

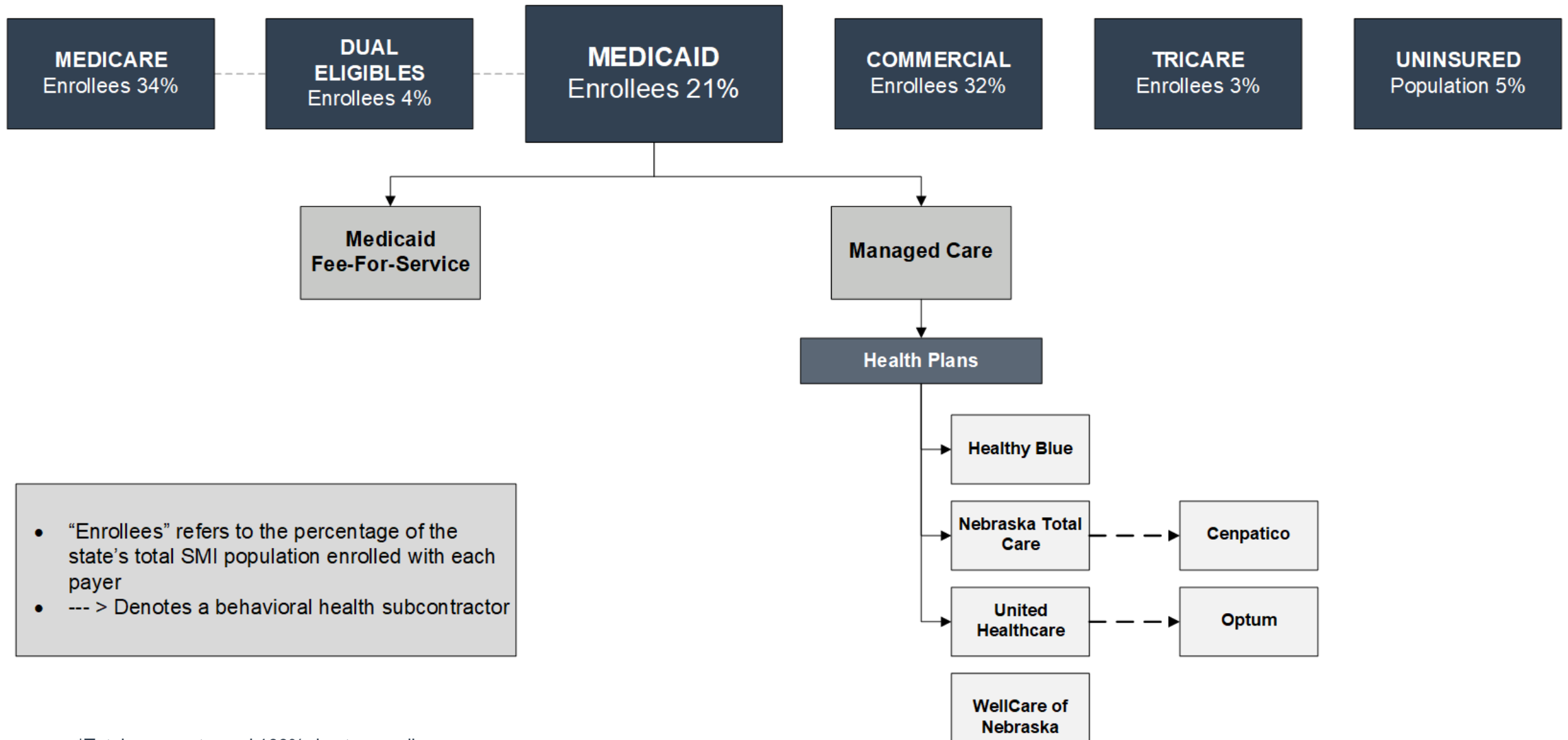
Estimated SMI Population- 133,213



“Enrollees” refers to the percentage of the state’s total population enrolled with each payer.

*Totals may not equal 100% due to rounding.

A.1. Nebraska Behavioral Health Care Coverage by Payer



*Totals may not equal 100% due to rounding.

A.2. Health & Human Services Care Coordination Initiatives

Care Coordination Entities For Chronic Care Populations (Including SMI)		
Care Coordination Entity	Active Program	Description
Managed Care Health Plan	✓	The MCOs are responsible for implementing performance improvement projects related to improving 7- and 30-day follow-up after a visit to the emergency department for behavioral health.
Primary Care Case Management (PCCM)		None
Accountable Care Organization (ACO) Program		None
Affordable Care Act (ACA) Model Health Home		The state is exploring health homes for adults with SMI and children with serious emotional disturbance, but no further steps have been taken.
Patient-Centered Medical Home (PCMH)	✓	The health plans are responsible for implementing a patient-centered medical home program.
Dual Eligible Demonstration		None
Managed Long-Term Services and Supports (MLTSS)		The state is planning to implement a MLTSS program but has not set a timeline for implementation.
Certified Community Behavioral Health Clinics (CCBHC) Grant	✓	The state currently operates two CCBHCs.

A.3. Health Care Safety-Net Delivery System

State Agencies Responsible For Uninsured Citizens & Delivery System Model

Physical Health Services

- The Department of Health and Human Services, Division of Public Health provides safety-net funding for physical health services.

Mental Health Services

- The Department of Health and Human Services, Division of Behavioral Health oversees the Regional Behavioral Health Authorities (RBHAs), which develop and coordinate safety-net behavioral health services for individuals in their catchment areas.

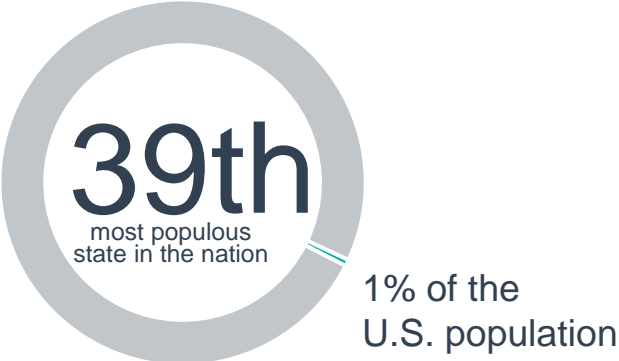
Addiction Treatment Services

- The Department of Health and Human Services, Division of Behavioral Health oversees the RBHAs, which develop and coordinate safety-net behavioral health services for individuals in their catchment areas.

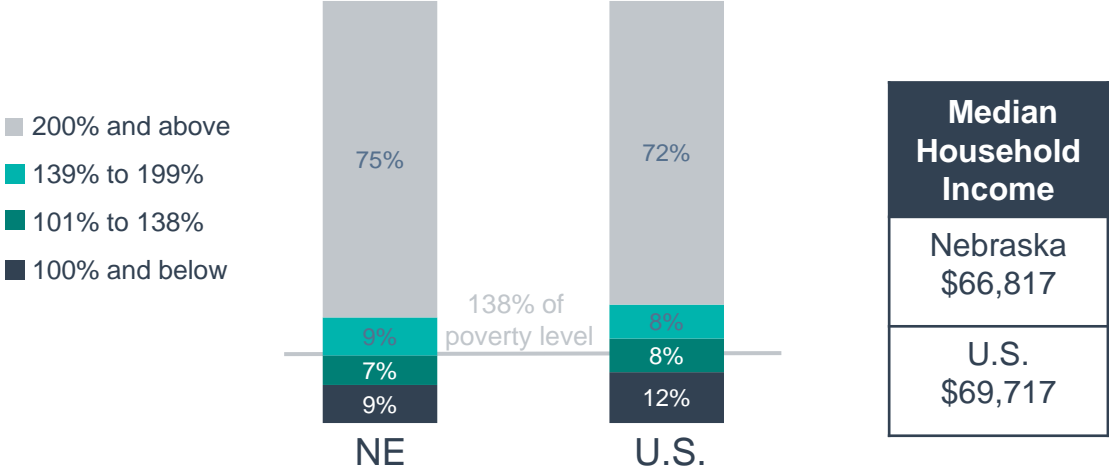
B. Nebraska Health Financing System Overview

B.1. Population Demographics

Total Nebraska Population- 1,963,692
 Estimated SMI Population- 133,213



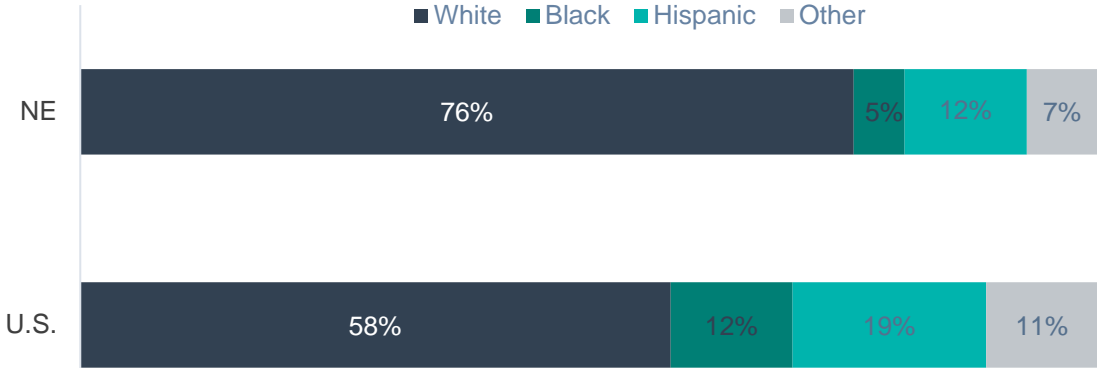
Population Distribution By Income To Poverty Threshold Ratio



Population Distribution By Age



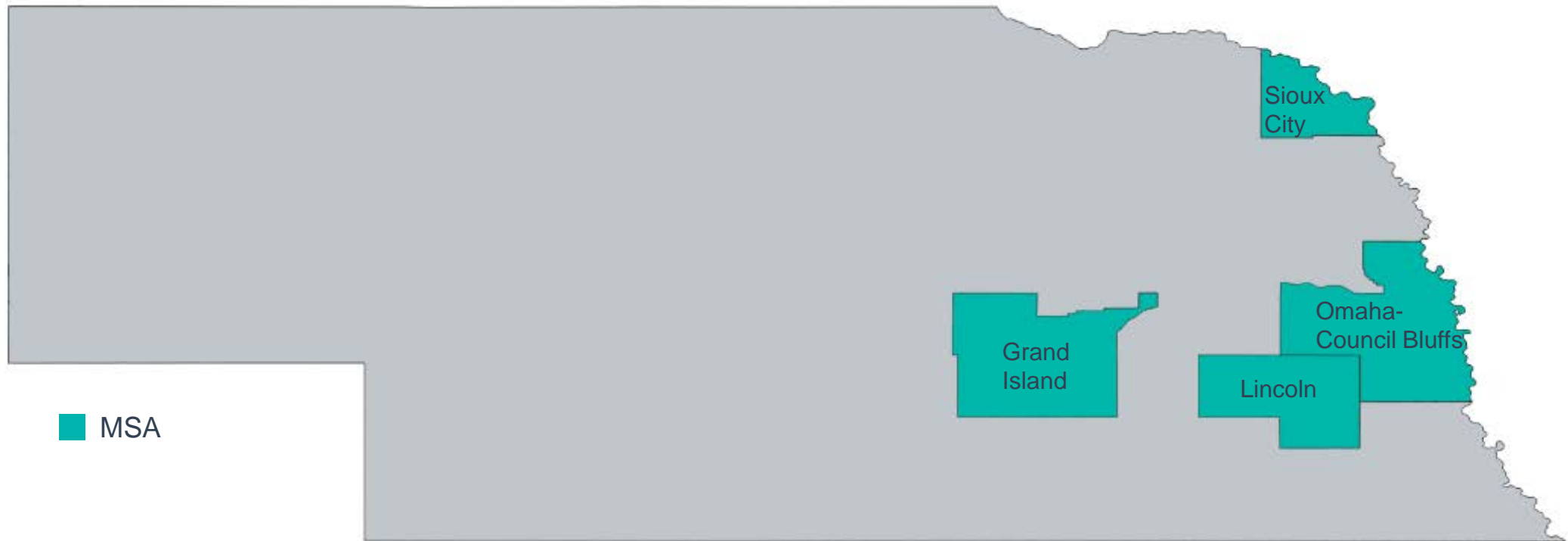
Nebraska & U.S. Racial Composition



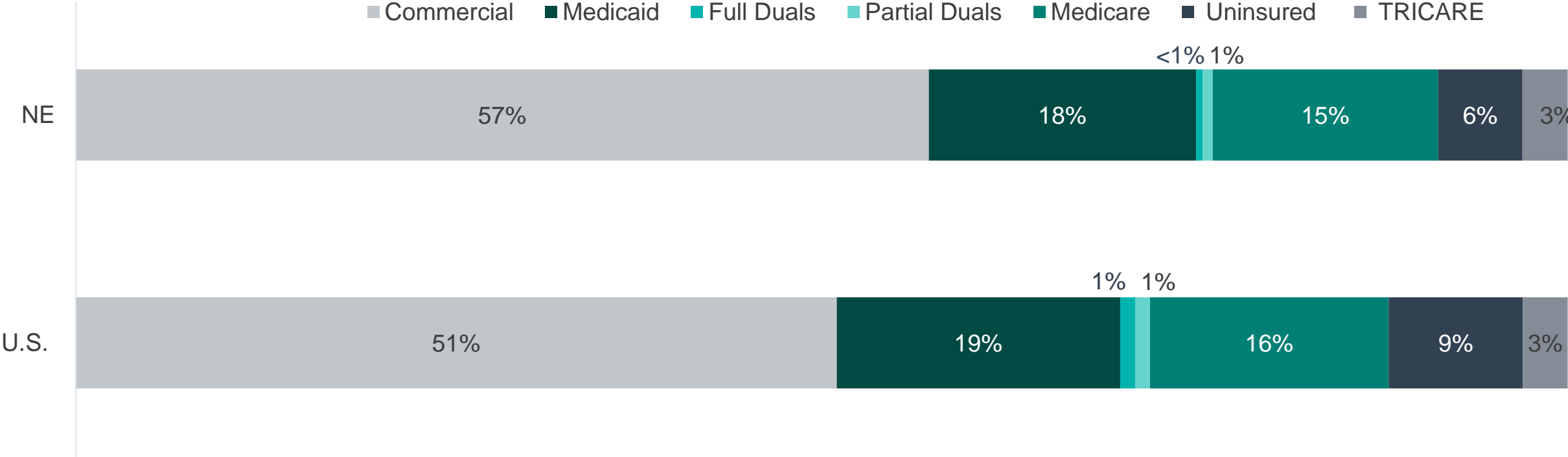
*Totals may not equal 100% due to rounding.

B.2. Population Centers

Metropolitan Statistical Areas (MSAs)		
MSA	Nebraska MSA Residents	Percent Of Population
Total MSA Population	1,539,194	78%
Omaha-Council Bluffs, NE-IA	971,637	49%
Lincoln, NE	342,117	17%
Sioux City, IA-NE-SD	149,265	8%
Grand Island, NE	76,175	4%

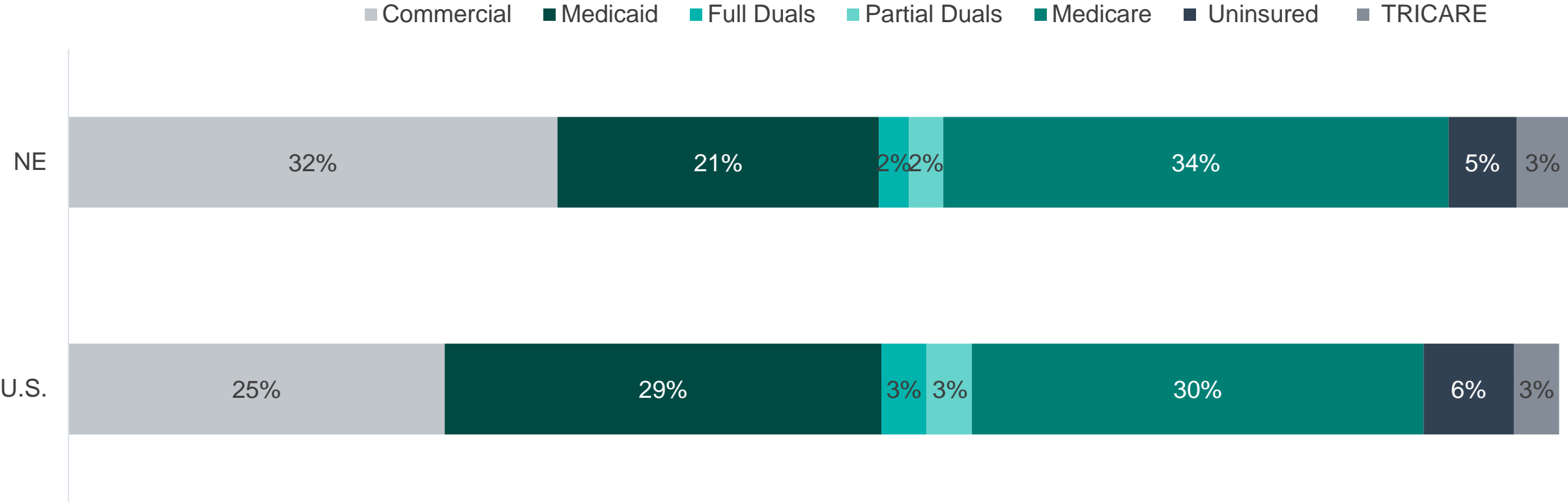


B.3. Population Distribution By Payer: National vs. State



*Totals may not equal 100% due to rounding.

B.3. SMI Population Distribution By Payer: National vs. State



*Totals may not equal 100% due to rounding.

B.4. Largest Nebraska Payers By Enrollment

Plan Name	Plan Type	Enrollment*
Blue Cross Blue Shield Nebraska	Commercial administrative service organization (ASO)	359,208
Medicare fee-for-service (FFS)	Medicare	261,751
UnitedHealthcare ASO	Commercial ASO	135,744
UnitedHealthcare Community Plan	Medicaid managed care	118,461
Nebraska Total Care	Medicaid managed care	118,405
Healthy Blue of Nebraska	Medicaid managed care	111,043
WellCare of Nebraska	Medicaid managed care	82,405
Medicare Insurance Company	Commercial	75,555
TRICARE	Other public	61,703
Coventry ASO	Commercial ASO	61,564

* Medicaid enrollment as of March 2023; TRICARE as of January 2023; Commercial as of March 2023; Medicare enrollment as of March 2023

B.4. Largest Nebraska Payers By Estimated SMI Enrollment

Plan Name	Plan Type	Enrollment*	Estimated SMI Enrollment
Medicare FFS	Medicare	261,751	41,880
BCBS of Nebraska	Commercial ASO	359,208	14,728
UnitedHealthcare Community Plan	Medicaid managed care	118,461	10,188
Nebraska Total Care	Medicaid managed care	118,405	10,183
Healthy Blue of Nebraska	Medicaid managed care	111,043	9,550
WellCare of Nebraska	Medicaid managed care	82,405	7,087
UnitedHealthcare ASO	Commercial ASO	135,744	5,556
UnitedHealthcare Dual Complete	Medicare Advantage	12,462	3,988
TRICARE	Other public	61,703	3,455
AARP MedicareComplete	Medicare Advantage	20,036	3,206

* Medicaid enrollment as of March 2023; TRICARE as of January 2023; Commercial as of March 2023; Medicare enrollment as of March 2023

B.5. Health Insurance Marketplace

Health Insurance Marketplace	
Health Plan Marketplace Percentage	5%
Type of Marketplace	Federal
Individual Enrollment Contact	https://www.healthcare.gov/
	1-800-318-2596
Small Business Enrollment Contact	No small group plans are available through the marketplace. Employers must purchase coverage directly from an insurance carrier or through an insurance broker.

2023 Individual Market Health Plans
<ol style="list-style-type: none"> 1. BCBS of Nebraska 2. Medica 3. Oscar 4. Ambetter from Nebraska Total Care

2023 Small Group Market Health Plans
None

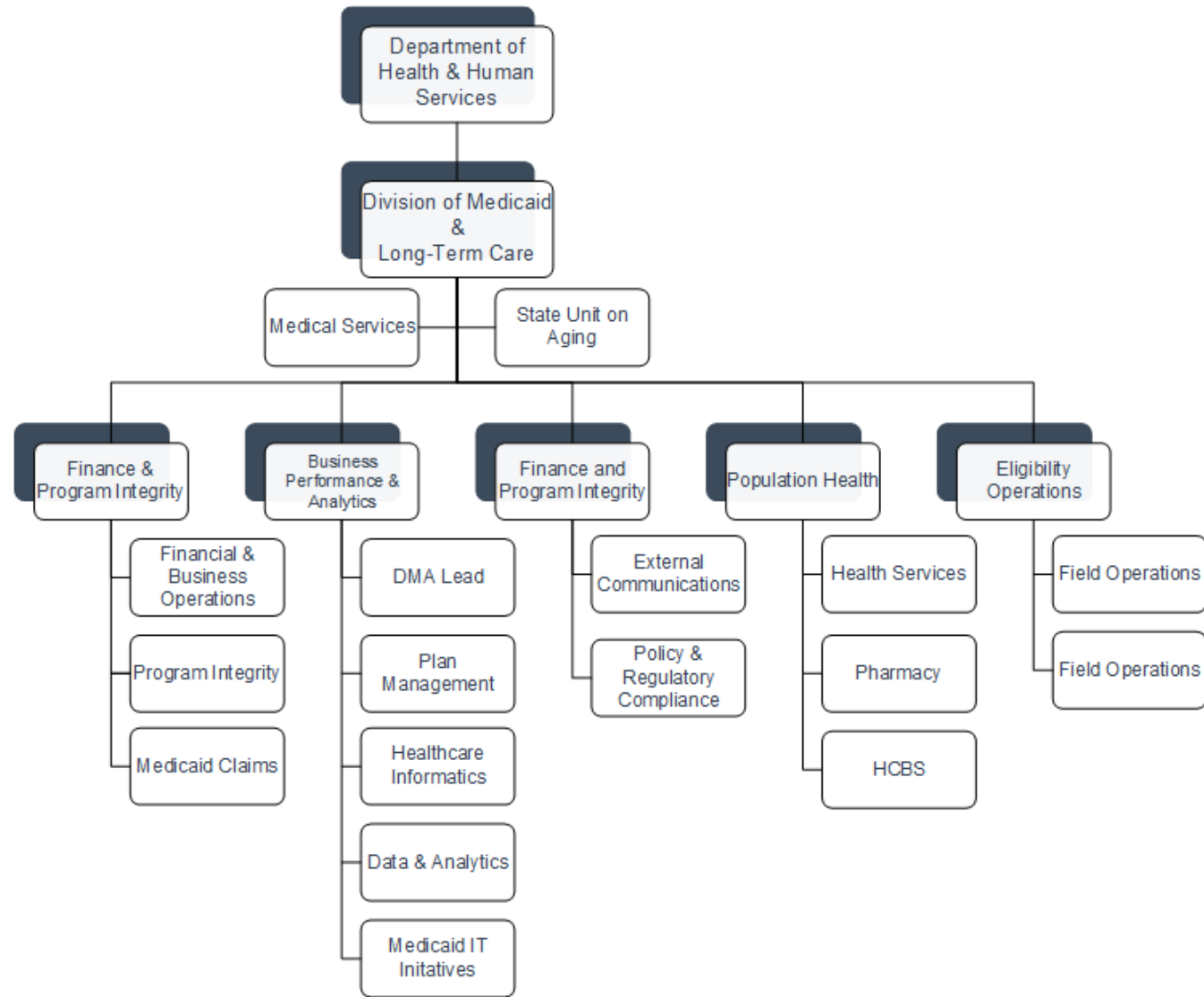
B.6. Accountable Care Organizations

Medicare Shared Savings ACOs	
1.	Alegent Health Partners, LLC
2.	Bryan Health Connect, ACO, LLC
3.	Caravan Health ACO 15, LLC
4.	Caravan Health ACO 22, LLC
5.	Caravan Health ACO 41, LLC
6.	Emergent ACO, LLC
7.	MercyOne ACO V, LLC
8.	Mercy Rural ACO, LLC
9.	Midwest Independent Physicians LLC
10.	Nebraska Health Network, LLC
11.	NPG Health Collaborative LLC
12.	OneHealth Nebraska ACO, LLC
13.	Think ACO, LLC

Commercial ACOs	
ACO	Insurer
Aetna Whole Health- CHI Health Accountable Care Network	Aetna Whole Health

C. Medicaid Administration, Governance & Operations

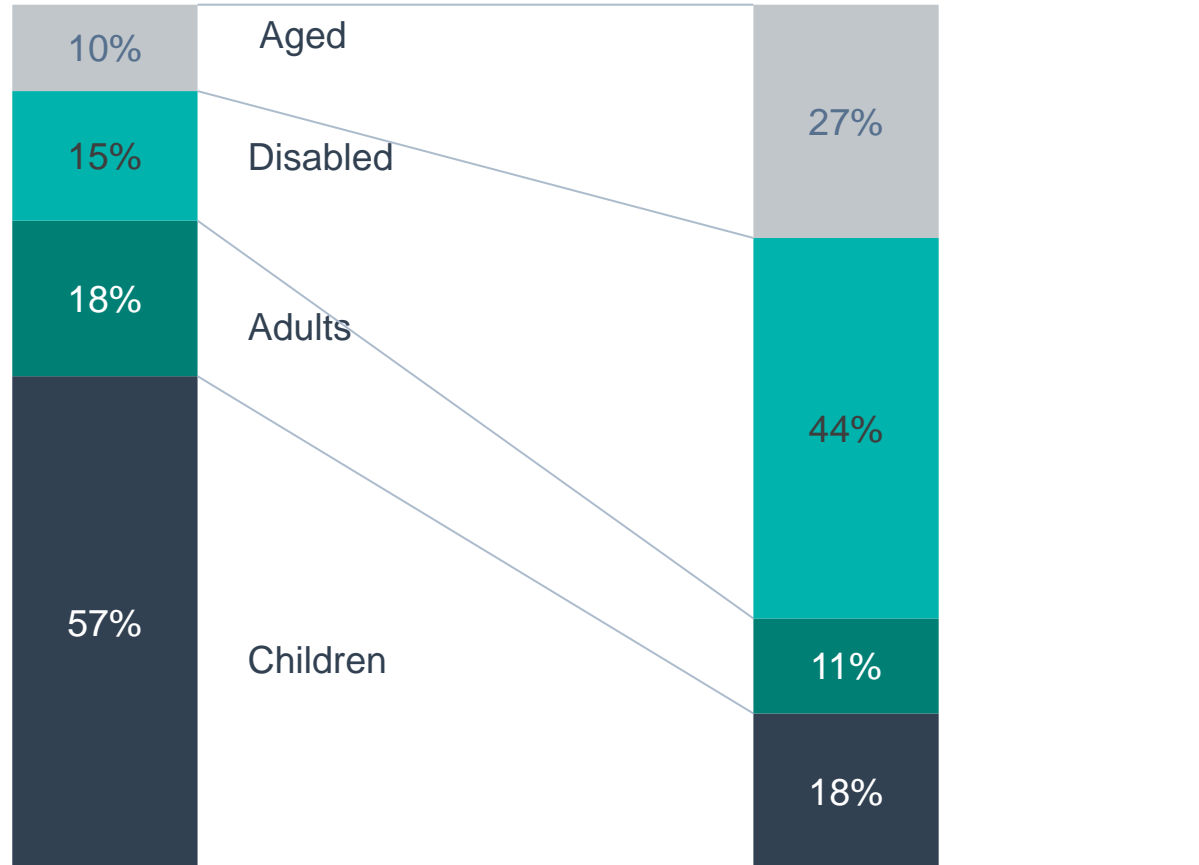
C.1. Medicaid Governance: Organization Chart



C.1. Medicaid Governance: Key Leadership

Name	Position	Department	Email
Dannette R. Smith	Chief Executive Officer	Department of Health and Human Services (DHHS)	dannette.smith@nebraska.gov
Kevin Bagley	Director	DHHS, Division of Medicaid & Long-Term Care	kevin.bagley@nebraska.gov
Elise Verbik, M.D.	Medical Services Director	DHHS, Division of Medicaid & Long-Term Care	elsie.verbik@nebraska.gov
Jeremy Brunssen	Deputy Director	DHHS, Division of Medicaid & Long-Term Care, Finance and Program Integrity	jeremy.brunssen@nebraska.gov
Matt Ahern	Deputy Director	DHHS, Division of Medicaid & Long-Term Care, Policy & Plan Management	Matt.ahern@nebraska.gov
Carisa Schweitzer Masek, Pharm.D.	Deputy Director	DHHS, Division of Medicaid & Long-Term Care, Population Health	carisa.schweitzermasek@Nebraska.gov
Vacant	Deputy Director	DHHS, Division of Medicaid & Long-Term Care, Eligibility Operations	N/A
Todd Baustert	Deputy Director	DHHS, Division of Medicaid & Long-Term Care, Program & Performance Management	Todd.baustert@nebraska.gov

C.2. Medicaid Program Spending By Eligibility Group



Percent of Total Medicaid Population

Percent of Total Medicaid Spending

*Based on FY 2019 data

* Totals may not equal 100% due to rounding

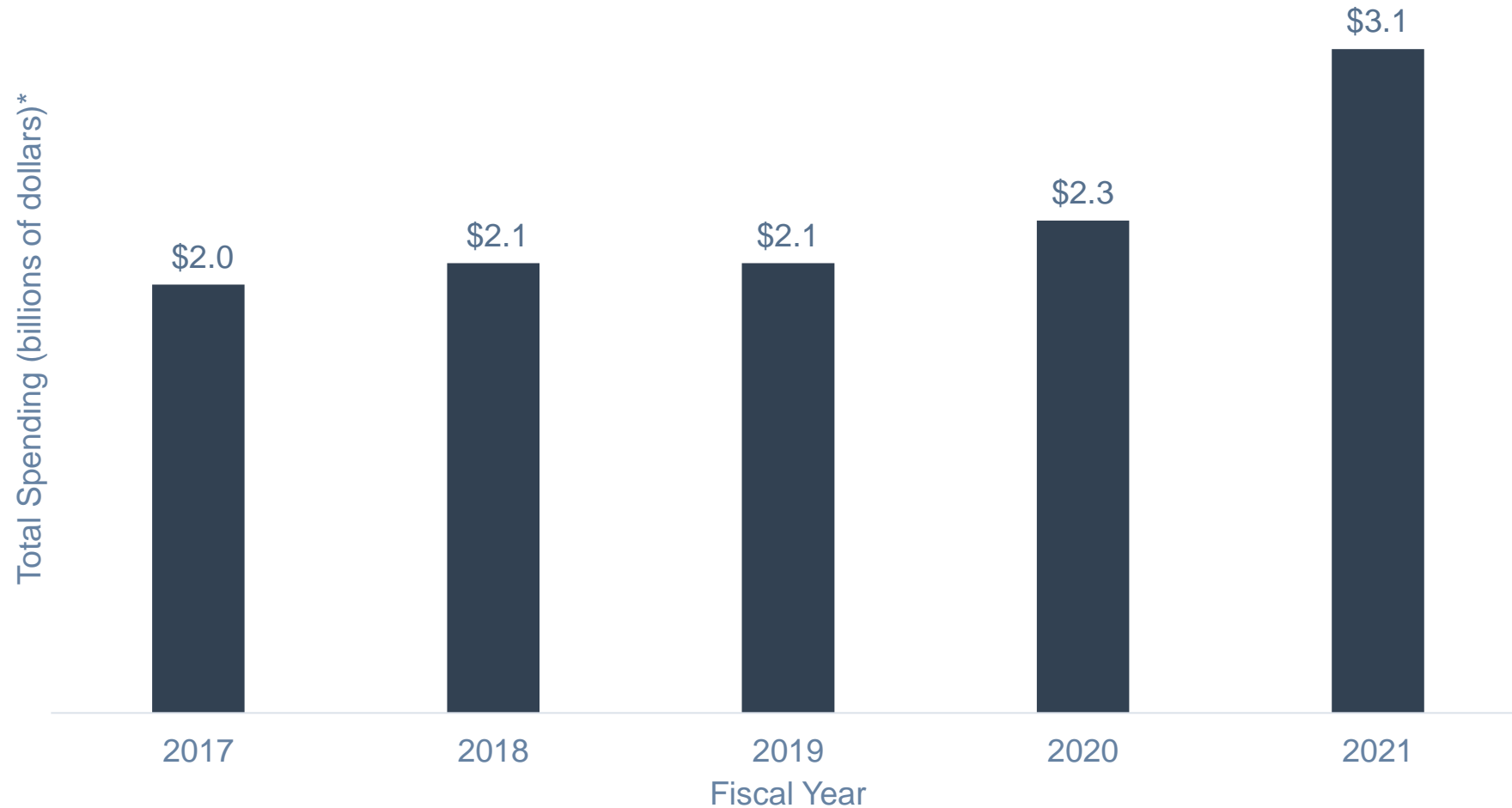
Medicaid Spending Per Enrollee, FY 2020		
	U.S.	NE
All populations	\$8,718	\$10,146
Children	\$3,495	\$3,187
Adults	\$5,461	\$7,216
Expansion adults	\$7,227	\$5,011
Blind and disabled	\$23,123	\$26,694
Aged	\$18,552	\$26,890

C.2. Medicaid Program Spending: Budget

Budget Item	SFY21 Spending	Percent Of Budget
Managed care and premium assistance	\$1,833,000,000	60%
Home- and community-based LTSS	\$570,000,000	19%
Institutional LTSS	\$499,000,000	16%
Medicare premiums and coinsurance	\$66,000,000	2%
Other acute	\$51,000,000	2%
Hospital	\$45,000,000	1%
Physician	\$2,000,000	<1%
Budget Total: \$3,066,000,000		

Federal & County Financial Participation	
FY 2023 Federal Medical Assistance Percentage (FMAP)	64%
CY 2023 Newly Eligible FMAP (expansion population)	88%
Counties contribute to state Medicaid share	No

C.2. Medicaid Program Spending: Change Over Time



C.3. Medicaid Expansion Status

Medicaid Expansion	
Participating In Expansion	Yes, Nebraska voters approved the Medicaid Expansion ballot measure in November 2018. The state submitted a state plan amendment (SPA) to implement the expansion on April 1, 2019 to the Centers for Medicare & Medicaid Services (CMS).
Date Of Expansion	October 1, 2020
Medicaid Eligibility Income Limit For Able-Bodied Adults	58% of the Federal Poverty Level (FPL) for parents; 0% of the FPL for childless adults
Legislation Used To Expand Medicaid	Nebraska Initiative 427
Number Of Individuals Enrolled In The Expansion Group (March 2022)	66,256
Number Of Enrollees Newly Eligible Due To Expansion	64,901
Benefits Plan For Expansion Population	The proposed alternative benefit plan (ABP) provides all essential health benefits based on the approved state plan for individuals with income over 100% FPL. Nebraska has fully aligned the benefits in its ABP with the approved Medicaid state plan by adding the remaining Medicaid covered services through Section 1937 coverage options.

C.3. Medicaid Expansion Status

- On November 6, 2018, Nebraska voters approved the expansion of Medicaid to individuals with income up to 138% of the FPL through Initiative 427. As a requirement of Initiative 427, the state submitted a state plan amendment to CMS on April 1, 2019.
 - The state began accepting applications on August 1, 2020, and individuals were supposed to begin receiving services on October 1, 2021.
- Despite the submission of a state plan amendment, the state also submitted a 1115 waiver on December 12, 2019, which has elements of a non-traditional Medicaid expansion.
 - The state planned for the waiver to be implemented in October 2020, but this was held up by the COVID-19 Public Health Emergency.
- Under the waiver, individuals will receive either basic or prime coverage. Medically frail individuals will receive all state plan services.
- Everyone who is eligible for Medicaid through expansion automatically received equal benefits, including dental, vision, and over-the-counter medications, effective October 1, 2021. Prior to this date, receipt of dental, vision, and over-the-counter medications was subject to specific criteria.

C.3. Medicaid Expansion Status: Prime Coverage

- Prime Benefits were originally scheduled to begin on October 1, 2020, but then were delayed due to the coronavirus pandemic. They began on October 1, 2021.
- The following populations are automatically eligible for Prime Coverage:
 - Medically frail individuals
 - Individuals aged 19 or 20
 - Pregnant women eligible under expansion
- For individuals not automatically enrolled to receive prime coverage, individuals must complete wellness and community engagement benchmarks. The state proposed a tiered approach to implementation of benefits.
 - Waiver Year 1: All individuals, except for the medically frail, will receive basic coverage. To receive prime coverage and additional benefits, individuals must select a primary care provider, participate in active case management, and complete an annual checkup.
 - Waiver Year 2 and beyond: All individuals are required to complete community engagement requirements to maintain their prime coverage. These community engagement requirements include completing 80 hours per month of active employment, job-seeking activities through the State of Nebraska, attending a post-secondary school or apprenticeship, or actively engaging in volunteer activities. Alternatively, individuals who provide care for a relative fulfill the community engagement requirements.
- All Medicaid expansion enrollees will receive basic coverage during the first six months of enrollment. If the individual does not complete the wellness and community engagement (for the second year and beyond) benchmarks, the individual will receive basic coverage during the next six months.
 - An individual receiving basic coverage can earn prime coverage during the enrollment period for fulfilling the wellness and community engagement requirements.

C.4. Medicaid Program Benefits

Federally Mandated Services

1. Inpatient hospital services other than services in an institution for mental disease (IMD)
2. Outpatient hospital services
3. Rural Health Clinic services
4. Federally Qualified Health Center (FQHC) services
5. Laboratory and x-ray services
6. Nursing facilities for individuals 21 and over
7. Early and Periodic Screening and Diagnosis and Treatment (EPSDT)
8. Family planning services and supplies
9. Free standing birth centers
10. Pregnancy-related and postpartum services
11. Nurse midwife services
12. Tobacco cessation programs for pregnant women
13. Physician services
14. Medical and surgical services of a dentist
15. Home health services
16. Nurse practitioner services
17. Non-emergency transportation to medical care

Nebraska's Optional Services

1. Prescribed drugs
2. Intermediate care facilities for the developmentally disabled (ICF/DD)
3. Home- and community-based services
4. Dental services
5. Rehabilitation services
6. Personal care services
7. Durable medical equipment
8. Medical transportation services
9. Vision-related services
10. Speech therapy services
11. Physical therapy
12. Chiropractic services
13. Occupational therapy services
14. Optometric services
15. Podiatric services
16. Hospice services
17. School-based administrative services
18. Hearing screening services for newborn and infant children
19. Private Duty Nursing
20. Clinic Services
21. Screening and Preventive Services
22. Case Management Services
23. Ambulatory Prenatal Care
24. Mental Health and Substance Use Disorder Services.

D. Medicaid Financing & Service Delivery System

D.1. Medicaid Financing & Service Delivery System

Medicaid System Characteristics		
Characteristics	Medicaid Fee-For-Service (FFS)	Medicaid Managed Care
Enrollment (March 2023)	513	45
SMI Enrollment	<ul style="list-style-type: none"> The majority of the Medicaid population is enrolled in managed care, as Nebraska operates a limited FFS program for individuals not eligible for full Medicaid benefits. Less than 1% of SMI population in FFS, 99% in managed care 	
Management	Department of Health and Human Services	Three health plans
Payment Model	FFS	Capitated rate
Geographic Service Area	Statewide	Statewide

Total Medicaid: 430,833 | Total Medicaid With SMI: 37,052

D.1. Medicaid System Overview

Medicaid Financial Delivery System Enrollment	
Total Medicaid population distribution	<ul style="list-style-type: none"> As of March 2023: <1% in fee-for-service (FFS), 99% in managed care
SMI population inclusion in managed care	<ul style="list-style-type: none"> Nebraska does not specifically preclude individuals with SMI from enrolling in managed care; therefore, the majority of the SMI population is enrolled in managed care Estimated <1% of the SMI population in FFS, 99% in managed care
Dual eligible population inclusion in managed care	<ul style="list-style-type: none"> Managed care is mandatory for all dual eligibles Estimated 0% of population in FFS, 100% in managed care
Long-term services and supports (LTSS) population inclusion in managed care	<ul style="list-style-type: none"> LTSS beneficiaries are excluded from managed care and receive services FFS.

Medicaid Financing & Risk Arrangements: Behavioral Health		
Service Type	FFS Population	Managed Care Population
Traditional behavioral health	Covered FFS by the state	Included in the health plan's capitation rate
Specialty behavioral health	Covered FFS by the state	Included in the health plan's capitation rate
Pharmaceuticals	Covered FFS by the state	Included in the health plan's capitation rate
Long-term services and supports (LTSS)	Covered FFS by the state	Covered FFS by the state

D.1. Medicaid Care Coordination Initiatives

Medicaid Care Coordination Entities For Chronic Care Populations (Including SMI)		
Care Coordination Entity	Active Program	Description
Managed Care Health Plan	✓	The MCOs are responsible for implementing performance improvement projects related to improving 7- and 30-day follow-up after a visit to the emergency department for behavioral health.
Primary Care Case Management (PCCM)		None
Accountable Care Organization (ACO) Program		None
Affordable Care Act (ACA) Model Health Home		The state is exploring health homes for adults with SMI and children with serious emotional disturbance, but no further steps have been taken.
Patient-Centered Medical Home (PCMH)	✓	The health plans are responsible for implementing a patient-centered medical home program.
Dual Eligible Demonstration		None
Managed Long-Term Services and Supports (MLTSS)		The state is planning to implement a MLTSS program but has not set a timeline for implementation.
Certified Community Behavioral Health Clinics (CCBHC) Grant	✓	The state currently operates two CCBHCs.

D.1. Medicaid Service Delivery System Enrollment By Eligibility Group

Population	Mandatory FFS Enrollment	Option To Enroll In FFS Or Managed Care	Mandatory Managed Care Enrollment
Parents and caretakers			X
Children			X
Blind and disabled individuals			X
Aged individuals			X
Dual eligibles	Partial benefit dual eligibles		Full benefit dual eligibles
Medicaid Expansion			X
Individuals residing in nursing homes			X
Individuals residing in ICF/IDD			X
Individuals in foster care			X
Other populations	<ul style="list-style-type: none"> • Aliens who are eligible for Medicaid for an emergency condition only • Individuals with excess income • Individuals who have received a waiver for enrollment/disenrollment • Individuals aged 21-64 in institutions of mental disease 		Former foster care children

D.2. Medicaid FFS Program: Overview

- FFS enrollment as of March 2023 was 519.
- All populations in Nebraska are enrolled in managed care unless they are only eligible for limited benefits.

D.2. Medicaid FFS Program: Behavioral Health Benefits

- The state covers all behavioral health benefits FFS for individuals not enrolled in managed care.

FFS Mental Health Benefits

1. Inpatient services
2. Evaluation and testing
3. Individual, group, and family therapy
4. Partial hospitalization services
5. Community support
6. Day rehabilitation
7. Residential rehabilitation
8. Assertive community treatment (ACT)
9. Applied Behavioral Analysis

FFS Addiction Treatment Benefits

1. Inpatient services
2. Individual, group, and family therapy
3. Outpatient services
4. Community support
5. Partial hospitalization services
6. Residential services
7. Initial Assessment*
8. Physical examination*
9. Ongoing assessment*
10. Therapy and treatment planning*
11. Care coordination*
12. Medication administration services*

*Opioid treatment only

D.2. Medicaid FFS Program: SMI Population

- The SMI population is enrolled in FFS if they receive limited benefits.
- As of March 2023, *OPEN MINDS* estimates that <1% of the SMI population was enrolled in FFS.

D.2. Medicaid FFS Program: Pharmacy Benefit

Nebraska FFS Program Pharmacy Benefit & Utilization Restrictions	
State Uses Pharmacy Benefit Manager	Yes, Magellan
Responsible For Financing General Pharmacy Benefit	Medicaid FFS
Responsible For Financing Mental Health Pharmacy Benefit	Medicaid FFS
State Uses A Preferred Drug List (PDL) For General Pharmacy	Yes
State Uses A PDL For Mental Health Drugs	Anxiolytics are included on the PDL. Antipsychotics and drugs for depression are not included on the PDL.
State Uses A PDL For Addiction Treatment Drugs	Yes, drugs for opioid dependence are included on the PDL.
Coverage Of Antipsychotic Injectable Medications	Injectable antipsychotics are covered as a medical benefit.
Utilization Restrictions For Mental Health Or Addiction Treatment Drugs	<ul style="list-style-type: none"> • Opioid dependence drugs- Failed trial of preferred drug, or patient-specific documentation of why preferred drug is not appropriate • Anxiolytics- Must fail two preferred drugs before a non-preferred drug will be approved
State Has A Pharmacy Lock-In Program Or Other Restriction Program	Yes, individuals are identified by the Nebraska Medicaid program and locked-in to a single pharmacy, clinical professional, and/or hospital depending on their prior utilization.

D.3. Medicaid Managed Care Program: Overview

- Managed care enrollment as of March 2023 was 430,314.
- The Medicaid managed care program is called Heritage Health.
- The three health plans deliver physical health, behavioral health, and pharmacy benefits to nearly all populations.
 - Health plans are available statewide, and enrollees have a choice of plans.
- 1.5% of the health plan's capitation rate is withheld and returned based on performance on quality measures.
- The health plans are required to enter value-based contracts with 50% of their provider organizations within five years. Value-based contracts include:
 - Accountability for improvements in health outcomes, care quality, or cost efficiency and;
 - Payment methodologies that align the provider organization's financial and contractual incentives with those of the health plans.

D.3. Medicaid Managed Care Program: Health Plan Characteristics

Nebraska TotalCare

1. Profit status: For-profit
2. Parent company: Centene-WellCare
3. Behavioral health subcontractor: Cenpatico
4. Pharmacy benefits manager: Rx Advance
5. Enrollment share: 28%

UnitedHealthcare Community Plan of Nebraska

1. Profit status: For-profit
2. Parent company: UnitedHealth Group
3. Behavioral health subcontractor: Optum
4. Pharmacy benefits manager: OptumRx
5. Enrollment share: 28%

WellCare of Nebraska

1. Profit status: For-profit
2. Parent company: Centene-WellCare
3. Behavioral health subcontractor: None
4. Pharmacy benefits manager: CVS/caremark
5. Enrollment share: 19%

Healthy Blue

1. Profit status: For-profit
2. Parent company: Anthem
3. Behavioral health subcontractor: None
4. Pharmacy benefits manager: Ingenio RX
5. Enrollment share: 26%

D.3. Medicaid Managed Care Program: Behavioral Health Benefits

- Behavioral health and pharmacy benefits are included in the health plan’s capitation rate. Nebraska authorizes additional benefits for the managed care population under its 1915 (b) managed care waiver. These services are marked with an asterisk.

Managed Care Mental Health Benefits	
1. Crisis stabilization*	11. Partial hospitalization
2. Inpatient psychiatric hospital services	12. Day treatment
3. Assertive community treatment	13. Intensive outpatient*
4. Day rehabilitation	14. Medication management
5. Community support	15. Group, family, and individual therapy
6. Short-term residential	16. Injectable psychotropic medications
7. Psychiatric residential rehabilitation	17. Psychological evaluation and testing
8. Secure residential rehabilitation	18. Electroconvulsive therapy
9. Halfway house	19. Initial diagnostic interviews
10. Outpatient assessment and treatment	20. In-home psychiatric nursing*
	21. Peer support

Managed Care Addiction Treatment Benefits*	
1. Assessment services	
2. Community support	
3. Intensive outpatient	
4. Partial hospitalization	
5. Halfway house	
6. Social detoxification	
7. Intermediate residential and therapeutic community	
8. Short-term residential	
9. Dual diagnosis treatment	

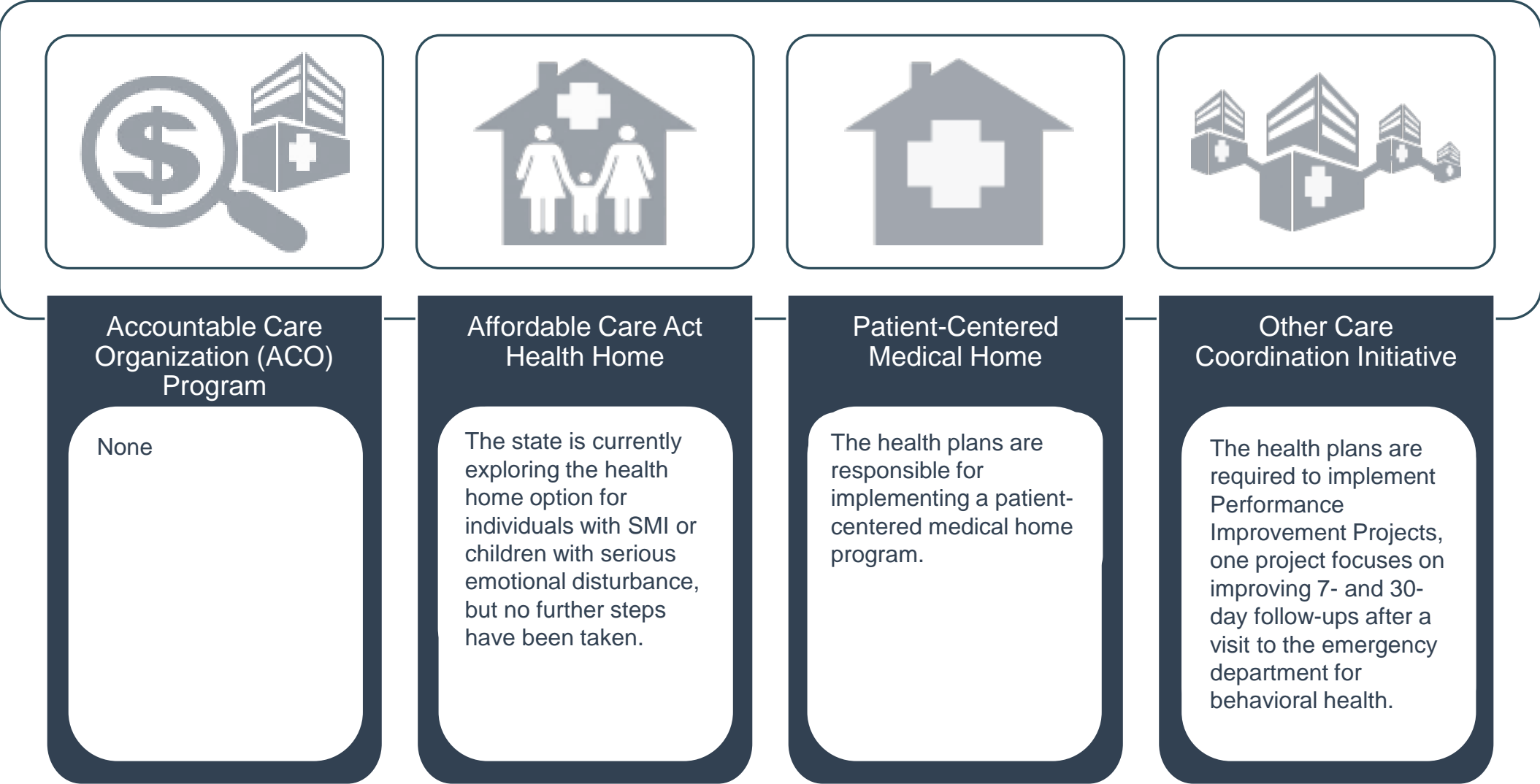
D.3. Medicaid Managed Care Program: SMI Population

- The SMI population is mandatorily enrolled in managed care unless they receive limited benefits.
- As of March, *OPEN MINDS* estimates that 99% of the SMI population was enrolled in managed care.

D.3. Medicaid Managed Care Program: Pharmacy Benefit

Nebraska Managed Care Program Pharmacy Benefit	
Responsible For Financing General Pharmacy Benefit	Health plan
Responsible For Financing Mental Health Pharmacy Benefit	Health plan
Health Plan Uses A Preferred Drug List (PDL) For General Pharmacy	<ul style="list-style-type: none"> The health plans are required to use the FFS PDL set by the state. Anxiolytics and drugs to treat opioid dependence are included on the FFS PDL. Antipsychotics and drugs for depression are not included on the PDL.
Health Plan Uses A PDL For Mental Health Drugs	
Health Plan Uses A PDL For Addiction Treatment Drugs	
Health Plan Use Of Utilization Restrictions For Mental Health & Addiction Treatment Drugs	<p>Each health plan is required to follow the state's prior authorization requirements:</p> <ul style="list-style-type: none"> Opioid dependence drugs- Failed trial of preferred drug, or patient-specific documentation of why preferred drug is not appropriate Anxiolytics- Must fail two preferred drugs before a non-preferred drug will be approved
Health Plan Allowed To Implement Pharmacy Lock-In Program	Yes, the health plans are required to operate pharmacy lock-in programs. Each health plan may design their own program, but it must be approved by the state.

D.4. Medicaid Program: Care Coordination Initiatives



D.4. Medicaid Program: Care Coordination Initiatives – Performance Improvement Projects

- The health plans are required to implement Performance Improvement Projects (PIPs) to improve member health. The three PIPs focus on the following measures:
 - Follow-up after emergency department visit for mental health illness or addiction disorder
 - Injection of 17-hydroxyprogesterone (17p) in pregnant women
 - Whooping cough (Tdap) vaccination in pregnant women
- Each health plan works with the state to set the amount they plan to improve on each measure. See the next slide for follow-up after emergency department visit goals.
- Each health plan is responsible for designing their PIP. Specific interventions for follow-up after emergency department visits include:
 - Nebraska TotalCare – Clinical professional education, case management and assistance with the social determinants of health, and collaboration with state health information exchange for real-time data sharing
 - UnitedHealthcare – Care management contact post-discharge, assess barriers to completing visits, assessment of post-discharge instructions, use of community health workers to address social determinants of health, and pilots to address real-time information sharing
 - Healthy Blue – Member education on emergency department follow-up and the community assistance line, review of emergency department utilization review with provider organizations and education on clinical practice guidelines, and improving data streams via the health information exchange and high-volume facilities
 - WellCare of Nebraska - Followup After Emergency Room Visit With a Diagnosis of Mental Health Illness or Substance Use Disorder, Initiation of 17 – Hydroxyprogesterone in Pregnant Women with a History of Spontaneous Preterm Birth, and Tdap Immunization During Pregnancy.

D.5. Medicaid Program: Demonstration & Care Management Waivers

Waiver Title	Waiver Description	Waiver Type	Enrollment Cap	Effective Date	Expiration Date
Heritage Health (NE-03)	Authorizes enrollment of the majority of Nebraska's Medicaid population into the comprehensive managed care plans.	1915 (b)	None	10/01/2022	09/30/2027
Nebraska Substance Use Disorder	Authorizes residential treatment for individuals with substance use disorders (SUD) receiving short-term treatment and withdrawal management services in facilities that meet the definition of an Institution for Mental Diseases (IMD).	1115	None	07/01/2019	06/30/2024

D.5. Medicaid Program: Section 1915 (c) HCBS Waivers

Waiver Title	Target Population	2023 Enrollment Cap	Operating Unit	Concurrent Management Authority
NE HCBS for Aged & Adults & Children w/Disabilities (0187.R06.00)	Individuals who are physically disabled 0 to 64, and individuals ages 65+	8,300	Division of Medicaid and Long-Term Care	No
NE Comprehensive Developmental Disabilities Services (4154.R06.00)	Individuals of any age who have autism or I/DD any age	4,500	Division of Developmental Disabilities	No
NE Developmental Disabilities Day Services Waiver for Adults (0394.R03.00)	Individuals with autism or with I/DD ages 21+	1,055	Division of Developmental Disabilities	No
NE Traumatic Brain Injury Waiver (40199.R04.00)	Individuals with brain injury ages 18 to 64	40	Division of Medicaid and Long-Term Care	No

D.6. Medicaid Program New Initiatives: Managed Long-Term Services & Supports

- In 2016, Nebraska contracted with Mercer Government Human Services Consulting and NASUAD to assist in the redesign of the state's LTC system. The 2017 LTC Redesign Plan identified several high priority systemic issues that the state should address to improve the overall LTC system. Building an effective navigation system for LTC was one high-priority recommendation identified in the report.
- The Mercer/NASUAD LTC Redesign Plan recommended establishing a No Wrong Door (NWD) model to address this recommendation. A NWD model offers a single, more coordinated system of information and access for all consumers seeking LTC, both publicly and privately funded. Under a NWD model, consumers can access information regardless of their entry point into the system. Activities that can be included in a NWD model include: outreach, referral, assessments, functional eligibility, and final determinations.
- Nebraska's effort to initiate the ADRC program has laid the foundation for the state to develop a statewide NWD system. The state can use the ACL NWD Framework to further advance growth towards streamlining access into the state's LTC system. Nebraska has been supportive of its NWD system's development through several pieces of state legislation:
 - The state can shore up its governance model by creating a formal NWD state agency owner, alongside adding more formal agreements with stakeholders across all populations and payors.
 - Nebraska's disability community needs to be encouraged to join the NWD effort as full partners in the project.
 - Nebraska should focus its efforts on encouraging standardized training for person-centered practices across all NWD staff and participating organizations. This training will help to ensure NWD staff have the necessary skills to serve persons across populations.
 - The state should increase efforts of public outreach through additional partnerships with key referral sources, educational systems, hospitals, and acute care settings. This will establish the state's NWD system as the trusted source of unbiased information into the LTC system.
 - Nebraska should leverage the NWD system to streamline access and the eligibility process for public LTSS programs, utilizing Medicaid administrative claiming to finance and sustain the development of ongoing operations of NWD functions.

D.6. Medicaid Program New Initiatives: Medicaid Expansion

- On November 6, 2018, Nebraska voters approved the expansion of Medicaid to individuals with income up to 138% of the FPL through Initiative 427. As a requirement of Initiative 427, the state submitted a state plan amendment to CMS on April 1, 2019.
- Despite the submission of a state plan amendment, the state has also submitted a 1115 waiver on December 12, 2019, which has elements of a non-traditional Medicaid expansion.
 - The state planned for the waiver to be implemented in October 2020, but this was held up by the COVID-19 Public Health Emergency. The waiver has since been terminated.
- Everyone who is eligible for Medicaid through expansion automatically received equal benefits, including dental, vision, and over-the-counter medications, effective October 1, 2021. Prior to this date, receipt of dental, vision, and over-the-counter medications was subject to specific criteria.
- By August 2022, there were 72,000 people covered under Nebraska's Medicaid expansion. Nebraska initially had two tiers of Medicaid expansion coverage, with various requirements to receive enhanced benefits. But the state terminated that approach in 2021, and all expansion enrollees now receive enhanced benefits.

E. Dual Eligible Financing & Service Delivery System

E.1. Dual Eligible Medicaid Financing & Service Delivery System

Dual Eligible* Medicaid System Characteristics		
Characteristics	Managed Care	PACE
Enrollment (March 2022)	30,484	183
Estimated SMI Enrollment	9,754	59
Management	Three health plans	One non-profit
Payment Model	Capitated rate	Blended capitated rate
Geographic Service Area	Statewide	Select counties

Total Dual Eligible Enrollment: 30,667 | Total Dual Eligible Enrollment With SMI: 9,813

*Unless otherwise noted, the term *dual eligibles* in this section refers to Medicare enrollees with full Medicaid benefits.

E.2. Largest Medicare Health Plans By Estimated SMI Enrollment

Health Plans	Parent Company	Plan Type	January 2023 Enrollment	Estimated SMI Enrollment
UnitedHealthcare Dual Complete	UnitedHealthcare	Medicare Advantage D-SNP	20,498	6,559
Humana Gold Plus	Humana, Inc	Medicare Advantage D-SNP	764	244
Aetna Medicare Assure Premier	Aetna/ CVS	Medicare Advantage D-SNP	260	83
Immanuel Pathways PACE	Immanuel	PACE	183	59

E.3. Dual Eligible Medicaid Financing & Delivery System: Overview

- Dual eligible enrollment as of March 2022 was 30,667.
- Medicare covers most acute services (which may include psychiatric care), while Medicaid, the payer of last resort, covers LTSS and non-physician behavioral health services.
- Dual eligibles are required to enroll in Medicaid managed care to receive Medicaid services.
- D-SNP enrollment as of January 2023 was 21,522. D-SNP SMI enrollment was 6,887.

E.4. Dual Eligible Medicaid Financing & Delivery System: New Initiatives

- Nebraska does not currently have any initiatives related to dual eligibles.

F. Long-Term Services & Supports Financing & Service Delivery System

F.1. LTSS Financing & Service Delivery System

Nebraska does not currently operate a MLTSS program.

LTSS* Medicaid System Characteristics	
Characteristics	Medicaid Managed Care
Enrollment (December 2020)	N/A
Estimated SMI Enrollment	N/A
Management	N/A
Payment Model	N/A
Geographic Service Area	N/A

*Long-Term Services & Supports

F.1. Medicaid LTSS Service Delivery System Enrollment By Eligibility Group

Population	Mandatory FFS Enrollment	Option To Enroll In FFS Or Managed Care	Mandatory Managed Care Enrollment
Disabled adults	-	-	-
Disabled children	-	-	-
Blind individuals	-	-	-
Aged individuals	-	-	-
Dual eligibles	-	-	-
Individuals with I/DD	-	-	-
Individuals residing in nursing homes	-	-	-
Individuals residing in ICF/IDD	-	-	-
Other HCBS Recipients	-	-	-
Other populations			

F.2. LTSS Medicaid Financing & Delivery System: Overview

- The state is planning to implement a MLTSS program but has not set a timeline for implementation.

F.3. Medicaid LTSS Program: Health Plan Characteristics

- The state is planning to implement a MLTSS program but has not set a timeline for implementation.

F.4. Medicaid LTSS Program: Health Benefits

Required Health Services

1. Inpatient hospital services other than services in an institution for mental disease (IMD)
2. Outpatient hospital services
3. Rural Health Clinic services
4. Federally Qualified Health Center (FQHC) services
5. Laboratory and x-ray services
6. Nursing facilities for individuals 21 and over
7. Early and Periodic Screening and Diagnosis and Treatment (EPSDT)
8. Family planning services and supplies
9. Free standing birth centers
10. Pregnancy-related and postpartum services
11. Nurse midwife services
12. Tobacco cessation programs for pregnant women
13. Physician services
14. Medical and surgical services of a dentist
15. Home health services
16. Nurse practitioner services
17. Non-emergency transportation to medical care

Optional Health Services

1. Prescribed drugs
2. Intermediate care facilities for the developmentally disabled (ICF/DD)
3. Home- and community-based services
4. Dental services
5. Rehabilitation services
6. Personal care services
7. Durable medical equipment
8. Medical transportation services
9. Vision-related services
10. Speech therapy services
11. Physical therapy
12. Chiropractic services
13. Occupational therapy services
14. Optometric services
15. Podiatric services
16. Hospice services
17. School-based administrative services
18. Hearing screening services for newborn and infant children
19. Private Duty Nursing
20. Clinic Services
21. Screening and Preventive Services
22. Case Management Services
23. Ambulatory Prenatal Care
24. Mental Health and Substance Use Disorder Services.

F.4. Medicaid LTSS Program: Health Plan Benefits

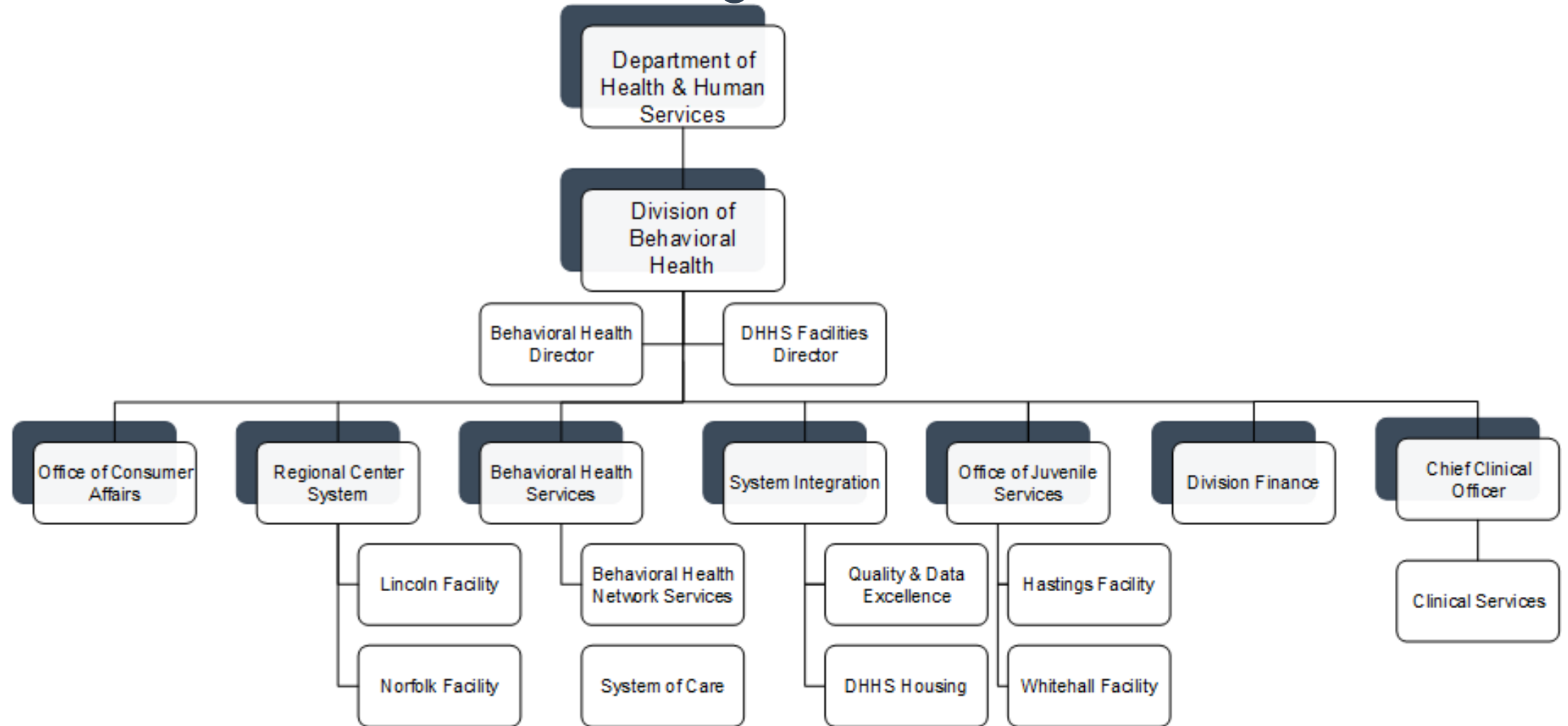
- The state is planning to implement a MLTSS program but has not set a timeline for implementation.

F.5. LTSS Medicaid Financing & Delivery System: New Initiatives

- In 2016, Nebraska contracted with Mercer Government Human Services Consulting and NASUAD to assist in the redesign of the state's LTC system. The 2017 LTC Redesign Plan identified several high priority systemic issues that the state should address to improve the overall LTC system. Building an effective navigation system for LTC was one high-priority recommendation identified in the report.
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 - Nebraska should leverage the NWD system to streamline access and the eligibility process for public LTSS programs, utilizing Medicaid administrative claiming to finance and sustain the development of ongoing operations of NWD functions.

G. State Behavioral Health Administration & Finance System

G.1. Nebraska Department Of Health & Human Services: Division Of Behavioral Health Organization Chart



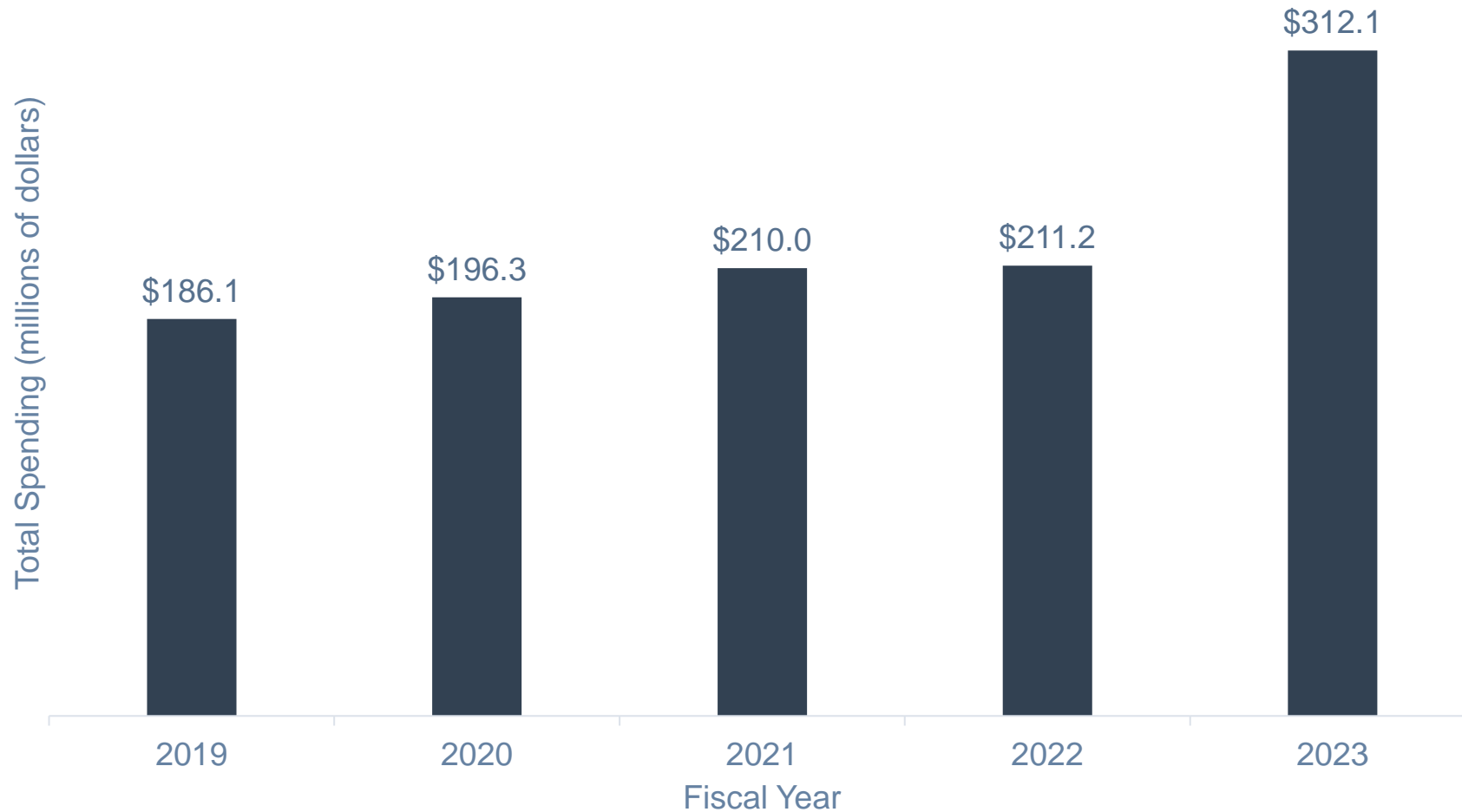
G.1. Nebraska Department Of Health & Human Services: Division Of Behavioral Health Key Leadership

Name	Position	Department	Email
Dannette R. Smith	Chief Executive Officer	Department of Health and Human Services (DHHS)	dannette.smith@nebraska.gov
Tony Green	Interim Director	DHHS, Division of Behavioral Health	tony.green@nebraska.gov
Larry Kahl	Director, DHHS Facilities	DHHS, Division of Behavioral Health	larry.kahl@nebraska.gov
Linda Wittmuss	Deputy Director, System Integration	DHHS, Division of Behavioral Health	linda.wittmuss@nebraska.gov
Brenda Moes	Director, Office of Consumer Affairs	DHHS, Division of Behavioral Health	brenda.moes@nebraska.gov
Karen Harker	Deputy Director, Division Financial Officer	DHHS, Division of Behavioral Health	karen.harker@nebraska.gov
Thomas Janousek	Deputy Director, Clinical Excellence	DHHS, Division of Behavioral Health	Not available
Michelle Nunemaker	Administrator, System of Care	DHHS, Division of Behavioral Health	michelle.nunemaker@nebraska.gov

G.2. Nebraska Department Of Health & Human Services: Division Of Behavioral Health Budget

Budget Item	SFY 2023 Appropriations	Percent Of Budget
Behavioral Health Aid	\$165,368,687	53%
Lincoln Regional Center	\$65,276,633	21%
Beatrice State Developmental Center	\$55,517,714	18%
Behavioral Health administration	\$16,457,182	5%
Mental Health operations	\$9,373,006	3%
Chemical Dependency program	\$116,415	<1%
Hastings Regional Center	\$1,632	<1%
Budget Total: \$312,111,269		

G.2. Nebraska Department Of Health & Human Services: Division Of Behavioral Health Budget Over Time



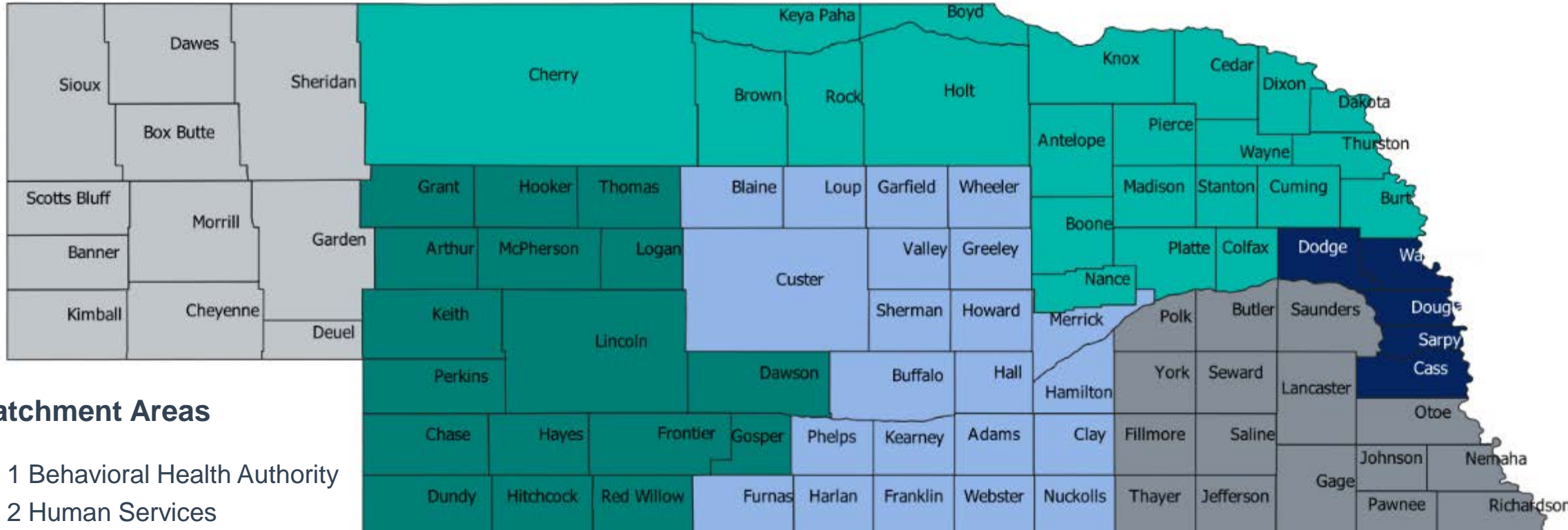
G.3. State Psychiatric Institutions

State Psychiatric Institutions		
Institution	Location	Beds
Lincoln Regional Center (licensed psychiatric beds)	Lincoln	250
Norfolk Regional Center (persons with a record of sex offenses only)	Norfolk	120
Hastings Regional Center (adolescent boys aged 13-19 in need of addiction disorder treatment)	Hastings	40
Total		410

G.4. Behavioral Health Safety-Net Delivery System

- Individuals with financial need who do not have health insurance and who are not Medicaid-eligible receive mental health and addiction disorder treatment services through six Regional Behavioral Health Authorities (RBHAs). The RBHA catchment areas are defined by state law.
- The RBHAs are responsible for developing and contracting a network of behavioral health services for the safety-net population.
- The RBHAs are funded by a combination of federal, state, and county funds, and Community Mental Health Service and Substance Abuse Treatment block grants. These funds are overseen by the Department of Health and Human Services, Division of Behavioral Health (DBH). All RBHA budgets and contracts are subject to DBH review.
- The RBHAs are governed by the counties, with each county supplying one member to its RBHA board.

G.4. Behavioral Health Safety-Net Delivery System: RBHA Catchment Areas



RBHA Catchment Areas

- Region 1 Behavioral Health Authority
- Region 2 Human Services
- Region 3 Behavioral Health Services
- Region 4 Behavioral Health System
- Region 5 Systems
- Region 6 Behavioral Healthcare

H. Appendices

H.1. OPEN MINDS Estimates For Share Of SMI Consumers Per Payer/Plan

Enrollment Category	Serious Mental Illness (SMI) Prevalence Estimate	Source
Commercial	4.1% of the commercially insured population over age 18	Substance Abuse and Mental Health Services Administration. (2022, January). Results from the 2020 National Survey on Drug Use and Health: Mental Health Detailed Tables. Retrieved January 2023 from https://www.samhsa.gov/data/sites/default/files/reports/rpt35323/NSDUHDetailedTabs2020v25/NSDUHDetailedTabs2020v25/2020NSDUHDetTabs01112022.zip
Medicaid	8.6% of persons enrolled in traditional Medicaid	Substance Abuse and Mental Health Services Administration. (2022, January). Results from the 2020 National Survey on Drug Use and Health: Mental Health Detailed Tables. Retrieved January 2023 from https://www.samhsa.gov/data/sites/default/files/reports/rpt35323/NSDUHDetailedTabs2020v25/NSDUHDetailedTabs2020v25/2020NSDUHDetTabs01112022.zip
Medicare	16% of persons in the Medicare population, not dually eligible for Medicaid	Centers for Medicare and Medicaid Services. (2021). Medicare-Medicaid Coordination Office Report to Congress. Retrieved January 2023 from https://www.cms.gov/files/document/reporttocongressmmco.pdf

H.1. OPEN MINDS Estimates For Share Of SMI Consumers Per Payer/Plan

Enrollment Category	Serious Mental Illness (SMI) Prevalence Estimate	Source
Medicare-Medicaid Dual Eligibility	25% of persons in the Medicare population dually eligible for partial Medicaid benefits	Congressional Budget Office. (2013, June). Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spends, and Evolving Policies. Retrieved January 2023 from https://www.cbo.gov/sites/default/files/113th-congress-2013-2014/reports/44308_DualEligibles2.pdf
	30% of persons in the Medicare population dually eligible for full Medicaid benefits	
Other Public	5.6% of persons served by the Veterans Administration health care system or the TRICARE military health system	United States Department of Defense. (2013, May 17). Efficacy and Cost of Case Management Services for TRICARE Behavioral Health Clients with Serious Mental Health Problems. Retrieved January 2023 from https://www.pdhealth.mil/efficacy-and-cost-case-management-services-tricare-behavioral-health-clients-serious-mental-health-0
No Health Care Insurance	5.6% of uninsured persons over age 18	Substance Abuse and Mental Health Services Administration. (2017, September 7). Results from the 2016 National Survey on Drug Use and Health: Mental Health Detailed Tables. Retrieved January 2023 from https://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs-2016/NSDUH-DetTabs-2016.pdf

H.2. Glossary Of Terms

Word	Abbreviation	Definition
Alternative Benefit Plan	ABP	State designed benefit package for the Medicaid expansion population (childless adults with income below 138% of the FPL). The benefit package must include the ten essential benefits as laid out in the PPACA. The Medicaid expansion population deemed medically frail (including those with SMI) are exempt from receiving benefits through the ABP.
Accountable Care Organizations	ACO	ACOs are groups of provider organizations—such as physicians and hospital systems—that form an agreement to coordinate care for a set group of individuals. If the ACO delivers high quality care—measured through performance metrics—and lowers the cost of providing care against a baseline, then the organization receives a portion of the savings generated. ACOs can exist alongside all payment structures (fee-for-service and managed care delivery systems) and payers (Medicare, Medicaid, commercial).
Administrative Services Organization	ASO	An arrangement in which an organization hires a third party to deliver administrative services to the organization, such as claims processing and billing. The ASO is not at-risk.
Capitation		A set amount of money paid per enrollee per month to a health care entity to cover the cost of health care services. Capitation can cover the cost of all health care services or subset of services, such as care coordination or home- and community-based services.
Carve-out		A carve-out is a Medicaid managed care financing model where some portion of Medicaid benefits—dental services, pharmacy services, behavioral health services, etc.—are separately managed and/or financed. Carve-out services can be financed on an at-risk basis by another organization or retained by the state Medicaid agency on a fee-for-service basis.
Certified Community Behavioral Health Clinic	CCBHC	Behavioral health clinics specially certified in a demonstration established by section 223 of the Protecting Access to Medicare Act of 2014. The clinics are designed to provide community-based mental health and addiction treatment services, to advance the integration of behavioral health with physical health care, and to provide care coordination across the full spectrum of health services.

H.2. Glossary Of Terms

Word	Abbreviation	Definition
Community Mental Health Center	CMHC	An organization that can demonstrate that it is actively providing all services in section 1913(c)(l) of the Public Health Services Act, including a.) Outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically mentally ill, and residents of the CMHC’s mental health service area who have been discharged from inpatient treatment at a mental health facility; b.) 24 hour-a-day emergency care services; c.) Day treatment, or other partial hospitalization services, or psychosocial rehabilitation services; and d.) Screening for patients being considered for admission to state mental health facilities to determine the appropriateness of such admission. Additionally, the organization must meet the specifications for the state where it provides services.
Dual Eligible		An individual who is eligible for Medicare (Part A and B) and Medicaid. Medicare serves as the individual's primary insurance, and Medicaid acts as a supplement. Dual eligibles are sometimes referred to as Medicare-Medicaid enrollees (MMEs).
Federal Poverty Level	FPL	The U.S. Department of Health and Human Services sets a standard level of income that is used to determine eligibility for services and benefits, including Medicaid. In 2023, the FPL is \$13,590 for an individual and \$27,750 for a family of four.
Fee-For-Service	FFS	A system where the payer, in this case Medicaid, contracts directly with provider organizations and pays for providing care on a per unit basis. Health plans may also reimburse provider organizations on a FFS basis meaning they pay for each unit of care or test.
Health Home		A “whole person” care coordination model that specifically targets populations with chronic conditions including those with SMI. Health homes provide six essential functions: 1.) Comprehensive care management; 2.) Care coordination and health promotion; 3.) Comprehensive transitional care from inpatient to other settings, including appropriate follow-up; 4.) Individual and family support; 5.) Referral to community and social support services; 6.) Use of health information technology to link services. Health homes were originally developed as a Medicaid program; but have been adopted by other payers. For a state to have an official health home program they must have an approved state plan amendment.

H.2. Glossary Of Terms

Word	Abbreviation	Definition
Health Insurance Marketplace	HIM	Created by the PPACA, the health insurance marketplace is an online platform where individuals and small businesses can purchase health insurance. The federal government subsidizes coverage purchased on the marketplace through premium tax credits for individuals with income up to 400% of the FPL.
Home- & Community-Based Services	HCBS	Long-term services and supports provided in the home or community in order to avoid institutionalization. Traditionally provided through 1915(c) waivers, HCBS services are usually limited to specific populations and a specific number of people. HCBS services include skilled nursing care, personnel care services, assistance with activities of daily living, and custodial care.
Institutions For Mental Disease	IMD	A hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including addiction. Federal financial participation is available for Medicaid IMD services for individuals under the age of 21 and age 65 and over. In recent years, CMS has relaxed the rules prohibiting payments in IMDs for individuals age 21-64. Medicaid health plans may provide up to 15 days of IMD services per month in lieu of state plan services if medically appropriate, cost effective, and consented to by the individual. Additionally, states may be granted a 1115 waiver authority to allow individuals to receive addiction and mental health treatment in IMDs.
Long-Term Services & Supports	LTSS	Services provided in the home, community, or institutional setting to those who experience difficulty living independently and completing activities of daily living as a result of cognitive disabilities, physical impairments, disabling chronic conditions, and/or age.
Managed Care		A health care delivery and financing system designed to manage cost, utilization, and quality. In Medicaid, states generally implement managed care through contracts with health plans, which provide a limited set of benefits to enrollees through a capitated or per person per month (PMPM) rate. The health plans generally assumes full-risk for the cost of treatment, and therefore contracts with a network of provider organizations to provide care at the most efficient rate possible while still maintaining member health.

H.2. Glossary Of Terms

Word	Abbreviation	Definition
Medicaid		Medicaid is a joint federal-state program that provides health coverage to economically disadvantaged populations, such as low-income adults, children, and aged, blind, and disabled (ABD) individuals. States establish their own eligibility standards, benefit packages, provider payment policies, and administrative structures under broad federal guidelines. Financing is a shared responsibility of the federal government and the states.
Medicaid Waiver		Granted by CMS, waivers allow states to make temporary changes to their Medicaid program in order to test out new ways to deliver health coverage.
Medicaid Waiver Section 1115	1115 waiver	Known as research and demonstration waivers, states can apply for program flexibility to test new or existing approaches to financing and delivering Medicaid and CHIP.
Medicaid Waiver Section 1915(b)	1915(b) waiver	States can apply for waivers to provide services through managed care delivery systems, or otherwise limit an individual's choice of health plan or provider organization.
Medicaid Waiver Section 1915(c)	1915(c) waiver	States can apply for waivers to provide long-term care services in home- and community-based settings, rather than institutional settings.
Medical Home		A medical home is not a physical place, but a model for care coordination. Medical homes provide primary care services, care coordination, enhanced access to care, and care that is culturally and linguistically appropriate. Medical homes exist across multiple payers.
Medicare		Federal health insurance for individuals over the age of 65, individuals with certain disabilities, and individuals with end stage renal disease. Medicare covers most acute care services (which may include psychiatric care), but does not cover LTSS or non-physician behavioral health services.
Medicare Advantage	MA	Medicare Part C - also known as Medicare Advantage - is a program which allows individuals who are eligible for Medicare Parts A and B to elect a private health plan to provide their Medicare coverage. The federal government pays the plan's premiums up to a set level, and individuals are responsible for the difference.

H.2. Glossary Of Terms

Word	Abbreviation	Definition
Medicare Advantage Special Needs Plan	SNP	A special type of Medicare Advantage plan that is designed to provide targeted coordinated care to individuals who are a) institutionalized; b) dual eligible; and/or c) meet the severe chronic disabled conditions set forth by CMS. Plans emphasize improved care primarily through continuity of care and care coordination.
Medicare Part A		Hospital Insurance: Covers hospital, skilled nursing care, hospice, and home health care for most eligible individuals at no cost. Financed through payroll tax and deductibles, copayments are only charged if a stay becomes long-term.
Medicare Part B		Supplementary Medical Insurance: Covers most outpatient services, and consumers pay a premium based on income level.
Medicare Part C		Medicare Part C - also known as Medicare Advantage - is a program which allows individuals who are eligible for Medicare Parts A and B to elect a private health plan to provide their Medicare coverage. The federal government pays the plan's premiums up to a set level, and individuals are responsible for the difference.
Medicare Part D		Outpatient Prescription Drug Benefit: Private plans contract with Medicare to provide coverage for prescription drugs. Most consumers pay premiums based on their income.
Metropolitan Statistical Area	MSA	An urbanized area with a population of at least 50,000 plus adjacent territory that has a high degree of social and economic integration as measured by commuting ties.
Patient-Centered Medical Home	PCMH	See Medical Home.
Patient Protection & Affordable Care Act	PPACA or ACA	U.S. health care reform signed into law in 2010. The legislation regulates certain aspects of private and public health insurance programs and authorizes an individual mandate to secure essential health coverage, premium tax credits for the purchase of private health insurance, and increased insurance coverage of preexisting conditions. In 2012 the Supreme Court ruled that state participation is optional for provisions of the law expanding Medicaid coverage to adults ages 18 to 64 with incomes under 138% of the FPL. In 2017, Congress repealed the tax penalties associated with the individual mandate essentially ending the mandate.

H.2. Glossary Of Terms

Word	Abbreviation	Definition
Primary Care Case Management	PCCM	A health care delivery system model with limited utilization and cost control. Under the PCCM model, Medicaid enrollees choose a primary care physician who acts as a gatekeeper for more intensive services. The primary care physician generally receives a per person per month (PMPM) fee for care coordination, and is reimbursed fee-for-service for all medical services provided.
Program Of All Inclusive Care For The Elderly	PACE	PACE serves populations over the age of 55 who are eligible for skilled nursing home care by utilizing a comprehensive delivery system of social, medical, and long-term care services to keep enrollees in the community for as long as possible. PACE is an optional state Medicaid program, and may only be available in certain states, or regions within states.
Serious Mental Illness	SMI	A mental, behavioral, or emotional disorder that lasts for a sufficient duration of time and causes impairment of major life activities. Serious mental illnesses include major depression, schizophrenia, bipolar disorder, obsessive compulsive disorder (OCD), panic disorder, post traumatic stress disorder (PTSD), and borderline personality disorder.
Supported Employment		Provides services and supports to help individuals with disabilities become employed in an integrated or competitive work environment, and retain that employment.
Supported Housing		Housing provided for as long as needed at little or no cost to individuals with mental illness, or other vulnerable populations who are homeless or at-risk for homelessness. Mental health and social services are offered to participants, but are not a condition for participation in the program. The goal is to allow individuals to live as self-sufficient, independent lives as possible.
Value-Based Reimbursement	VBR	Reimbursement model in which payers financially reward or penalize health care provider organizations for performance on quality and cost of care. VBR payment mechanisms include P4P; capitation; shared savings models; shared risk models; and payments based on clinically-defined episodes, called episodes of care or bundled payments.

H.3. Sources

A. Executive Summary

1. Information compiled from sources provided throughout the profile.

B.1. Population Demographics

1. United States Census Bureau. (2021). 2021 American Community Survey 1-Year Estimates S0101 Population By Age and Sex. Retrieved April 2023 from <https://data.census.gov/cedsci/table?q=S0101>
2. United States Census Bureau. (2021). 2021 Current Population Survey Annual Social and Economic Supplement POV-46 Poverty Status By State. Retrieved April 2023 from <https://data.census.gov/cedsci/table?q=S1701>
3. United States Census Bureau. (2021). 2021 American Community Survey 1-Year Estimates S1901 Median Income In the Past 12 Months. Retrieved April 2023 from <https://data.census.gov/cedsci/table?q=S1901>
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B.2. Population Centers

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