IN THE DISTRICT COURT OF LANCASTER COUNTY, NEBRASKA

MELLISSA ELY and GERALD BROWN Relators, v. DANNETTE SMITH, CHIEF EXECUTIVE OFFICER, and MATTHEW VAN PATTON, DIRECTOR OF THE DIVISION OF MEDICAID AND LONG-TERM CARE, NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES, in their official capacities, Respondents.	)	Case No._____ **PETITION**

COME NOW, the Relators, by and through their attorneys and allege as follows:

PRELIMINARY STATEMENT

1. The Relators are individuals eligible for the expanded Medicaid program through Initiative 427, codified at Neb. Rev. Stat. § 68-992, and administered by the Nebraska Department of Health and Human Services ("the Department").
2. The Respondents are the Chief Executive Officer of the Department and the Director of the Division of Medicaid and Long-Term Care for the Department.
3. According to Neb. Rev. Stat. § 68-992(3), the Respondents have a clear duty to "take all actions necessary to maximize federal financial participation in funding medical assistance pursuant to this section."
4. The percentage of federal financial participation ("FFP") will drop from 93 percent in 2019 to 90 percent in 2020. 42. U.S.C. § 1396d(y)(1).

5. The Respondents have a duty to open enrollment for Medicaid expansion on or before November 17, 2019 in order to be eligible to receive 93 percent of FFP.

6. Under federal law, a state agency only has two years from the calendar quarter that a payment is made for a service to claim FFP. 45 C.F.R. § 95.7; 45 C.F.R. § 95.13(b). Accordingly, the last date to have an expenditure that qualifies for 93 percent of FFP is last day of 2019.

7. At the same time, an expenditure cannot occur until an individual enrolls in and uses Medicaid coverage with a service provider, and the Medicaid agency has 45 days for most individuals to approve or deny their initial program eligibility. 45 C.F.R. § 95.13(b); 42 U.S.C. §1396a(a)(8); 42 C.F.R. § 435.912(c).

8. Therefore, the deadline to maximize FFP, to capture an expenditure that qualifies for the higher 93 percent of FFP, is November 17, 2019 (45 days prior to the end of the year).

9. Moreover, since the Respondents must "take all actions necessary" to maximize FFP in funding Medicaid expansion pursuant to Neb. Rev. Stat. § 68-992(3), they have an ongoing duty to capture FFP once open enrollment has begun.

10. Yet, on April 1, 2019, Respondent Van Patton announced they would not begin statewide operation of Medicaid expansion until October 1, 2020 and chose to make the relevant Medicaid State Plan Amendments effective October 1, 2020. Exhibit 1, pg 2; Exhibit 2, pg. 1.

11. As a result of the Respondents' refusal to complete their duty, Nebraska will not receive approximately $149 million in FFP in one-half of 2020 alone. Exhibit 3, pg 10.

12. The Respondents' actions are invalid and exceed their authority, and the Court should compel performance of their proper duty.

13. The Relators have a clear right to the performance of the Respondents' duty, as they are eligible for the Medicaid expansion program and are ineligible for traditional Medicaid.

14. The Relators have no adequate remedy at law.

15. This is a mandamus action requesting this Court issue a writ of mandamus to compel the Respondents to perform their duty.

PARTIES

16. Relator Mellissa Ely resides in Lincoln, Nebraska.

17. Relator Gerald Brown resides in Lincoln, Nebraska.

18. Respondent Dannette Smith is the Chief Executive Officer for the Department, and is responsible in her official capacity for overseeing all Department functions and their operation consistent with state and federal law. She is sued in her official capacity.

19. Respondent Matthew Van Patton is the Director of the Division of Medicaid and Long-Term Care for the Department, Nebraska's Medicaid agency, and is responsible in his official capacity for overseeing all Medicaid Division functions and their operation consistent with state and federal law. He is sued in his official capacity.

20. The Respondents have offices at 301 Centennial Mall South, Lincoln, Nebraska.

JURISDICTION

21. Jurisdiction in this matter is proper pursuant to Neb. Rev. Stat. § 24-302 and Neb. Rev. Stat. § 25-2156.

STATUTORY AND REGULATORY FRAMEWORK

Medicaid

22. Medicaid is a jointly funded state and federal program established in 1965 that provides medical coverage to certain categories of low-income persons pursuant to Title XIX of the Social Security Act, 42 U.S.C. Secs. 1396 to 1396w-5.

23. State participation in Medicaid is optional, but when a state chooses to participate it must comply with the requirements of the federal Medicaid Act and the rules and regulations governing the program. 42 U.S.C. § 1396a(a)(5); *Kai v. Ross*, 336 F.3d 650, 651 (8th Cir. 2003).

24. Nebraska has chosen to participate in the Medicaid program. Neb. Rev. Stat. § 68-903.

25. In order to be found eligible for Medicaid, individuals must fill out an application with the Department. Neb. Rev. Stat. § 68-914.

26. Applications for Medicaid must be approved or denied with "reasonable promptness," which for most applicants means within 45 days. 42 U.S.C. §1396a(a)(8); 42 C.F.R. § 435.911 to 912; 465 NAC 2-001.

Federal Financial Participation

27. Federal law authorizes the federal government to provide grants to states to provide medical assistance to eligible individuals. 42 U.S.C. § 1396; 42 U.S.C. § 1396b; 42 C.F.R. § 430.0.

28. A state that operates it Medicaid program in accordance with federal law and its approved state plan is entitled to FFP for a percentage of its program expenditures. 42 U.S.C. § 1396a; 42 U.S.C. § 1396b; 42 C.F.R. § 430.30.

29. FFP means "[t]he Federal Government's share of a State's expenditures under the Medicaid program." 42 C.F.R. § 400.203.

30. Nebraska accepts FFP to support its Medicaid program. Neb. Rev. Stat. § 68-905(8).

31. The Centers on Medicare and Medicaid Services ("CMS") will pay FFP for "[a] State agency expenditure * * * only if the State files a claim with us [CMS] for that expenditure within 2 years after the calendar quarter in which the State agency made the expenditure." 45 C.F.R. § 95.7.

32. An expenditure for services is considered "[t]o have been made in the quarter in which any State agency made a payment to the service provider." 45 C.F.R. § 95.13(b).

Medicaid Expansion under the Affordable Care Act

33. Until the passage of the Affordable Care Act ("ACA"), the federal government offered FFP to states to assist only certain categories of individuals, including pregnant women, children, needy families, the blind, the elderly, and the disabled. 42. U.S.C. §1396da (hereafter referred to as the traditional Medicaid group).

34. The ACA expanded the scope of Medicaid coverage, requiring states to cover adults under the age of 65 with incomes up to 133 percent of the federal poverty level. 42. U.S.C.§1396da(a)(10)(A)(i)(VIII) (hereafter referred to as the expansion group).

35. The ACA also included an enhanced percentage of FFP for the expansion group. 42. U.S.C.§1396d(y)(1).

36. While the traditional Medicaid group may receive FFP for no less than 50 percent of medical expenditures, the ACA ensured that states would receive FFP of 100 percent for medical expenditures for the expansion group through 2016, decreasing to 95 percent in 2017, 94 percent in 2018, 93 percent in 2019, and 90 percent starting in 2020 and thereafter. 42. U.S.C.§1396d(y)(1).

37. In 2019, FFP of 93 percent is available for medical expenditures for the expansion group, but the percent of FFP will fall to 90 percent in 2020 and after. 42. U.S.C.§1396d(y)(1).

38. In 2012, the U.S. Supreme Court determined that requiring states to expand Medicaid or face a loss in Medicaid funding was unconstitutional, resulting in Medicaid expansion becoming an optional program that may be taken up at the discretion of each state. *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519 (U.S. Sup. Ct. 2012).

39. In November of 2018, Nebraska voters passed Initiative 427, codified at Neb. Rev. Stat. § 68-992. Through Initiative 427, Nebraska opted to take up Medicaid expansion and provide coverage for the expansion group in Nebraska.

40. According to Neb. Rev. Stat. § 68-992(1), "Eligibility for medical assistance shall be expanded to include certain adults ages nineteen through sixty-four whose income is equal to or less than one hundred thirty-eight percent of the federal poverty level, as authorized and using the income methodology defined by 42

U.S.C. 1396a(a)(10)(A)(i)(VIII) and related federal regulations and guidance, as such statute, regulations, and guidance existed on January 1, 2018."

41. Neb. Rev. Stat. § 68-992(2) states, "On or before April 1, 2019, in order to ensure that eligibility for medical assistance is expanded as required by this section, the Department of Health and Human Services shall submit a state plan amendment and all other necessary documents seeking required approvals or waivers to the federal Centers for Medicare and Medicaid Services."

42. Neb. Rev. Stat. § 68-992(3), "The Department of Health and Human Services shall take all actions necessary to maximize federal financial participation in funding medical assistance pursuant to this section."

FACTUAL ALLEGATIONS

Relator Mellissa Ely

43. Relator Mellissa Ely resides in Lincoln, Nebraska.

44. Ms. Ely is 46 years of age.

45. Ms. Ely has two sons over the age of 18 that are not her dependents.

46. Ms. Ely is not eligible for traditional Medicaid.

47. Ms. Ely has a number of health conditions that prevent her from working; however, she acts as a caretaker for her aging mother who has health issues.

48. Ms. Ely's only source of potential income is delinquent child support in an amount ranging from $30-75 each month, if paid.

49. Ms. Ely has a number of serious health issues for which treatment is needed.

50. On July 6, 2019, Ms. Ely had a heart attack and received two stents and prescriptions for a statin, a blood thinner, blood pressure medication, and aspirin.

She was also instructed to see a cardiologist a month after her emergency hospitalization for follow up.

51. Her partner purchased her first prescriptions, but Ms. Ely is unsure if she will be able to complete the follow up appointment and continue the prescriptions because she is uninsured and cannot afford them.

52. Ms. Ely had strokes in 2014 and 2016.

53. Ms. Ely has arthritis in both hands and a lump on her thyroid that needs to be evaluated by a doctor.

54. If Ms. Ely had Medicaid expansion coverage, she would seek treatment for her untreated health issues and engage in any follow up course of treatment for her heart attack.

55. Ms. Ely was denied Medicaid coverage by the Department in July of 2019.

56. Ms. Ely meets the income and criteria limits for expanded Medicaid.

57. Ms. Ely has a clear right to relief she seeks and no adequate remedy at law.

Relator Gerald Brown

58. Relator Gerald Brown resides in Lincoln, Nebraska.

59. Mr. Brown is 51 years of age.

60. Mr. Brown has one son over the age of 18 that is not his dependent.

61. Mr. Brown is not eligible for traditional Medicaid.

62. Mr. Brown is employed through People360 and makes less than $1,000 per month.

63. Mr. Brown has a number of health issues for which treatment is needed.

64. In a previous job, Mr. Brown suffered a shoulder injury that has not been treated. This injury causes chronic pain for which surgery is needed.

65. The chronic pain in his shoulder makes manual labor difficult.

66. Mr. Brown also experiences chest pain and needs a colonoscopy and dental treatment.

67. If Mr. Brown had Medicaid expansion coverage, he would seek treatment for his untreated health issues.

68. Mr. Brown applied for Medicaid in late 2018 and was denied.

69. Mr. Brown meets the income and criteria limits for expanded Medicaid.

70. Mr. Brown has a clear right to relief he seeks and no adequate remedy at law.

Respondents' Failure to Perform Their Required Duty

71. On April 1, 2019, the Respondents submitted three State Plan Amendments to CMS. State Plan Amendments – Benefits; Eligibility; Finance. Exhibit 1, pg 2.

72. On April, 1 2019, Respondent Van Patton announced they would not begin statewide operation of Medicaid expansion until October 1, 2020. Exhibit 2, pg 1.

73. The State Plan Amendments submitted by the Respondents included an effective date of October 1, 2020 for the expansion of the program. Exhibit 1, pg 2.

74. Under Neb. Rev. Stat. § 68-992(3) the Respondents are required to "take all actions necessary to maximize federal financial participation in funding medical assistance pursuant to this section."

75. The Respondents are in clear and continuing dereliction of this statutory duty.

76. Based on the plain language of Neb. Rev. Stat. § 68-992(3), the Respondents must maximize FFP.

77. To do so, the Respondents have a duty to open enrollment for Medicaid expansion on or before November 17, 2019 in order to be eligible to receive 93 percent of FFP.

78. Under federal law, a state agency only has two years from the calendar quarter that a payment is made for a service to claim FFP. 45 C.F.R. § 95.7; 45 C.F.R. § 95.13(b). Thus, the last date to have an expenditure that qualifies for 93 percent of FFP is last day of 2019.

79. At the same time, an expenditure cannot occur until an individual enrolls in and uses Medicaid with a service provider, and the Medicaid agency has 45 days for most individuals to process their initial program eligibility. 45 C.F.R. § 95.13(b); 42 U.S.C. §1396a(a)(8); 42 C.F.R. § 435.912(c).

80. Therefore, the deadline to maximize FFP, to capture an expenditure that qualifies for the higher 93 percent FFP, is November 17, 2019 (45 days prior to the end of the year).

81. Moreover, since the Respondents must "take all actions necessary" to maximize FFP in funding Medicaid expansion pursuant to Neb. Rev. Stat. § 68-992(3), they have an ongoing duty to capture FFP once open enrollment has begun.

82. As a result of the Respondents' refusal to complete their duty, Nebraska will not receive approximately $149 million in FFP in one-half of 2020 alone. Exhibit 3, pg 10.

83. As such, the Respondents have failed to perform their required duty.

REQUEST FOR RELIEF

WHEREFORE, the Relators respectfully request that the Court:

A. Issue a writ of mandamus to order the Respondents to open enrollment for Medicaid expansion on or before November 17, 2019, and to continue to capture FFP to support Medicaid expansion once open enrollment has begun;

B. Award Relators reasonable attorney fees and court costs; and

C. Grant such other and further relief as may be deemed just and proper.

DATED:

Sept. 19, 2019

MELLISSA ELY and GERALD BROWN

BY THEIR ATTORNEYS:

NEBRASKA APPLESEED
James A. Goddard, #24150
Nebraska Appleseed Center for Law
In the Public Interest
941 O Street, Suite 920, Lincoln, NE 68508
Phone: (402) 438-8853
Fax: (402) 438-0263
jgoddard@neappleseed.org

Molly M. McCleery, #25151
Nebraska Appleseed Center for Law
In the Public Interest
941 O Street, Suite 920, Lincoln, NE 68508
Phone: (402) 438-8853
Fax: (402) 438-0263
mmccleery@neappleseed.org

Robert McEwen, #24817
Nebraska Appleseed Center for Law
In the Public Interest
941 O Street, Suite 920, Lincoln, NE 68508
Phone: (402) 438-8853
Fax: (402) 438-0263
rmcewen@neappleseed.org

STATE OF NEBRASKA)
)ss.
COUNTY OF Lancaster)

MELLISSA ELY, being first duly sworn and deposes and states that she is the relator in the above-caption action, that she has read the forgoing petition, knows the contents thereof and the facts contained therein are true.

Mellissa C Ely
MELLISSA ELY, Relator

Subscribed and sworn to before me this 18 day of September, 2019.

General Notary - State of Nebraska
Trisha Thompson
My Comm. Expires Apr. 17, 2022

Trisha J Thompson
Notary Public

STATE OF NEBRASKA)
)ss.
COUNTY OF Lancaster)

GERALD BROWN, being first duly sworn and deposes and states that he is the relator in the above-caption action, that he has read the forgoing petition, knows the contents thereof and the facts contained therein are true.

Gerald Brown
GERALD BROWN, Relator

Subscribed and sworn to before me this 19th day of September, 2019.

General Notary - State of Nebraska
Trisha Thompson
My Comm. Expires Apr. 17, 2022

Trisha Thompson
Notary Public

CERTIFICATE OF SERVICE

This is to certify that on this 19th day of September, 2019, that a true and accurate copy of this Petition was sent to Respondents' counsel Ryan Post, Assistant Attorney General, via electronic mail.

By: 

James A. Goddard, #24150
Nebraska Appleseed Center for Law in the Public Interest
941 O Street, Suite 920
Lincoln, NE 68508
(402) 438-8853 x 108
Attorney for Relators

Exhibit 1

NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

April 1, 2019

James G. Scott, Director
Centers for Medicare & Medicaid Services
Kansas City Regional Operations Group
601 East 12th Street, Room 355
Kansas City, Missouri 64106-2898

RE: Nebraska SPA 19-0003 methodology for identification of applicable FMAP rates

Dear Mr. Scott:

Enclosed please find the above referenced amendment to the Nebraska State Plan regarding methodology for identification of applicable FMAP rates.

The Division of Medicaid and Long-Term Care sent notice on January 31, 2019, (attached) to the federally recognized Native American Tribes and Indian Health Programs within the State of Nebraska to discuss the impact the proposed State Plan Amendment might have, if any, on the Tribes. No comments were received.

If you have content questions, please feel free to contact Rocky Thompson at Rocky.Thompson@Nebraska.gov, or for submittal questions, Nancy Keller at Nancy.Keller@Nebraska.gov, or 402-471-6975.

Sincerely,

Matthew A. Van Patton, DHA, Director
Division of Medicaid and Long-Term Care
Department of Health and Human Services

Enclosures

cc: Barbara Cotterman
Rocky Thompson

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: NE 19-0003

2. STATE: Nebraska

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
October 1, 2020

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 435.119, 42 CFR 433.10(c)(6), 42 CFR 433.204(a), 42 CFR 433.206

7. FEDERAL BUDGET IMPACT:
a. FFY 2019 $0.00
b. FFY 2020 $0.00

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Supplement 18 to Attachment 2.6-A (new page)
Attachment A and E

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Not Applicable

10. SUBJECT OF AMENDMENT:
Methodology for identification of applicable FMAP rates

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Governor has waived review

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Matthew A. Van Patton, DHA

14. TITLE:
Director, Division of Medicaid and Long-Term Care

15. DATE SUBMITTED:
April 1, 2019

16. RETURN TO:

Nancy Keller
Division of Medicaid & Long-Term Care
Nebraska Department of Health & Human Services
301 Centennial Mall South
Lincoln, NE 68509

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

22. TITLE:

23. REMARKS:

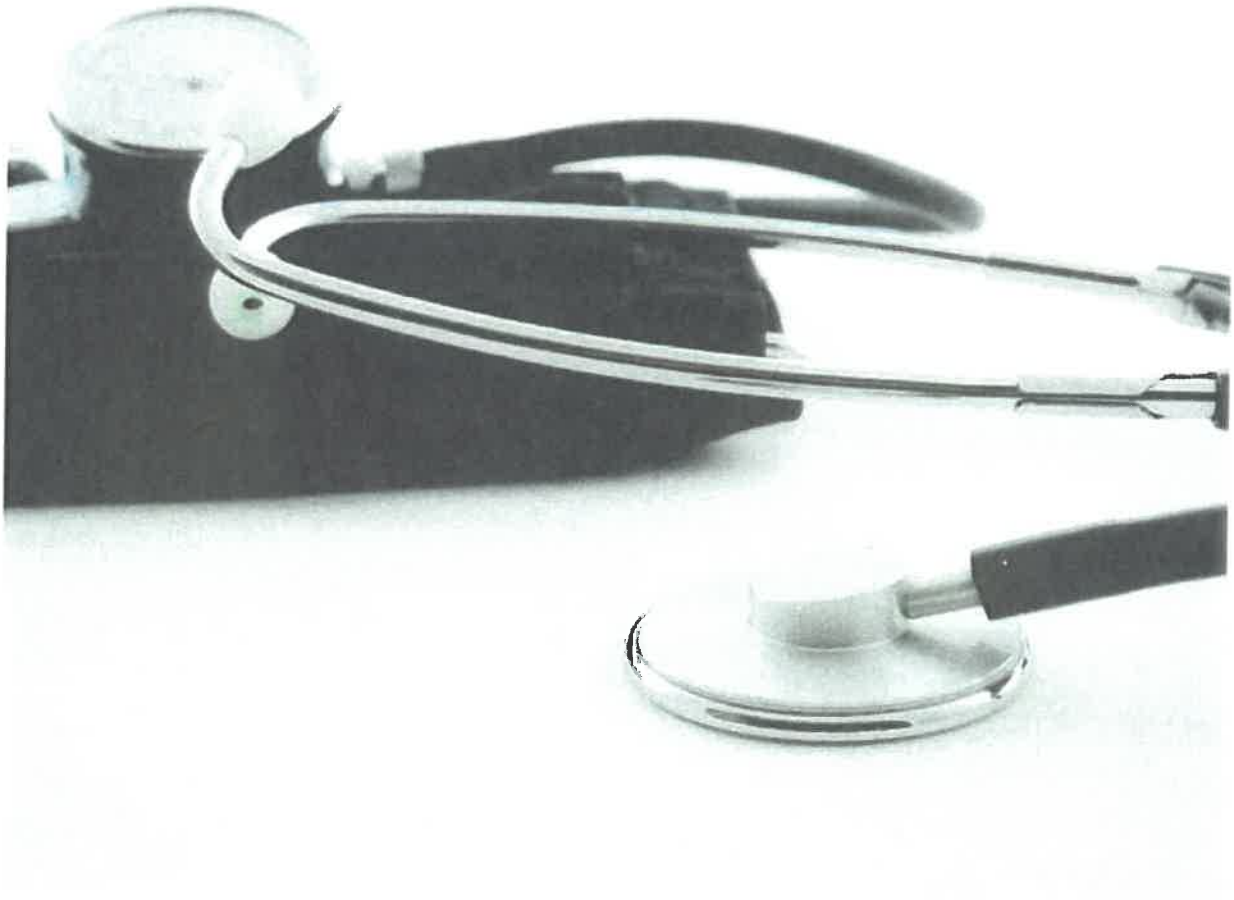
FORM HCFA-179 (07-92)

Exhibit 2

https://www.omaha.com/livewellnebraska/nebraska-s-medicaid-expansion-plan-won-t-start-until-late/article_1e80c01d-ddc7-5d98-870c-063cd2073283.html

Nebraska's Medicaid expansion plan won't start until late 2020, has two tiers of coverage

By Martha Stoddard / World-Herald Bureau Apr 2, 2019



LINCOLN — An estimated 94,000 low-income Nebraskans will have to wait until Oct. 1, 2020, to get the Medicaid coverage approved by voters last year.

Under a plan announced Monday, those newly eligible Nebraskans will have different benefits and requirements than others on Medicaid. To get full coverage, they would have to work, care for a family member, volunteer, look for work, or attend college or an apprenticeship.

The proposed timeline and limits did not sit well with State Sen. Adam Morfeld of Lincoln, who led the petition drive to get Medicaid expansion on the ballot. He said he and other backers will be looking at their options, which could include litigation.

"This is not acceptable and in violation of the law," he said. "This flies in the face of the clear will of the people that enacted Medicaid expansion in November, and I will fight this vigorously."

But Gov. Pete Ricketts said the plan fulfills the will of the voters. The ballot measure required Nebraska to submit documents for federal approval of the Medicaid expansion by April 1.

"The plan sets a timeline that will help Nebraska avoid mistakes made by others states and will help ensure that newly covered Nebraskans are able to use their Medicaid coverage," he said.

Dannette R. Smith, the new chief executive officer of the Department of Health and Human Services, agreed, saying that experience has taught her that it is better for citizens to have the department "carefully and methodically" carry out such a major project.

"It is critical that a monumental undertaking such as Medicaid expansion be customer-centered and be delivered in a deliberate and thoughtful manner," she said. "The department is committed to ensuring that Nebraska's Medicaid expansion is fully functional and viable on the first day of implementation."

The state law approved by voters requires Medicaid to cover additional low-income Nebraska adults, as allowed under the federal Affordable Care Act.

The law said "no greater or additional burdens or restrictions on eligibility, enrollment, benefits, or access to health care services shall be imposed" on the newly eligible.

That group includes single adults and couples without minor children who cannot qualify for Medicaid now, no matter their income level. Also included are parents and disabled people with incomes higher than the current Medicaid cutoff.

Citizens who make up to 138 percent of the federal poverty level — $16,753 for a single person or $34,638 for a family of four — will be eligible. Noncitizens are not eligible.

Matthew Van Patton, the state Medicaid director, said the newly eligible would be offered two levels of coverage, basic and prime. He said basic coverage would be modeled after a Blue Cross Blue Shield small group insurance plan, rather than traditional Medicaid coverage.

Unlike people covered by private health insurance, state officials are not currently planning to charge co-payments and deductibles to the people being added to Medicaid.

The prime level would include additional benefits such as dental, vision and over-the-counter medications. All three are part of traditional Medicaid coverage. Specifics of the coverage provided under each tier will be worked out with federal officials.

Most people would start out with basic coverage managed by one of the state's existing Medicaid managed-care contractors, Van Patton said. Disabled people and others with special medical needs would be covered under traditional Medicaid.

In the first year, to move up to prime coverage, people would have to cooperate with care management activities offered by the contractors. They also would have to choose a primary care provider and attend an annual checkup.

Van Patton said the goal is to quickly address any health problems that may have gone untreated because people lacked insurance. Care management could include getting people connected to social services or health education.

In the second year, the newly eligible group would have to meet "community engagement" requirements to get prime coverage. Those include caring for a family member or spending at least 80 hours a month volunteering for a public charity, attending a postsecondary school or apprenticeship, working or looking for work.

"We've tailored this uniquely to Nebraska," Van Patton said. "The Heritage Health adult program is designed to effectively use managed care to encourage paths to wellness and life success while rewarding personal engagement and responsibility."

He said the community engagement requirements differ from those blocked by a federal judge last week in Kentucky and Arkansas. In Nebraska, he said the proposed requirements would apply only to people seeking the higher level of coverage and would not keep people from getting basic benefits.

Nebraska will have to seek federal approval of a so-called 1115 demonstration waiver to adopt the two-tier program. That process can take several months. Such waivers allow states to deviate from traditional Medicaid rules for innovative programs.

Renee Fry, executive director of the Open Sky Policy Institute, a Lincoln think tank, expressed disappointment that the program is set to launch 10 months later than Ricketts had included in his budget plan.

She noted that the later date means that the state budget will not realize some of the savings anticipated in corrections and mental health services. It also means costs will be less during the two-year budget period that starts July 1.

Medicaid is a federal-state collaboration covering more than 70 million people, or about 1 in 5 Americans, and that makes it the largest government health insurance program. Expansion of the program was made possible by the federal Affordable Care Act. Under that law, the federal government will pick up 90 percent of the cost for covering the additional Nebraskans.

17 rare and unusual health stories out of Omaha

One rare disease left an Omaha doctor eating a shakelike formula to supplement her diet. A friend said it tasted like cat food. An Omaha man woke up after his family took him off life support. And a Lincoln teen is allergic to almost everything.

Check out the stories on their unusual ailments and sometimes equally unusual treatment plans.

1 of 17

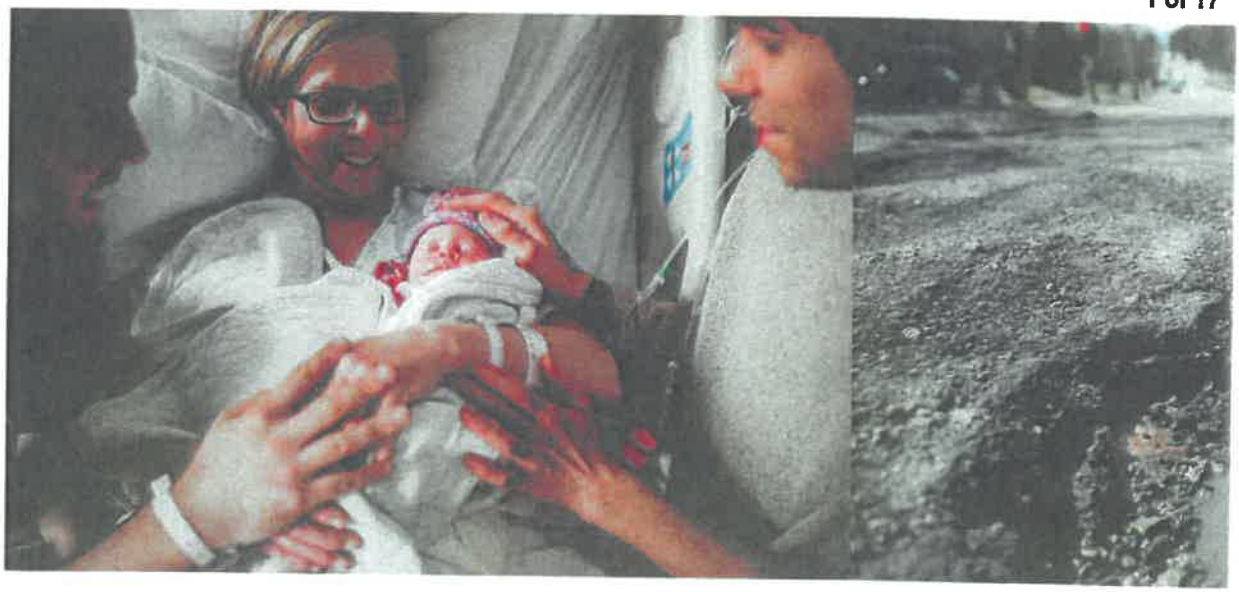


Exhibit 3

Analysis; Fiscal Impact of Initiative 427

9/21/2018

Introduction

Initiative 427 is a proposal to expand the Medicaid program to cover childless adults, 19 to 64 years of age, under the provisions of the Patient Protection and Affordable Care Act of 2010 (the ACA). This ballot initiative is similar to several bills that have been proposed in the unicameral over the past six years – all failing to pass into law.

Numerous stakeholders, including state legislators, have asked the Nebraska Division of Medicaid and Long-Term Care (MLTC), what the cost to MLTC would be if the ballot initiative passes. Building upon numerous analyses of the past legislative proposals, and the experience of other states that have opted into the ACA Medicaid Expansion, MLTC has determined that the complete fiscal impact to the Department of Health and Human Services that can be estimated through state fiscal year (SFY) 2029 will increase expenditures by $5.5 billion, $669.89 million of that amount state funds. However, there is the potential to offset some of the state general fund amount with additional federal funding, leaving the state impact to $591.19 million. MLTC estimates that over ten years there will be 93,036 new people enrolled in Nebraska Medicaid if Initiative 427 passes. These estimates are based upon current economic data. If there is an economic downturn, more individuals will become Medicaid-eligible, and the cost of the expansion population will increase. For example, if enrollment grows an additional 3% beginning in SFY 2021, it would result in the total number of eligible individuals to grow to 112,110 enrolled by 2029, resulting in a total aid cost of $6.3 billion over ten years, of which $736 million would be new state costs. Considering potential offsets, the total cost would be $6.35 billion, of which $689.6 million would be state general funds. The assumptions made are detailed below.

Nebraska Medicaid

Medicaid, established in 1965, is a federal-state program that pays for health care for persons with disabilities, the aged, and low-income children and families. Certain services and populations are mandatory for states to cover if a state opts-into Medicaid. Other populations and services are optional as shown below.

Table 1. Federal Mandatory and Optional Medicaid Eligibility Groups

Mandatory eligibility groups	Optional eligibility groups
Poverty-related infants, children, and pregnant women and deemed newborns	Low-income children, pregnant women, and parents above federal minimum standards
Low-income families (with income below the state's 1996 Aid to Families with Dependent Children limit)	Elderly and disabled individuals with incomes above federal minimum standards or who receive long-term services and supports in the community
Families receiving transitional medical assistance	Medically needy
Children with Title IV-E adoption assistance, foster care, or guardianship care and children aging out of foster care	Adults without dependent children (the ACA Medicaid Expansion Group)
Elderly and disabled individuals receiving Supplemental Security Income (SSI) and aged, blind, and disabled individuals in 209(b) states	Home and Community-Based Services and Section 1115 waiver enrollees
Certain working individuals with disabilities	Enrollees covered only for specific diseases or services, such as breast and cervical cancer or family planning services
Certain low-income Medicare enrollees	

Source: MACPAC, 2017, analysis of the Social Security Act and the *Code of Federal Regulations*.

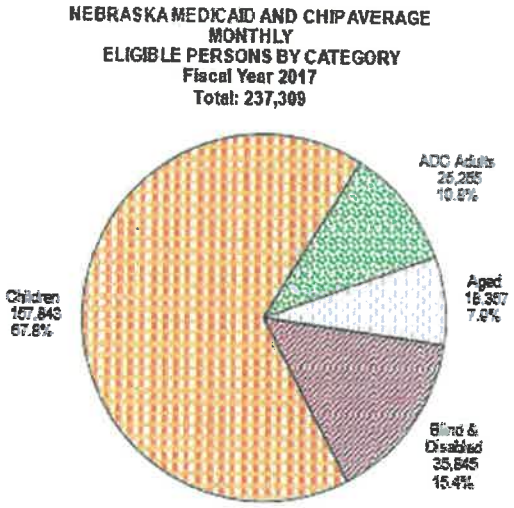
Table 2. Nebraska Mandatory and Optional Medicaid Services

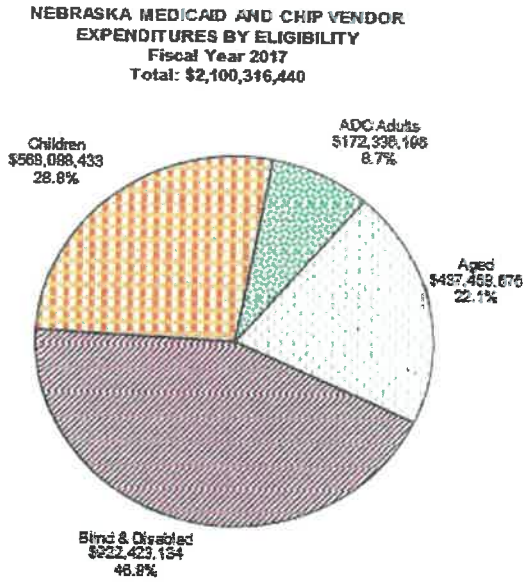
Mandatory Services	
Inpatient and outpatient hospital services	Medical and surgical services of a dentist
Laboratory and x-ray services	Nurse practitioner services
Nursing facility services	Nurse midwife services
Home health services	Pregnancy-related services
Nursing services	Medical supplies
Clinic services	Early and periodic screening and diagnostic treatment (EPSDT) for children
Physician services	

Optional Services	
Prescribed drugs	Physical therapy services
Intermediate care facilities for the developmentally disabled (ICF/DD)	Hearing screening services for newborn and infant children
Home and community based services (HCBS)	Occupational therapy services
Dental services	Optometric services
Rehabilitation services	Podiatric services
Personal care services	Hospice services
Durable medical equipment	Mental health and substance use disorder services
Medical transportation services	Chiropractic services
Vision-related services	School-based administrative services
Speech therapy services	

Source: 2017 Nebraska Medicaid Annual Report

The current focus of Nebraska's Medicaid program is on children, low income families, and persons with disabilities. Percentages of people eligible and their cost by those categories are shown below.





Source: 2017 Nebraska Medicaid Annual Report

Medicaid is jointly funded by the federal government and the states. Both states and the federal government have been dedicating a greater amount of their state budgets to Medicaid over the past fifty years. Nationally, Medicaid is the largest state expenditure. In 2008, Medicaid was 20.5% of total state spending. In 2017, it was 29%. Fifty-five percent of spending growth in states since 2012 is due to increased Medicaid expenditures. The annual spending growth from Medicaid has averaged 8.1% since 2012 compared with other programs of 2.2% annual growth. Of general fund expenditures, in federal fiscal year 2016, 36.5% went to elementary and secondary education, 19.7% went to Medicaid, and 9.7% to higher education.[i] From 2015 to 2016, the annual general fund percentage change in Nebraska Medicaid expenditures was 7.8%.

Table 3. Nebraska State Spending by Function, as a Percentage of Total State Expenditures, Fiscal 2016

Function	Percentage
Elementary & Secondary Education	14.2%
Higher Education	23.9%
Public Assistance	0.4%
Medicaid	17.1%
Corrections	2.9%
Transportation	8.3%
All Other	33.2%
Total	**100%**

Source: "State Expenditure Report: Examining Fiscal 2015-2017 State Spending," National Association of State Budget Officers. Available at: https://bit.ly/2PKLkmO

Table 4. Nebraska Medicaid Expenditures, as a Percent of Total Expenditures, FFY 15-17

FFY 2015	FFY 2016	FFY 2017
16.9%	17.1%	17.5%

Source: "State Expenditure Report: Examining Fiscal 2015-2017 State Spending," National Association of State Budget Officers. Available at: https://bit.ly/2PKLkmO

The ACA and Medicaid Expansion

Signed into law on March 23, 2010, the ACA was a comprehensive piece of legislation fundamentally changing the American health care system, addressing private insurance, Medicaid, Medicare, the Indian Health Service, and long-term care. Two of the most significant issues faced by states following the passage of the law were the implementation of state health insurance exchanges (later known as the health insurance marketplace) and the addition of previously ineligible adults into the Medicaid program (expansion eligible). Both programs were given January 1, 2014, effective dates.

The exchange would serve as a portal for individuals and small businesses to purchase health insurance coverage. If an individual or family had a certain income from 100% to 400% of the federal poverty level (FPL), they had available certain federal subsidies to help purchase health insurance coverage. The law, as written, gave states the option to establish their own health insurance exchanges or to opt-into the federal exchange. Most states, including Nebraska, declined to establish an ACA exchange. Today, about 88,000 Nebraskans have exchange coverage.

The ACA mandated states to expand existing Medicaid programs to cover otherwise able-bodied, non-disabled adults aged 19 to 64 years of age. Following the law's passage, there were numerous legal challenges to its provisions, three of which reached the United States Supreme Court. In the first case, *National Federation of Independent Business v. Sebelius*, 567 U.S. 519 (2012), the Supreme Court upheld the law, but found that the mandate for states to expand their Medicaid programs or lose federal funding for their existing programs was unconstitutionally coercive. The Court gave individual states the option to expand their own Medicaid programs.

Since 2014, 33 states and the District of Columbia have expanded their Medicaid programs through the ACA. The most recent state to implement the expansion program was Louisiana in July 2016. In Maine, voters approved expanding Medicaid by ballot initiative in 2017. The Virginia General Assembly approved of Medicaid expansion in May 2018. The program is set to begin on January 1, 2019.

Assumptions and the Fiscal Impact of Initiative 427

MLTC has built off the fiscal estimates of previous Medicaid expansion proposals introduced over the past six years, updated assumptions, and incorporated current data, e.g. the population estimate due to the availability of the American Community Survey for 2017 and changes to the estimated capitation rates since the implementation of Heritage Health. Additional years of Medicaid expansion, as well as more research of a broader range of other states' experiences, helped to inform the reasonableness of the assumptions used in these new estimates.

Effective Date

Initiative 427, if approved, has no effective date for the coverage to begin. The only deadline is to submit documents seeking approval of the program to the federal government by April 1, 2019. However, the drafting and submission of documents like a state plan amendment (SPA) or a waiver amendment is only one part of implementing a Medicaid program. As described below, other considerations include:

- contract amendments with every existing managed care entity;
- changes to state regulation;
- hiring and training of staff; and
- changes to existing information technology systems.

To put the timeline in perspective, it took several years to prepare for the implementation of the Heritage Health managed care program, including drafting of the request for proposal, receiving the necessary federal authorities, promulgating regulations, and making changes to the information technology systems. Even after contracts were signed, implementation still took eight months. Taking the above considerations into account, it is assumed the full implementation of this program will be no earlier than January 1, 2020.

Federal Authorities

In order to utilize federal funding for Medicaid, any change to the program, including deciding to cover adults under the ACA, requires federal approval. Federal approval can be gained through an amendment to the Medicaid state plan (SPA), through a waiver, or a combination of both.

The Medicaid state plan is the contract a state has with the federal government on how the Medicaid program is administered. An amendment is achieved through the state submitting a SPA, starting a 90-day negotiation period with the federal government. During the 90-day period, the federal government may send to a state a request for additional information (RAI). A formal RAI stops the 90-day clock until the state responds. When the state responds, it begins a new 90-day clock that ends with the approval or disapproval of the SPA. Other requirements, prior to the submission of a SPA, include public notice (if there is a rate or methodology change for a service) and tribal notice (30 to 60 days prior to the SPA submission).

Medicaid waivers allow states to administer programs without certain requirements of the Social Security Act. Nebraska currently has five waivers, four for its home and community-based services (Section 1915(c) waivers) and one for its managed care program, Heritage Health (a Section 1915(b) waiver). Other states have expanded their Medicaid programs using Section 1115 demonstration waivers. Depending upon the type of waiver, certain public notice requirements must be met prior to submission and the entire development and approval of a waiver can take nearly a year.

To implement the provisions of Initiative 427, MLTC must develop and submit a SPA and an amendment to its 1915(b) waiver to enroll this expanded population into managed care.

Heritage Health

On January 1, 2017, MLTC launched Heritage Health, an integrated Medicaid managed care program combining physical, behavioral, and pharmacy services. Three plans are contracted with the state to

deliver Heritage Health services to most Medicaid members: Nebraska Total Care (Centene), United Health Care Community Plan, and WellCare of Nebraska. Dental benefits are provided separately by Managed Care of North America (MCNA). Heritage Health is not only is focused on the quality of services provided to Medicaid members, but also on the costs. Better coordination of care slows the cost growth of the Medicaid program. Most states expanding eligibility through the ACA have covered the expanded population in their managed care programs.[ii] If Initiative 427 passes, the expansion eligible group will also be enrolled in managed care.

In addition to the Section 1915(b) amendment mentioned above, in order to enroll these expansion eligible adults into managed care, MLTC will have to negotiate contract amendments with the four health plans. These amendments will also include rates that must be developed by MLTC's actuary and possible risk-sharing arrangements due to the uncertainty of the cost in covering this expansion population.[iii] Both the rates and the contract amendments must be approved by CMS prior to the program's implementation.[iv]

Regulatory Changes

Medicaid eligibility is governed both by state legislation and regulations promulgated by MLTC. The regulatory process takes considerable time and required a public hearing and approval by the attorney general's office. If Initiative 427 passes, Title 477 of the Nebraska Administrative Code must be amended to include the new eligibility category.

Matching Rates

Medicaid is funded jointly by federal and state governments. The most a state has to contribute for eligible costs is 50%. The match rate for those considered in the expansion population under the ACA is higher than the match rate for most other populations covered by Medicaid. From January 1, 2020, onwards, the match rate for this population is 90/10. That is, the federal government will contribute 90% of the cost of the new population while the state will pay 10%. The 10% matching rate is only available for medical services to the expanded population and IT development. Other administrative costs are matched at 75/25 or 50/50. MLTC's fiscal analysis assumes a continuation of the 90% matching rate. However, there is always the possibility that Congress may change the match rate, as has been seen recently with the elimination of the 23% enhancement for the children's health insurance program (CHIP) earlier this year.

States are funding the 10% match in a variety of ways, as listed in the table below.

Table 5. How states fund the ACA Medicaid Expansion Program

State	Source of Funding
Arizona	Hospital Tax
Arkansas	Work Requirements, Premiums
California	Cigarette Taxes, Hospital Tax
Colorado	Hospital Tax
Indiana	Cigarette Taxes, Hospital Tax, Work Requirements, Premiums
Kentucky	Work Requirements, Premiums
Louisiana	Tax on HMO
Minnesota	Provider Tax
Montana	Cigarette Taxes (Proposed)
New Hampshire	Liquor Taxes, Work Requirements
North Dakota	Provider Reimbursement Cut
Oregon	Tax on Hospitals and Health Insurance Plans
Virginia	Provider Tax

Source: Quinn, Mattie, "As Federal Medicaid Money Fades, How Are States Funding Expansion?" Governing, available at: https://bit.ly/2QlWLCe

Population Size

On September 13, 2018, the United States Census Bureau released its 2017 American Community Survey, the best sources for information on Nebraska's uninsured population and those who would be covered through the ACA Medicaid expansion.[v] While this is the best information available, there are still some data limitations. The 2017 data showed:

Table 6. Uninsured population in Nebraska

Group	Population
Total Population	1,891,453
Total Uninsured	156,784
Total Uninsured under 19	25,713
Total Uninsured between 19 and 64	91,875
Total Uninsured 65 or older	1,881
Total Uninsured Citizens	122,919
Total Uninsured Aliens	33,865
Total Population below 138% FPL	326,637
Total Insured Below 138% FPL	263,857
Total with Private Insurance Below 138% FPL	128,140
Total with Public Coverage* Below 138% FPL	168,189
Total Uninsured Below 138% FPL	62,780

*Medicare, Medicaid, VA
Source: 2018 American Community Survey

The number of individuals below 138% FPL also includes individuals who are covered and receive premium assistance on the health insurance marketplace. The Nebraska Department of Insurance estimates this number to be a little over 16,000. If the state opts-into the ACA Medicaid expansion, these individuals cannot maintain their private plans with premium assistance and must enroll in

Medicaid.[vi] The Department of Insurance also estimates that the impact on the general fund will be a reduction of $712,727 by 2020 as the private insurance carriers currently pay a premium tax on the lives they cover.[vii] It is unknown what impact this will have on the continued viability of the exchange (it has a current enrollment of about 88,000).

Also of note is that many states initially underestimated the number of individuals who would enroll in Medicaid as expansion eligible.[viii] For example, Arkansas initially predicted 215,000 enrollees prior to implementation. In 18 months, enrollment was nearly 300,000.[ix]

Crowd-out

Those who are shown as currently insured, but below the threshold to be covered by the ACA Medicaid expansion, might still qualify if they decide to drop their insurance coverage or if their employer drops coverage. Individuals and families who currently purchase their health insurance coverage on the individual market or through their employer might chose to have Medicaid coverage instead. Employers, especially those who employ a large number of low-income individuals, may find it more economically advantageous to have Medicaid provide coverage to their employees instead of providing it themselves.

Woodwork

The woodwork effect refers to those individuals currently eligible for Medicaid coverage who enroll based upon the increased outreach around Medicaid expansion. One study found a clear woodwork effect with the enrollment of previously eligible children.[x] However, due to the existing outreach and the focus on insurance coverage since the passage of the ACA, it is assumed that this number will be low, approximately 865 per year.

Growth rate

Based upon experience from other states, and analysis of population trends in Nebraska, it is estimated approximately 65% of those eligible for Medicaid benefits under this proposed expansion ballot initiative would actually enroll with Medicaid in year one. By year two, it is estimated that this percentage of eligible persons actually enrolled would grow to 80%, and MLTC assumes by year three all potentially eligible individuals who chose to enroll would be enrolled in Medicaid.

Since eligibility for the ACA expansion group is income-based, if there is an economic downturn the growth rate will increase, as will the cost of the expansion population. For example, if enrollment grows an additional 3% beginning in SFY 2021, it would result in the total number of eligible persons to grow to an 112,110 individuals. This would result in an estimated total cost to $6.3 billion, increasing the state aid cost to $736 million.

Table 7. Estimated increase in enrollment (and associated aid costs) if Initiative 427 is approved assuming stable economic conditions

State Fiscal Year	Estimated Expansion Population by Year	State Funds	Federal Funds	Total Aid Cost
FY20 (Half a Year)	57,592	$19,826,774	$149,351,013	$169,177,787
FY21	70,882	$49,269,837	$371,139,560	$420,409,397
FY22	88,602	$62,416,513	$470,170,776	$532,587,289
FY23	89,223	$64,833,312	$488,376,023	$553,209,335
FY24	89,847	$67,343,690	$507,286,187	$574,629,877
FY25	90,476	$69,951,271	$526,928,562	$596,879,833
FY26	91,109	$72,659,820	$547,331,499	$619,991,319
FY27	91,747	$75,473,244	$568,524,449	$643,997,693
FY28	92,389	$78,395,606	$590,538,000	$668,933,606
FY29	93,036	$81,431,123	$613,403,926	$694,835,049
FY20 to FY29		**$641,601,190**	**$4,833,049,996**	**$5,474,651,186**

Table 8. Estimated increase in enrollment (and associated aid cost) if Initiative 427 is approved and enrollment grows an additional 3% per year

State Fiscal Year	Estimated Expansion Population by Year	State Funds	Federal Funds	Total Aid Cost
FY20 (Half a Year)	57,592	$19,826,774	$149,351,013	$169,177,787
FY21	73,008	$50,747,932	$382,273,747	$433,021,679
FY22	91,260	$64,289,009	$484,275,899	$548,564,908
FY23	94,774	$68,949,962	$519,385,902	$588,335,864
FY24	98,423	$73,948,834	$557,041,380	$630,990,214
FY25	102,212	$79,310,124	$597,426,880	$676,737,004
FY26	106,147	$85,060,109	$640,740,328	$725,800,437
FY27	110,234	$91,226,966	$687,194,002	$778,420,969
FY28	114,478	$97,840,921	$737,015,567	$834,856,489
FY29	118,885	$104,934,388	$790,449,196	$895,383,584
FY20 to FY29		**$736,135,019**	**$5,545,153,915**	**$6,281,288,934**

Capitation rates

Since the adult expansion population will receive services through the state's managed care entities, the plans will be paid a per member, per month rate for all of their services. This is known as a capitation payment. For purposes of this fiscal analysis, it is assumed that the expansion population will receive the same services as the existing Medicaid population, including optional services like dental care and chiropractic services.

The capitation rates in this analysis are a blended average rate for the expected categories of aid that the expansion populations are expected to fall into under the current Medicaid eligibility groups. The