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DATE PREPARED:	January 29, 2014
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LB 887

Revision: 01

Revised to include an agency's revised fiscal note

FISCAL NOTE

LEGISLATIVE FISCAL ANALYST ESTIMATE

ESTIMATE OF FISCAL IMPACT – STATE AGENCIES (See narrative for political subdivision estimates)

	FY 2014-15		FY 2015-16	
	EXPENDITURES	REVENUE	EXPENDITURES	REVENUE
GENERAL FUNDS	(754,613)		(2,578,534)	
CASH FUNDS	264,500		264,500	
FEDERAL FUNDS	318,359,073		373,381,199	
OTHER FUNDS				
TOTAL FUNDS	317,868,960		371,067,165	

Any Fiscal Notes received from state agencies and political subdivisions are attached following the Legislative Fiscal Analyst Estimate.

Bill Summary

This bill requires the Department of Health and Human Services to submit, not later than 30 days after the effective date of the bill, a state plan amendment to cover the new Medicaid adult group, commonly referred to as Medicaid Expansion. The bill directs the department to apply for a benchmark benefit package for Secretary-approved coverage to include full Medicaid coverage and other coverage required by the Affordable Care Act (ACA) and services covered by the federal Paul Wellstone and Pete Domenici Mental Health Parity Act of 2008. This bill establishes the Wellness in Nebraska (WIN) Act. The state plan amendment would be in effect until enactment of waivers implementing the WIN Act. The department is required to apply for any waivers or state plan amendments to implement the Wellness in Nebraska plan beginning January 1, 2015, or as soon after that date that the waivers are enacted. The WIN Act has two components: WIN Medicaid Coverage and WIN Marketplace Coverage. WIN Medicaid Coverage is for: a) those with income at or below 100% of the Federal Poverty Level (FPL), or b) those who are medically fragile or those with exceptional medical conditions with incomes at or below 133% of FPL. WIN Marketplace Coverage is for those with incomes above 100% of FPL and at or below 133%. They would be eligible for premiums paid by the department to purchase: a) qualified health plans on the health benefit exchange, or b) employer-sponsored health insurance. The department shall pay all co-payments, co-insurance, deductibles and wrap-around benefits. The department shall pay premiums directly to the qualified health plans issuer. Wrap-around benefits include non-emergency transportation, early and periodic screening (EPSDT), diagnostic and treatment program for those under age 21, a fee-for-service dental plan. Beginning January 1, 2016, all newly eligible individuals enrolled in WIN shall be enrolled in patient-centered medical homes, where available. If patient-centered medical homes are not available for all WIN clients, the department with the WIN Oversight Committee will develop plans for increasing the number of patient-centered medical homes or developing alternative integrated care models and pilot projects. By January 1, 2016, the department in conjunction with the WIN Oversight Committee shall recommend a reimbursement methodology and incentives for participation in the patient-centered medical home and health home systems to ensure that providers enter into and continue to participate in the system. Beginning January 1, 2016, the WIN participants with incomes at or above 50 percent of FPL shall contribute two percent of their monthly income towards their coverage. For members who complete the required preventative care services and wellness activities, the monthly contributions will be waived during each subsequent year until the member fails to complete the required activities. Total monthly contributions plus cost-sharing each quarter shall be limited to one quarter of five percent of the yearly income. The policy shall include guidelines for hardship exemptions. Individuals are eligible for covered benefits for 12 months. The department shall conduct an annual review of eligibility. The WIN Oversight Committee is created. It consists of nine members of the Legislature appointed by the

Executive Committee. The WIN Oversight Committee shall oversee and monitor the WIN Act. The committee has the authority to hire a consultant. The bill states that if the Federal Financial Participation Rate (FMAP) falls below 90%, the Legislature shall affirm, amend or repeal the Medicaid Expansion coverage. The bill has the emergency clause.

Implementation Assumptions

In this fiscal note and the department's, it is assumed that implementation of the Medicaid Expansion would begin on August 1, 2014. The bill also directs the department to apply for a waiver to establish the WIN Program by January 1, 2015 or as soon thereafter as the waiver is enacted. The department estimates that the waiver would begin on July 1, 2015. For a Medicaid waiver to be approved, the costs must be budget neutral. This means the waiver cannot cost the federal government more than what would have otherwise been spent absent the waiver. An actuarial study is required for the waiver application to determine cost neutrality. For purposes of this fiscal note, the costs are assumed to be the same if implemented with or without a waiver.

The Department of Health and Human Services contracted with Milliman to project the costs of implementing the Affordable Care Act. Milliman provided a revised report in January 2013. Milliman provided two projection scenarios, full participation and what they call mid-range participation. The full participation assumes 100% of all eligible persons will apply for and utilize the services. The mid-range participation rates range from 80% to 85%; except of the category of "insured switchers" which are at 50%. The Milliman projections assume these will be the participation rates from the start and will continue at the same level throughout the seven years of their projections. Although Milliman provided the full participation scenario, in their report they state: "While we provided a full participation scenario, we do not expect full enrollment to occur. Rather, we have provided the full enrollment scenario to indicate an endpoint for reference and discussion." The fiscal note of the Department of Health and Human Services states that the full enrollment scenario is used to project costs to FY 2020. In the first two years the costs between the full participation and mid-ranged scenarios. The department stated that they have again retained the services of Milliman to provide an actuarial analysis of this bill.

The Legislative Fiscal Office also studied the impacts of the ACA and included their projections in a report released in November 2012. The participation rate in this report is 60%; except of the category of "insured switchers" which is at 25% in the first year. By the fourth year, the participation rate is anticipated to reach 75%; except for the "insured switchers" who remain at 25%.

In this fiscal note, the aid costs are the midpoint between the mid-range estimates from the Milliman Report and the Legislative Fiscal Office projections. Administrative costs in this fiscal note those estimated by the department. For non-waiver administrative costs, the cost are those estimated in the Milliman Report. Waiver costs are also those estimated by the department, adjusted for reasonable administrative overhead. The department estimates indirect costs at 46% of salary and benefits. In this fiscal note non-personnel costs are estimated to be $7,500 per person per year. The department's fiscal note includes a contractual costs for the state plan amendment and contractual costs for preparation work for the waiver. In this fiscal note, those costs are combined at the cost for waiver application preparation. The department has already retained Milliman for actuarial costs for the bill. Milliman's work will constitute the majority of the information needed for the state plan amendment. These costs are shown in the chart at the end of this fiscal note. IT costs are estimated to be $419,000 ($41,900 GF and $377,100 FF) in FY 15. If the waiver is approved, there would be additional costs of $1,537,500 ($153,750 GF and $1,383,750 FF) in FY 16. The administration costs are 50% General and 50% federal. IT costs are at a 10-90% split with the federal government paying the higher percent.

There is a great degree of uncertainty in projecting the cost of this provision. Medicaid Expansion covers a population that previously has never been covered by Medicaid. The pool of those potentially eligible coupled with assumptions regarding their behavior as to whether or not to participate and when, their health status and their decisions with regard to dropping insurance coverage and opting for Medicaid all make the impact difficult to project.

Aid

The Federal Medical Assistance Percentage (FMAP) is the percentage paid by the federal government for the aid costs of Medicaid. Initially the aid costs are fully funded by the federal government and are gradually phased down to 90% in 2020. The chart on the following page shows the federal match rates for the calendar years 2014 to 2020:

Calendar Year	Fed. Match
2014	100%
2015	100%
2016	100%
2017	95%
2018	94%
2019	93%
2020 and after	90%

This fiscal note shows projected costs through 2020. The projections beyond the next biennium are shown because of the changes in the FMAP and due to the assumption that participation will increase over time. Waiver administrative costs are only shown for the first two years. If the waiver is approved, those ongoing costs would need to be assessed. If it is not approved, the coverage would continue under the regular Medicaid Expansion. Those costs have been included in the out years. The waiver provision has a wellness component which in the private sector insurance market has shown to reduce medical costs. No savings are projected for the wellness component, but those savings would be available to offset the ongoing costs of the administration of the waiver.

The aid costs by fund source are shown in the chart below along with the projected number of enrollees:

Fiscal Year	State	Federal	Total	# of Enrollees
FY 2014-15	0	301,672,058	301,672,058	53,640
FY 2015-16	0	354,205,813	354,205,813	63,091
FY 2016-17	9,192,190	358,495,396	367,687,585	64,824
FY 2017-18	20,854,444	358,317,261	379,171,705	65,209
FY 2018-19	25,418,368	365,633,443	391,051,811	65,597
FY 2019-20	34,280,970	369,024,561	403,305,531	65,989
Total	89,745,971	2,107,348,532	2,197,094,503	

In calendar year 2013 and 2014, the ACA requires states to pay primary care rates at the Medicare rates. The federal government is paying the full costs. After the expiration of the mandate, it is assumed the state would continue to pay at the higher rate. The impact of continuing those rates are included in this fiscal note. The FY 15 and FY 16 costs are $3,100,000 FF. Beginning in FY 17, match rates will be the enhanced Medicaid Expansion match rates.

The ACA established a new tax on insurers. The tax applies to managed care plans. Since the state contracts for managed care, it is anticipated that the cost of the contract will increase. The cost in FY 15 is $5,600,000 FF and $6,800,000 FF in FY 16. Beginning in FY 17, match rates will be enhanced Medicaid expansion match rates.

The Department of Health and Human Services did not include an estimate of the costs for providing EPSDT nor has the LFO calculated the impact of those services. Those services likely will result in additional costs but additional study of the impact is needed to determine those costs. The department fiscal note references the costs for habilitative services. Habilitative services are not included in the bill and therefore, there will not be any costs.

Program Savings

The State Disability Program will be eliminated if Medicaid is expanded per this bill. The State Disability Medical Program covers individuals whose disability is expected to last not less than six month up through 12 months. After twelve months, if the disability continues Social Security and Medicare coverage begins. Although persons eligible under this program are considered disabled under the state's definition, they are not considered disabled under federal law, so their medical care would be covered under the Medicaid expansion. Savings in FY 15 would be $7,583,333 and $9,100,000 in FY 16. FY 15 costs assume a two-month lag in payments.

The state currently provides coverage for prescription drugs for low-income individuals who are HIV positive or have AIDS. These individuals would be eligible for drug coverage under the provision of this bill, so the state drug program will no longer be utilized. Savings in FY 15 would be $750,000 and $900,000 in FY 16. There is also a two-month lag in payments assumed in these savings in FY 15.

The state provides behavioral health funding to the mental health regions to cover individuals who are not insured and services that not covered by insurance or Medicaid. Estimated savings, net of the costs that would not be covered by Medicaid, are up to $6 million annually for those who would be covered by Medicaid expansion. However, to avoid a disruption in services, the savings will be gradually captured and additional anticipated savings will be placed in a separate budget program and if needed available for the regional behavioral health providers. In FY 16 the appropriation will be reduced by $1 million and $2 million moved into the separate set-aside budget program. In FY 17, the savings and set-aside amount are equal at $2 million each. In FY 18, savings are $3 million with $1 million set aside. In FY 19 and thereafter, the savings are anticipated to be $4 million with no funds set aside.

Corrections

Inmates of correctional facilities are not eligible for Medicaid; however, if inmates are hospitalized outside of the correctional facility, they are eligible for Medicaid for the services provided while in the hospital. Estimated savings of $364,808 are anticipated in FY 15 and full year savings would be $729,616. These savings are less than total inpatient hospital expenses due to the following reasons: some inmates may not be legal residents, some may not cooperate with the application process or the service provider may not accept Medicaid.

Counties

Counties would see a reduction in costs currently spent on covering individuals through General Assistance. The savings would vary from county to county; however county by county information is not available. The state's two largest counties Douglas and Lancaster provided projected cost savings. Douglas County estimates savings of $1,650,000 annually in reduced reimbursements to medical providers and $300,000 in payments for prescription drugs. They could have additional savings of $1,869,000, if their Primary Health Care Clinic is closed. Lancaster County projects savings of $2,500,000 annually in their General Assistance Program. Savings in FY 15 would be approximately one quarter of estimated annual savings.

As noted above, inmates of correctional facilities are eligible for Medicaid coverage for inpatient hospital services. Counties will have savings for inpatient hospital services for jail inmates, but as with General Assistance, those costs would vary from county to county. No estimate is available at this time.

Insurance

The Department of Insurance indicates that five additional staff will be needed. The department is solely cash funded. The total cost would be $264,500 in FY 15 and FY 16. Additional revenue of $86,000 annually is also anticipated.

WIN Oversight Committee

The WIN Oversight Committee has the authority to hire a consultant. The cost would be $50,000 in FY 15 and FY 16.

Fiscal Impact

The chart on the next page shows the fiscal impact of the Medicaid expansion through FY 2019-20:

	Summary							
1		FY14-15	FY15-16	FY16-17	FY17-18	FY18-19	FY19-20	Total All Years
2	Aid Costs New Eligibles							
3	General	0	0	9,192,190	20,854,444	25,418,368	34,280,970	89,745,971
4	Federal	301,672,058	354,205,813	358,495,396	358,317,261	365,633,443	369,024,561	2,107,348,532
5	Total	301,672,058	354,205,813	367,687,585	379,171,705	391,051,811	403,305,531	2,197,094,503
6								
7	Primary Care to Medicare							
8	General	0	0	77,500	170,500	201,500	263,500	713,000
9	Federal	3,100,000	3,100,000	3,022,500	2,929,500	2,898,500	2,836,500	17,887,000
10	Total	3,100,000	3,100,000	3,100,000	3,100,000	3,100,000	3,100,000	18,600,000
11								
12	Administration							
13	General	7,225,000	7,284,532	7,750,000	7,800,000	7,900,000	7,950,000	45,909,532
14	Federal	7,225,000	7,284,532	7,750,000	7,800,000	7,900,000	7,950,000	45,909,532
15	Total	10,858,313	14,569,063	15,500,000	15,600,000	15,800,000	15,900,000	88,227,376
16								
17	Waiver Staff							
18	General	296,528	967,801					967,801
19	Federal	390,015	1,142,104					1,142,104
20	Total	458,551	2,110,104					2,109,905
21								
22	Contracts							
23	General	162,500	80,000					242,500
24	Federal	162,500	80,000					242,500
25	Total	325,000	160,000					485,000
26	IT							
27	General	209,500	768,750					978,250
28	Federal	209,500	768,750					978,250
29	Total	419,000	1,537,500					1,956,500
30								
31	ACA Managed Care Fee							
32	General	0	0	136,000	350,000	432,000	584,000	1,502,000
33	Federal	5,600,000	6,800,000	6,664,000	6,650,000	6,768,000	6,716,000	39,198,000
34	Total	5,600,000	6,800,000	6,800,000	7,000,000	7,200,000	7,300,000	40,700,000
35								
36	Program Savings (All General)							
37	State Disability	(7,583,333)	(9,100,000)	(9,100,000)	(9,100,000)	(9,100,000)	(9,100,000)	(53,083,333)
38	AIDS Drugs	(750,000)	(900,000)	(900,000)	(900,000)	(900,000)	(900,000)	(5,250,000)
39	Behavioral Health		(1,000,000)	(2,000,000)	(3,000,000)	(4,000,000)	(4,000,000)	(14,000,000)
40	Total	(8,333,333)	(11,000,000)	(12,000,000)	(13,000,000)	(14,000,000)	(14,000,000)	(72,333,333)
41								
42	Corrections							
43	General	(364,808)	(729,616)	(729,616)	(729,616)	(729,616)	(729,616)	(4,012,888)
44								
45	Department of Insurance							
46	Cash	264,500	264,500					529,000
47	WIN Oversight							
48	General	50,000	50,000					100,000
49								
50	Grand Total							
51	General	(754,613)	(2,578,534)	4,426,074	15,445,328	19,222,252	28,348,854	64,109,360
52	Cash	264,500	264,500					529,000
53	Federal	318,359,073	373,381,199	375,931,896	375,696,761	383,199,943	386,527,061	2,213,095,932
54	Total	317,868,960	371,067,165	380,357,969	391,142,089	402,422,195	414,875,915	2,277,734,293

LB(1) 887 FISCAL NOTE 2014

ESTIMATE PROVIDED BY STATE AGENCY OR POLITICAL SUBDIVISION

State Agency or Political Subdivision Name:(2) Department of Health and Human Services

Prepared by: (3) Steve Shively Date Prepared:(4) 1-27-14 Phone: (5) 471-0676

	FY 2014-2015		FY 2015-2016	
	EXPENDITURES	REVENUE	EXPENDITURES	REVENUE
GENERAL FUNDS	-$224,064*		$2,895,324*	
CASH FUNDS				
FEDERAL FUNDS	$269,231,273*		$357,116,597*	
OTHER FUNDS				
TOTAL FUNDS	$269,007,209*		$359,911,921*	

Return by date specified or 72 hours prior to public hearing, whichever is earlier.

Explanation of Estimate:

The Nebraska Medicaid program currently provides coverage for low-income individuals in specified categories: children to age 19, their qualifying caretaker relatives, pregnant women, the aged, and the disabled. The program provides a wide variety of medical services, as well as non-medical services designed to help the aged and disabled live in the community. In Fiscal Year 2013, Nebraska Medicaid covered a monthly average of 240,639 individuals, at a total annual cost of more than $1.8 billion.

In 2010, President Obama signed the Patient Protection and Accountable Care Act (hereinafter the ACA), creating an individual mandate to have health insurance and establishing health insurance exchanges. In June 2012, the Supreme Court ruled the expansion of Medicaid to a new adult group could not be mandated but rather was voluntary for states. In order to get assistance in estimating the impact of the ACA to the Nebraska Medicaid program, the Nebraska Department of Health and Human Services retained Milliman, Inc., an international actuarial and consulting firm with expertise in Medicaid and the private health insurance market. The additional appropriation necessary to implement the required provisions of ACA were included in LB 195 for SFY14 and SFY15, the mainline budget bill. The Department has retained the actuarial services of Milliman, Inc., to analyze the impact of LB 887. The information in this fiscal note may be updated based on this analysis.

Optional Medicaid Expansion of the Affordable Care Act

LB 887 seeks to implement the optional Medicaid expansion in Nebraska providing Medicaid services to the optional adult group not previously covered. The Department estimates that the expansion under LB 887 will result in enrollment of an additional 95,059 new individuals in Medicaid by Fiscal Year 2020. The average annual costs for the optional population are based on Milliman's analysis which was originally drafted in November, 2010, and updated January 8, 2013. The analysis relied on contracted managed care data on capitation rates, Nebraska Medicaid service costs, the Medicaid Statistical Information System (MSIS) State Summary Datamart, and Medicaid expansion data from other states. The estimates are based on expenditures for current adult Medicaid enrollees. The annual estimates assume a 2.5% growth for capitated expenditures and a 3.5% growth for Fee-for-Service expenditures. Expenditures for benefits are estimated at $595.3 million through Fiscal Year 2016. Implementation of LB 887 is estimated for 7-1-14 assuming the timely approval of State Plan Amendments (SPAs). WIN Nebraska is projected to begin 7-1-15 assuming 1115 waivers are approved. Due to the complex and rigorous SPA and 1115 waiver approval processes, the implementation dates could be delayed. The year-by-year analysis and breakdown by State Funds and Federal Funds is set out in the Cost of Benefits table below.

In order to handle the additional 95,059 individuals estimated to enroll in the optional program created by LB 887, the Department would need 217 additional baseline staff by State Fiscal Year 2016. This staff is necessary in order to determine eligibility, process claims, and administer Medicaid requirements such as contract management, program integrity, legal, financial, human resources and data analysis. Additional staff expenditures are estimated at $25.4 million through Fiscal Year 2016. The year-by-year analysis and breakdown by State Funds and Federal Funds is set out in the Administrative Costs table below.

Optional Medicaid Expansion	New Enrollees	Staff Positions
SFY2015	59,227	176
SFY2016	72,845	217

Optional Medicaid Expansion/Provision – Cost of Benefits

Benefits	Total	State Funds	Federal Funds
SFY2015	$256,155,608	-$6,416,667	$262,572,275
SFY2016	$339,165,046	-$6,720,000	$345,985,046
TOTAL	**$595,320,654**	**-$13,136,667**	**$608,557,321**

Optional Medicaid Expansion/Provision – Administrative Costs

ADMIN	Total	State Funds	Federal Funds
SFY2015	$10,858,313	$5,429,157	$5,429,157
SFY2016	$14,569,063	$7,284,532	$7,284,532
TOTAL	**$25,427,376**	**$12,713,689**	**$12,713,689**

Additionally, LB 887 requires coverage for the optional population of at least two benefits not currently offered to the adult population. It would expand Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services to ages 19 through 21, and provide habilitative services to an undefined population. It is impossible for the Department to estimate what the costs would be, but they would be in addition to the costs of benefits referenced above.*

In addition, computer changes would be necessary to meet business requirements for processing the optional population. The cost of the necessary computer changes are estimated at $419,000 ($41,900 GF, $377,100 FF) in SFY15 and $1,537,500 ($153,750 GF, $1,383,750 FF) in SFY16. Computer changes are reflected in the table below.

Cost of Computer Changes

Computer	Total	State Funds	Federal Funds
SFY2015	$419,000	$41,900	$377,100
SFY2016	$1,537,500	$153,750	$1,383,750
TOTAL	**$1,956,500**	**$195,650**	**$1,760,850**

A contract at the estimated cost of $150,000 ($75,000 GF, $75,000 FF) would be needed in SFY15 to apply for a State Plan Amendments to cover the newly eligible individuals within 30 days after LB 887 is passed. Additional contract(s) would be necessary to prepare the required 1115 waiver(s) and assist the Department with the development, procurement, and implementation of WIN Marketplace at a cost of $325,000 ($162,500 GF, $162,500 FF) in SFY15 and $160,000 ($80,000 GF, $80,000 FF) in SFY16.

In addition to the baseline staff identified above, an additional 12 staff members in SFY15 and 52 staff members in SFY16 will be needed to administer the various requirements of the Wellness in Nebraska (WIN) programs. Additional staff and contracts are in the Staff and Contracts tables below and are required for the following:

- Medical Team – 1 dedicated full-time Medical Director beginning 7-1-14 to assist in the development of the Alternative Benefit Plan State Plan Amendment and to determine the criteria for the “Medically Frail” population defined in section 24 of LB 887; 3 Nurses and 1 Staff Assistant beginning 7-1-15 to assist in the identification of the “Medically Frail” population.
- Financial Team (Marketplace/HIPP) – 1 Administrator I beginning 1-1-15; 2 Unit Managers, 1 Staff Assistant, and 20 Payment Reviewers starting 7-1-15 to process payments of premiums for persons buying into the Exchange, and to process Employer Sponsored insurance premiums for qualified individuals.
- Financial Team (2% Contribution) – 1 Administrator I beginning 7-1-15; 1 Accountant I, 1 Staff Assistant, and 10 Accounting Clerk II positions starting 1-1-16 to facilitate the collection of the 2%

contributions by clients as defined in Section 43 of LB 887, to document when wellness quality measures are met and the contribution is waived, and track total contributions.

- Eligibility Team – 1 Program Specialist starting 7-1-14 to assist in the development and administration of the 1115 waiver; 2 Statistical Analyst II positions starting 7-1-14 for data collection for the 1115 waiver application and establishing data quality metrics; 1 Business Analyst and 1 Unit Manager beginning 1-1-15 to assist in the identification, design and development of computer changes due to the 1115 waiver; 1 Program Accuracy Specialist, 2 Statistical Analyst II, 1 Staff Assistant, 1 Quality Program Specialist starting 7-1-15 to facilitate quality measurement development, gathering, and additional reporting.
- SIU Team – 2 Quality Control Specialist starting 7-1-15 to investigate possible abuse and fraud in WIN Marketplace.
- Managed Care Team – 2 Program Quality Specialists starting 7-1-14 for quality and financial oversight of the WIN Medicaid Program; 4 Program Quality Specialists beginning 1-1-16 to manage and oversee the WIN Marketplace and WIN Medicaid contracts.
- Program Team – 2 Program Specialists beginning 1-1-15 to develop, implement, and evaluate the incentives for providers and clients, as well as develop plans and manage Health Home and Accountable Care Organizations.
- CMS 64 Reporting – 1 Program Analyst starting 1-1-15 for additional CMS 64 reporting requirements associated with the 1115 waivers.
- Actuarial Annual Update Contract – To set initial rates and update annually.
- Wellness Contract – Monitor compliance with wellness contract by clients.

Additional – Cost of Staff

Staff	Total	State	Fed
SFY15	$960,287	$414,546	$545,741
SFY16	$4,268,311	$1,991,042	$2,277,269
Total	**$5,228,598**	**$2,405,588**	**$2,823,010**

Additional – Contract Costs

Contracts	Total	State	Fed
SFY15	$614,000	$307,000	$307,000
SFY16	$372,000	$186,000	$186,000
Total	**$986,000**	**$493,000**	**$493,000**

Total of all Medicaid Expansion/Provisions that can be estimated*

TOTAL	Total	State Funds	Federal Funds
SFY2015	$269,007,209	-$224,064	$269,231,273
SFY2016	$359,911,921	$2,895,324	$357,116,597
TOTAL*	**$628,919,130**	**$2,671,260**	**$626,347,870**

For questions regarding the content of this note, contact Erin Yardley at 471-9101.

MAJOR OBJECTS OF EXPENDITURE

PERSONAL SERVICES:

POSITION TITLE	NUMBER OF POSITIONS 14-15	NUMBER OF POSITIONS 15-16	2014-2015 EXPENDITURES	2015-2016 EXPENDITURES
Administration/Staff	188	269	$11,818,600*	$18,837,374*

	2014-2015	2015-2016
Benefits		
Operating	$614,000*	$372,000*
Travel		
Capital Outlay	$419,000*	$1,537,500*
Aid	$256,155,608*	$339,165,046*
Capital Improvements		

TOTAL..	$269,007,209*	$359,911,920*

*Does not include the estimated impact for the provisions of LB 887 requiring the expansion of EPSDT and adding habilitative services.