[LR467]

The Select Committee on LR467 met at 9:00 a.m. on Thursday, September 16, 2010, in Room 1510 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public hearing on LR467. Senators present: Mike Gloor, Vice Chairperson; Kathy Campbell; Tanya Cook; Galen Hadley; Lavon Heidemann; Heath Mello; Jeremy Nordquist; and Rich Pahls. Senators absent: Tim Gay, Chairperson.

SENATOR GLOOR: We're going to get started. I'm Senator Mike Gloor. I am not the Chairman of this Select Committee; Senator Gay is. But Senator Gay was unable to be here and has asked both Senator Campbell and I to serve as cochairs of this august group. I'll do this morning and Senator Campbell will do this afternoon and tomorrow morning. I would remind everybody that this is really a...more an informal gathering, information gathering. I'm going to read what the interim study is. This interim study, LR467, is to conduct research and provide recommendations for implementing the federal Patient Protection and Affordable Care Act, and this is the research piece. We have lined up individuals to come in to provide us with some research, some information, specific information that could be helpful to us, so it's not a traditional public hearing. We're not taking hearing or testimony from people who are observers. We appreciate that if you are, but there is a date set up, October 7, I believe, which will be an opportunity for people to provide public testimony if you would like to do so. It may also include October 8, if there are enough people who have an interest and having something to say. Would ask you when you sit down, if you're a testifier, to please state and spell your name for the record, but you don't need to fill out a testifier sheet today. That's not required. There will be some senators who have to come and go. If I have to leave, Senator Campbell will fill in as Chair and vice versa this afternoon, but I would ask the senators here and those around the table to introduce yourself, starting with Mrs. Mack, committee clerk.

ERIN MACK: I'm Erin Mack, committee clerk.

SENATOR COOK: I'm Tanya Cook. I'm the state senator representing Legislative District 13.

SENATOR GLOOR: Mike Gloor.

SENATOR CAMPBELL: I'm Kathy Campbell, representing District 25.

SENATOR HADLEY: Galen Hadley. I represent District 37 which is Kearney County and Kearney.

SENATOR NORDQUIST: Jeremy Nordquist representing District 7 which is downtown and south Omaha.

MICHELLE CHAFFEE: I'm Michelle Chaffee, legal counsel to the Health and Human Services Committee of the Legislature.

SENATOR GLOOR: Thank you, and with that, I think we'll get started. Our first testifier is Joy Johnson-Wilson. It's nice to have you back in the state of Nebraska.

JOY JOHNSON-WILSON: Thank you. It's a pleasure to be here. Is this on? [LR467]

SENATOR GLOOR: I believe so, yeah. [LR467]

JOY JOHNSON-WILSON: (Exhibit 1) Okay. Mr. Chairman and members of the committee, it's a pleasure to be here in Lincoln, and I'm looking forward to seeing the rest of your Capitol because everybody that I talked to and said I'm going to the Capitol, they go don't stay in the basement (laughter), so I'm not going to stay in the basement. I'm going to get to the other part which apparently is fabulous, and I want to see it. I'm here today to do what is as close to a 101 on the health bills as I guess is possible in a

short period of time, so I'm going to go fairly quickly so that I can answer questions which is, of course, the most important part. I have for the legislators a little side piece that I've done that's kind of a humorous take on the health law and what states have to do, and it's about the kinds of things that you're going to have to do in order to be successful, which is holding hands with your federal partners and your in-state partners as well, and maybe couples counseling will be called for and that kind of thing as you move forward. But this has to be...this is a big group project, and if the group doesn't play well together, it's going to be very difficult to move forward on this project. So in the beginning, there are two bills. The first bill is the Affordable Care Act that was signed on the 23rd of March, and after that was the Health Care and Education Reconciliation Act which was signed on March 31. We in Washington are now referring to the package as the Affordable Care Act, but it's important to note that there are two separate pieces of law. So the main framework of the reform builds on our existing health care system, so if you look at it as...from a home building perspective, we had the option of doing a knockdown and putting up a mini-mansion, but we didn't do that. We could have painted and hung new curtains, but we didn't do that. We did a major renovation on an old house, and so with that comes certain interesting aspects. But then you throw in that, in doing the renovation project, we had 535 people working on deciding what the renovation would look like. So we're through that process, and some things, you know, some rooms don't match, some appliances don't go together, some don't work. But we've got what we've got and we're trying to move forward on implementation, but it's important to note how we got there. Probably most important and while this is inside baseball in Washington, I think it informs how the legislation was crafted. The reconciliation process is a budget process, so the only amendments that were permitted under the reconciliation process were amendments that had substantial budget impact. Okay, so hold that thought. Secondly, the legislation was drafted, assuming that it was going to be enacted in law in the fall of last year. Well, that didn't happen. So the dates in the bill reflect what they thought was going to happen, not what happened. Going through the reconciliation process, dates were not allowed to be changed. So that is why there were some effective dates that actually happened before the bill was

enacted. There were January 1 effective dates for a bill that was signed in March. There are many other technical drafting issues that would have been addressed in a conference committee had there been one but there wasn't. So by using the reconciliation process and not having a conference committee, they moved forward on legislation that has some shortcomings in drafting and has some issues that are timing based and we're stuck with those. And as you know, getting amendments to this bill in the Congress right now is a tough thing, so we're mostly going to have to deal with any of those issues in the administrative rule process. So a lot of those glitches will be addressed by regulation, so I just think that's important to point out as you move forward. So what does the bill do? It maintains the employer-based system and puts in place provisions that provide incentives for large employers to continue to provide coverage. Why is that? Eighty-five percent of people currently receive their healthcare coverage through their employer. The financing is based on that staying pretty much the same, so that if a lot of large employers were to release their employees into the Exchange, it would throw off the financing of the act. It expands and modifies Medicaid. This, again, is a...it's partially a financing issue. It's clearly an administrative issue, and that states are already...we're already in for the money in Medicaid. There's a certain amount of money that states put in that supports the Medicaid Program that finances healthcare. So they weren't going to let that go because at the end of the day the health bill had to be budget neutral. So it's important to note, we were in from the start, and they made other changes to Medicaid that many people had wanted to do for a long time, such as raising the floor--the income eligibility floor--and providing for coverage for noncategorically eligible individuals. The individual mandate, which of course in previous health reform discussions was a third rail, was not much of a debatable issue this time around, which is kind of interesting, partially because in order to get the insurance industry to agree to the insurance reforms that were being proposed, they insisted that then all individuals or as close as possible to all individuals needed to be in the pot in order to address issues of adverse selection. And so we have an individual mandate. Finally, there is a real change in the way insurance will be regulated in this country. As you know, state governments had the primary responsibility for the

regulation of the individual and small group market. We're now sharing that territory with the federal government. I think it is fair to say that states know more about this than our federal partners. However, we are now having to share that space and work in tandem with the federal government on the rules that will determine how we work with insurers going forward. And that struggle continues, and we'll talk about that. And then, finally, the new piece, that new room that we didn't have before is the Health Insurance Exchanges. These are designed to be one-stop shopping centers for individuals who want to get coverage and for small businesses who want to get coverage for their employees. The Exchanges can be a number of things. The lowest level is it would be a one-stop shopping where any insurer that meets the minimum standards in the federal law would set up shop, and so people could come and purchase coverage at this Exchange or through the Exchange Web site. It can be much more and that, of course, depends on what states and state legislators like you decide you would like to see in your state. The Exchange is also where the subsidies for premiums and cost-sharing will be determined, and that becomes part of your insurance coverage. So as you know, there are subsidies for individuals with incomes between 133 percent of poverty and 400 percent of poverty. So you go to the Exchange and you are at 140 percent of poverty, that goes into the calculation when they're finding your coverage because you would be eligible for some premium assistance and some cost-sharing assistance, so that goes into the calculation of what coverage would be good for you. So now we're going to talk quickly about the Medicaid expansion. As you know, the law sets a new national minimum standard at 133 percent of poverty, and it eliminates the current disregards that states use and replaces it with a standard 5 percent income disregard. So the real minimum eligibility is somewhat higher than 133 percent of poverty when you take into account the 5 percent disregard. Now, that was the national minimum and the new way that the eligibility will be calculated was put in place, and that's going to be for most new people going into Medicaid. Your eligibility will be determined on an income-only basis, modified adjusted gross income, and the reason why this was put in place is so that the Medicaid Program and the Exchange can be interoperable, so that if I'm a Medicaid-eligible person but I go to the Exchange because I don't know, they'll

say, well, you can't...we can't provide you with insurance here, but we can facilitate your application for Medicaid right now. And the same would be true if someone who's not eligible for Medicaid shows up at the Medicaid agency. The Medicaid agency would be expected to facilitate the application of that individual. So this is a whole new world because Medicaid is not interoperable with anything right now, and so this is some heavy lifting that's going to have to be done. Now, in addition to the new modified adjusted gross income standard, you will have to retain your existing eligibility standards for people who come onto the Medicaid Program through another program. So if you have someone who gets Medicaid because they are receiving Supplemental Security Income, SSI--that's for low-income, disabled individuals--they still have the resource test and all the things that come with SSI. So, while a simplification on one side, it's not that simple when you take into account that you will still have to retain your old system as well and run them in tandem. The new law adds some new mandatory categories, eligible categories, and these are single, childless adults who are not disabled, parents of low-income kids, and also former foster care children up to age 26. Now, a lot of people have asked why is that in there, and that provision parallels a provision in the insurance reforms that allows parents to carry adult children on their policies up to age 26. The enhanced match for Medicaid is the next thing. We've tried to get 100 percent for the whole time, but we were not successful in that, but I'm happy to say we were able to get three years of 100 percent coverage for enhanced match for...and let me...it's newly eligibles. So this doesn't address any underfunding that exists in the underlying program, but it does provide for enhanced coverage for the new people coming on. And so the match for the new eligibles ends up being a 10 percent match for states after...2020 and after. Maintenance of effort, this was also something we had not lobbied for, but we got anyway. As you might recall in the stimulus legislation, they imposed a maintenance of effort on eligibility, which prohibits a state from making any changes in eligibility standards, methodologies, or procedures. They basically took the stimulus language and placed it into the new health law, so that we now have a maintenance of effort on eligibility that runs for nonmandatory adults up to 2014 and for children under age 19 to 2019. They also made a change in the CHIP Program, the

Children's Health Insurance Program, that really turns the CHIP Program into a grant...a condition to continue to get Medicaid funding. So if you were to eliminate your CHIP Program, you would not be able to participate in Medicaid. There is a state financial hardship provision that's in the health law. It requires...if you are to get it, the Governor has to certify that the state is in deficit or will be in deficit in the next budget year. And if you were to certify that, then the Secretary would then be able to allow you to get out from under the maintenance of effort for nonmandatory adults. The first opportunity to use this exemption would be this coming December. Now I can tell you that there aren't many governors that are anxious to certify that they're in deficit, since most states aren't allowed to be in a deficit, so that is problematic. Although there has been some interest in at least seeing what HHS was going to put out in terms of a template for a governor to fill out, we've not seen that. But I understand they are working on something that they will then make public, so that it would basically be something a governor would fill in and sign. And so we don't know what that's going to look like, but that should be available in the next month or so. There are several new Medicaid mandates. The first one is kind of interesting. It would phase in Medicare rates for primary care providers for two years, starting in 2013. And people ask why two years and it was financing basically. They didn't have enough money to put it in permanently, puts states in something of an awkward position because you're going to have this higher amount, and then you're going to either continue it or have to reduce it at the end of that second year. There is a provision that says that there's no cost-sharing for preventive services. There's a clarification about whether Medicaid services can be provided in a school-based setting, and they go, yes, it can be. And there's actually funding other places in the bill to facilitate school-based health clinics, quality measures for adult beneficiaries. Nonpayment for health-acquired conditions is something that your Medicaid agency will be working very hard to put in place. This is something that is a priority for the administration, and they had already put it in place for Medicare. They had encouraged Medicaid to do the same. It kind of left Medicaid vulnerable...in case something didn't get covered by Medicare, they might run it through Medicaid and...yeah. So there are technical issues about how that's going to be done because

Medicare and Medicaid don't always connect with each other about their payment policy and what they've done. But this is a...something that your Medicaid agency will probably talk to you about, and it's probably going to require some additional funding. There...state use of National Correct Coding which is a very techy thing that is supposed to go into effect October 1. I think that it might get delayed. There seem to be some issues about making it happen. But it's supposed to be basically standardizing coding for claims to help reduce fraud and abuse. Coverage for comprehensive tobacco cessation services for pregnant women, and background checks for direct patient access employees of long-term care facilities and providers. This is a fairly far-reaching provision that hasn't gotten much attention, but basically it requires both FBI and state background checks for any employee that has direct contact with a client in a long-term care facility or who is receiving long-term care services. So this would be your home health and some of those, and clearly, there are costs associated with this, and you have to decide how you're going to...whether you're going to charge the facility; whether you're going to charge prospective employees--how that's going to work. And also, there are privacy issues that you have to address, and so I suspect that most states will have to do some legislation in this area. [LR467]

SENATOR GLOOR: Joy,... [LR467]

JOY JOHNSON-WILSON: Yes. [LR467]

SENATOR GLOOR: Would it...is it going to disrupt the flow if we allow committee members to go ahead and start asking questions of you? [LR467]

JOY JOHNSON-WILSON: Oh, no, however you want to do it. [LR467]

SENATOR GLOOR: I'll...then let's do that. But before we do, we've had some senators who have been able to join us. Senator Nordquist is with us; Senator Pahls...or excuse...yeah, were you here? [LR467]

SENATOR NORDQUIST: I was here. Yeah. [LR467]

SENATOR GLOOR: I'm sorry. (Laughter) [LR467]

SENATOR NORDQUIST: Kind of hard to miss usually but (laughter). [LR467]

SENATOR GLOOR: Senator Hadley, I think, was here, too, so we won't reintroduce him. Senator Pahls, Senator Heidemann, and Senator Mello have joined us. Senator Campbell, you had a question. [LR467]

SENATOR CAMPBELL: Just a very quick question on that. Is...will it require an annual background check or...? As, I mean, in some of ours, we have it on like a three-year or a two-year. Do you know that? [LR467]

JOY JOHNSON-WILSON: I think there's some flexibility on that. There's been some discussion about having some sort of certification process, so that...that it would cover a certain period of time because they realize that a lot of workers in that industry switch jobs frequently, and they would be constantly being...having new background checks done. There is also the issue of interstate, and the FBI in two to three years will have something in place where you would be able to find out if a worker has a record somewhere else that's not in your state, and it would be a Web-based kind of thing, but it's not in place now so... [LR467]

SENATOR CAMPBELL: Thank you. [LR467]

SENATOR NORDQUIST: Just, I guess, real quick... [LR467]

SENATOR GLOOR: Sure. [LR467]

SENATOR NORDQUIST: ...on a previous point. On the maintenance of effort, before I forget, nonmandatory adults, would that be for expansion states that have already provided coverage to adults? [LR467]

JOY JOHNSON-WILSON: Well, the mandatory adults are disabled and, yeah, so it's the...it's mostly expansion (inaudible)... [LR467]

SENATOR NORDQUIST: Um-hum, okay. The states that have already...okay, okay. [LR467]

SENATOR GLOOR: Senator Heidemann. [LR467]

SENATOR HEIDEMANN: Going back to the changes, you said that for those eligible, there would be premium help. Where does that money come from? [LR467]

JOY JOHNSON-WILSON: That's federal money. [LR467]

SENATOR HEIDEMANN: Federal money. [LR467]

JOY JOHNSON-WILSON: Yes, the subsidies are federal. [LR467]

SENATOR HEIDEMANN: A hundred percent. [LR467]

JOY JOHNSON-WILSON: Yes. [LR467]

SENATOR HEIDEMANN: And you also said there would be people that wouldn't be eligible for an Exchange. Then they would be eligible for Medicaid. Who wouldn't be eligible to get into an Exchange? [LR467]

JOY JOHNSON-WILSON: If your income is over (sic) 133 percent of poverty, you are

ineligible for the Exchange. So, I mean, people below...at 133 percent of poverty and below are forced into Medicaid. [LR467]

SENATOR HEIDEMANN: Okay. [LR467]

SENATOR GLOOR: Senator Pahls. [LR467]

SENATOR PAHLS: Thank you. Since we are going backwards a little bit, just...just a really fast answer. On these Exchanges, what would be your recommendation or your thinking? Should it be set by the state, region, and do you have any preference? It'd be yours. [LR467]

JOY JOHNSON-WILSON: I'm not sure that I have an opinion yet. Here's my observation. Your choice is either the state operates the Exchange or you allow HHS to. We don't have any idea, at this point, what HHS has in mind if they were going to run the Exchange. So absent that, I think if I were a state, I would at least be looking at what I think I might would do if I were going to... [LR467]

SENATOR PAHLS: Okay. Thank you. [LR467]

JOY JOHNSON-WILSON: ...in absence of knowing what the other alternative would be. [LR467]

SENATOR PAHLS: Thank you. [LR467]

SENATOR GLOOR: Senator Mello. [LR467]

SENATOR MELLO: Thank you, Senator Gloor. Thank you, Ms. Wilson, for providing testimony.... [LR467]

JOY JOHNSON-WILSON: Oh, sure. [LR467]

SENATOR MELLO: ..and your expertise on this issue today. A couple of points just maybe to walk us through, so that we know, I guess, the time line, because I think that seems to be somewhat of a concern. [LR467]

JOY JOHNSON-WILSON: Yes. [LR467]

SENATOR MELLO: The increased FMAP eligibility for new Medicaid enrollees start in 2014. [LR467]

JOY JOHNSON-WILSON: Right. [LR467]

SENATOR MELLO: On the maintenance of effort issue, which I think is an issue that I don't think most people aren't as familiar with, the state of Nebraska can, under this bill, reduce our eligibility, our current eligibility which is at 185 percent, if we so choose, starting in 2014 for nonmandatory adults, correct? [LR467]

JOY JOHNSON-WILSON: Correct. [LR467]

SENATOR MELLO: So would it be safe to say that we as a state ultimately has the authority, while we do receive additional federal funds, 100 percent FMAP for people who are enrolled, that if we wanted to reduce our eligibility down to 150 percent, 133 percent is the floor, that we as a state ultimately could do that to, I guess, stave off any potential additional state funds that would need to happen after we see the 100 percent FMAP increase disappear, when it goes down to 95 percent and then 94, 93? [LR467]

JOY JOHNSON-WILSON: Oh, yes. [LR467]

SENATOR MELLO: Okay. I think that answers my question. Thank you. [LR467]

SENATOR GLOOR: I would ask a quick question. [LR467]

JOY JOHNSON-WILSON: Sure. [LR467]

SENATOR GLOOR: The healthcare acquired conditions, just to make sure I understand the definition, we're talking about acquired infections, wrong side surgeries, that traditional list of...yeah, okay. [LR467]

JOY JOHNSON-WILSON: Yes, and they're reviewing the list and expanding the list, so...yes. [LR467]

SENATOR GLOOR: Ah, that should have been my next question. [LR467]

JOY JOHNSON-WILSON: Yeah, so just...and there's certainly some issues surrounding that, but I think probably the biggest issue now is more operational in just how Medicaid and Medicare work together on this to make sure that there's not, you know, shifting costs between one and the other. [LR467]

SENATOR GLOOR: Okay. Thank you. [LR467]

JOY JOHNSON-WILSON: The next is a reduction in Disproportionate Share Hospital payments. I suspect you're going to hear from your hospitals on this one. I won't spend a lot of time on it. The reductions are significant. They begin in 2014, and the act does not say exactly how the reductions will be taken. That is left to the Secretary of HHS to determine, with some guidelines that are set in statute. So we don't really know exactly...there's no way to tell how your state would be hit. There are some suggestions about what they think are good ways of using DSH and bad ways of using it, and if you're using it in bad ways then you're probably higher up on the list for getting larger reductions. [LR467]

SENATOR GLOOR: It probably...since this is supposed to be an educational gathering, would be worth...if you can give a quick definition of disproportionate share. [LR467]

JOY JOHNSON-WILSON: Disproportionate Share Hospital payments are payments that are made to hospitals for services they provide to uninsured individuals and Medicaid and Medicare clients. So a hospital that has a disproportionate number of uninsured, Medicare, and Medicaid clients are eligible for these payments. [LR467]

SENATOR GLOOR: Thank you. [LR467]

SENATOR NORDQUIST: Real quick along those lines, as they prepared this legislation, did they do...I mean, the $14 billion that they're reducing...did they do any analysis on covering this many people? I mean, is that...do they think that much is going to be offset or more is going to be offset in covering these people and them not utilizing emergency rooms? [LR467]

JOY JOHNSON-WILSON: I'm not sure that's how they reach their numbers, but I'm not certain about that. [LR467]

SENATOR NORDQUIST: Okay. All right. [LR467]

JOY JOHNSON-WILSON: I think part of the assumption that they used, just to go to...I know some of the factors they use, they made certain assumptions about what they thought would happen to coverage through the provisions of the act, so they decided there would be a certain number less of uninsured people and that went into the calculus. Now how they arrived at that, you know, I think one could quibble but... [LR467]

SENATOR NORDQUIST: I'm sure there are no politics involved in it (laugh). [LR467]

JOY JOHNSON-WILSON: None, never. But that was part of the reason. Now there are some states that are very concerned about it because the bill does not...the law does not provide for any coverage for undocumented immigrants. And so it's not clear whether that went into the calculus on the DSH payments which help hospitals pay for some of those costs. So that is an ongoing issue for states that have large numbers of undocumented immigrants, particularly in the urban areas where it would affect some of their big public hospitals. So that's an issue that I think is going to be an ongoing issue, but since the reductions don't happen till 2014 it's not on the radar screen right now. There are a number of demonstration projects and I know eventually your Medicaid director will come and talk to you about Medicaid in detail. I just thought I'd mention what the demonstration projects were and there may be some interest in these. Mainly for states that are already doing something in the area, the demonstration projects may provide you some additional funding and structure for moving forward on things that you are already working on. There are a number of prevention and wellness provisions within the Medicaid Program. There is an incentive program which would require that you cover a very large number of preventive services, but if you were to do that you get a one percentage point bump on your regular Medicaid match for covering those. I already mentioned that there is a requirement that you provide comprehensive tobacco cessation services for pregnant women. There are incentive grants for prevention of chronic diseases that would become available next year. It's a promoting healthy lifestyles grant program. The state has tremendous amount of flexibility in what they would propose for funding for this area, so a lot of states were already moving in this area. I expect that a lot of states will seek funding for that. And there is now a new state option for medical homes. I know that this is something that a number of states were already working on. You needed a higher level, a waiver or something, to do it and now you can do it as an option, and I suspect that a lot of states will be doing some combination work with medical homes and the healthy lifestyles piece. And there's also a grant program that almost every state applied for on maternal and child health. It's a home visitation program. And, again, I would suspect that there would be some overlap

in what states do on medical homes, the home visitation, and healthy lifestyles granting. There are a few Medicaid long-term care provisions. I thought I'd focus on the Community First Option because your disability community is probably very excited about this. This would provide funding for home attendants, so not just home health but for...they would be able to provide activities of daily living, so that individuals who are disabled but would like to be in the work force but would need help getting ready, getting out, it would provide some funding for that. So this is the first big initiative in this area, and to say that the disability community is excited is an understatement, and I suspect that you will hear a lot about that. So I just thought I'd mention that. And also, there is a new federal office that is directed to find ways to improve the way that Medicaid and Medicare provide services to dual eligibles--people who are eligible for both Medicaid and Medicare. This is a longstanding problem. Some of the problems are statutory. Some of them are just people not talking to each other. The hope is that having one office that focuses solely on trying to identify the key issues and then how to resolve them will move...will improve the services for these very vulnerable people. So that office has been established. They just hired, I think, the person to run it. [LR467]

SENATOR GLOOR: Got a question here. [LR467]

SENATOR CAMPBELL: Can we go back... [LR467]

JOY JOHNSON-WILSON: Sure. [LR467]

SENATOR CAMPBELL: ...to the home attendants? There's been some discussion about whether the...when the disabled person would go out and work. Does the bill speak at all to the protection of their Medicaid coverage even as they start making more and more money? [LR467]

JOY JOHNSON-WILSON: I don't know if it goes beyond existing law that has some provisions for that. I'd have to check that. I'm not absolutely certain, but I can... [LR467]

SENATOR CAMPBELL: Because that's been an issue that has been discussed here in terms of what Nebraska allows and what some of the other states do, so I thought maybe the federal law just said, we're going to have a blanket; we're going to protect that income. [LR467]

JOY JOHNSON-WILSON: I don't know. I'll have to...I'll have to check that. [LR467]

SENATOR CAMPBELL: That would be great. Thank you. [LR467]

JOY JOHNSON-WILSON: And I will get back to you on that. CHIP, what happens to CHIP? We always get asked that. The CHIP Program...as you know, we struggled to get that program reauthorized even though it is very popular. This law extends the authorization till September 30, 2014. But there are provisions that would make it seem like the CHIP Program runs at least through 2019. But they didn't have enough money in the health budget to fund CHIP through 2019, so it is only funded through September 30, 2014, at which point we have a cliff. Should it be reauthorized, they've provided for a 23 percentage point bump for states between 2014 and 2019. People have laughed when I tell them that because they said, well, it's fine that they give us the bump when the program doesn't really exist. But I said, well, that's incentive for states to fight to get the program reauthorized. I assume that's there, but that is...that does exist. The maintenance of effort runs past the authorization for the program...yes, it does. I can't explain other than say that's what it does. And then we already mentioned that CHIP is now a grant condition for Medicaid. Now, one difference on the maintenance of effort in CHIP and the maintenance of effort on Medicaid. CHIP is a block grant program, so you get a fixed allotment. If in 2014 you have reached your allotment and there are more children that are eligible and applying for CHIP, they would be deemed ineligible for CHIP because there's no money, and then they would be able to be covered in the Exchange. Now, there is an assumption, there is a requirement in the law that when the Exchanges are in place that they will have child coverage that is at least as good as

what's in CHIP. And that's to ensure that any children that are getting coverage through the Exchange would not lose coverage if they went off of CHIP and into private coverage. So that's....that's that. There is a provision under previous law, the children of state and local government employees were not eligible for CHIP. There was a specific exclusion in the law for children of state and local government employees...did not apply to federal government employees, I might note (laughter). So they've put a provision in that opens the door a crack for state and local government...the children of state and local government employees, so that's in there. I don't know how many states would actually choose to participate, not...I don't know that anybody has run their numbers yet on that provision. But I just throw that out there that that's in there. I was in Mississippi last week and they informed me that they were the exception in that they actually...the kids of state employees in Mississippi were eligible to participate in CHIP because the state does not provide any family coverage. So they are one of, I guess, three states that either provide no family coverage or provide coverage that provides less than $15 of assistance to the family or something like that. So all the other states, that would be something that they might look at. So now I'm going to move quickly into employer responsibility because I thought I should mention since that's the major part of the law. I am not an expert on the employer responsibility section, but I would...I can certainly get back to you if you have more specific questions. But the gist of it is, if you are a business with over 50 full-time equivalent employees, you would then be part of the employer responsibility provisions of the bill. So what this says is that you need to provide coverage for your employees or you can opt to pay $2,000 per with...there's a 30 full-time employee disregard, so you get, you know, there's a little bit of give there but that's the gist of it. If you provide coverage, and there are requirements that you have to have coverage that's a certain actuarial value, so if you provide coverage and your people still wind up going and getting a subsidy from the Exchange, then there is a $3,000 per penalty which is capped. If you have a waiting period, there is also a penalty for that. Small businesses under 50 are exempt from the employer responsibility provision. They have put some things in place to encourage small businesses to provide coverage, the first thing being the small business tax credit which is available now. It is

run through the IRS, and so the information on the small business tax credit is on the IRS Web site, which is not where most people thought to go to look for it. But they do have a very good Web site which includes a calculator, so that if you are a small businessperson, you can run your numbers and figure out whether you think that it's worth you participating in the program. Now I have heard that if you are a owner-proprietor, that there are some difficulties with this that it doesn't really work well for you. But I don't know enough about that to...other than to say that that is something that you might want to seek some additional assistance from your accountant or someone on that. But... [LR467]

SENATOR GLOOR: You mean the calculations don't work well for you or the ability to...? [LR467]

JOY JOHNSON-WILSON: Right. It doesn't...the tax program doesn't benefit you. [LR467]

SENATOR GLOOR: Okay. [LR467]

JOY JOHNSON-WILSON: So...but for other people, I've heard that the Web site is helpful in making a determination of whether you think that it works for your particular company. On individual responsibility, there...on the employer part, they call it employer responsibility. On the individual side, they call it a mandate. And so you are required to have coverage, and it has to be...meet the minimum essential coverage requirements, but, of course, we don't have the minimum essential benefit package yet so we don't know exactly what that is. The penalties are financial. They are...it's administered by the IRS. They are extremely low to start, and they ramp up over time. A lot of people question whether the penalties in the beginning are high enough to really make people want to participate in health reform or get coverage. I think the...what the Congress decided is let's see how it works, and if it doesn't work then maybe they have to make changes. But the idea was that, hopefully, having affordable coverage available will get

some people to just go ahead and get the care. There are exceptions and exemptions to the individual responsibility provisions. The exceptions are religious objectors, individuals not lawfully present. As I mentioned, there's really no coverage for undocumented immigrants in this law and incarcerated individuals. Exceptions are for...if it's determined that the coverage is not affordable, and they define affordable as if the premium exceeds 8 percent of income, then you would get a hardship waiver. Taxpayers with income under 100 percent of poverty are excepted, members of Indian tribes. And if you lose coverage, you have three months to find new coverage before you would be subject to a penalty. It's kind of using the HIPAA standard. So... [LR467]

SENATOR GLOOR: Senator Nordquist has a question. [LR467]

SENATOR NORDQUIST: Yeah, related to this. So taxpayers with incomes under 100 percent of poverty are exempt, up to 133 percent of poverty are eligible for Medicaid. So largely, the newly eligible Medicaid population wouldn't have to get in Medicaid right away. I mean, they could... [LR467]

JOY JOHNSON-WILSON: There's no penalty for them not. [LR467]

SENATOR NORDQUIST: There's no penalty. So to assume 100 percent participation is probably not...I mean, people would be slow to...I mean wouldn't necessarily be in the program. [LR467]

JOY JOHNSON-WILSON: Well, and I think part of it is that they'd have a hard time enforcing on people who are not filing... [LR467]

SENATOR NORDQUIST: Sure. [LR467]

JOY JOHNSON-WILSON: ...so I think there was a practical aspect of that in terms of the way that the individual mandate is being enforced. [LR467]

SENATOR NORDQUIST: So...but it could be similar to what we have now in that there are a lot of people that are eligible, people are referring to them as woodwork--people that, they're saying, are going to come out and enroll. But these people may not necessarily because they have no penalty for not enrolling and may just not want to go forward with the enrollment process at this time until they need it. Is that...? [LR467]

JOY JOHNSON-WILSON: Right. [LR467]

SENATOR NORDQUIST: Okay. Great. [LR467]

JOY JOHNSON-WILSON: That's right. [LR467]

SENATOR NORDQUIST: Thank you. [LR467]

JOY JOHNSON-WILSON: That's going to be one of the issues that states will have to deal with in terms of whether they're going to aggressively go out and get those people signed up or not. [LR467]

SENATOR NORDQUIST: Okay, thanks. [LR467]

JOY JOHNSON-WILSON: I know that tomorrow you have your insurance commissioner, so I figured I wouldn't spend a lot of time on the insurance reforms, just to say that they're happening now and that much of the insurance reforms will have to be...the meat of how they will work is being done by administrative rule. And we are in that process right now, and it's a hairy process. And I did mention that...in the remarks that a number of Nebraska entities were approved for the early retirement reinsurance program, including the state of Nebraska, so that's a financial boon for those who got in and made application and filed those claims. There's only $5 billion for that program which is a national program. There's no cap on the number of applicants so I would say,

file those claims often and early because when the $5 billion is exhausted there is no more money in the pot, so. I'm going to skip the other insurance. If there's some question on the insurance provisions, otherwise I'll let you...I'll leave that to your insurance commissioner. [LR467]

SENATOR CAMPBELL: I'd like to go back to Senator Nordquist's question about the people who wouldn't necessarily come on until they needed it. [LR467]

JOY JOHNSON-WILSON: Right. [LR467]

SENATOR CAMPBELL: But if those folks start becoming more frequent flyers and emergency room...I mean, which is...what we've all tried to do through medical home and so forth, get away from that, is there anything in a law that would trigger someone talking to them about signing up for that, enrolling? [LR467]

JOY JOHNSON-WILSON: No. That's why I was saying I think that, in large part, this is going to be a state problem and that one of the biggest challenges for states in the Medicaid area is signing up the nontraditional Medicaid client. And I think that means that states are going to have to look at alternative delivery systems; they're more likely to want to go to ambulatory care rather than a private physician. Some of them do shift work and off-hours, and so I think states are going to probably have to lead the way in figuring out the best way to reach that population. [LR467]

SENATOR CAMPBELL: But nothing would preclude a trigger that a state might put into place. [LR467]

JOY JOHNSON-WILSON: That's correct. [LR467]

SENATOR CAMPBELL: Okay. Thank you. [LR467]

JOY JOHNSON-WILSON: Sure. So now we're on the Exchanges, and it's interesting that in the law there is...the law actually, at least in the beginning, required every state to put an Exchange in place, and through amendment it changed it to say...it didn't remove the requirement, but later on in a separate section it provides a way for the Secretary to run the Exchange in lieu of the state if the state chooses not to. So the original thought was that every state was going to run an Exchange, and then it occurred to someone along the way that perhaps not every state would want to or would, and then what would be...what would happen? So the way it is structured now, there is an assumption that states will run the Exchange in their state, but there is a provision that if a state chooses not to, for the Secretary of HHS to contract with some entity to run the Exchange in a state that chooses not to. So that's how that would work. The states have to declare whether or not they intend to actually administer the Exchange in their state by the end of 2012. Up until the last couple of weeks, HHS was assuming that state legislation would begin in 2012. I think upon reflection, they have figured out that perhaps states should start working on legislation on Exchanges in 2011. And so, as partially a response to their change in view, the planning money which was due to be available before March of next year, they've made available now so that states can begin to gather data and make some...do some just baseline research on (a) whether they want to do it, (b) how they might do it and where the people are in their state, and, you know, just get some idea of whether you would want to have one Exchange or to have regional Exchanges or, you know, just...so there the first $1 million of planning money becomes available this month. There will be a second round of funding sometime early next year, all of this designed to help states as they go forward in planning what to do about the Exchanges. And this second slide on page 15 talks about some of the requirements the Secretary has to do in terms of setting up certifications and standards and that kind of thing. The biggest issue outstanding, of course, is the essential benefit package. The law sets out some very broad parameters, but all the detail has to be worked out by administrative rule. But the essential benefit package, of course, will drive the cost of the premiums and cost-sharing and determines what exactly the coverage is and what's missing. And for states, it becomes particularly

important because every state has mandated benefits. This law does not preempt state mandated benefits, but what it does is it says if you have mandated benefits that are outside of the essential benefit package and you want to keep them, you have to pay for them. So that means that you would either have to pay the plan or individuals, which means that you have to find...get the actuarial value of your mandated benefits that are outside of the essential benefit package to make some assessment about the cost of keeping or eliminating some of your mandated benefits. So until we have the essential benefit package, you don't know exactly what you're dealing with. But for states that have a large number of mandated benefits, they can be fairly certain that they're going to have some decisions to make in terms of what to do there. And, of course, as you all know, mandated benefits don't happen overnight, and there are constituencies for each of those mandated benefits. So for state legislators, this is going to be a fairly interesting process. [LR467]

SENATOR GLOOR: There's a question, I think. [LR467]

SENATOR NORDQUIST: Just real quick, any idea on the time frame on when the regulations are going to be out on that? [LR467]

JOY JOHNSON-WILSON: Well, we keep asking and they keep saying, we're working on them, but I don't think they're working that hard on them right... [LR467]

SENATOR NORDQUIST: All right. You think by the end of the year or...might be...yeah, all right. [LR467]

JOY JOHNSON-WILSON: I hope that by the end of the year. [LR467]

SENATOR NORDQUIST: Okay. [LR467]

JOY JOHNSON-WILSON: Because like I said, it drives so many things,... [LR467]

SENATOR NORDQUIST: Yeah. [LR467]

JOY JOHNSON-WILSON: ...and it would be very helpful. [LR467]

SENATOR NORDQUIST: Sure. [LR467]

JOY JOHNSON-WILSON: But I think that particular rule is going to be...however many comments they've gotten on everything else... [LR467]

SENATOR NORDQUIST: It's going to be triple. [LR467]

JOY JOHNSON-WILSON: ...it's going to pale in comparison to the comments they get for leaving anything out of the essential benefit package. [LR467]

SENATOR NORDQUIST: Yeah, exactly. [LR467]

JOY JOHNSON-WILSON: So, but hopefully, by the end of this year. The Exchange plans, there are standard benefit plans in terms of actuarial value, and there are...I call them the precious metal plans. You know, it goes from bronze to platinum. And the key difference...the essential benefit package remains the same. The difference is cost-sharing. So the platinum is the closest to first dollar coverage in that, you know, your...it's a high premium, low cost-sharing plan. The bronze is low premium, high-cost sharing, so that's the trade-off. There also, as I mentioned, has to be a child-only plan that would closely mirror the CHIP Program. And late in the game they permitted a catastrophic coverage plan which was previously called the young invincible plan, but they (laughter) went for something a little more sedate in the... [LR467]

SENATOR GLOOR: They didn't define young by any chance, did they? [LR467]

JOY JOHNSON-WILSON: Pardon me? [LR467]

SENATOR GLOOR: They didn't define young by any chance? [LR467]

JOY JOHNSON-WILSON: Well, yeah. Well, now they have. [LR467]

SENATOR GLOOR: Oh, well... [LR467]

JOY JOHNSON-WILSON: Is under age 30. So this was a...so this is a plan that it has to cover the essential benefit health benefits, so the essential health benefits package runs through everything. They require that it at least covers three primary care visits, and the cost-sharing requirements are the same as those that are in current law for health savings accounts. And I've provided what that is below. So this is another effort to get people who would not normally purchase insurance to be able to comply with the individual mandate without having to spend a lot of money. In addition to whatever the states decide to do with the Exchange, there are a couple of...there will be this multistate plan that was the compromise on not doing the public option which you probably heard quite a lot about during the debate. So instead of the public option, which nobody was quite sure what that was, but instead of doing that, there will be a federal plan that will be offered in every Exchange. This would be operated by the Office of Personnel Management and would be patterned after the Federal Employees Health Benefit Program. So that is...so whatever your Exchange does, it's going to have one of those. And there's also the opportunity to have a cooperative, which is kind of a citizen-run health program, in each of the Exchanges. So in terms of the Exchanges, states have quite a lot of decisions to make. The first one is the threshold to do or not to do, and as I said, the real question is, no one is right clear at this moment on not doing what you get. So you give up control over the operation. But there are some reasons why a state might think about not doing it. There's this issue of, what kind of party do you want to have? You could do a state compact, which I understand some of western states are looking at because they feel that they would be able to get better participation

by insurers by grouping their populations. And I believe the National Association of Insurance Commissioners will be working on some model legislation to help states with that, probably not in the next few months. That would be kind of a second-tier thing once they work on model legislation for the Exchanges. There's a basic health plan which a state could operate. It would be a state-run plan for people with incomes between 133 and 200 percent of poverty. Some states are interested in doing that because they think people are going to move back and forth from the Exchange at that 133, and if they had something in between that would kind of stabilize; they wouldn't be moving those people on and off of Medicaid, that they would be in another plan that is more likely to get some of the working poor. And also for states that think they have a better idea and want to do it, there is a waiver provision in the law that becomes effective in 2017. The template for that should be available in 2013, I believe, and basically, this would be a state putting in a substitute program for the Exchange. The funds that you would have received...or your constituents would have received as subsidies through the Exchange would go to the state. This requires the state to enact legislation and to be able to demonstrate that the citizens would not lose coverage as the result of being part of the state alternative program. And, again, we don't know what that template looks like or, you know, they've not gone there yet. In terms of the Exchanges, a state could have more than one. And some states, due to their geography or to demography, are thinking about having more than one or substations or something like that. You must establish a board, and you have to decide who would be on that board and what the functions of the board would be. And then probably, one of the biggest decisions, if you decide that you're going to do an Exchange, is what kind of Exchange is it going to be? Is it going to be a one-stop shopping center and anybody who meets the minimum standards can play? Or you could decide that you're going to put additional requirements beyond what's in the federal legislation, so that in your Exchange you have to meet the minimum federal standards plus some other standards that you put in place to be a Nebraska Exchange, okay. Or you can go one step further and say, in addition to the standards...the federal standards and the state standards, we want to negotiate other things like rates or some other things in order for you to

participate. So states have a tremendous amount of flexibility on how regulatory they want to be with the Exchanges, what they want the Exchanges to do, how they want them to function. Every state will be required to have a Web basis for their Exchange. Many states will have to also have a system...a fairly rigorous system outside of the Web-based system because they lack broadband in large areas of the state and things like that which would make the Web base not terribly functional. And so I think that, of course, is one of the challenges of how do you...once you decide you want to do it, certainly the biggest challenge is getting the eligibility hardware/software functioning and training staff to actually run it and getting people where they need to be so that their information can be input. So that is a very huge challenge, and there is not money in the legislation for the hardware. There are hopes that there is some way to take high-tech act money, which is money for health Internet technology from the stimulus, and apply it to things that are needing to be done in the health bill. Exactly how that happens, I think, has not been determined, so that is certainly a challenge. And bigger than that is how will you pay for it? [LR467]

SENATOR GLOOR: Excuse me. We have a question from Senator Mello. [LR467]

JOY JOHNSON-WILSON: Oh. [LR467]

SENATOR MELLO: Ms. Wilson, I have a couple of questions real quick here regarding the Exchange and then another issue. From what you just explained, is it almost that the future of Medicaid really is going to be dependent upon whether or not (1) we choose to do an Exchange or how many Exchanges we might set up, since it's my understanding they're very cohesive, essentially? At least that's the way the bill was drafted, that the Exchanges in the Medicaid system are supposed to be able to be interchangeable? I mean, not...I shouldn't say the word "interchangeable" but... [LR467]

JOY JOHNSON-WILSON: Well,...well, they have to be interoperable,... [LR467]

SENATOR MELLO: Okay. [LR467]

JOY JOHNSON-WILSON: ...which means that if you're not operating the Exchange, whoever is will have some say about your Medicaid Program because they have to work together. So there's...so you have to deal with an outside entity to make the interoperability thing work,... [LR467]

SENATOR MELLO: Okay. [LR467]

JOY JOHNSON-WILSON: ...so, you know, because the Exchange and Medicaid are attached in that way through the eligibility process. [LR467]

SENATOR MELLO: Okay. And one other question. I looked at your slides here, and I wasn't able to find it and maybe it's...and if you don't have information or the perspective to share I can understand it, appreciate it. With the passage of the Affordable Care Act, I think there was a lot of information put out in regards to abortion coverage... [LR467]

JOY JOHNSON-WILSON: Yes. [LR467]

SENATOR MELLO: ...in regards to what the federal and/or state governments paid for comparable to if an individual chooses to pay for coverage on their own. [LR467]

JOY JOHNSON-WILSON: Right. [LR467]

SENATOR MELLO: Can you share with us what actually, I guess, from NCSL's perspective, what actually is covered, is not covered? You know is it just, I guess, from soup to nuts? Because I'm sure other colleagues of mine would like to know as well since it seems that there is a dearth of information from various perspectives on this issue. [LR467]

JOY JOHNSON-WILSON: There is, and there's really no agreement about what it says. Proponents...well, of the coverage would say that what's in there is that if you want abortion coverage through the Exchange, you have to purchase it as a separate rider and pay for it with a separate check, so to speak, so that that's the separation. Other people feel that that is not separation enough in that there is still federal coverage. But pretty much, that's what it is; that they isolated the abortion coverage so that you have to purchase it separately with a separate...there's a separate premium, I believe, so that, you know. But for some that is not separation enough. They still feel that that represents federal coverage. [LR467]

SENATOR MELLO: So how would that impact the...or how would that impact the state funds? There would be no state government funds then since this is being done through the Exchange, right? [LR467]

JOY JOHNSON-WILSON: Well, the subsidies for the Exchange are all federal... [LR467]

SENATOR MELLO: Okay. [LR467]

JOY JOHNSON-WILSON: ...so, and that's...so the Exchange...the subsidy program in the Exchange is federal funds. And so they're saying that even if you pay for the abortion coverage separately, you may be receiving subsidy funds for your overall premiums, and they feel like that's not separation enough. So, yeah, it's a very tough issue,... [LR467]

SENATOR MELLO: Okay. [LR467]

JOY JOHNSON-WILSON: ...and I don't know if there are likely to be any changes through regulation to try and address any of the concerns that have been expressed,... [LR467]

SENATOR MELLO: Okay. [LR467]

JOY JOHNSON-WILSON: ...but it's an ongoing discussion. [LR467]

SENATOR MELLO: Okay. Thank you. [LR467]

SENATOR GLOOR: Senator Nordquist. [LR467]

SENATOR NORDQUIST: Thank you, Senator Gloor. The speaker of the Utah House always says this when at conferences, that them and Massachusetts were the first two penguins to dive off the cliff and they weren't eaten,... [LR467]

JOY JOHNSON-WILSON: Yes. [LR467]

SENATOR NORDQUIST: ...so now the rest of us are going to dive off on this Exchange idea (laughter). And so, looking at those two states, they're very different in how they set up. Are there any lessons that we could learn from them? Can we look to them as models for this? Are there...I mean? [LR467]

JOY JOHNSON-WILSON: Well, Massachusetts is the closest to what the federal government is proposing. Utah does not meet the standard and won't...and may not be grandfathered. [LR467]

SENATOR NORDQUIST: Okay. [LR467]

JOY JOHNSON-WILSON: That's still being determined. Massachusetts will be grandfathered, we believe, although I don't know that that's happened yet. I think that they do have some lessons in terms of process. They have lessons in terms of working with the stakeholders. I mean, I think they certainly have...I think that Massachusetts

would say they didn't do enough looking at cost containment issues when they were putting their Exchange together, that getting the small business sector in is tough and takes a lot of work. And that small business needs a lot of assistance in this area, and part of the reason small business owners don't offer insurance--even the ones that could financially--is that they don't have the time to go through the whole vetting of plans and that kind of thing. So, you know, I think a lot of small business owners would say, if I had an HR person that could just do that, and so the Exchanges will have to kind of do that and make that...make it known that that's what they do. You know, I think the other issue that you..that will come up with the Exchange is the role of agents, and you're going to hear from the agent community. And there, I believe, probably is a role for agents because there's going to be...people are going to need a lot of assistance. People who have not been insured previously, maybe they're not low income; maybe...but they've just not had insurance. They could have been self-employed and just couldn't afford it, and they just paid for healthcare when they needed it. So there's a whole group of individuals who, for various reasons, have had little nexus with the insurance industry and health insurance and how it works. And so there's going to be a very huge education effort that's going to have to go on regardless of whether there's one-stop shopping. And I think Massachusetts and Utah can speak to that issue, that they've had to do a lot more in terms of marketing and education than they might have anticipated. [LR467]

SENATOR NORDQUIST: Uh-huh. Sure. I was surfing around on the Massachusetts...I think it's called the Health Connector Web site. [LR467]

JOY JOHNSON-WILSON: Yes. [LR467]

SENATOR NORDQUIST: Is that...are they going to be able to use that infrastructure that they've already developed for the...I mean, have they...have you heard any...? [LR467]

JOY JOHNSON-WILSON: We don't know and that's the other question that we've been...a lot of states and certainly if you have strong feelings about this, this is a good time to let HHS know. A number of states have said, rather than 50 states trying to develop some sort of infrastructure on this eligibility, if the federal government has an idea of what they think it should look like or want it to look like or have some specs or anything, that would be great, because then everybody could work off the same sheet and try to not reinvent the wheel 50 times. And we've not gotten any feedback on that other than, you know, we hear you. But that's a big question and it really is important before a state moves forward to know if there's going to be some sort of national uniform baseline specs or something, so that everybody can work off of that same piece. And the same thing on Medicaid. Are there...you know, is there something to work from? And I think that that's critical, especially given the very short time frame that we have. And you know, there are a limited number of vendors that do this work, and if it's going to have to be done for all 50 states, it would probably be easier if there was some standard. But right now, there isn't one and that's a question. [LR467]

SENATOR NORDQUIST: Sure. [LR467]

SENATOR GLOOR: Senator Pahls's Banking, Commerce and Insurance Committee has already had a hearing on the impact of the act, and the agents were in attendance... [LR467]

JOY JOHNSON-WILSON: Ah, I bet they were. [LR467]

SENATOR GLOOR: ...to a large extent, very much so. I'm looking at the clock, and in order to provide opportunity for a stretch break and people to visit the house of comfort and whatnot, I think I'd ask if you have some summation comments and points you'd like to make. [LR467]

JOY JOHNSON-WILSON: My last one. [LR467]

SENATOR GLOOR: Okay. [LR467]

JOY JOHNSON-WILSON: How are you going to pay for the Exchange? They have to be self-sustaining after the first year, so that means that you have to figure out how you're going to fund the operations of the Exchange after the first year. And so that is clearly something the Legislature will have on its plate. And just to note that the NAIC is working on what I would call a skeleton model act on Exchanges that they will make available to all states, and they will be doing...we hope to do some tandem technical assistance, NCSL and NAIC, for state legislators on their model act. And basically, what they'll do in the model act is extract all the requirements that the state legislation must have and kind of just...and frame it out but not put any of the bells and whistles. They'll leave that all for you to do. But that should be ready...they hope to have that ready by the end of the month. So I will stop there and... [LR467]

SENATOR GLOOR: We've got a couple of questions, Joy. Let Senator Pahls go ahead and then we'll... [LR467]

SENATOR PAHLS: Yeah, mine will be short. By looking at this and the information you're giving us, the Department of Insurance will need additional help because of just the...running this program or part of the Exchanges. Am I hearing that from you? [LR467]

JOY JOHNSON-WILSON: Let's just say that most of the insurance departments, when asked do they have sufficient resources at the present time to do all the requirements, they said no. [LR467]

SENATOR PAHLS: Okay, and...because that's the...the reason why I asked that question, because I need your help now. [LR467]

JOY JOHNSON-WILSON: Yeah. [LR467]

SENATOR PAHLS: Because in the past, the Legislature, and I have several people who sit on the Appropriations Committee, have been very...I shouldn't say, but they've taken a look at the cash fund for the Insurance Department, and they have been willing to take money from that. And I'm asking them that in the future they may have to rethink that type of thinking because the demands are going to be much more. [LR467]

JOY JOHNSON-WILSON: Right. [LR467]

SENATOR PAHLS: It's just an inside statement. Thank you. (Laughter) [LR467]

SENATOR GLOOR: Senator Nordquist. [LR467]

SENATOR NORDQUIST: Received. Joy, I know part of your job is...a big part of your job is federal relations. On the state waiver, it's a coverage waiver... [LR467]

JOY JOHNSON-WILSON: Yes. [LR467]

SENATOR NORDQUIST: I know...I think I read Senator Wyden is trying to get that moved up. [LR467]

JOY JOHNSON-WILSON: Yes. [LR467]

SENATOR NORDQUIST: Is there any movement at all, any potential that that would...? [LR467]

JOY JOHNSON-WILSON: I have met with his staff, and they are most anxious to find some...put a coalition together to try to move the date up from 2017 to some earlier date yet to be determined. And he's talking to a number of members. I think now he has to

see who's left in the Senate when...after November to really move forward on that. But there is some interest in moving the...to make the waiver more...something that's more reasonable for someone to do. If you've already got...put everything in place, it's unlikely that you're going to move forward on a waiver. So we've talked to him. We told his staff when they are ready to put something together and move forward, to let us know because we know that there are states that are interested in at least looking at the waiver idea. [LR467]

SENATOR NORDQUIST: Great. Well, I'd like to thank you and NCSL for allowing you to come. I know she's been on a whirlwind tour of states for the last couple of months, so... [LR467]

JOY JOHNSON-WILSON: (Laugh) Well, it's my pleasure. I always learn a lot when I come to the states, too, so that's helpful to me. [LR467]

SENATOR NORDQUIST: Thank you. [LR467]

SENATOR GLOOR: And I would add my thanks. This is the second time I've had a chance to hear you and both times have been equally beneficial to me, and I'm sure to other committee members so... [LR467]

JOY JOHNSON-WILSON: Well, thank you. And as you all know, you can call me anytime so... [LR467]

SENATOR GLOOR: Time of day or just anytime? (Laughter) [LR467]

SENATOR CAMPBELL: Be careful what you ask for there. [LR467]

JOY JOHNSON-WILSON: Yeah, I'm going to stop there (laugh) and... [LR467]

SENATOR GLOOR: Thank you, Joy. We'll take a short break and please try and be back here as... [LR467]

BREAK

SENATOR GLOOR: Who's here...thank you for your interest, Senator Wallman. Is there another state senator I have overlooked? I should have said this at the beginning; I'll say it now. Please check your phones (laughter) and put them in the silent position or better yet just turn them off. Our next half of the morning will be a bit of a juggling act. Oh, and by the way, I want to make sure I don't forget to thank counsel for the committee, Michelle Chaffee, for taking the time to help get this organized. I think we have had a very productive session so far, thanks to Joy, and I have no doubt the rest of the day will continue the same way. It's going to be a juggling act. For benefit of the senators, and I'll try and get the ear of the senators who haven't been able to make it back yet, the university has set up a process in this presentation with four different areas covered by our four different presenters. If you absolutely have to ask a question, feel free to go ahead, but I think we'll find it more beneficial if we can take notes on a question we may have. It may be addressed by another presenter. Hang on to those questions--that way we'll also have a better idea of how much time we have at the end for questions. So with that, again, I'd ask presenters, Mark, if you'd introduce yourself, spell your name for the record and we'll start. Thank you. [LR467]

MARK BOWEN: (Exhibit 2) Thank you. I'm Mark Bowen, M-a-r-k B-o-w-e-n. I'm director of Government Relations for the University of Nebraska Medical Center. We have been a group of us, representative group of us as folks from the University of Nebraska Medical Center, the Nebraska Medical Center Hospital, our partner, and area business folks have been meeting on the legislation and now the law for about 17 months as it evolved from the five bills that it had started out as to the two bills it ended up as, which ended up being, as Joy described, the ACA package. It has gone through many turns during those 17 months. Our goal has been to look at it from a variety of points of view,

because we have a variety of things that we provide as service, as we are both a major employer, we are a provider of health delivery services, and we are the academic health center, the only academic health center for training most of the health professionals in the state of Nebraska. So we took a broad picture view and have maintained that view and continue to maintain that view as we look at the law and the opportunities within the law. This morning, we thought we'd break it into a couple of parts. I'm going to do a...sort of a...little bit of an overview. I'm going to talk about some of the things that Joy brought up with a little different aspect, and then I'm going to turn it over to Cory Shaw, who's with a physicians group, and he'll talk about delivery and some Medicaid issues related to delivery from our points of view. We will then turn to Pam Bataillon, assistant dean of nursing, and Tom Tape, Dr. Tom Tape, who's in general medicine at the University of Nebraska Medical Center, deals with family practice primarily and primary care primarily. So let me just start there. Implementation and time line, there is a fairly long implementation period for this bill. It started this year, but it's going to go for many years. The most important year is probably 2014, when the bulk of the bill begins to be implemented. So there's a lot of planning period between now and then to do things and to get ready for things and to make a lot of decisions, as Joy described. Some of those things have already happened. We've seen some of the insurance changes already occur this year. Some are starting to occur actually, officially, after tomorrow. The most common one we hear asked and we're asked about most commonly is the age 26 on being able to maintain adult children on a parent's policy. I'm sure that that will be talked about later with Ann tomorrow, but most commonly the question is, well, when will that happen; when can I get my child back on the policy that we had them on? And for most individuals covered under a current policy, we understand that will happen as part of open season for the employers when they offer that. So that will be between now, starting tomorrow and the end of the calendar year. From our point of view on time line, there are a couple of factors that come into play from previous legislation, such as the stimulus bill, and some of the things that are established as baselines that we'll have to start dealing with from this point forward, such as quality reporting. It's an important issue for providers, hospitals in particular, that their quality of reporting standards are

geared toward the quality outcome that they want for their patients. Those reporting standards will become the baselines that we are reporting right now and will be stepped up during the next few years. As the service reimbursement changes from being a service...individual item service reimbursement to a quality outcome performance-based payment, those standards will become a factor of whether we'll receive additional reimbursements or less reimbursements, so that's an important factor for us. The quality standards, we all agree need...we all strive for the same thing which is the best outcome for the patient himself. But in terms of time line, we'll start seeing those changes from this point forward. By 2014, we'll start to feel some of the effects of are our standards and performance measuring up to the reimbursements we'll receive? There will be issues that will pop up for providers, such as if patients are readmitted too soon after leaving a hospital, was it because of something that happened, a hospital infectious disease or an infection that occurred during the hospital stay? That may affect if there's an additional reimbursement or not. It's getting to the outcomes. Everything is outcome-based, so we'll keep our eye on those. Tied to that, another item which really started in the stimulus bill was the electronic medical records. There was a lot of money in the stimulus bill to allow people to begin preparing for electronic health records. That's great. That's going to be viewed and is viewed long term as a cost saver for everybody. But, again, you've got to prepare, you've got to get the standards in place, everybody has got to be on the same page. That's taking time. Stimulus dollars provided some of that to get ready for that. As we move toward health reform, the standards of electronic records will be an asset, both efficiencywise and dollarwise, down the road, but we all have to get to the point where we're all using them. Here in Nebraska, we've got sort of a jump on that with NeHII and other folks in the state who are dealing with trying to prepare for electronic health records; that will be an asset. The reason I bring both of those up is because those both require a lot of collaboration, and that's occurring in Nebraska. Nebraska has got a good reputation for being in partnerships and collaborations. I think that will play well for us as this implementation period plays out for the next four to seven years. Another time line feature which is important to us as a medical institution is, this bill reauthorized the Title VII aspects

which are the federal ways that we pay for residency training programs for graduate physicians. This bill reauthorized that. It had been delayed in being reauthorized, and it's such an important provision that it was included in the bill for academic medical centers. Joy talked about some of the changes that are underway so I won't repeat those things. I just came back from a meeting in Washington where...it was a national meeting of academic medical centers, and got a chance to hear some of the things going on in other states. And in my readings, as well as hearing the folks from the presenters at the meeting, it became clear lots of states are starting in at about the same place we are. About 40 percent of the states are organizing some sort of more formal task force committees. Many times the academic health centers or the health institutions, the hospital associations are involved. I don't know what's going to...how it's going to evolve in Nebraska yet because we're just in the process at the beginning of this work. But the message I would relay is the sooner we get started probably the better off we'll be and the fact that we have a good reputation for collaboration, probably the better off we'll be. But we'll probably need to get started sooner than later. (Intercom announcement) [LR467]

SENATOR NORDQUIST: We were under a lockdown for a while, so... [LR467]

SENATOR PAHLS: We're inside (inaudible). (Laughter) [LR467]

SENATOR NORDQUIST: ...maybe they didn't want to tell us if we were going to leave (inaudible) under lockdown, but it's been resolved so... (Laughter) [LR467]

SENATOR GLOOR: With that deep sigh of relief, go ahead, Mark. [LR467]

MARK BOWEN: Thanks. It's okay. Implementation, you know, as a group is assembled, I think, in our reputation as a state it should be broad-based. We think that would be the best for overall implementation and I'm sure that's on everybody's mind how to make it that way. As far as the Exchanges, they're also an area that will be a very important

area for all states to deal with, us in particular, because we'll have to sort out what's the best solution for Nebraska. I know the state of Nebraska is starting to wrestle with that now. They applied for the planning funds to start working on that process. From an academic health center point of view, again, it's going to take collaboration to keep those kinds of things in play. From the academic health side, from a hospital writer side, the DSH payments were mentioned earlier, that is a very important factor for hospitals that deal with large numbers of uninsured, low insured, Medicare, and Medicaid patients. As Joy started to describe, it's important because there is going to be sort of a transition that occurs because the logic was, as more people become insured, there will be less of a need for those DSH payments. But there's going to be that transition, and the assumption is insurance coverage will rise at the same rate that DSH payments might reduce, and this is all going to be determined by federal regulation. It's not specified directly in the bill, so we'll see a lot of regulations and draft regulations coming out from HHS on this. But academic centers and hospitals are all going to watch to see, is that transition occurring in balance. And I think that's why it's one asset to have that in regulation because HHS can adjust that if they're going to have to. And I can tell you based on the meeting I came back from, everybody is going to be watching that; they want to make sure that that transition occurs so there isn't a cash flow problem that occurs. It's going to be different in different parts of the country, but that's going to be a very important issue as we just make the transitions here. We can anticipate from the meeting I just came back from that the draft regulations will probably be issued on essential benefits package some time later this fall. The meeting I was at yesterday, they referenced probably November for the drafts. They suspected--and these were HHS officials addressing this--that we would probably see the drafts come out in November. We would probably see finals come out in spring. They didn't specify a month, but some time in the spring. And, again, as Joy described, because HHS is trying to give as much time to everybody to make their decisions about Exchanges, that's a key part of it. And deadlines are quite short in many cases, so everybody has got to pay attention, which is why the conversation between all of us has to keep going on and continuing. Same thing is true, as Joy also mentioned, between Exchanges and

Medicaid. You can just tell the way this bill is established. It is encouraging communication. The fact that Medicaid and Exchanges maybe have a lot of interplay is important. There are some efficiency aspects that it appears, by the bill drafters, that's what they were going for to make it more efficient and to make it more cost effect. So that exchange between a collaboration on both those entities, as well as the partners and the stakeholders in those areas, have to deal with each other directly. In my testimony, you'll see there are a couple of questions about the policy levels and I have one chart in there to give you an idea of the different standards for the bronze, silver, gold, and platinum, as well as the under-30 option that was mentioned earlier. The one comment I will add is the questions that come up regarding abortion, as we looked through the bill, it does appear that the state Legislature will have that option to decide that based on what they want to do with the Exchanges. They can allow the coverage to be covering abortion or not; that will be a state option, so that will come to your plate in some fashion. I'm not sure how it's going to end up on your plate, but it'll be brought up for you guys to deal with. More importantly than anything--and this will be my last area before I turn it over to Cory--is opportunities for collaboration and grants. While this bill or sets of bills is largely an insurance reform bill, throughout it there are many opportunities for benefits for health changes and for health improvement. We have identified dozens ourselves. We have already applied for eight. We have noticed that because of the deadlines in some cases, the turnaround time for submitting grants is very short so far. We think that might stretch out after the beginning of the calendar year as things sort of settle down with some of the regulations coming out. But, again, we see a variety of opportunities here for Nebraska to benefit healthwise as well as policy and programwise. There are opportunities within grants, within pilot programs, within demonstration programs. They're in the areas of workplace wellness, medical home possibilities, rural physician training, nurse-managed clinics, work force planning grants that deal with chronic conditions in some cases. There are just a variety of things. What we've looked at--and we do a lot of grant writing at the University of Nebraska Medical Center so we pay attention to those details--what we've noticed is that the eligibility, the eligible applicant is not always an academic institution. It may be a community college.

It may be the state of Nebraska. It may be a nonprofit. It may be a hospital. It may be any of the combination. Collaboration is going to be very important as far as we put together grants. We've already reached out to others and we've had people ask us if we're willing to participate in collaborations and the answer is, absolutely. These are opportunities where we should work together, but so far the turnaround times are fairly short so we need to be organized. If there is some effort to try to do that more efficiently or more formally, we'll be willing to participate in that because we can see how this can benefit the state and the patients as well. So the message is, be open to collaborations. Along with that, in the conversations we've had with individuals at CMS, and it was mentioned throughout some of the discussion during the consideration of the bill, the Center for Medicaid and Medicare seems to be open for the request for waivers tied to some of those applications. They've sort of indicated informally that if, as a part of a grant application or a demonstration program or a pilot within what you want to propose, you see a need for a request of a waiver, they will be open to that as a part of the innovation, as a part of a cost-saving idea. One of the things that will be brought up later is ACOs, accountable care organizations, and some of the benefits there is that you share in the savings you create from your program. That seems to also play out through some of the grants that are being written or being talked about, and we'll see the regs when they come out. So, again, that's collaboration. It's going to take that kind of working together to make all this work efficiently. And I think, you know, based on Nebraska's history, we can do that. I think I'll stop there and turn it over to Cory Shaw with the physicians group. [LR467]

CORY SHAW: It's C-o-r-y S-h-a-w. My name is Cory Shaw. I'm the CEO, UNMC Physicians. I work for... (Intercom announcement) [LR467]

SENATOR HADLEY: We know that. Senator Heidemann is here. [LR467]

CORY SHAW: (Exhibit 3) I work for 550 physicians at the Med Center and, as you can imagine, they all have strong opinions about the current status of our healthcare

delivery system and the way that the system is financed. What might surprise you, or maybe not, is that there's not unanimity among those 500 physicians about what the right answers are in terms of how to move forward, and that's probably a fine example of the way the healthcare industry and really our society at large is trying to tackle some difficult issues around delivery and financing. I've presented some testimony. Rather than repeat some of the things that Ms. Wilson commented on with respect to Medicaid and I know Director Chaumont will touch on later this afternoon, I'm going to point out maybe just a couple of items that are really germane to Nebraska that I'll highlight for your attention that is worth having on your radar screen as things start to roll out here over the next couple of years. Very clearly this is a complicated bill. And when we started our work 17 months ago, we thought it was challenging to track five different bills and the politics around each one. Frankly, that was easy compared to trying to speculate and anticipate what's going to happen in the rule-making process around each of the individual provisions that are embedded in the bills that are now law. And I think one of the most frustrating things that we feel as a provider community, and I think frankly senators in Nebraska and also around the country are trying to figure out how to best manage this going forward from a state perspective, is trying to anticipate what might or might not come out of that rule-making process. And I think Mark's point early on around making sure that we collectively work together as a state--the executive branch, the government, the Unicameral, the private provider community, as well as insurers in the state, along with constituents--make sure that we are staying focused on those things that are particularly important to our state is going to be critical. I'll touch on the DSH payments just as an example of how Nebraska as a state can potentially be affected both positively and negatively based on the way that those DSH payments are phased out over the next several years. As we talked about, I'll start with Medicaid, the expansion of Medicaid, we've talked about the numbers in terms of federal poverty limit figures. Just to put that into perspective, according to 2008 census data, there are about 310,000 Nebraska residents with incomes up to 133 percent of the federal poverty limit. Now, again, that's not adjusted for the 5 percent income level that's exempted so that number probably creeps up a little bit, but that's the data that's available out of the

census currently. What's interesting about that population is that they're roughly equally distributed among three categories as it relates to health insurance coverage. About a third of those individuals are covered by Medicaid, about a third are covered by some form of private health insurance, either acquired through an employer or through individual coverage, and about a third are uninsured. It doesn't fall out exactly along those lines, and interestingly enough, maybe not surprisingly, in Nebraska, a slightly higher percentage of those individuals are actually...enjoy private health insurance today and a corresponding smaller percentage are enrolled in Medicaid. So we have a higher proportion of private health insurance penetration in that population in the state today. All of those individuals, excluding those that are undocumented residents, will be eligible for Medicaid under the new program. And one of the questions that obviously is weighing heavily on everyone right now is how many of those folks will wind up enrolling in Medicaid and how many of those folks will, because of the individual mandate, elect to take advantage of employer-offered coverage who haven't up this point. And that's really an open question for debate and the variables that will influence what ultimately happens with Nebraska Medicaid versus private insurance in the state, you know, are going to revolve around those residents who are currently eligible who have not elected to enroll in Medicaid--I think Senator Nordquist touched on those individuals, folks that are newly eligible for Medicaid but are currently buying private insurance through individual programs or through their employer, and the newly insured residents or newly eligible who are currently insured are going to all influence what happens. What happens with those individuals is anybody's guess, frankly, at this point. The impact of employer tax credits and penalties is certainly going to play a role in that, as well as how we approach enrollment in this state. One thing I'd point out with respect to that question is that right now providers in this state generally are very active with respect to enrolling patients that they identify as Medicaid eligible once they touch the healthcare system. We have a small army of people at the Med Center, frankly, who spend quite a bit of their time working with patients who have a clinical need to help them access all of the public programs that they might otherwise not be aware of. And so there is already some of that mechanism built in to the delivery system. But certainly, as the Exchange

rolls out, there's going to be a greater need for that kind of activity happening before someone needs healthcare, and that's a critical consideration, I believe, for the state. I'll just touch on one other item with respect to Medicaid that maybe was touched on but needs some further expansion. Currently, about $28.5 million of payments were made to Nebraska hospitals under the DSH Program, and those are the dollars that we're talking about being at risk or being phased out as health insurance coverage is implemented. And we've talked about the match between the expansion of coverage, the reduction of the number of uninsured that hospitals care for. (Intercom announcement) [LR467]

SENATOR GLOOR: We would like to. (Laughter) Let's hope the third time is the charm. [LR467]

CORY SHAW: That's right. [LR467]

SENATOR GLOOR: Go ahead. [LR467]

CORY SHAW: One thing that's important to note is that there are a whole bunch of other providers in the state who care for uninsured and Medicaid patient populations and a disproportionate number, and the payments today that are going to hospitals sometimes wind up supporting those other providers but most often don't. And in addition to those DSH payments being distributed or used for funding other things, they're going to be diluted. I mean, the fact is that physicians, community-based pharmacists, federally-qualified health centers, and others who are currently caring for uninsured or Medicaid patients are going to actually be the beneficiary of redistribution of some of those DSH funds. So it's not just a matter of a one-to-one, hospitals end up with less uninsured burden and that can offset the DSH payments. The fact is that those DSH payments that are today going to hospitals are actually going to be distributed across a broader provider community, which poses some significant challenges for hospitals because I'm relatively confident that my hospital counterparts would tell you

that they don't anticipate all their DSH payments being replaced by funding from the expansion of either Medicaid or the expansion of private insurance through the individual mandate and the employer responsibility portions of the act. So I think that's an important consideration from a Nebraska standpoint, because certainly, when you look at the hospitals that are affected by that, it's those hospitals that are currently bearing a significant burden with respect to taking care of those patients, not just in Omaha. But clearly in Omaha and Lincoln and the rural communities outside and throughout the rest of the state, it's an important consideration for those on a local level. This is...the Medicaid law is complicated and I emphasized that at the beginning. There's a heck of a lot of work to do in the coming months to make sure that we stay on top of how CMS makes rules and, specifically, how they're going affect Nebraska. And I think Mark highlighted the fact that it's going to be critical for us to work together on both public and private entities to ensure that we understand those rules and how they affect Nebraska and how we respond together. What I would offer, and I think what Mark said before I'll say maybe a little more pointedly, is that you all are going to have questions that arise as you try to make policies around Nebraska's response. And it's difficult to cover the waterfront and hit each of the specific issues that you may have. And I guess I'd encourage the committee, as you develop questions, to engage us with those specific questions and give us and others that we can work with an opportunity to research each one of those questions in a little bit more detail, specifically as it relates to Medicaid and on some of the other issues. Let me touch and transition for a moment to the whole notion of accountable care organizations, because, frankly, we can talk at length about reforming the financing portion of the healthcare industry, but if we don't change the way the system delivers care, insurance costs what healthcare costs, and the reality is if we're not more effective as consumers and as deliverers of healthcare, we won't bend the cost curve, to use the term that was bandied about quite a bit. And one of the organizational vehicles that has been enabled in the act is the accountable care organization. You've heard quite a bit about it. It's maybe helpful to give a little bit of background on the concept and where it came from. Dartmouth researchers, who have done quite a bit of work on regional variations in healthcare spending, conceived

of accountable care organizations or conceptualized an accountable care organization in about 2005, 2006, and it grew out of their attempt to come up with a way to explain and then also come up with a mechanism for managing those regional variations. If you don't know or aren't familiar with their work, they have done a pretty nice job of demonstrating that, depending on where you live, as a Medicare beneficiary, the cost to care for you varies significantly without any direct relationship to the underlying burden or illness burden that that population carries, suggesting that there's differences in the way providers deliver care. Not surprising, but the differences are astounding in some instances, sometimes two and three times when you look at regional variations across the country. Their concept of an accountable care organization is to try and align physicians and hospitals and other providers around a single purpose, and that is to...a dual purpose, which is to improve quality and reduce expense primarily by reducing variation. There's been a lot of talk about whether or not accountable care organizations are a redact of what went on in the early 1990s as part of the last attempt to reform healthcare and also some of the work that was done with health maintenance organizations in capitation. And to be perfectly honest, depending upon how their implemented as we move forward, there's not a lot of difference. You're talking about a funder, whether it be government or an employer, passing premiums to somebody, whether it be a health insurance company or a organization of providers, hospitals, and physicians, and asking them to take some or complete responsibility for not only the clinical quality but also the fiscal outcomes of taking care of that patient population. The current act, as it's written, really focuses on what I'd call physician-centered organizations as the vehicle to do this, either group practices, networks of physicians that are in independent practice, and then hospital physician partnerships, then health systems that actually employ physicians. The challenge is, as mentioned earlier, is the regulations are undefined at this point. But I do think that as a state that there are some opportunities for us to rethink how we look at the relationship between payers, hospitals, physicians, and government as it relates to managing care. But one of the challenges we've talked about, and I think it's important to consider the opportunity for a waiver and pilot programs was discussed, is one of the challenges that a physician practice faces,

whether it's trying to manage diabetes or managing...with an individual patient or multiple patients that have diabetes, is the fact that they may have 100 diabetics in their patient population; 25 of them might be Medicare enrolled; 15 might be Medicaid; 10 Blue Cross; 10 United HealthCare; 5 Coventry; whatever. Each one has different rules and the expectations around what they want for that patient population. And as we think about trying to actually be serious about changing the way we deliver care, I think the opportunity that exists for us in the state is to look at how we can help systems, physicians, other providers, federally qualified health centers disengage as much as they can from the concerns about who the payer is and focus more on what do we want in terms of outcomes. So, for instance, if this state were to say that we're going to work towards developing a program that...with dual eligibles, that we manage our Medicaid and Medicare beneficiaries in the state who have diabetes and set these kinds of outcomes and targets and engage providers in that discussion, I think we can actually demonstrate some significant improvement in care. And the good news is that the Accountable (sic) Care Act gives us some latitude at a state level to start thinking about those things. The challenge is, it's not easy and it's new work; it's going to require some investment. And the practical reality that we face right now is that much of the capital to invest in these initiatives are tied up in hospital balance sheets and insurance plan balance sheets. And that's not meant to be critical; it's just a recognition of where the capital today that's available to invest in new things is largely held from a healthcare delivery system perspective. And so it's going to require, despite the fact that the act is very focused on physician organizations and medical homes being the vehicle for managing care, most physician practices, whether they're 2 physicians or a 500-physician-group practices, don't have the infrastructure that's in place or that's needed to be in place in order to manage care longitudinally, whether it be health information technology, whether it be the necessary management skills, or just changing the way care is delivered. That's going to be a challenge for us and one of the things, I think, from a state perspective we need to tackle. The notion of exercising the opportunity that's there, it's created by the act to improve interoperability between private insurance and publicly funded care, and particularly that Exchange is something

that we ought to look long...take a good, long, hard look at as a state. Again, trying to make a physician's practice environment a place where they can worry first about managing the care of a patient population, whether they are funded by Medicaid or funded by private insurance, is really, I think, a critical goal for us that we can tackle as a state going forward, so...I'm certain you've got several questions. I'm going to go ahead and step out and let, I think, Pam, are you going to come next or Tom? Who's going next? And we'll answer any questions you have at the end. Thanks. [LR467]

THOMAS TAPE: Good morning. [LR467]

SENATOR GLOOR: Good morning. [LR467]

THOMAS TAPE: (Exhibit 4) I'm Thomas Tape, T-h-o-m-a-s T-a-p-e. I'm a general internist at the University of Nebraska Medical Center, and I'd like to share some of my thoughts on the primary-care work force issues facing the state of Nebraska and how that's likely to be impacted by the passage of the Affordable Care Act. Just to take a minute to define primary care, this is one of those words that gets bandied around a lot and people sometimes say, well, I know it when I see it but I can't define it. It's, I think, best defined as a usual source of healthcare that provides first contact, comprehensive, longitudinal, and coordinated care. In this increasing era of high-tech medicine, people sometimes wonder, well, why do we need primary care anyway. But there's growing evidence that having a primary-care provider actually results in better healthcare outcomes and lower costs of care. The Health Affairs journal in the May issue was almost entirely devoted to primary care, the issues that we're facing with the growing shortage of primary-care doctors. And in that issue, they reviewed the literature on the benefits of primary care, and I would draw your attention to that. They found better preventative care, better patient satisfaction, lower costs of care, lower utilization of the emergency department, and better quality measures on several chronic diseases. Primary care offices are simply set up to keep track of patients better than a specialist who's focused on one particular area. Indeed, in the American Journal of Medicine in

2008 there was a very interesting study that simply looked at the major metropolitan areas of the United States, and they compared the percentage of physicians in that metropolitan area who were primary-care physicians with the utilization of services. And what they found is if you could take an average-sized American city--which just by coincidence happens to be about the size of Omaha--for every 1 percent increase in the proportion of primary-care physicians, there was an associated decreased yearly utilization of over 500 hospital admissions, almost 3,000 emergency department visits, and 500 surgeries. So the evidence is clear that having a strong primary-care infrastructure is a good thing for our country. Unfortunately, our primary-care infrastructure is going in the wrong direction. The American Association of Medical Colleges, the AAMC, recently reported that although 35 percent of the physicians in the United States are currently practicing primary care, if you look at where are the recent graduates going, only 20 percent of residency graduates are choosing to practice primary care now. This is clearly an unsustainable trend. And the AAMC predicts that by the year 2025 the national shortage of primary-care docs will be between 35,000 and 44,000. Nebraska has not been insulated from this trend. The rural nature of our state creates additional challenges. As you're well aware, although 42 percent of the state's population is rural, only 28 percent of the physicians in this state actually practice in a rural area. There's only 3 counties--Douglas, Lancaster, and Scotts Bluff--who have a provider-to-population ratio that's better than the national average, and 51 of our counties are designated health professional shortage areas for primary care. And the Medical Center has been aware of these trends and been trying to address these trends now for some time, and we've been successful in increasing the enrollment across all our professional schools. This year it was up 7.7 percent. But I think it's worth pointing out that training a healthcare professional is a long process and it's going to be years before these newly enrolled students are fully trained and ready to enter the work force. And we also have to help these students appreciate the value of making a choice to pursue a primary-care career as I'll get into a minute. Even though we're training more students and enrolling more students, it doesn't guarantee they're going to end up practicing the kind of care that's most needed by our state. So why are trainees

choosing to practice something other than primary care? It's a complicated question. It's hotly debated. But from someone who sees what primary care is like on a day-to-day basis in the trenches, I can tell you that it's a tough career and it's getting tougher every day. Number one, and I think the most important factor is, there is a huge financial impact for physicians who choose primary care over some specialty practice. Again, in that May issue of Health Affairs, there was an analysis of what would be the lifetime financial difference between a cardiologist and a primary-care doc, and it amounts to, at a conservative estimate, $3 million. So if you're coming out of medical school with a substantial debt, and amongst my students being $200,000 in debt--mind you, that's going to the state school, private school debts are higher--and you see that there's an ability to retire that debt in a reasonable amount of time by specializing versus spending the rest of your career trying to pay off the debt as a primary-care doc, our students aren't ignorant of these facts and many of them are simply going to where the money is. But it's more than money. The practice of primary care, due to the peculiar way our health system is involved to pay for services, isn't well-aligned with taking good longitudinal care of patients. You've heard about the idea of the accountable care organization taking responsibility for the care of a population. The way our system is financed now, all you get paid for is when the physician or the mid-level provider has a face-to-face encounter with the patient, and so doing things that will benefit the health of the population outside of that face-to-face encounter aren't paid for in our current system. This is one of the things that's contributing to the income differential. Our system pays for doing things to patients, particularly high-tech types of procedures which primary-care providers simply don't do. And as this income differential between primary care and other specialties continues to widen and the challenges of finding time to take care of the demand for primary-care patients increases, increasingly our students simply see this career as a nonviable option. Those who are in the field are getting increasingly frustrated as well. Many of the older primary-care physicians are choosing to retire early; some of the younger primary-care physicians are going back to get speciality training and having second careers in other types of practice that are more manageable. What about the new law? The Affordable Care Act, as you've heard,

is focused mainly on providing coverage for patients. There certainly are some provisions in there that encourage primary care but they're, frankly, way too small, in my opinion, to have a major effect on the problem. Currently, our uninsured Americans mainly get their healthcare through emergency departments, and they're taking advantage of a provision that was passed in 1986 that requires emergency departments to provide medical care to anybody, regardless of their ability to pay. And I think it's been an underdiscussed part of our healthcare system to not point out that we take care of people when they get sick enough, no matter who they are, no matter what their financial means. And as a primary-care physician, it just doesn't make any sense to me to wait until someone is in the eleventh hour and has extreme illness to try to resolve the problem. And I'd see time and time again, when I'm covering the hospital service, patients who are admitted with problems that become enormously expensive to deal with that could have been prevented had the patient had an ability to get coverage at a much earlier stage of their illness. So it's been assumed that when the new act rolls out, and in 2014, the now uninsured will have coverage that they'll no longer need to use the emergency department. And that's true in terms of the financing, but the problem we're dealing with here is the coverage does not ensure access to care. If there aren't enough primary-care docs in our state to provide the services, where are people going to go for care? We've already talked this morning about Massachusetts having a jump-start, if you will, by their universal coverage provisions that were put into place in 2006. From the Massachusetts data before that was in place, if you move to Massachusetts and had insurance and wished to find a primary-care doc, the average wait to get in to see someone was 17 days; now it's 44 days. In Massachusetts, emergency department utilization since the new system has actually gone up 10 percent. I believe we have a few years in Nebraska to get ready for this onslaught of newly covered patients, and I think we need to work together now to prepare what we're going to face in 2014 when health insurance becomes mandatory. So what about potential solutions? I believe the model of care and payment must fundamentally change if primary care is going to remain viable in our state and in our country. Primary-care providers have to believe that their work is manageable, fun, and rewarding, and right now most of primary-care

docs are working well beyond their full capacity. Asking them to see more patients is just going to increase their frustration. The state should look for new ways to encourage/incent models of care delivery that promote primary-care services. Indeed, the groundwork for one such model has already been laid by Senator Gloor, who championed LB396, signed into law last year, and this provides for patient-centered medical home pilots. As you know, the patient-centered medical home is a new model of practice; it's team-based, and oversees and coordinates the care of a panel of patients. The key to this model is a mechanism of funding that provides for outside of the face-to-face physician encounter care--the disease management, the maintaining registries of chronic diseases, making sure that we're staying on top of patients' illnesses and taking care of them before they come in major problems. There was a recent series on NPR looking at the patient-centered medical home, and I commend that to you if you didn't get a chance to hear it, looking at medical home in Maine. And one of the key features of that is that the people who work in that setting find their work is now more manageable. Because you have a team of people to provide care and it's not just all falling on the primary-care physician, the physician can actually focus his or her skills where they're most needed and so they're not so inundated with routine types of care. Not only is it more enjoyable to work in such an environment, when you look at the cost of the medical homes and providing care to populations, it actually has been shown to reduce the overall cost of healthcare for the population being managed. You've also heard about the benefits of the accountable care organizations. This is another very promising model of care which can actually incorporate the patient-centered medical home concept into its overall organization of financing. UNMC can play a role in this crisis, both in training new providers who are prepared to practice in these new models of care as well as in studying the costs and outcomes of care provided by such new models. Our UNMC Physicians Turner Park internal medicine clinic is one such example. Starting about two years ago, we began to change the way that clinic was organized to work along the lines of a patient-centered medical home. And so our internal medicine residents who are receiving their training today are learning how to practice in this new model of care so that it will be less challenging for

them as they go out and try to work in the real world as the models of care are shifting. Other approaches to promoting primary care involve incentives to help students and residents decide they would like to choose a career in primary care, and UNMC has a long history of such programs, as well as the state through loan-forgiveness programs. However, I would emphasize that while these incentives are important in making the choice of primary-care training financially viable, if we don't change the day-to-day practice issues we are not going to get a significant impact simply by dangling carrots at trainees up-front. They see right through it. When they go out in rural Nebraska as part of their medical education and work with their preceptors, they see what life is like in the real world and our state, and many of them are coming back disillusioned and saying, I need to find something else, I just can't have a life like that. So to conclude, the work force shortage in primary care is severe and it's projected to become worse as more citizens obtain health insurance coverage. Because the causes are complex and multifactorial, the solutions are going to be challenging as well. But we do have a long history in our state of innovative programs to incentivize primary care as well as rural healthcare. We should seek to continue and expand such programs and we should also take advantage of the opportunities that are provided by the grant programs in the Affordable Care Act. And I'd like to thank you for your interest and your support. And I'll turn things over to Pam. [LR467]

SENATOR GLOOR: Thank you, Doctor. Good morning. [LR467]

PAM BATAILLON: (Exhibit 5) Good morning. I'm Pam Bataillon, P-a-m B-a-t-a-i-l-l-o-n. I'm the assistant dean at the College of Nursing at UNMC, and I add my thanks, too, for your interest in this topic. Before expanding on Dr. Tape's comments relative to the health work force, I'd like to frame the work force demand with the notion that our health work force needs precede and transcend this recent health reform legislation. The population is aging. People are living longer with more chronic illnesses and that demands more health attention. Consider this fact: large waves of retiring baby boomers will dramatically increase the health work force demand. Currently, one in six

Nebraskans is over 60 years of age. And consider this: Simply put, the demand already outstrips the supply in our state. Eighteen counties are without physicians of any kind; one-half of our counties have a shortage of primary-care physicians; more than 33 counties have no nurse practitioners; 81 percent of our counties have a shortage of nonphysician primary-care providers; and 9 counties have no registered nurses; and 23 counties have a shortage of registered nurses. If those statistics are not bleak enough, listen to this one: 55 percent of the state's nurses and one-third of the state's physicians and dentists will retire in the next 10 to 15 years. The impact, for example, by the year 2020, Nebraska will have a shortage of nearly 4,000 registered nurses. UNMC and other educational programs, as Dr. Tape referenced, recognized the need for an increased number of health professionals some years ago and underwent increased enrollment and other initiatives to meet that need. But despite those efforts, they have not been enough and will not be enough as we have increased numbers of insured coming into the system in the coming years. So what is being done besides trying to produce more health professionals? Interprofessional education, as Dr. Tape referenced, and practice may be the key to meeting future health work force objectives. Curricula in schools of nursing, schools of medicine, schools of pharmacy, dentistry have all been changing and evolving toward interprofessional education. The law supports further evolution of that effort through such mechanisms for the practice arena, as Cory Shaw mentioned--bundled payments, medical homes, independence at home, demonstration projects, and so on. The Institute of Medicine produced a report as early as 2003 which urged training programs to produce graduates who can work effectively in interprofessional teams and transform the way care is delivered. Historically, you might know and you can imagine that nurses have been educated with nurses, physicians largely with physicians, dentists with dentists, and so on, so that future health professionals only have a vague sense of how the whole team can work and what the practice areas and scope of expertise might be in their colleagues. By learning early on in their health professional education about the team and about the team approach, they can improve patient care and become ready to enter the practice arena the way it will be evolving. This is the nature of education now at

UNMC--interprofessional education. What conclusions might be drawn from other states and in the health work force arena? It's clear that addressing health work force supply requires a multifaceted approach with a number of stakeholders. State governments have long been key players in many states. In recent years, a number of states have recognized the emergent need to ensure an adequate health work force. And some of the outcomes are these: A centralized health work force effort at the state level; resources for distance education programs, telecommunications, and capital infrastructure; recruitment and retention areas with incentives to encourage health professionals to locate in areas of shortage; loan repayment and scholarships providing students and medical residents financial support in return for an agreement to provide services for a period of time in those underserved areas; differential Medicaid reimbursement for providers in certain areas; resources to support team-based models in the Medicaid population and support for greater mainstreaming of these pilot efforts; low or no cost capital financing for new medical practices; encouraging cooperation among the Legislature in licensing and regulatory boards to structure and coordinate efforts in the state licensing procedures toward simplifying and consolidating processes; and pilot programs to demonstrate the efficacy of expanding the scope of programs in narrow ways. I want to thank you again for your attention to this. I cut my remarks down to a manageable part right before lunch, so we now invite any questions you might have for any of the panel. [LR467]

SENATOR GLOOR: Senator Pahls. [LR467]

SENATOR PAHLS: I'm looking at your conclusions, and since you happen to be the...this is what I have found out. I have grouped your conclusions in two categories, and I'm going to start with the second. I see the word "resources." The third one I see, "incentives"; the third one I see, "repayment"; the fourth one, "additional resources"; the fifth one, "resources"; the sixth one, "reimbursement"; the next one, "low or no cost capital." I've grouped that all into the money situation, which I know is needed. Then I grouped the other conclusions. Number one, you talked about centralization; and then

you go down to collaboration on the third from the bottom; then cooperation; then pilots. It seems to me that we're talking about money and then we're talking about basically the concept of cooperation. It's based down...as I look at the answers to a lot of your questions deals with money. [LR467]

PAM BATAILLON: Well, one thing we could point out is that resources aren't always just financial. Resources can be your ability to put such issues on the public agenda. People working...then you go into the collaboration aspect of it. Some things do take money. Some things could be taken advantage of with the health legislation to support...to apply for and get grant programs. Others may be such collaborative projects that involved resources from other places such as northeast Nebraska and the Northeast Community College partnership with the UNMC. The public raised the money for the building on the campus of Northeast Community College, which now houses...just opened, now houses the NECC program, nursing programs--A.D. and...the associate degree nurse, and the LPN program. It also houses UNMC's program. So there are other ways that we could consider resources. [LR467]

SENATOR PAHLS: Okay. Well, let me ask you, do we have statutes that are standing in the way? I know you want the Legislature, I mean, we are...we need to be involved in this process. Are there statutes...and I know you may not have them on top of your head (laugh) and I'm not asking you for that information, but are we standing in the way, the way we have created past, I'm going to say, laws or statutes? Is that part of the issue? Do you... [LR467]

PAM BATAILLON: You're right, I can't answer that question. [LR467]

SENATOR PAHLS: Okay. And I'm not trying to put you on the...I'm trying to find...because I know in the past we've even had issues when we've had nurse practitioners. There's always been some type of a, I think, professional conflict while listening to some of our past legislation that's come forth. I mean, I'm willing to help. And

I understand resources is more than just dollars, and if I implied that, I apologize for that, but... [LR467]

PAM BATAILLON: Well, one way might be for you all to put on the public agenda the health work force needs. And then my point in other states' outcomes in terms of consolidating and simplifying the processes of the licensing board, so the Legislature going arm in arm with the licensing regulatory boards, putting it out front in front of everyone: Here's a big issue--who will care for you as you get older? [LR467]

SENATOR PAHLS: Okay, okay, okay. And so then maybe by changing some of the requirements or helping with that...okay. Thank you. [LR467]

SENATOR GLOOR: And by the way, the committee members are welcome to ask questions of any of the four, but we're going to ask you to come up. We're taping this so we need to be able to pick it up on the microphone if you're asked a question. Senator Nordquist. [LR467]

SENATOR NORDQUIST: I guess Senator Pahls tripped an issue and I think kind of with the diverse panel that we have here from nursing and medicine, I'd like your thoughts on our scope of practice for nurse practitioners in the state. I know at NCSL a lot of other states are looking at it or making changes to their scope of practice to open up and give a little more autonomy to nurse practitioners to meet this need. And I'd just kind of like to hear your guys' thoughts. [LR467]

PAM BATAILLON: Well, it's a partnership, as you may have heard throughout all of our comments. It has to be a partnership among the licensed professionals. Physicians and nurses and physician's assistants have to be able to talk together, work together, and in the spirit of interprofessional education and interprofessional practice, we have to give up some of our territory that we've had before, some of our long-held beliefs. We need to look at what the research shows about the appropriate use and the appropriate times

for mid-level providers. So that's part of our professional responsibility. We also have to work together with the licensing and regulatory boards, you all, in putting it on the public agenda to really keep in the forefront what is the goal we're trying to accomplish here. It's not for nurse practitioners to do more or physician assistants to do more or for physicians to do less; it's for providing the best care to the patient. [LR467]

SENATOR NORDQUIST: Sure. Absolutely. [LR467]

SENATOR GLOOR: Senator Hadley. [LR467]

SENATOR HADLEY: Thank you. I would ask anybody on the panel, am I correct that in certain states it is difficult for a person that is on Medicaid or Medicare to find physicians to go to because physicians do not take Medicare or Medicaid patients? Is that a correct statement? [LR467]

THOMAS TAPE: That's a correct statement. [LR467]

SENATOR HADLEY: I guess my concern then is, is if we set up a system in Nebraska where we have more people on Medicaid, are we eventually down the line going to run into the same problem that other states have of fewer providers and the providers saying, I will spend my time with the more lucrative patient? And so we've set up a system that even if we have people with Medicaid, they may not find the healthcare that they need? [LR467]

THOMAS TAPE: One of my trainees a couple of years ago moved to another state nearby here, and one of the things her practice asked her to decide before she went down there was what did she want her quotas to be, her limits, on the number of Medicaid and Medicare patients in the practice. And the reason for that is because there is a substantial differential in how much those governmental programs reimburse providers compared to most private insurance plans. Physicians have the ability to

negotiate with the insurance companies. They do not have the ability to negotiate with the state and federal government programs. Cory may want to comment on that further. [LR467]

SENATOR GLOOR: Although, let me interject something. We are talking, though, about the state, it's one of the challenges financially of having to adopt the Medicare reimbursement rates in, what, 2014, is that correct? So somewhere in the future we're looking at that great discrepancy going away. Now that doesn't necessarily mean that it's going to solve that problem, but I'm correct in that based upon what we've... [LR467]

CORY SHAW: Well, for primary-care physicians I think is what the act requires. For preventative is, is for primary-care physicians, I believe, is what the requirement will be. [LR467]

SENATOR GLOOR: It's only for preventative. [LR467]

CORY SHAW: I believe so. [LR467]

SENATOR GLOOR: Okay. Thank you. [LR467]

THOMAS TAPE: But the point needs to be made that, although right now many states' Medicaid payments are below Medicare, even if you brought everybody up to Medicare, that's still substantially below the reimbursements for private insurances. And one of the reasons for that is that there is a system called the sustainable growth rate system which limits the rate at which Medicare can increase its total outlays to physicians. And it was designed to keep those payments basically expanding no greater than the growth in the GEP. And the problem with that is it was put in place in 1997 and it didn't account for new technology. So as new healthcare technologies become available and we spend money on them, the pie didn't get any bigger so the slice of the pie that goes to any individual physician service, that has decreased. And it's hit primary care

particularly hard. On November 30 of this year, if Congress doesn't do something to prevent this system from kicking in again, there will be a 21 percent reduction in Medicare payments for all physician services. And so this issue of can a physician in practice afford to have a large proportion of his or her patients on Medicare really comes into question. [LR467]

MARK BOWEN: The other thing I'll add is that regarding the reference to the Medicaid, enhanced payments--and Joy mentioned this earlier as well--for the newly enrolled eligible...the newly enrolled Medicaid patients, they (inaudible) enhanced payment up to Medicare rate for two years, and then it ratchets down to 90 percent. So the states' share of that will be at 10 percent. Rather than an unfunded mandate, they'll receive 90 percent payment from the feds. [LR467]

SENATOR HADLEY: I'd like to make one other comment. It's not a question, but it struck me when we were talking about the difference between a cardiologist. And having a niece that just graduated from med school and talking about debt and what she was going to do, it did hit me. And I would like to throw down the gauntlet to medical schools, to academic medical schools that maybe it's time we look at how we do train physicians, how we make it so that there aren't $3 million and $4 million differences over a lifetime between whether you work on a heart or whether you're general practice. And until we do that, we're going to have these changes, and economics works. I'm a young physician and you tell me I can make $3 million more being a cardiologist than I could be at family practice, I'm probably...if I'm capable, I'm probably going to look at cardiology. So I just kind of charged the whole...we're looking at the system, so let's not forget the way we train physicians and the best way to do it and incentivize physicians to go into these areas that we need. [LR467]

MARK BOWEN: Uh-huh. The interdisciplinary training that Pam described I think will be one of those benefits down the road that will benefit all of us, because as some of those barriers are eliminated for future generations of providers, they will start working

together more naturally and without many conflicts. [LR467]

SENATOR GLOOR: Senator Campbell had a question. [LR467]

SENATOR CAMPBELL: A statement and then a question. One of the things that I think this panel needs to look at is to do an inventory of the incentives and scholarships that we do already have in place. The Appropriations Committee probably sees a lot of those. We've seen some. And also work force issues, we put one into effect in LB603 and that seems to be (inaudible). We've been really excited about some of the things we've seen there. But we've piecemealed over the years and maybe now is the hour that we bring these all together and take a look at them and figure out where our money is best spent to address those questions. My question really goes to Cory Shaw, and I have to tell you that he served on the Medicaid Reform Council and I hated to see him leave. He did a great job and helped us in many areas. Cory, on your statistics, I'm going to go back to Senator Nordquist's question and mine, and that is, do you think we'll have to put in some kind of a trigger for those people who are the uninsured who may want to stay uninsured... [LR467]

CORY SHAW: Yeah. [LR467]

SENATOR CAMPBELL: ...but really putting pressure on the systems? [LR467]

CORY SHAW: So maybe the way I interpret the question is, should the state of Nebraska do something more in addition to what's already in the... [LR467]

SENATOR CAMPBELL: Try to get the... [LR467]

CORY SHAW: ...Accountable (sic) Care Act? I think to the extent that we create the right mechanism to facilitate people getting enrolled and reduce whatever barriers that might be there, boost education, I think that will be helpful. Asking the question whether

we take the step of increasing the penalty, if you will, or is probably a little bit more difficult question to answer definitively. My gut tells me that we'll have a difficult time coming up with sticks, if you will, to get people to enroll in either an exchange-based product or into Medicaid. But I think that's an example of where the provider community, the advocates that are community based today, whether they be agencies that are partially funded by grants or a community-based agencies, and the state can work together to make sure that everybody that does have access, either through Medicaid or a subsidy of some kind available through the Exchange, that they get enrolled into some kind of a health insurance product. I mean, in my...and I think the data would show that having financial barriers removed, notwithstanding the fact that there aren't enough of any one kind of provider, will lead over the long run to better health. And, ultimately, the way we're going to bend the cost curve is not only by making the system more efficient but ensuring that we do get people into the system and cared for and managing some of those chronic diseases before they become, you know, problems that could have easily been avoided, so... [LR467]

SENATOR CAMPBELL: If we could all identify what those red flags are in a collaborative nature, then we'd all be looking for them and could...and I agree with you, incentivize may be the better step. [LR467]

CORY SHAW: Yeah. [LR467]

SENATOR GLOOR: Dr. Tape, the RHEN program used to have a history of good success of allowing some of the academics to be done in those outstate communities for family practitioners, pharmacists, physical therapists. Is that still an effective... [LR467]

THOMAS TAPE: Still very successful program, both RHOP and RHEN, and it's recently been expanded to include Kearney. [LR467]

SENATOR GLOOR: And are the numbers still pretty strong for those programs? [LR467]

THOMAS TAPE: As far as I know, the numbers are still in pretty good. [LR467]

SENATOR GLOOR: Is it less costly to educate those students outstate or is it hard to do an apples-to-apples comparison? [LR467]

THOMAS TAPE: I don't know the cost data. Perhaps Pam or Mark would. [LR467]

MARK BOWEN: I don't. (inaudible) I could get that for (inaudible). [LR467]

SENATOR GLOOR: Well, I mean, the question I ask is if, in fact, having more of those healthcare students, is it less costly when they go out into the communities where community providers are involved in the education than having them on campus? That seems to be sort of a no-brainer of looking at ways to try and expand that program if possible. And I understand there are accreditation issues and it's...I know personally it's not an easy thing to pull off, but the provider communities have a vested interest in those rural areas of making sure there are enough trained professionals. [LR467]

THOMAS TAPE: The key is to figure out a way to help people stay in those communities, in other words, once they enter a practice to feel that they're viable. We have two very good primary care and rural, family medicine oriented training programs in the residencies at UNMC. But some of the people that have gone into careers in those rural communities, after their training was over, once they'd served out their obligations to stay in the rural area for two or three years, said I can't take this anymore and have come back to the Med Center to retrain in something else. I did want to mention in answer to the question about the differential in income potential of the different specialties. One of the things in the new act which really doesn't seem to have gotten much discussion yet, maybe because it's a couple of years down the road, is a

panel which will be assigned the task of, quote, revaluing misvalued payment codes. And so there will be an opportunity for an independent panel to look at some of these disparities and what physicians are paid for different types of services. [LR467]

SENATOR GLOOR: Clearly, the healthcare system pays for procedures. It doesn't pay for face-to-face time. Senator Nordquist, do you have a question? [LR467]

SENATOR NORDQUIST: I guess a couple broad questions maybe for Mark. In your testimony you touched on other states were establishing kind of formal working groups. Is that something that you would recommend to us to go forward with, to establish next legislative session some sort of formal recognized working group? [LR467]

MARK BOWEN: Because it's comprehensive, I would think you'd want to be involved with the whole magnitude of what's going to happen over the next four to seven years. I'm not going to suggest the Legislature has to, but it seems like that is a move that other states that are doing. It seems valuable, from what I've heard from other reports in the conference I've attended; something you at least ought to look at to see how it will work for you and what would work best for you. [LR467]

SENATOR NORDQUIST: Okay. The report that's been floating around on cost of this bill from the Department of Health, our Department of Health and Human Services, the Milliman report includes...says that the state is going to pay Medicaid, Medicare rates for both primary and specialty care. I know you've studied the bill a lot. Is that a provision in the bill that we have to do it for both primary and specialty care or...? [LR467]

MARK BOWEN: The federal statute focuses on primary. [LR467]

SENATOR NORDQUIST: Okay. [LR467]

MARK BOWEN: It does not focus on specialty. [LR467]

SENATOR NORDQUIST: Okay. And then this is kind of a broad, systemwide, philosophical question. If we have...we hear a lot about the differential and payment between primary and speciality care, and I'll...with the understanding I have a brother that's an oncologist, so do we have too many specialists and are we paying them too much? Is that the problem? It doesn't seem like we have a shortage of people wanting to go into the medical field. I have three friends right now that are in med school, a couple at the Med Center that worked like heck to get in. They're bright guys and they got in. It doesn't seem like there's a shortage of people wanting to go into the practice, so it seems like there's a significant unbalance there. And as you said, there's provisions to try to rebalance that, but do you see that as a problem that maybe... [LR467]

SENATOR GLOOR: We'd like each of you to answer yes or no (laughter). But it's a question that is part and parcel to the problem, obviously. [LR467]

THOMAS TAPE: There are actually is projected to be a shortage of most types of physicians going forward with the aging of the population that Pam talked about. The aspect we didn't really mention is that a huge proportion of our work force in this country is actually filled by foreign-trained physicians. We are not producing the volume of physicians in our medical schools and residency programs needed to meet the nationwide demand and, as a result, that differential is filled by foreign-trained docs. [LR467]

CORY SHAW: And that's an...it's an economy question. I mean the reality is, is it's not just about what discipline do I choose in medical school; it's do I go to medical school, do I get my MBA, or do I get my J.D.? And people looking at the road that's in front of you, as a senior in college, and saying, four years of medical school, a minimum of three years of residency, and I can go to two years and get my MBA and go to Chicago

or go to New York. I mean, that's one of the challenges that medicine faces and I think the point that was made about looking at physician training I think is true of every healthcare professional. You're competing for the brightest with these other nonhealthcare disciplines. That's tough. [LR467]

SENATOR NORDQUIST: Yeah. I think...I don't remember if it was in JAMA, the medical association journal, or where it was, but there was a study done a few years back about the costs of taking into account the cost of the education and the years of the education and the amount a person makes over a lifetime. A person with an MBA comes out relatively close if not better than someone going to med school. So kind of the purpose of that question, I guess, was to get to the point that maybe we're not training enough physicians in our country, and there are a lot of good qualified people that aren't getting in that want to I think. You know, you guys are probably closer to the ground on that. But how do...I mean, what's it going to take to increase the capacity to educate more physicians? Money? I mean obviously faculty and...I mean, there's... [LR467]

MARK BOWEN: Faculty is one issue. Because of accreditation standards for practically any college, it may require more faculty at some point. It may require or at least taking a look at are there incentives for providing for some of those retiring physicians to (inaudible) service. That happens. We need more residents. We need more preceptors as well, so places for them to go once they get into residencies. [LR467]

THOMAS TAPE: One of the issues in medical training is it's very intensive in terms of it's basically a type of apprenticeship. And you can't just say, well, we have a large lecture hall, let's fill it up. We have to have preceptors with whom the students/residents can work, and we have to have an adequate volume of patients for the trainees to interact with. And we're getting to the point in some cases where there are days when I have more trainees rounding with me in the hospital than I have patients to go see. It's not to say we don't have enough patients. But because we're getting people out of the hospital quicker and doing more training or more patient care in the outpatient setting,

our traditional venue of training in a hospital is becoming a little more challenging. [LR467]

CORY SHAW: Well, when you layer on top of that the comments we've made about the challenges that you face in private practice, trying to make the practice work, and when you're asked to serve as a preceptor taking on that additional burden of having a student or a resident come spend time with you, recognizing you're trying to keep your practice viable or you're trying to run your hospital efficiently is difficult. [LR467]

MARK BOWEN: Some of it gets back to the interdisciplinary as well because, in addition to do we have the faculty, do we have enough lab spaces for biology or for the chemistries, we run those departments pretty hard during the academic year and there's not much open space for them. If we add more students, we're going to have to deal with that issue. [LR467]

SENATOR GLOOR: I worry about unintended consequence in this act. And you talked about NeHII which is a wonderful idea, and going to a universal medical record is a necessary thing for us to move towards, but it will come with expense and I don't mean capital expense. Having bought upgraded systems and new systems through my career, any smart marketer, any vendor would say, you will recoup this expense within three to five years by recaptured costs because of better documentation. And, clearly, as we move towards a better level of documentation that we all share, we will take charges that have been moved from the category of not going to pay it because I can't find the documentation even though the care was provided, it just wasn't documented appropriately or well, or fraud--some consider that to be a classification of fraud--to must be paid. And when we hear about how moving towards a uniform health information system will provide better care, that's true. But I don't think there is any figure that's been put out there that tells us how much of that lost charge will now have to be paid, and it will be in the billions of dollars I'm sure. And that's the sort of unintended consequence that concerns me about implementation of some of this. I don't think we

know all the surprises that are out there. I think we have time for one more question. Senator Pahls. [LR467]

SENATOR PAHLS: Thank you. Mark, I'm going to direct this to you. Let's say you and I have to make this decision within the next 24 hours, and with all your past experiences, should the state of Nebraska have an Exchange, should we have a compact with the surrounding states, or should we wait for the HHS? [LR467]

MARK BOWEN: I think that's the $64 question. [LR467]

SENATOR PAHLS: But, I mean, your own gut-level feeling. And, I mean, I'm just trying to... [LR467]

MARK BOWEN: I don't know that I can tell you because we haven't seen many of the draft regs come out yet, but I think you've got to keep all your options open. There are reasons to have a state Exchange. I mean, at an Insurance Committee meeting you had last week, you heard the agents talk about they wanted to be involved. [LR467]

SENATOR PAHLS: Yeah. The agents really wanted it. [LR467]

MARK BOWEN: There is a role for them to be involved. I think they'll be needed as part of that. At the meeting I was at this last week, and Ms. Wilson made reference to that as well, we know other states are starting to look at multistate Exchanges. There's an opportunity there for us in terms of cost-benefit ratios for (inaudible) pools, bigger costs. [LR467]

SENATOR PAHLS: So you're saying multistate is...that's what you're telling me. [LR467]

MARK BOWEN: No, I'm saying that's one option (laughter) that we at least ought to

take a look at. You should throw it into the mix and, Cory, you've got some thoughts on this as well I know. [LR467]

CORY SHAW: Well, I've said from the beginning and without knowing the regs, I think given the size of our state and knowing that, in the insurance world, scale matters, I think that we need to take a good, long, hard look at doing something with more than just one state. [LR467]

SENATOR PAHLS: Okay. Thank you. [LR467]

CORY SHAW: That's my own Cory Shaw opinion. [LR467]

MARK BOWEN: Where Nebraska ends up, I mean, we're Nebraskans. We have a system. We want a device that works best for us in the end. So I don't know if I can give you the answer to that, what the answer is at this moment. [LR467]

SENATOR PAHLS: Okay. [LR467]

MARK BOWEN: But we should take a look at all of it. [LR467]

SENATOR GLOOR: Good question. By way of transitioning the gavel to Senator Campbell this afternoon, she gets last question today. (Laugh) [LR467]

SENATOR CAMPBELL: And I just want to say, if you did that, you'd really have to look at what the Medicaid portion of that because you don't want to lose that control. Last statement is, it would seem to me, Mark, that as we all go forward here, it would be very helpful if we created some type of collaborative nature so that people who have information and doing study can all be shared. Somehow we're going to have to find a system to do that. So I'm assuming that you're all willing to keep having input here, and I'm sure there are a number of people in the audience that would be in that same boat.

[LR467]

MARK BOWEN: We are open to that. We know that there's value in collaboration. We do it as much as we can so, yeah, if we can do more of it, I think that's to our benefit as a state. [LR467]

SENATOR CAMPBELL: Think we need to come up...maybe the committee needs to come up with a way for which people who are doing a lot of work on this area, because Nebraska is only going to be ahead of the game the more we can all put our thoughts together and be ready to go. So we probably need to talk about that. [LR467]

SENATOR GLOOR: Good point. [LR467]

SENATOR NORDQUIST: Thank you. [LR467]

SENATOR GLOOR: Thank you for your participation and for being a resource for us. [LR467]

SENATOR PAHLS: Thank you. Appreciate it. [LR467]

PAM BATAILLON: Uh-huh. Thank you. [LR467]

CORY SHAW: Thanks. [LR467]

SENATOR GLOOR: And we'll reconvene at 1:00. [LR467]

BREAK

SENATOR CAMPBELL: Good afternoon. This is the continuing hearing. Do we have anyone in the audience this afternoon that was not here this morning? Okay. I just

wanted to make sure that everybody...be sure to turn off your cell phones and all that kind of good stuff. We had a great session this morning. Judy and Captain, you've met everybody. Okay. I was going to go through all the line up again, but if we've got...everybody has heard and knows everybody, why, welcome to Nebraska. [LR467]

JUDY BAKER: Thank you. [LR467]

SENATOR CAMPBELL: We are delighted to have you. You were sort of intimating it's a little chilly here (laughter) when we met. [LR467]

JUDY BAKER: That's good when you're on a hot seat. [LR467]

SENATOR CAMPBELL: It must be chilly outside. Is it chilly outside? We're all used to 100-degree... [LR467]

JUDY BAKER: It's all of a sudden really warm (laugh). No, it's not too bad at all. [LR467]

SENATOR CAMPBELL: That's quite all right. To start the afternoon session, I do want to repeat a couple of things. One is, many, many thanks to Michelle Chaffee for putting all of the agendas together and the speakers and so forth, and preparing certainly the Health and Human Services Committee with documents that we can start working on. So we are delighted. For the audience, in case you do not realize, this special hearing has special representation in the fact that there are members from the Health and Human Services Committee, the Banking Committee, and Appropriations. And as I had said to Senator Pahls when we finished this morning, I really enjoyed that because we are coming at this topic from different perspectives and it's very interesting to hear those. So with that, Judy, I think we'll start and whatever you would like to impart here. [LR467]

JUDY BAKER: (Exhibit 6) Thank you, Chairwoman. I appreciate that so much. And let

me just say right off the bat that I'm very, very impressed with the state of Nebraska for even holding these hearings. As far as I know, you're the first state in my region, which is four states, to be doing this. It shows a lot of forethought and I do appreciate...we do appreciate at the department the opportunity to engage with you all. And so with that, I have handed out testimony as written and I will be reading from that. It is lengthy. It is dense. I apologize for that. It is the afternoon. But I wanted to make sure that I got as much into this as I could so that you could ask intelligent questions. I have sat on that side of this conversation and I totally understand the responsibility that you all have and the seriousness with which you take your task. So with that, good afternoon. I am Judy Baker, the regional director of the Department of Health and Human Services, Region 7. I'm here today with Captain Jose Belardo, acting regional health administrator for Region 7. We are honored to be here today and thank Senator Gay for the invitation. Today, I would like to present to you an overview of the Affordable Health Care Act with two goals in mind. One is to address what is to be accomplished by 2014; and number two, to address the bridge programs that are key steps towards the 2014 horizon. Following that, I will outline the implications of state governments, leaving time for questions and answers at the end. On March 23, the Patient Protection and Affordable Care Act was signed into law. The unsustainable status quo was the primary reason for the need to pass the law. Healthcare costs in this country have been increasing much faster than inflation in the past decade, making it difficult for individuals and families to afford health insurance. Since 1999, family premiums for employer-sponsored insurance have increased at over four times the rate of inflation, squeezing the middle-class and working families. In 2007, 45 million nonelderly adults went without health insurance, and 8 in 10 of those adults were in households with at least one worker. The percentage of large firms providing workers with retiree coverage dropped from 66 percent in 1988 to 31 percent in 2008. Nine percent of Missouri's children were...Missouri. I apologize for that. I don't know the figure for Nebraska. But in general, we had quite a few uninsured children in the nation. The insurance coverage gap has been widening for quite some time, whether it be because of preexisting conditions, employers who no longer provide insurance, or patients' inability to find affordable

options on the open market. All of us understand that health insurance status greatly impacts the well-being of an individual. You know that people without comprehensive health insurance rarely have access to the healthcare they need, and that treatable conditions can escalate into life-threatening disease as a result of lack of access to care and severely increase costs in the long run. This dangerous escalation has been illustrated to me all too starkly in my visits to area agencies on aging in the past few months. I've heard from multiple caseworkers that when seniors have reached the so-called "doughnut hole" in Medicare coverage, some will try to stretch their medications by cutting pills in half or not taking them at all. The caseworkers told me that those seniors often end up in the emergency room with life-threatening and costly conditions as a result of not taking their medication as prescribed by their doctor. This underinsurance in Medicare poses a grave threat to the health of our seniors and it exponentially increases our nation's healthcare costs. The Affordable Care Act was designed to address the problem of uninsurance and underinsurance in America and, thereby, stem the rising costs of healthcare in general. To understand the current system and where the ACA points us toward can be illustrated visually. I think I may need to go with this one. On the lower level, we have the working poor, disabled, elderly on Medicaid, and families below the 133 percent of the federal poverty level that have access to healthcare through safety net clinics, hospitals, and other institutions. Mid to upper income citizens largely had insurance from their employers or Medicare. The middle area is the time when relatively small and insurance can be purchased with a job or time without coverage would be short. The middle section, instead of remaining small, started to widen. The cost to cover the uninsured started to increase and the cost for the upper level and insurance companies needed to increase their rates, and with increasing costs, many employers started to drop employer-based insurance or charged the employees higher contributions. And access to a lower level option was not an option. The ACA, as written, is largely market-based, state-run, and consumer centric. The ACA preserves the uniquely American system of private and public insurance. The ACA provides for state-controlled Health Insurance Exchanges, that regulate health insurance rates, and states and organizations receive grant opportunities for innovative

care expansion and improvement. The ACA also protects consumers from insurance rate hikes and preexisting condition exclusions, increasing access to affordable healthcare, and improved healthcare quality. By 2014, three major horizons are established: the Health Insurance Exchanges, the expansion of Medicaid, and the guaranteed issue of insurance with new consumer protections. The Affordable Care Act helps create a new competitive private health insurance market through state-run Health Insurance Exchanges, for the most part, that will give millions of Americans and small businesses access to affordable coverage, and the same choices of insurance that members of Congress will have. Today, many individuals and small businesses are on their own when trying to find affordable health insurance. Because they lack purchasing power and the ability to pool risk, individuals and small businesses too often pay higher rates when it comes to insurance. The Affordable Care Act changes that by putting greater control and greater choice in the hand of individuals and small businesses through these Exchanges. Starting in 2014, improved choices will be offered through the Health Insurance Exchanges. Although state Exchanges are not required to be up and running until 2014, work is already underway to conduct the necessary market research and planning. These grants will give states the resources to conduct the research and planning needed to build a better health insurance marketplace and determine how their Exchanges will be operated and governed. And I missed a section, the HHS has announced the availability of a first round of funding up to $1 million for each state and District of Columbia. Until ACA, Medicaid beneficiaries generally had needed both to have a low income and to be in certain specific categories such as being pregnant or having a disability. But in 2014, ACA will provide coverage of all individuals under age 65, children, parents, and childless adults with incomes at or below 133 percent of the federal poverty level, regardless of disability or other category. Starting September 23, full implementation of discrimination due to preexisting condition or gender is accomplished, and annual limits on coverage will also be eliminated. That anniversary is next Wednesday, I believe, the 23rd. Other consumer protections include new regulations that give consumers in new health plans in every state the right to appeal decisions, including claims, denials, and recisions made by their health plans.

The rules issued by the Department of Health and Human Services, Labor, and Treasury give consumers the right to appeal decisions made by their health plan through the plan's internal process. For the first time, the right to appeal decisions may be made by their health plan to an outside independent decision maker, no matter what state they live in or what type of health coverage they have. States will work to establish or update their external appeals process to meet new standards, and consumers who are not protected by a state law will have access to a federal external review program. Medicare will be stronger and offer new benefits. The act preserves the guaranteed benefits under Medicare, makes recommended preventive services available with no cost-sharing, and provides an annual wellness visit. It closes the Medicare Part D prescription drug program doughnut hole over time, and beginning with a $250 rebate to seniors who reach that limit in 2010. By lowering cost-sharing, the act empowers providers who will have to worry less about patients being unable to afford needed treatments. ACA is also designed to reduce paperwork and increase administrative simplification that will bring down the cost of care. With the horizon set at 2014, the ACA addresses the uninsured with a series of bridge programs. These programs address the needs of small businesses, individuals with preexisting conditions, early retirees, and young adults, and children. First, I'll speak about small business. Up to four million small businesses are eligible for tax credits to help them provide insurance benefits to their workers. The first phase of this provision provides a credit worth up to 35 percent of the employer's contribution to the employer's health insurance. Small nonprofit organizations may receive up to 25 percent credit. In Nebraska there's 38,300 small businesses that could be helped by a new small business tax credit that makes it easier for businesses to provide coverage to their workers and make premiums more affordable. The preexisting condition insurance plan is administered by either...will be administered by either your state or the United States Department of Health and Human Services. Nebraska has elected to have HHS run their program. Is that the...is...are you all aware? I think we were having some...I'll deal with it in just a moment. It will provide...the preexisting condition insurance plan will provide new health coverage option for citizens if they have been uninsured for at least six months, have a

preexisting condition, or have been denied health coverage because of a health condition and are U.S. citizen or are residing here legally. The plans are active from 2010 to 2014, the horizon, and the plans will cover primary and specialty care hospital stays and prescription drugs. For early retirees, the percentage of large firms providing workers with retiree coverage has dropped from 66 percent to 31 percent in 2008. The Affordable Care Act will provide $5 billion in financial assistance to employers to help them maintain coverage for early retirees age 55 and older, who are not eligible for Medicare. Employers can use the savings to either reduce their own healthcare costs, provide premium relief to their workers and families, or a combination of both. This temporary program will make it easier for employers to provide coverage to early retirees. Employers who are accepted into the program will receive reinsurance reimbursement for medical claims for retirees age 55 and older, who are not eligible for Medicare, and their spouses, surviving spouses and dependents. Under the new law young adults will be allowed to stay on their parent's plan until they turn 26 years old. In the case of existing group health plans, this right does not apply if the young adult is offered insurance at work. Some insurers began implementing this practice early. The new law includes new rules to prevent insurance companies from denying coverage to children under the age of 19 due to a preexisting condition. And further on young adults and children, the Children's Health Insurance Program has been extended through September 30, 2015, and provides states with additional funding to ensure children have access to this proven successful program. The funding increases outreach and enrollment grants to help reach more eligible children. As I have mentioned throughout my briefing, the states are definitely involved in the implementation of ACA. I have highlighted some of the provisions of ACA that are already in effect and I started my testimony with the end horizon that is expected by 2014. Currently state Legislatures are beginning to consider what initial steps should be taken to implement some of the measures needed. ACA does provide the state opportunity to address the following: future healthcare costs, such as maximizing receipt of federal funds and reducing the cost of care for high-cost individuals; new strategies that bolster quality and outcomes. Keep in mind that ACA does not make changes to the healthcare system, but it does

make available grants and demonstration project opportunities to assist states in addressing certain problems in a gradual manner, just like the implementation of ACA. The Legislature may need to consider the state's response to work force and infrastructure capacity and ACA provides the grants for state level work force planning. State may need to consider enhancements to insurance oversight and regulation at the state level. A $30 million grant to establish and strengthen consumer assistance offices in the states and territories is available. The new Consumer Assistance Grants Program will help states establish consumer assistance offices or strengthen existing ones. The new funds will be used to provide consumers with the information they need to pick from a range of coverage options that best meets their needs. States can now apply for the first round of funding up to $1 million for each state and the District of Columbia to conduct research and planning needed to build a better health insurance marketplace and determine how their exchanges will be operated and governed, if they so choose. Future funding will support development and implementation for activities the states will undertake through 2014. And as far as I know, the state of Nebraska has applied for one of those planning grants. They're called the planning grants. New programs could generate additional federal healthcare funds. There are costs in the state's implementation of ACA. However, ACA also establishes a number of new federal grant programs, some monies distributed by formula, others awarded through a grant application process. It will be important for the state to ensure that state agencies maximize their opportunity to obtain additional federal funds, particularly in cases where doing so could offset state costs. States will also have a role in policymaking around the enrollment and eligibility provisions of ACA. States must consider coordination of enrollment, data sharing, the role of state agencies, HIT standards, income methodology requirements, and integration of current programs, and proposed Exchanges. ACA provides for administrative simplification around these issues. These topics may be touched on by other presenters later on, or before I've been here, for consideration to this committee. Again, these are short-term implications...these short-term implications may vary from state to state but are items that the state of Nebraska may need to consider. And as part of my testimony, I will include the

long-term implications to state health programs as well. Mentioned earlier, the Medicaid 1115 waivers allow flexibility and provide federal funding. New federal funding opportunities to offset enrollment of persons currently eligible but not enrolled, or the success of the state Health Insurance Exchange include--and these are some of the changes that can be made now and each state can kind of do some of their own quality programs: Medical homes are for persons with significant health needs. Medical homes are proposed as a model of care where a person's care is coordinated through a central hub rather than a person being directed to seek care from a jumbled network of providers. Support is available at a 90 percent federal and 10 percent state funding rate beginning in 2011. Optional attendant service benefits can be included. Bundled payments are an alternative to fee-for-service payments, in which each physician receives reimbursement for the individual services provided. The intent of an ACO is to reduce costs by delivering coordinated care. And within the bill, ACOs have been authorized as demonstrations. The new federal funds could help relieve fiscal pressure on the states to maintain funding for uncompensated care historically provided by clinics. Prevention and public health funds are also available and used to promote community-based preventive health activities, and you'll be hearing more from Captain Belardo on those, as well as other activities permitted under the previously enacted Public Health Services Act, such as immunizations, public health preparedness, and cancer detection programs. Maternal, infant, and early childhood home visiting programs authorizes grants for home visitation programs following models that have been proven to improve health outcomes for mothers and babies. You will hear more about that as well from Captain Belardo. Home visitation programs provide low-income, pregnant, and parenting families services such as smoking cessation programs, advice on nutrition and exercise, basic information on newborn care and child development and family planning. Just as a note, states need to know there could be redirection of Disproportionate Share Hospital Fund payments to hospitals that serve a larger percentage of Medicaid beneficiaries and uninsured. States will need to consider the impact of this. The Legislature does have policy options on the design and role of the Exchange. The state will need to answer these questions: Should the state establish an

Exchange? How would an Exchange be governed? And what role should the Exchange play in the health insurance market? As a committee, you have much to consider, and I applaud the time you have set aside to study this most important piece of legislation. You do have opportunity now to impact the lives of Nebraskans for years to come. I have given you two more handouts. One of them is the Affordable Care Act immediate benefits for Nebraska. This is kind of "know your numbers" by the numbers for Nebraska on many of those, especially on those bridge programs, like the small business tax credits, closing the Medicare doughnut hole, support for health coverage for early retirees, and the new consumer protections for the insurance market beginning on September 23. For instance, roughly 23,000 Medicare beneficiaries in Nebraska hit the doughnut hole and will be impacted by that portion of the legislation. So this is just kind of a "know your numbers" kind of thing. And then I've also given you an introduction to HealthCare.gov, which is the portal. Many people want to call it a Web site, but it is more than a Web site. It is actually an interactive portal, and will become the way that Americans interact with health insurance well into the future. And I've given you a little bit of a walk through of what's there. When you go to HealthCare.gov, you can find insurance options, learn about prevention, compare care quality. And this has a lot to do with those quality care organizations that we're talking about. Understanding the new law, the actual law is there, links to it, if you want to read it. It's actually there. There's also understanding the new law. There's a time line, which you can go completely through the time line and it shows you what things are going to happen when. And the information for you is more for individuals. There's one-page fact sheets for...if you're a senior, what does the Affordable Care Act do for seniors, children, families, employees, etcetera. And then one of the interactive parts, I've just given you a couple of pages here of the kinds of questions on HealthCare.gov that are asked. This is the interactive part for any given individual that wants to go on to this Web site. They can answer a series of questions. What state do you live in? What best describes you? Maybe an individual with a medical condition. Am I losing my health insurance through work? How old am I? We have actually done one of these, you'll see I've filled in. So this person was an 18 or under. Do any of the following apply: a disability, or breast

cancer, or nursing home, etcetera? If they're an American Indian or Alaska Native. And that actually will take you then to the Indian Health Service Web page. Do you find it difficult to afford insurance? Yes or no. And then once you have answered that series of questions, you push submit, and this is what you get. You get a page that gives you...for this person, nine options came up for this scenario of what is available in their state for their particular situation. When I'm visiting with individuals in groups, most of the questions fall into one of two buckets, either is, what does the Affordable Care Act do for me, or what does the Affordable Care Act do for my employer? This Web site begins to answer that question and that interactive part gives them essentially the options that they have currently. In the future there will, of course, will be more. By December, this Web site hopes to actually have competitive pricing from insurance companies, the actual price to compare premiums will be on the Web site by state. So give your insurance commissioner a pat on the back. They're working very, very hard on all these new provisions. And with that, I'm going to bring up Captain Belardo and then we'll take questions after, if that's all right with you. If you want to do questions now, that's fine too. [LR467]

SENATOR CAMPBELL: That's excellent. That's fine. Captain Belardo is with us today and was interesting. He was explaining some of the places he'd been in the Public Health Service. So you may want to mention that too. [LR467]

JOSE BELARDO: (Exhibit 7) Okay. Well, thank you. Well, good afternoon, everyone. As stated, my name is Jose Belardo. I am a commissioned officer in the United States Public Health Service and most people are unaware of our service. We've been around since 1798 and we are a sea service, like the Navy, and that's why my uniform looks like the United States Navy. Well, it is...we get it from the Navy stores. However, it is a uniform specifically tailored to be...identify us as Public Health Service officers by our emblem. Just a little bit of history about the Public Health Service. As you mentioned, I was detailing earlier to you some of the missions that I've been on. I recently came off the U.S.S. Bataan, which is an amphibious assault ship out of Norfolk, Virginia. I

deployed to Haiti for three months, a day after the earthquake. So with fellow Navy officers and Marines, we were there to provide humanitarian assistance mission. We also had a hospital on the ship where we were able to bring patients on, after being triaged on shore. My mission was that of being a public health mission. The public health mission consisted of providing immunizations or vaccines because the vaccine rate or immunization rate in Haiti was very poor. And especially when you look at earthquake, the majority...the far majority of the injuries that we saw were crush injuries and infected wounds. And for most people, they had never received a tetanus shot, so we provided the tetanus shot; measles for children, and we call it DTaP, actually measles, mumps, rubella and DTaP which is diphtheria, tetanus and pertussis for...or whooping cough; and DT or diphtheria and tetanus for adults, and because people were dying there of tetanus. So that just gives you a little bit of information about what we did from the immunization standpoint. Actually, we had our environmental health engineers provide water and sanitation services so that people had access to clean drinking water because people dysentery was a big problem and other types of diseases. So that, and a veterinary mission, and we were there for nearly three months. So thank you for the opportunity to kind of divert a little bit to tell you a little bit about a mission that I recently had the honor of being a part, so. Well, at any rate, I'm here today to talk about the prevention provisions of the Affordable Care Act. I am the acting regional health administrator for the U. S. Department of Health and Human Services, Region 7. I'll talk about the HHS structure in a second. But before I get started, I do have some handouts to provide to you that will serve as a guide. I've been in Kansas City now for three...we're located in the regional office in Kansas City. I've been in Kansas City for three years. However, if I look at a total of my time, I've actually been deployed on Navy ships for at least almost one year of the three years I've been there. When I came to this region, and actually before coming here, I noticed that a Nebraska city...I think you say Norfolk or Nor...I think you said here. Oddly enough, I grew up in Norfolk, Virginia, as we say it there. So when I said that to someone, someone said no, you don't say it that way. But anyway, just a little connection. [LR467]

SENATOR CAMPBELL: Now, that's my hometown, so you've got to be real careful here. (Laughter) [LR467]

JOSE BELARDO: Is it? (Laughter) What is...how do you...is it...? [LR467]

SENATOR CAMPBELL: Norfolk. [LR467]

JOSE BELARDO: Norfolk. See I even...I messed that up. [LR467]

SENATOR CAMPBELL: It's a convoluted story, Captain. Be glad to tell you afterwards why we say Norfolk. (Laughter) [LR467]

JOSE BELARDO: Okay. (Laughter) Well, thank you for this opportunity. I want to first go over very quickly, just as an overview guide, the HHS organizational structure and really highlight some agencies or what we call "OPDIVs," or operating divisions, within HHS that are critical and with the Affordable Care Act. However, my office, I fall under what we call a staff division and you'll see it on the left. We fall under the Assistant Secretary for Health, who is Dr. Howard Koh, and we primarily represent Dr. Koh, and within the office of the Assistant Secretary for Health is the United States Surgeon General, Dr. Regina Benjamin. So my job is to carry out the priorities of the ASH, as we say. And Dr. Koh had a funny story, and tobacco is a topic that we address all the time, but he said how the ASH, the Assistant Secretary of Health, oddly enough, is called the ASH, and we talk about tobacco prevention all the time. And Dr. Benjamin, Dr. Regina Benjamin, our Surgeon General, we represent her in carrying out her priorities in working with different groups, primarily work with state health officers, do a lot of work with the wonderful state Health Department here, Dr. Joann Schaefer and Jackie Miller primarily. Have great experience in working with them in many different topical areas. But briefly to highlight some of the missions, some of our HHS operating divisions, for example, the Administration for Children and Families, ACF, they're responsible for programs that promote economic and social well-being of children, families, and communities. And like

I said, I'm going to only highlight a couple. The Center for Medicaid and Medicare Services, or CMS, they provide healthcare to about everyone in...about one in every four Americans. Medicare provides health insurance for elderly and disabled Americans. Medicaid, a joint federal/state program, provides health coverage for low-income persons, including children and nursing home coverage for low-income elderly. The Centers for Disease Control and Prevention provide a system of health surveillance to monitor and prevent disease outbreaks, including bioterrorism, implement disease prevention strategies, and maintain national health statistics. The Food and Drug Administration, they assure the safety of foods and cosmetics and the safety and efficacy of pharmaceuticals, biological products, and medical devices. The National Institutes for Health is the world's premiere medical research organization supporting research projects nationwide in diseases, including cancer, Alzheimer's, diabetes, arthritis, heart ailments, and HIV/AIDS. The Indian Health Service works with tribes, Native American or American Indian tribes. The Indian Health Service provides health services to American Indians and Alaska natives in more than 560 federally recognized tribes. And last but not least, the Health Resources and Services Administration provides access to essential healthcare services for people who are low-income, uninsured, or who live in rural areas or urban neighborhoods where healthcare is scarce. Very quickly on the next slide, I want to just highlight where we are. HHS is broken out into ten regions. Our region is Region 7. We're actually the smallest region of all of the ten regions. And if you look at the number of states, there are four states that are in Region 7: the states of Iowa, Nebraska, Kansas, and Missouri. And as I mentioned, as a regional health administrator, we perform essential functions for HHS in three areas: prevention, preparedness for different types of man-made or natural disasters, and agencywide coordination. These functions directly and indirectly support the work of the U.S. Department of Health and Human Services and its operating divisions, and supports the administration and the secretary's priorities, as I mentioned. Within our office, in my office in Region 7, we have a regional minority health program, a regional HIV/AIDS program, a women's health program, a medical reserve component, the U.S. Commissioned Corps of the United States Public Health Service, and family

planning. Now quickly going into the history of the...just a little background once again, the history of the Affordable Care Act, House bill 3590 became Public Law 111 through 148, called at that time the Patient Protection and Affordable Care Act; and then House bill 4872 became Public Law 111 through 152, called the Health Care and Education Reconciliation Act of 2010. The bill makes a number of health-related financing and revenue changes to the Patient Protection and Affordable Care Act, and also modifies higher education assistance provisions. The prevention provisions under the Affordable Care Act are community prevention, clinical prevention, and strategy and planning. Community prevention. Community prevention requires the President to establish the National Prevention, Health Promotion, and Public Health Council. It establishes the advisory group on prevention, health promotion, and integrative public health, and appoints the United States Surgeon General as the chairperson of the council in order to develop a national prevention, health promotion, and public health strategy. It requires the Secretary of Health and Human Services, Secretary Kathleen Sebelius, and the comptroller general to conduct periodic reviews and evaluations of every federal disease prevention and health promotion initiative program and agency. It requires the director of the Centers for Disease Control to convene an independent community preventive services task force to review scientific evidence related to effectiveness, appropriateness, and cost-effectiveness of community preventive interventions for the purposes of developing recommendations for individuals and organizations delivering population base service and other policy matters. Community prevention, Prevention and the Public Health Fund: It establishes a Prevention and Public Health Fund to provide for expanded and sustained national investment in prevention and public health programs to improve health and help restrain the rate and growth in private and public sector healthcare costs. This year it was at $500 million, was allocated. Next year, $700 million is allocated for this fund, and years beyond that $2 billion per year. This community prevention fund requires the Secretary to provide for the planning and implementation of a national public health...private...public-private partnership for prevention and health promotion, outreach and education campaign to raise awareness of health improvement across the life span. It requires the Secretary, acting through the

director of the Centers for Disease Control, to establish and implement a national science-based media campaign on health promotion and disease prevention, and to enter into a contract for the development and operation for a federal Web site personalized prevention plan, too, and Director Baker mentioned that earlier. It requires the Secretary, acting through...also through the director of CDC, to award grants, these are community transformation grants, to state and local governmental agencies and community-based organizations for the implementation, evaluation, and dissemination of evidence-based community preventive health activities in order to reduce chronic disease rates, prevent the development of secondary conditions, address health disparities, and develop a stronger evidence base of effective prevention and programming. I believe Nebraska actually received one of the grants, it was the Communities Putting Prevention to Work, and that was a grant for obesity prevention. These grants were actually...were in two categories: one to address obesity and its chronic...related chronic diseases, and the other for tobacco. This also amends the Federal Food, Drug and Cosmetic Act to require the labeling of food items offered for sale in retail food establishments that is part of a chain of 20 or more locations under the same name to disclose on the menu and the menu board the number of calories contained in the standard menu item, the suggested daily caloric intake, and the availability on the premises and upon request of specified additional nutrient information. It requires self-service facilities to place, adjacent to each food offered, a sign, a sign that lists calories per displayed food item or per serving. It requires vending machine operators, who operate 20 or more vending machines, to provide a sign disclosing the number of calories contained in each article of food. Clinical prevention, general: This requires that the director of the Agency of Health, Research, Quality to convene the prevention services task force to review scientific evidence related to the effectiveness, appropriateness, and cost-effectiveness of clinical preventive services for the purpose of developing recommendations for the healthcare community. Emphasis on personalized prevention plans at all levels. Medicare patients have access to annual wellness visits, and HHS to develop a Web site where people can develop their own personalized prevention plan. It removes barriers to preventive services in general by

eliminating or reducing cost-sharing for preventive services. This act also funds scholarships and loan repayment programs to increase the number of primary care physicians, nurses, physician's assistants, mental health providers, and dentists in areas of the country that need the most. With the comprehensive approach focusing on retention and enhanced educational opportunities, the act combats the critical nursing shortage. Actually, with the $500 million that was allocated this year from the Prevention Trust Fund, $251 million was allocated for just that cause for work force development to add more family care physicians, nurses, dentists, and other healthcare providers. Clinical prevention under maternal child health services, you'll see in your slide that these are two examples of how Medicaid will improve clinical prevention. This is maternal and child health services. These are grants that are eligible...to eligible entities for early childhood home visitation programs. These programs will be implemented at the national level and by the Health Resources and Services Administration, one of the operating divisions within HHS, and grants to eligible entities to carry out personal responsibility education programs to educate adolescents on both abstinence and contraception for the prevention of pregnancy and sexually transmitted infections or diseases. These grants will probably be available in the next fiscal year. [LR467]

SENATOR CAMPBELL: Captain, can I interrupt you for a minute? [LR467]

JOSE BELARDO: Yes, ma'am. [LR467]

SENATOR CAMPBELL: Will they require a match by the states? [LR467]

JOSE BELARDO: That is still being discussed and I don't think they have finalized the plan for that as of yet. [LR467]

SENATOR CAMPBELL: Thank you. [LR467]

JOSE BELARDO: You're welcome. Clinical prevention under Medicare: In general, the

act will protect and preserve Medicare as a commitment to American seniors. It will save thousands of dollars in drug costs for Medicare beneficiaries for closing the coverage gap called the doughnut hole. Doctors, nurses, and hospitals will be incentivized to improve care and reduce unnecessary errors that harm patients. And beneficiaries in rural America will benefit as the act enhances access to healthcare services in underserved areas. The act takes important steps to make sure that we can keep the commitment of Medicare for the next generation of seniors by ending massive overpayments to insurance companies that cost American taxpayers tens of billions of dollars per year. As the number of Americans without insurance falls, the act saves taxpayer dollars by keeping people healthier before they join the program and reducing Medicare's need to pay hospitals to care for the uninsured. This also amends the Social Security Act, Title XVIII, Medicare, to provide coverage of personalized prevention plan services, including a health risk assessment for individuals, and prohibits cost-sharing for such services. It eliminates cost-sharing for certain preventive services recommended by the United States Preventive Services Task Force and it authorizes the Secretary to modify Medicare coverage of any preventive service consistent with recommendations of such task force. Clinical prevention under Medicaid: This amends Title XIX, Medicaid, of the Social Security Act to extend Medicaid coverage beginning in calendar year 2014 to individuals under 65 who are not entitled to or enrolled in Medicare and have incomes at or below 133 percent of the federal poverty line. It grants a state the option to expand Medicaid eligibility to such individuals as early as April 1, 2010; provides that for between 2014 and 2016 the federal government will pay 100 percent of the cost of covering newly eligible individuals. The act give flexibility to states to adopt innovative strategies to improve care and coordination of services for Medicare and Medicaid beneficiaries. And it extends prescription drug coverage to certain drugs used to promote smoking cessation. It provides Medicaid coverage of counseling for cessation of tobacco use by pregnant women and it amends the Social Security Act, Title XIX, Medicaid, to provide Medicaid coverage of preventive services and approved vaccines. And it also requires the Secretary to award grants to states to carry out initiatives to provide these incentives to Medicaid beneficiaries who improve, to

participate in programs to lower health risk, and demonstrate changes in health risk outcomes. Under clinical prevention, private plans, this act puts individuals, families, and small business owners in control of their healthcare. It reduces premium costs for millions of working families and small businesses by providing hundreds of billions of dollars in tax relief, the largest middle-class tax cut for healthcare in history. It also reduces what families will have to pay for healthcare by capping out-of-pocket expenses and requiring preventive care to be fully covered without any out-of-pocket expense. I believe Director Baker spoke about this earlier so I will move forward to our strategy and planning, our next slide. This act...or the Affordable Care Act helps patients take more control, as we've talked about, of their healthcare decisions by providing more information to help them make decisions that work for them. And it strengthens the doctor-patient relationship by providing doctors access to cutting-edge medical research to help them and their patients make the decisions that are best for them. All data and reports will be made available, not just to the relevant agencies within the federal government but also to the public. Much of the information will be disseminated through the Web as well as through national media campaigns. The act will promote prevention, wellness, and public health...and the public health, and provides an unprecedented funding commitment to these areas. It directs the creation of a national prevention and health promotion strategy that incorporates most effective and achievable methods to improve the health status of Americans, and reduce the incidence of preventable illnesses and disability in the United States. The Secretary has the authority to coordinate with other departments, develop and implement a prevention health promotion strategy, and work to ensure more Americans have access to critical preventive health services. Some of these topics I've already talked about, especially with the National Prevention, Health Promotion and Public Health Council I mentioned that was chaired by the Surgeon General, but that an advisory committee of nonfederal experts who will be appointed by the President, they haven't been appointed yet, and this will be a group of health professionals. Licensed health professionals participate on that advisory group. There will also be a federal advisory group, which these people have been identified, and they will be having their meeting, I believe, next month, the

federal advisory group for the National Prevention, Health Promotion and Public Health Council. There's an interagency working group also on health quality, which will help to implement the national strategy to improve healthcare quality. It creates within the Centers for Medicaid and Medicare Services a center for Medicare and Medicaid innovation to test innovative payment of service delivery models, to reduce program expenditures, while preserving or enhancing the quality of care furnished to individuals. It also establishes the National Health Care Workforce Commission to review current and projected healthcare work force supply and demand, to make recommendations to Congress and the administration concerning national healthcare work force priorities and goals. And what does this actually mean when it comes down to the individual? What is all...everything of what I've said? I'll just give you a few examples. Depending on your age and your health plan type, you may have easier access to such preventive services such as blood pressure, diabetes, cholesterol tests, many cancer screenings; counseling from healthcare...from a healthcare provider on such topics as quitting smoking, losing weight, eating better, treating depression, and reducing alcohol use; routine vaccines for diseases such as measles, polio, and meningitis, flu and pneumonia shots, which are available now and I encourage all of you to get your flu shot this year; counseling, screening, and vaccines for healthy pregnancies, and regular well baby and well child visits from birth to age 21. Keeping your children healthy, what does this mean for children? Well, this means well baby and well child visits, as I mentioned, which this includes a doctor's visit every few months when your baby is young, and a visit every year until your child is age 21. These visits will cover a comprehensive array of preventive health services, physical exams, measurements, vision, hearing screenings, oral health risk assessments, developmental assessments to identify any developmental problems, screenings for hemoglobin levels, lead, and other tests; counseling and guidance from your doctor on your child's health development; screenings and counseling to prevent and detect and to treat common childhood problems like obesity and depression and dental cavities; immunizations, as I mentioned earlier, like an annual flu shot or flu vaccine, and many other childhood vaccinations and boosters from the measles to polio. Promoting healthy pregnancy, and

for pregnant women these will include screenings for conditions that can harm pregnant women or their babies, including iron deficiency, hepatitis B; special pregnancy-tailored counseling from a doctor that will help pregnant women quit smoking and avoid alcohol use, and counseling to support breast-feeding and help nursing mothers. Preventing heart disease and obesity: These screenings include, once again, blood pressure, screenings for obesity, and counseling from your doctor, once again, to promote, sustain...and then counseling with other health professionals to promote sustained weight loss, including dietary counseling from your physician and other primary-care providers, and counseling on the daily use of aspirin to reduce the risk of stroke; tests to screen high cholesterol and diabetes. [LR467]

SENATOR CAMPBELL: Thank you, Captain, very much, for that report. [LR467]

JOSE BELARDO: Thank you. [LR467]

SENATOR CAMPBELL: Would you join us, Ms. Baker, at the table? Are there questions from the senators for the two presenters? Senator Nordquist and then Senator Hadley. [LR467]

SENATOR NORDQUIST: Thank you, again, for joining us. Obviously, there's an extensive amount of investment in the Affordable Care Act in prevention, in strategies to bend the so-called health curve. I was just wondering, are there any projections that you're aware of, either on a national level or a state level, that lay out, whether it's one program or multiple programs, the projected savings that these investments could lead to in our healthcare system? [LR467]

JUDY BAKER: I am unaware of any projections. I know the CBO was unable to score. When the CBO scored savings with different revenue streams and so on, they did not include anything like the prevention measures in that scoring, because it's unpredictable. It is intuitive that we know that when you do prevention measures that

costs are reduced. There are...in the past, and I apologize for not having CMS with us here today. We would have loved to have brought our regional partners HRSA and CMS, but they're all in Washington doing training. So there's just a whole lot of activity going on with this Affordable Care Act. But what I do know and what I can say, while it's not official, the CBO was unable to score really any savings for these prevention methods. From my experience in the past, CMS does have some statistics out there and survey and so on where they have studied, for instance, when you...and these are former CBO estimates as well. These are several years ago. But when you, for instance, allow for no cost-sharing on mammograms for Medicare patients, the cost to the federal government is reduced long term. So there are individual studies out there that show that prevention works and that it is...it both raises the quality of care, the outcomes, the length of life, and reduces the cost on the public dollar. [LR467]

SENATOR NORDQUIST: So there were no...in the calculation of the bill's costs, there were no savings included from these provisions. [LR467]

JUDY BAKER: As far as I know. [LR467]

SENATOR NORDQUIST: Okay. [LR467]

JUDY BAKER: As far as we know, there was no (inaudible) each one of these individual programs was not scored as offsetting costs to the healthcare bill. But intuitively... [LR467]

SENATOR NORDQUIST: Yeah, absolutely. [LR467]

JUDY BAKER: That's why several health economists out there actually do score that and score the actual bending of the cost curve to be lower than the CBO did. [LR467]

SENATOR NORDQUIST: Uh-huh. Sure. Yeah. [LR467]

SENATOR CAMPBELL: Senator Hadley. [LR467]

SENATOR HADLEY: Thank you. Appreciate your both being here. I don't whether you were here this morning to hear any of the testimony this morning, but... [LR467]

JUDY BAKER: We were not. [LR467]

SENATOR HADLEY: ...I find it real interesting that it's the Patient Protection and Affordable Care Act, and I certainly agree with that and I think in Nebraska we can certainly make it work. The one "A" we've left out is "accessible." And this morning we talked that...we had testimony that 18 counties in Nebraska are without a physician. Twenty percent of our counties do not have a physician in the county. One-half of the counties have a shortage of primary-care physicians. Thirty-three counties have no nurse practitioners. One-third of our counties do not have a nurse practitioner. Eighty-one percent of our counties have a shortage of nonphysician primary-care providers. And lastly, nine counties do not even have a registered nurse in them. So do you have any suggestions of how, even if we come about coming up with the affordable healthcare for every citizen in Nebraska, how do we go about making it accessible for citizens of Nebraska? [LR467]

JUDY BAKER: That's a great question, Senator, and many rural states are grappling with that very question. And I'd like for him to address it because he put it also in his report what we're doing for work force. But let me just emphasize and stress, we just did the Affordable Care Act, that's what you're studying right now, but the American Reinvestment, Recovery and Reinvestment Act, ARRA, the stimulus package, a year and a half ago started working on the healthcare work force issues. There was $250 million, I think, in that effort towards healthcare work force development. In ACA, there is a national work force planning advisory council that's being put together. And there is also, as I mentioned in my remarks, there is also at the state level going to be monies

available for states to put together their own individual and local work force planning advisory groups. It is important to look at that horizon of even 20 years from now and plan for now how we're going to fill those positions. Now...and I'll hand it over to Captain Belardo, but the Affordable Care Act then also had some provisions in it for the National Health Service Corps. [LR467]

JOSE BELARDO: Right. We mentioned that the Health Resources and Services Administration, they have been provided $250 million for just this very reason to address the shortage areas of physicians...not only primary-care physicians, but primary-care nurse practitioners, dentists, and others. And these providers actually will, as part of their payback, will be required to go to what we call health shortage areas. These health shortage areas are considered to be rural areas or working with American Indian tribes, and so that is part of their payback for providing funds for their education. HRSA, the Health Resources and Services Administration, also has a National Health Service Corps Scholarship Program, with once again these scholarships will be provided to those who are in the health professions, not only physicians but other health professions, which I'm very happy to see now even mental health professions because of the problem with depression, suicide with certain communities around the country. They are a part of this also. But they will also be providing providers to go up to primarily rural areas and that will work in federally qualified community health centers around the country. [LR467]

SENATOR HADLEY: Okay. You know, I just think this is so important and it's almost like building a highway system and the people can't afford cars. [LR467]

JUDY BAKER: Exactly. [LR467]

SENATOR HADLEY: We've got to make sure affordability and accessibility go hand in hand. [LR467]

JUDY BAKER: Absolutely, Senator, and I applaud you for having that insight. The states will get an opportunity to do planning. Sure it will be run by Legislature, probably established by Legislature, and so we can get you more information about that. Let me put a number on it for you. Between ARRA and the ACA, there is the plan to train 16,000 more healthcare professionals and they are geared toward primary care and rural distribution. So I think that, overall, we're looking at some vision and logic in both ARRA and ACA in addressing that very issue. Now, I will say that, you know, we've got a lot of work to do. There's also money available within ACA for opening up more slots for training, you know, residency slots, training more professors, opening up classrooms. Because one of the bottlenecks we have found over the years is this bottleneck at the actual training where there's not enough slots even in our academic institutions for training. So there is some provision for that in ACA as well. [LR467]

SENATOR HADLEY: Thank you. [LR467]

SENATOR CAMPBELL: Senator Pahls. [LR467]

SENATOR PAHLS: You know, and that really mystifies me a little bit, the comment you...the information you're giving us, and the professionals this morning did not seem to be aware of this. You know, we asked questions about needing additional people out there in the field. That surprises me a little bit that this information is out there. And this goes to show you how complicated this is because we had some very enlightened people speaking to us this morning, but I'm surprised they didn't throw some of this information back to us. But maybe they did and I was...my mind was floating someplace else. But remember, we had a question about the needs of individuals and how we can meet them. [LR467]

JUDY BAKER: Well, some of it...I mean this is the federal response to the issue. You know, traditionally, for instance, academic institutions have looked to the states for their opening up of slots for more healthcare training. So they may have been...you know,

there's...and there's going to have to be that effort. It has to be a partnership between the federal and state. The federal is not going to ever have enough resources out there to do all that each state needs, especially ones who have the very severe access issues you all are describing. So perhaps there was, you know, an appeal to, in addition to the federal... [LR467]

SENATOR PAHLS: Okay. Now I see, they were appealing to us... [LR467]

JUDY BAKER: Perhaps. I don't know. [LR467]

SENATOR PAHLS: Okay. No, no, no, I... [LR467]

JUDY BAKER: And they may not be aware of what the federal is doing. And it's new. You know, all of this is new. Not all this information is widely disseminated yet and only, you know, in some cases if you're proactive looking for the information are you going to come across it. But these things have been announced in regular press releases that the money is coming down the pike. [LR467]

SENATOR PAHLS: Okay. Well, in fairness to them, maybe they were approaching us at the state for us. Okay. [LR467]

SENATOR CAMPBELL: Senator Gloor, you wanted to add to this? [LR467]

SENATOR GLOOR: Yeah, I think part of the response to...they did talk about some of those. But some of the programs you mentioned, Captain, people fulfill that obligation and they leave. I mean, when it comes to loan forgivenesses, when it comes to placement in federally qualified health centers, they fulfill that obligation and once they've fulfilled it...and then you're in the process of starting all over again with somebody new, and it could be quite an uncomfortable yo-yo effect for patient populations and leave those clinics unstable, if they're good programs. But in reality, as

is the case with anything, sometimes it's hard to get people to put down roots and there's that challenge. [LR467]

JUDY BAKER: While we're on this topic, let me also mention that in ARRA there was quite a bit of funding made available for broadband distribution as well, because many rural communities have found a part of their overall strategy for addressing these issues is a very robust telehealth network and telemedicine. For instance, I have visited with an EICU, an electronical...electronic intensive care unit, that where the specialists operate out of Kansas City and the hospital is in Hays, Kansas. And they have been able to show a lower length of stay at the hospital, a higher outcomes rate, a better health status of the individual as they're discharged, less readmissions to the hospital, and lower costs over time. So they, you know, they have actually used this type of telehealth to raise quality and lower costs. That was dealt with in ARRA knowing that rural hospitals, rural communities really need to have broadband access in order to share the electronic medical information it's going to take to have an overall strategy. [LR467]

JOSE BELARDO: I was going to say in addition to that, in addition to telemedicine services, training for primary-care providers in rural health shortage areas, there are webinars that are for training services, for the trained providers. Webinars are being posted and actually where people can participate and be talking with someone possibly in Washington, D.C., or other parts of the country. So there are training opportunities via webinars that will be available also. [LR467]

SENATOR CAMPBELL: Other questions from the senators? Senator Mello. [LR467]

SENATOR MELLO: And I...this...you mentioned earlier that you were unable to have someone from CMS here today, but...and if you can't answer my question, I'd prefer that... [LR467]

JUDY BAKER: We will take it back. Uh-huh. [LR467]

SENATOR MELLO: ...we could follow up afterwards to CMS. In reference to the maintenance of effort issue, it was brought up with...when the state took funding from the American Recovery and Reinvestment Act that we had to have a maintenance of effort through Medicaid. And it was brought to the attention to our Department of Health and Human Services last November by CMS that we were providing Medicaid services under a program for pregnant women and unborn children. Ultimately, this program was not acted on by the Legislature or by the Governor and we essentially got rid of that component of Medicaid. The question I have is, does that affect anything we do currently or our standing within the American Recovery and Reinvestment Act because we didn't maintain our maintenance of effort of care prior to us accepting those funds? [LR467]

JUDY BAKER: I believe that is under review right now, am I correct? Do we have anyone from Medicaid here in the audience? [LR467]

SENATOR CAMPBELL: They will be here at 2:30. [LR467]

JUDY BAKER: That would be a good question for your Medicaid director. I think that's still under review. I'm not certain, so I would ask...I would refer that question to your Medicaid director, and if in case there is no answer from her and you would like to ask us again, please feel free to call us and ask. [LR467]

SENATOR MELLO: Okay. [LR467]

JUDY BAKER: I can get an answer, you know, potentially kind of grease the wheels to get you an answer quicker, but... [LR467]

SENATOR MELLO: Okay. [LR467]

JUDY BAKER: I am familiar with the issue. I just do not know where it stands in status right now. [LR467]

SENATOR MELLO: Okay. Thank you. [LR467]

JUDY BAKER: But thank you for asking. [LR467]

SENATOR CAMPBELL: Any other questions or comments? Thank you very much for sharing your expertise with us today. And we will take a 15-minute break, assuming that the Medicaid folks will be here at 2:30. [LR467]

JUDY BAKER: May I make one correction? [LR467]

SENATOR CAMPBELL: Oh, I'm sorry. [LR467]

JUDY BAKER: Because I believe we actually passed out a previous version, an uncorrected version of remarks. As far as I know, Nebraska has a PCIP, a preexisting condition insurance pool. Am I correct? [LR467]

SENATOR NORDQUIST: Uh-huh. Yeah. [LR467]

SENATOR COOK: Yes. [LR467]

JUDY BAKER: Yes. Okay. [LR467]

SENATOR CAMPBELL: Oh, that's right. We were going to get back to that. [LR467]

JUDY BAKER: Yes. So please correct that. Don't take that as the fact because you all have it and I'm sure it's going well. (Laugh) [LR467]

SENATOR CAMPBELL: Thank you very much. [LR467]

JUDY BAKER: Thank you. [LR467]

SENATOR PAHLS: It is. Thank you. Thank you. [LR467]

BREAK

SENATOR CAMPBELL: We will resume the hearing for LR467 and I want to take the opportunity because she slipped in the room and I think we...Senator Gloor and I are tag teaming this, filling in briefly here for Senator Gay. And Kathleen Dolezal, I think, was not here earlier and we want to thank her for the cookies that she provided to the committee. I do not think there may be one cookie here left. So thank you, Kathleen. We always appreciate the cookies. And for those who are on the Appropriations and Banking Committee, the Health and Human Services Committee was the lucky recipient of cookies every day we met. [LR467]

SENATOR NORDQUIST: Wow! Man. [LR467]

SENATOR MELLO: This about healthcare, right? (Laughter) [LR467]

SENATOR CAMPBELL: Absolutely. [LR467]

SENATOR MELLO: Double-checking. [LR467]

SENATOR NORDQUIST: Prevention and obesity, yes. (Laugh) [LR467]

SENATOR CAMPBELL: These are the healthiest cookies we have ever eaten. [LR467]

SENATOR HADLEY: Well, on the Revenue Committee, they give us a hundred dollar

bill every meeting. (Laughter) [LR467]

SENATOR CAMPBELL: Oh, sure. If you hear me say, I just have one quick question, I want you to know I always throw that in because that's what Senator Hadley says every day in the Transportation Committee and we razz him about it constantly. [LR467]

SENATOR HADLEY: Just one quick question. [LR467]

SENATOR CAMPBELL: Just one quick question. So thank you for indulging us in a little frivolity here. We are so glad to have the director of Medicaid with us, Vivianne Chaumont. Tell me, are you proposing to read this entire package here? [LR467]

VIVIANNE CHAUMONT: Pretty much. (Laughter) If I had to write it, you all have to listen to it. (Laughter) All is fair in love and war, huh? [LR467]

SENATOR CAMPBELL: Well, we're delighted you're here and can close out the day for us. It's been an interesting and an educational day for us. But Medicaid is a huge piece, so we're delighted to have you. [LR467]

VIVIANNE CHAUMONT: (Exhibit 8) Okay. Well, thank you, Senator Campbell and members of the LR467 Select Committee. My name is Vivianne Chaumont, and as Senator Campbell said, I'm the director of the Division of Medicaid and Long-Term Care for the Department of Health and Human Services. And I'm here to provide you with a high-level overview of the Affordable Care Act, which I will call the ACA, and its impact on the Division of Medicaid and Long-Term Care. As I am sure you're aware, the Department of Health and Human Services, in order to get a better idea of the fiscal impact of the changes required under the ACA, contracted with Milliman, Inc., an actuarial firm, to provide a fiscal impact estimate of the costs of preparing for and implementing the ACA. The Milliman report only examined the fiscal impact of the ACA on the Medicaid Program. A copy of the report is included in your handouts. The

changes required to Medicaid as a result of the ACA are numerous. I am going to address some of the larger changes with you in some level of specificity. Each of these changes involves some level of resource dedication from the Division of Medicaid and Long-Term Care to assess the change, develop a plan, and implement the required change. Most, if not all, of the changes also require some level of IT resource dedication for associated system changes. Likely, the most significant change to Medicaid is the addition of a new category of Medicaid-eligible individuals. Under the ACA, on January 1, 2014, Medicaid eligibility is extended to childless adults. This group will be eligible for Medicaid up to 133 percent of the federal poverty level, with a 5 percent income disregard. Therefore, eligibility will actually be at 138 of the FPL. Under the ACA, the federal government will fully fund the cost of services for individuals who are newly eligible for Medicaid through 2016, at which time the percentage of federal financial participation, FFP, decreases to 95 percent in 2017, 94 in 2018, 93 in 2019, and 90 from 2020 onward. Beginning in 2016, states will have to pay the increased match necessary to cover this population under Medicaid. Due to the increased FFP for the new eligibility group, the Division will need to make system changes to identify those newly eligible clients in order to determine which clients are eligible for the higher FFP. The higher FFP amounts are only available to those clients who are eligible as a result of the ACA expansions. The standard FFP will still apply for those individuals who would have been eligible for Medicaid under the standards in place prior to the ACA. Currently, that match is approximately 60 percent federal and 40 percent General Fund. This means that when making eligibility determinations, there will have to be two processes in place: one process that applies to the new eligibility category, and one process that applies to the current categories of eligibility under the current guidelines. States are to provide coverage for this expansion group under a benchmark or a benchmark equivalent plan. Nebraska Medicaid does not currently have a benchmark plan. A benchmark plan, as currently defined by federal requirements, is a benefit package that is based on the standard Blue Cross Blue Shield preferred provider option under the Federal Employees Health Benefit Plan; or the HMO plan with the largest commercial, non-Medicaid enrollment in the state, which I believe is Blue Cross Blue Shield at this

point in Nebraska; any generally available state employee plan; or any plan that is approved by the Secretary of the federal Department of Health and Human Services. The division will have to undertake an assessment to determine what type of benchmark plan should be developed for this population. Development and implementation of a benchmark plan will result in significant costs to the Medicaid Program. These costs include analysis of the options and potential population, as well as system and program costs. For example, the claims system will need to deal with two benefit packages rather than one. This will result in significant costs to the eligibility system and to Nebraska's already cumbersome MMIS system, the system that pays Medicaid claims. In addition to the cost of covering the services for this new expanded population, it is anticipated that there will be costs of covering the services of additional populations who become eligible as a result of other changes in the ACA. You will hear this population commonly called the woodwork population. This includes persons who are currently insured through the private market or who are uninsured but seek insurance as a result of the mandates of the ACA. There is no enhanced federal funding for this population since they could otherwise have been eligible for Medicaid prior to the ACA but chose not to apply for the program. So the regular 60-40 match applies to those populations. In addition to mandating coverage of childless adults effective January 2014, the ACA mandates Nebraska to add another population effective January 1, 2014. States will be required to provide Medicaid eligibility to children who are in foster care on their 18th birthday until their 26th birthday. Clients who qualify for Medicaid through this eligibility group will receive all benefits under Medicaid, including benefits under EPSDT, which is the Early and Periodic Screening, Diagnosis and Treatment benefit of the Medicaid Program. Currently, Nebraska provides this coverage for former foster care children to age 19. This new federal mandate results in an expansion of eligibles, has a fiscal and system impact. State plan and regulatory changes will also be necessary. Under the ACA, in order to be eligible for the higher match for the childless adult population, states are prohibited from changing the eligibility standards, methodologies, and procedures they had in place on the date of the ACA enactment, March 23, 2010. This requirement applies to adult populations until

December 31, 2013, and to children in CHIP effective September 30, 2019. This results in the inability of the state to implement any changes to Medicaid coverage which would make eligibility determinations more restrictive or eliminate certain groups from coverage, thereby limiting flexibility for budget purposes. And you'll recall that this provision came in with the health stimulus legislation a year or so ago. It's just carried on now with the ACA. Along with the necessary programmatic and system changes, there will also be increased administrative costs to the department related to the new category of Medicaid eligibles and the anticipated increase in the Medicaid population resulting from the ACA and the effects of the ACA. More eligibles result in the need for more staff to process more claims, to work with providers, to ensure compliance with different program requirements. Statutory changes will be made during the 2012 Legislative Session. Significant state plan and regulatory changes will need to be made. All these changes will need to be in place by January 1, 2014. Another requirement of the ACA relates to the interplay between the Medicaid Program and the Insurance Exchange each state will be required to have in place. Because Medicaid will be one option of insurance available to persons, the Exchange will need to be able to make Medicaid eligibility determinations and there will need to be an interchange of information between the Medicaid Program and the Insurance Exchange in order to provide seamless enrollment for all programs. This issue represents major fiscal and systems impacts for the department, as the department's eligibility and MMIS systems will need to be changed in order to interface with the Exchange. I'm just beginning conversations and planning with Ann Frohman and her department on the Exchange issue. Many of these details will be examined under the auspices of federal Exchange planning grant that Nebraska is seeking. The increase in eligibles is probably the largest but certainly not the only significant change required by the ACA. Effective January 1, 2010, the rebate percentages for covered outpatient drugs provided to Medicaid clients increased. The minimum rebate percentage increased from 15.1 to 23.1 for brand-name drugs and from 11 percent to 13 percent for generic drugs. The impact of the increased rebate accrues 100 percent to the federal government. It's anticipated that this increase in the rebate will result in a significant reduction in Nebraska's supplemental rebates, or

a loss of roughly $74 million from 2011 to 2020. The ACA requires Medicaid Programs to pay physicians for certain primary care services at 100 percent of the Medicare fee schedule for services provided between January 1, 2013, and January 1, 2015. During that time period, the increased costs of that federally required rate increase will be paid with 100 percent federal funds. These changes will result in increased workload and system impacts to Medicaid and IT staff. ACA provides that states will have the option of reducing payments for these codes on January 1, 2015. Nebraska Medicaid currently participates in making payments to hospitals under the Disproportionate Share Program, DSH. Under DSH, if hospitals exceed the statewide average thresholds for uncompensated care, they are eligible to receive a DSH payment, which helps offset the cost of a portion of the uncompensated care provided. The ACA reduces DSH allotments to states as their uninsured rates decline. This reduction begins in 2013. This will have a fiscal impact and will result in state plan and regulatory changes. As you know, Nebraska operates a Medicaid expansion CHIP Program. Under the ACA, states are required to maintain income eligibilities for CHIP through September 30, 2019. Nebraska's current income eligibility level for CHIP is 200 percent of FPL. Beginning on October 1, 2015, and ending September 30, 2019, states will receive a 23 percentage point increase in the CHIP match rate, subject to a cap of 100 percent. Based on Nebraska's federal match for CHIP, this would bring the federal financial participation to roughly 93 percent for that period of time, which will result in a savings to us. There are a number of other issues of particular significance that I'd like to point out at this time. And this is a short list of all the things that are in the ACA, but many include requirements that impact the current, already taxed, MMIS system. The ACA requires states to implement the National Correct Coding Initiative, known as the NCCI, for use in processing Medicaid claims by October 1, 2010. The NCCI is a group of edits used in the claims processing system to detect fraud. These edits are currently used by Medicare in processing claims. This change has a major impact in our claims processing system. Guidance related to the NCCI requirements was provided by CMS on September 1, 2010, one month before the implementation is supposed to be in place, which gives states little time, I would say no time, to implement the changes.

States must provide coverage for freestanding birth centers. These providers are not currently enrolled in the Medicaid Program and, therefore, this will result in an expansion and this requires program and system changes. I think we're not aware of any freestanding birth centers currently, in Nebraska anyway. Medicaid must provide concurrent care for children who are eligible to receive hospice services. This allows children who are enrolled in either Medicaid or CHIP to receive hospice services without foregoing curative treatment related to a terminal illness. The Secretary of the department, federal Department of Health and Human Services, will be creating regulations to ensure that states develop service systems designed to eliminate barriers to providing home and community-based services. This includes allocation of resources to maximize beneficiary independence, including the use of client-employed providers, supporting the beneficiary in designing an individualized, self-directed, community-supported life, and improving coordination among providers. The regulations issued by the Secretary will be reviewed for a determination of impact at that time. Many questions that state programs have remain unanswered because details must be promulgated as federal regs by CMS. Beginning on January 1, 2012, states are responsible for the collection of adult health quality measures, similar to the CHIP pediatric quality measures. Effective September 30, 2014, states will have to provide annual reporting to the Secretary of Health and Human Services related to adult health quality measures. Collection of the required quality health information is limited by our current claim system, the MMIS. This will result in policy changes and have a system impact. The Secretary of HHS will be providing the states regulations that prohibit Medicaid payments for services related to health-acquired conditions. The Secretary will develop a list of healthcare-acquired conditions. When this direction is made available to the states, this change will have a program and system impact. Provider screening and other enrollment requirements under Medicaid, CHIP, and Medicare are being reviewed by the Secretary of Health and Human Services and the Office of the Inspector General to determine screening procedures for enrolling providers and suppliers in Medicaid, CHIP, and Medicare. The level of screening will be determined according to the risk of fraud, waste, and abuse for a category of providers or suppliers.

Screening procedures must include a licensure check, and may include, at the Secretary's discretion, a criminal background check, fingerprinting, unscheduled and unannounced site visits, database checks, and other screening as deemed appropriate. To pay for the new screening measures, the Secretary is required to impose a fee of $500 for institutional providers. The new screening procedures will apply to these providers and suppliers revalidating their enrollment beginning September 19, 2010. It will apply to new providers and suppliers beginning March 23, 2011, and to current providers and suppliers March 23, 2012. Additional information is necessary prior to the implementation of this section. Recovery Audit Contractor, better known as RACs, Program audits are being expanded to Medicaid effective December 31, 2010. States must contract with a RAC to identify and recoup with the RAC contractors, to identify and recoup underpayment and overpayments in Medicaid and waiver programs. RACs are paid on a contingency basis. Additional information is required from CMS before we can move forward in implementing this program. Providers who are terminated from participation under Medicare or another state plan must be terminated from participation under Medicaid. States must terminate individuals or entities from Medicaid participations if individuals or entities are terminated from Medicare or another state's Medicaid Program. That's effective January 1, 2011. Medicaid must exclude individuals or entities from participation in Medicaid for a specified period of time if the entity or individual owns, controls, manages an entity that has failed to repay overpayments during the period, as determined by the Secretary, is suspended, excluded, or terminated from participation in any Medicaid Program, or is affiliated with an individual, entity that has been suspended, excluded, or terminated from Medicaid participation. It is clear that health reform results in sweeping changes to the Medicaid Program in Nebraska and that it will take significant effort to assess, develop, and implement these changes. Thank you for the opportunity to provide you with this information. [LR467]

SENATOR CAMPBELL: Well done. Questions from the senators? Senator Mello said he had a full page. [LR467]

VIVIANNE CHAUMONT: A full page of questions? [LR467]

SENATOR MELLO: I'll try to keep this as quick as possible, Director Chaumont. Thank you for your testimony, a very thorough testimony, and it shed some light on some issues that I was going to ask questions about so I might have to review it again. I'd like to start off, I guess, expressing a bit of disappointment in regards to some correspondence I've had with the Department of Health and Human Services. I sent a letter to Director Winterer requesting information that your department used, compiled, as well as working papers that were developed or used or utilized from staff from the department to compile the Milliman report. Unfortunately, my letter got lost in the mail apparently, and thus, we've been scrambling to try to get this information from Director Winterer and which my office provided me today before the hearing, essentially a letter he sent Senator Nordquist's office, which didn't ask for the exact same information but asked for some similar tidbits here and there. So while it appears that the department is not providing the information that I request, I hope that we can find some resolution in regards to find whether it's e-mails between staff and HHS, Department of Insurance, the Governor's Office, everyone who is involved in compiling this report, because I know that there is information that the public deserves. But if the agency is not willing to provide the legislative branch this information, I'm concerned of what the general public would have access to. So hopefully, it's something we can work on after the hearing. I couldn't get it today prior to, but it's something I'm sure that we can sit down and work on together afterwards. [LR467]

VIVIANNE CHAUMONT: There's absolutely no problem with that. And I apologize, I've been out of the office for the last two and a half weeks. But I know that a letter, whatever it was you sent, nobody has a copy of it. I saw your e-mail that said that what your e-mail asked for was documentation and materials used in the drafting of that report. I have asked Milliman to provide me with that so that I can provide it to you in a letter. So that's been requested and, you know, the Milliman folks are the ones that did the report, so I'm asking them exactly what it was that they used and you'll be provided

that information. [LR467]

SENATOR MELLO: Okay. Thank you. I appreciate that, Director. Real quick, and it might just be good for the record and to have...provide us a little background to know kind of where we're at, it was my understanding that the department engaged in a contract with Forethought to provide some computer services for MMIS, a large contract anywhere between $40 million to $50 million, in which the department ended up terminating that contract but still ended up spending close to...it averaged $6 million to $7.5 million on a product that ultimately we are not using or not going to be able to use. Can you give us an update of kind of what happened after, I guess, that we became aware of that, I guess, that the money that was spent on a product that essentially we don't use? [LR467]

VIVIANNE CHAUMONT: Well, the department contracted with Forethought Group to build a new MMIS system. After approximately 9 to 12 months, it became clear to us that this contractor was not going to be able to produce a product that was going to be satisfactory to the department, so we moved to terminate. So Forethought Group did not end up producing an MMIS system. They did produce some work product for which we paid, which we will be able to use when we contract again to do an MMIS system with a different contractor when we decide to go down that route. So to say that we got nothing out of the money that we spent isn't accurate. We didn't get what ultimately we wanted to get, which was a new MMIS system, but it wasn't...you know, we did get something that we'll be able to use again. [LR467]

SENATOR MELLO: So we'll be able to get...we got some workable product. [LR467]

VIVIANNE CHAUMONT: Yes. [LR467]

SENATOR MELLO: Would it be safe to say then that...I noticed multiple times in your testimony you mentioned significant costs to the MIS, MMIS system, but somewhere

would it be safe to say that we already had $40 million to $50 million budgeted to build a new MMIS system, so any changes that would happen in Medicaid with healthcare reform, the ACA, we could build that into a new system that we currently already have the money budgeted for to build the system? [LR467]

VIVIANNE CHAUMONT: Theoretically, but no. Because in fact, (laugh) I wish I...trust me, I wish the answer to that was yep, no problem, but it isn't. And the problem is that these things are going to have to be in place January 1, 2014. And I can tell you that there is no way that if we started...if we had a contractor starting today that we would have a system, a new MMIS system in place on 2014. So what we're talking about is having to make some changes, some adjustments to our current system and then, absolutely, at some point, bringing...when we build a new MMIS, we will build into the new MMIS all of the things that we're talking about here. But it's not going to be that...changes are going to have to be made, you know, starting sooner than we would have a new MMIS system. [LR467]

SENATOR MELLO: So it's safe to say that then the department will not be building a new MMIS system. [LR467]

VIVIANNE CHAUMONT: No, it's...what I said was that we will not have a new MMIS system in place by January 1, 2014. [LR467]

SENATOR MELLO: So we're going to then build two systems or essentially...or build a new system which won't be done by January 1, 2014, and then revamp our existing one to allow us to get to January 1, 2014, and... [LR467]

VIVIANNE CHAUMONT: We're going to have to make some adjustments to our current system to be in compliance with some of the things that we need to do. [LR467]

SENATOR MELLO: Okay. One question and I'll let other members, I know have other

questions. Something that I took from your report here, from the Milliman report, is that...it was based on using census data. And I think we heard from multiple testifiers today that the Affordable Care Act does not include coverage for those who are illegal immigrants or undocumented citizens of our country. How did the Milliman report then account for that component of the bill, that component of the legislation knowing that census data completely includes anyone regardless of documentation or citizenship? And how did...I guess the bigger question is, how much cost is associated with that population that they included in your report? [LR467]

VIVIANNE CHAUMONT: My recollection, and I'm going to have to go back and check on that, I apologize for not remembering that detail, but my recollection was that there is an adjustment made in the report for undocumenteds. And don't forget that undocumented folks are not eligible for your regular Medicaid Program, but undocumented folks are eligible for emergency services. And so those costs are going to, you know, continue to be paid currently under the Medicaid Program and a large cost of that service of emergency services is labor and delivery, which is considered an emergency. And if anyone of you have ever had a baby, you would know why. And that gets paid for and that's a big part of those costs. But I can follow up on that. [LR467]

SENATOR MELLO: Okay. Well, I know that...please do because I know the George Washington University study, specifically, I think, lays out that the Milliman report appears to have included undocumented citizens or illegal immigrants into the report without making any mention at all of withdrawing that population. [LR467]

VIVIANNE CHAUMONT: Right, and I don't think anyone from George Washington University has contacted me or Milliman to ask them if they, in fact, did. [LR467]

SENATOR MELLO: Okay. [LR467]

VIVIANNE CHAUMONT: The report, I think, says exactly what you said, "appears to

have included." [LR467]

SENATOR MELLO: Okay. [LR467]

SENATOR CAMPBELL: Senator Gloor. [LR467]

SENATOR GLOOR: Thank you, Senator Campbell. Misery loves company and so as we talk about the MMIS system challenges we have, there are going to be a lot of other states that have that similar challenge. Don't we have an opportunity to take advantage of vendors who are, in fact, trying to put together and cobble together updates? It isn't just a case of misery loves company. It's that when this happens, usually the price has the potential of going down. What do we know or what do we finding out about that? [LR467]

VIVIANNE CHAUMONT: You know, yeah, that's a really good question. You know, unfortunately, I have to tell you that in the MMIS world, that hasn't been the experience of most states that, you know, you build an MMIS over here and then when they build a second one, it's less expensive. But I think that... [LR467]

SENATOR GLOOR: But we've also looked for different things. Now we don't have...now we're all looking for somewhat the same things. [LR467]

VIVIANNE CHAUMONT: Well, yes and no. Don't forget that the basic Medicaid Program is still, you know what they say, 50 Medicaid...50 states, 50 Medicaid Programs. So...and that's still the majority of Medicaid clients are going to come through that. So then the other, you know, maybe the expansion, populations of childless adults up to 138, might be easier. In spite of that, I think that the federal government is getting tired of paying for MMIS systems. Don't forget, they pay 90 percent of the costs of the MMIS systems over and over and over again in the states, and there is finally movement among the vendors to create a product that is more easily transferable or that's more

modular so that...so that the costs are down. Unfortunately, a lot of states that have brand new MMISs, Oregon, for instance, just had theirs about a year ago, EDS built theirs, and that system isn't 5010 compliant, isn't ICD-10 compliant, and doesn't do any of the health reform stuff. So they have a new system and they're going to have a whole lot of expenses. So in a way, the bad experience that we had with our contractor, which I'm not going to say wasn't a bad experience because it was pretty painful, may have been...I think will be a blessing in disguise because when we go to build a system we will have all these things that we wouldn't have had. We would have had that system and then we still would have had a lot of things to build. So hopefully the MMIS world is improving. You know, I get a lot of phone calls from vendors that build MMIS systems and there are places--God, where is that one, just--where new systems are coming up but that hopefully, once we decide to go with a product, we can...we can do more of that. I also think that the...that we'll change our approach to the way we looked at doing the MMIS system. Instead of saying, you know, here's the way Nebraska does things, you need to build us a system to absolutely copy everything Nebraska does, maybe what we need to do is say, okay, here's a system that's already built. You know if they do provider enrollment slightly different than the way we do it, can we just do it their way and save us the cost of that, you know, if there's no difference as to quality or, you know, anything for the program, efficiency, why wouldn't,...you know? So we're going to be much...looking at that much more than was the case in the previous build. [LR467]

SENATOR GLOOR: Okay. [LR467]

SENATOR CAMPBELL: Senator Nordquist. [LR467]

SENATOR NORDQUIST: Okay. Thank you, Director Chaumont, for being here today. I'd like to start just with kind of what I see as limits of the Milliman report and kind of the reason, I mean, for the report. At this time, with so many questions around healthcare reform and a lot of unanswered pieces, why did the division...was it the division that made the decision, was it the department, but who made the decision and why at this

point in time was it conducted? [LR467]

VIVIANNE CHAUMONT: Well, you know, as health reform was happening, as the different amendments and things, we kept getting requests of, you know, how much is this going to cost, how much is it going to cost by everybody. (Laugh) And we did our best at the time to try to figure out those...what those numbers were. At some point, we determined that we really didn't have the expertise in the department to do a full analysis of some of the things that were in health reform. I think we believed that it was prudent planning to get an idea of how much this was going to cost because you folks would, at some point, need to know how much budget impact was going...it was going to be on the state of Nebraska. So we asked then for an actuarial firm to help us with that. [LR467]

SENATOR NORDQUIST: And the numbers that are in the report are just for the Division of Long-Term Care and Medicaid? [LR467]

VIVIANNE CHAUMONT: Medicaid. The numbers in the report are Medicaid numbers so there isn't anything in the report about if you're going to save money on your high-risk pool, how's that going to impact. You know, we just ask what is the Medicaid impact for...you know, for us. [LR467]

SENATOR NORDQUIST: Okay. So it would be wrong for someone to say that this is the cost of healthcare reform without... [LR467]

VIVIANNE CHAUMONT: Oh. [LR467]

SENATOR NORDQUIST: ...I mean if... [LR467]

VIVIANNE CHAUMONT: This is the cost to the Medicaid Program... [LR467]

SENATOR NORDQUIST: Okay. Good. Okay. [LR467]

VIVIANNE CHAUMONT: ...about...with healthcare reform. [LR467]

SENATOR NORDQUIST: Okay. [LR467]

VIVIANNE CHAUMONT: Uh-huh. [LR467]

SENATOR NORDQUIST: And I had some correspondence with Director Winterer and he indicated in his letter that at this point in time they're still assessing the impact on other divisions. I asked for a list of programs that were impacted and they weren't able to provide it at this time. So I think there still are a lot of questions, a lot of impacts on other places that I believe will create a lot of potential savings. I want to look at the numbers of enrollees provided under the Milliman report. They have two estimates: a midrange and a full participation. Full participation, it doesn't say specifically but is that a 100 percent participation... [LR467]

VIVIANNE CHAUMONT: Yeah. [LR467]

SENATOR NORDQUIST: ...that by full? [LR467]

VIVIANNE CHAUMONT: Uh-huh. [LR467]

SENATOR NORDQUIST: I guess my question...I brought this up earlier with, I think, Joy from NCSL. There's an exemption in the personal individual mandate, if you're below 100 percent of poverty, from paying a fine for not having insurance. [LR467]

VIVIANNE CHAUMONT: Uh-huh. [LR467]

SENATOR NORDQUIST: I guess why would we even consider a full participation rate

when if those people don't have that financial incentive to get...or to get coverage, it's very similar to what they have now and we don't have full participation in Medicaid now? [LR467]

VIVIANNE CHAUMONT: Right. Because what I wanted was give me the worst-case scenario. A hundred percent is the worst-case scenario. So now you have 100 percent numbers. Do you want 80 percent numbers? Back it off by 20 percent. You think 60 is an appropriate number? Back it off by 40 percent. [LR467]

SENATOR NORDQUIST: Okay. Okay. [LR467]

VIVIANNE CHAUMONT: You think nobody is going to come to Medicaid? It's only 20 percent? [LR467]

SENATOR NORDQUIST: Sure. [LR467]

VIVIANNE CHAUMONT: You know, but you have the worst-case scenario. We have the outside parameter so that's the reason. [LR467]

SENATOR NORDQUIST: Okay. [LR467]

VIVIANNE CHAUMONT: And I don't think the report says and I don't think any of us have ever said we're, you know, we're betting my firstborn son that... [LR467]

SENATOR NORDQUIST: Sure. Sure. [LR467]

VIVIANNE CHAUMONT: ...that, you know, it's going to be 100 percent. [LR467]

SENATOR NORDQUIST: Sure. I have heard people throw that number around, though, from the administration, saying, you know, up to, and that certainly... [LR467]

VIVIANNE CHAUMONT: Uh-huh, it's up to. Yeah. [LR467]

SENATOR NORDQUIST: ...while it's "up to," it certainly is a very extreme estimate, I would say. If this is just for Medicaid and Long-Term Care, there's $25 million in there for an Insurance Exchange. Do you anticipate that being under your division? [LR467]

VIVIANNE CHAUMONT: I don't...no, we haven't had any discussions about that coming under us. [LR467]

SENATOR NORDQUIST: Okay. [LR467]

VIVIANNE CHAUMONT: I think states are doing...are talking about doing it different, and so far everyone is just talking. [LR467]

SENATOR NORDQUIST: Okay. If I can find my correspondence I got, been sending a few letters out recently,... [LR467]

VIVIANNE CHAUMONT: Yes. (Laugh) [LR467]

SENATOR NORDQUIST: ...because...and I don't know where this...maybe you can give me some insight where the $25 million figure came from. I had correspondence with Director Frohman and she indicated that she's not researched the cost associated with creating a Health Insurance Exchange; hence, I do not have any information upon which to applying on Milliman's report. So how is $25 million included in there without...I mean Director Frohman doesn't have any idea where that number came from and is it just a shot in the dark? [LR467]

VIVIANNE CHAUMONT: Where are you seeing $25 million? Oh. [LR467]

SENATOR NORDQUIST: Probably (inaudible). [LR467]

VIVIANNE CHAUMONT: I think on administration. Let me tell you where the $25 million I believe came from. Basically, a Medicaid Program and our Medicaid Program has about a 3 percent admin. load. That's where the 25 percent additional money came from. [LR467]

SENATOR NORDQUIST: Uh-huh. Okay. And is it... [LR467]

VIVIANNE CHAUMONT: I don't...I don't read that to say, and I know...and I know Milliman...the Milliman actuary isn't saying the Insurance Exchange will cost $25 million. I think they put that money in as far as admin. is concerned. You know, we have 100 percent FFP for some things, we have less FFP for other things. The state has got zero administrative costs. The ACA gives HHS $1 billion for administrative costs; it gives the state zero for administrative costs. And that's, you know, that is the point I was trying to make throughout the testimony. There's all these things that we need to do in order to implement the bill and we got no administrative costs, no additional allotment to do any of it. [LR467]

SENATOR NORDQUIST: Uh-huh. For the Exchange, though, I've heard some people...and maybe the $25 million isn't just for the Exchange but other administrative costs,... [LR467]

VIVIANNE CHAUMONT: It is. [LR467]

SENATOR NORDQUIST: ...but it says "as well as the establishment of an Exchange." Many states are talking about those being self-supporting, I mean, and that there's no indication here that we would do that. [LR467]

VIVIANNE CHAUMONT: That's true. I've heard those talks as well, but that is

self-supporting after establishment of the Exchange. And these things don't just... [LR467]

SENATOR NORDQUIST: Yeah. Okay. [LR467]

VIVIANNE CHAUMONT: ...come up out of nothing. I mean there's a cost to build it. [LR467]

SENATOR NORDQUIST: Sure. [LR467]

VIVIANNE CHAUMONT: Maybe it is self-supporting afterwards,... [LR467]

SENATOR NORDQUIST: Uh-huh. [LR467]

VIVIANNE CHAUMONT: ...but it needs to be built. [LR467]

SENATOR NORDQUIST: Sure. I guess I jumped around here. Back to the Milliman enrollment numbers, the department sent...or not the department, the Governor sent a department estimate to the federal delegation in mid-December of '09, at which time the eligibility provisions didn't change in the bill from that point in time. In those numbers I guess two things strike me. First, they're pretty...they're significantly different. Under the department's estimate of December '09, it's roughly 71,000 to 74,000 new enrollees. Now those are not all newly eligible. Some of those are woodwork individuals. Milliman's is, the mid participation range is 107,000. The department scaled up theirs from 71,000 to 74,000 from 2014 to 2019. Milliman's started at the top end right away in 2014 assuming that 107,000 enrollment. Do you know why that change in philosophy and why the change, I guess, overall and the significant...that's a 30 percent difference in...30-40 percent difference in numbers. [LR467]

VIVIANNE CHAUMONT: Yeah, I just know that we asked Milliman, give us your best

estimate of what these things are going to cost based on your actuarial experience and whatever data they have. They provided this report. The reason we asked them to provide the report was that we didn't believe that our current staff had the level of...the depth of expertise. [LR467]

SENATOR NORDQUIST: Okay. [LR467]

VIVIANNE CHAUMONT: They're great, don't get me wrong, but they're not used to doing this kind of thing. [LR467]

SENATOR NORDQUIST: Sure. Sure. [LR467]

VIVIANNE CHAUMONT: That was necessary and we asked them to do that estimate for us. [LR467]

SENATOR NORDQUIST: Okay. One last question, and maybe I just didn't see it in the Milliman report. The increased 20 percent or 23 percent in CHIP support to the state, I guess I did see it in there, it seemed like it was significantly smaller again than the numbers provided by the department. I think the department was looking in the neighborhood of...it was around $6 million a year. Here, the numbers here started at an additional $6.5 million in 2014, and by 2019 it was $9.3 million a year in increased federal funds and a decrease...an equivalent decrease in state funds, for a total during that period of $52 million additional federal funds and $52 million less state funds. I guess, number one, was it in the Milliman report? And I don't think it was the...the numbers were significantly less. Do you know? [LR467]

VIVIANNE CHAUMONT: The... [LR467]

SENATOR NORDQUIST: I'm trying to find where that was. [LR467]

VIVIANNE CHAUMONT: Page 7 in the Milliman report talks about the enrollment shift. [LR467]

SENATOR NORDQUIST: Okay. All right. Okay. I'll have to look through some of the... [LR467]

SENATOR CAMPBELL: Senator, of course we'll let you look for just a minute... [LR467]

SENATOR NORDQUIST: Yeah, go ahead. Yeah. [LR467]

SENATOR CAMPBELL: ...just because Senator Mello has got a question. [LR467]

SENATOR NORDQUIST: Yeah, absolutely. [LR467]

SENATOR CAMPBELL: So we'll come back to you if you find it in the report. [LR467]

SENATOR MELLO: Thank you, Senator Campbell. And thank you, Director Chaumont. I mean to some extent, just hearing your interchange with Senator Nordquist, I want to make sure I get this correct. I mean the Milliman report is still based on data from the Department of Health and Human Services, so your previous statement to Senator Nordquist, saying you didn't have the expertise, you still provided them the data, though, that they utilized to produce this report. So that discrepancy he mentioned in regards to the 75...74,000 and the 107,000 that ultimately was in the Milliman report,... [LR467]

VIVIANNE CHAUMONT: Uh-huh. [LR467]

SENATOR MELLO: ...that's still your department's data. That would be correct, right? [LR467]

VIVIANNE CHAUMONT: No, it was census data. It was department data and all data

can be interpreted differently. You know, it's one thing to collect data and it's another thing to analyze data. And where I felt that we needed more help was in data analysis. So, yeah, we provide data to them. We provide, you know, what we had done, but we expected them not to take what we had done and put their stamp on it. We asked them to do an independent review, an, you know, actuarial review of the data and of the information that we had, and that's what they did. [LR467]

SENATOR MELLO: Was there correspondence, I imagine, in-between Milliman and the agency then regarding some of this data, asking questions perhaps about the report that the Governor sent to the federal delegation in December regarding your department's initial assessment? I mean their... [LR467]

VIVIANNE CHAUMONT: I don't remember that coming up but, yeah, they asked us, you know, what...we asked them what can we give you and they told us what we could give them and we gave it to them. Uh-huh. [LR467]

SENATOR MELLO: And there was...do you remember, was there any correspondence furthering that in the sense of whether or not your agency provided some of your own analysis to them of here's the data, here's the components of the data? [LR467]

VIVIANNE CHAUMONT: We provided to them what...the analysis that we had done... [LR467]

SENATOR MELLO: Okay. [LR467]

VIVIANNE CHAUMONT: ...which is data, yeah. [LR467]

SENATOR MELLO: Okay. And I'm sure it's... [LR467]

VIVIANNE CHAUMONT: And told them here's what we did but we want you to analyze.

Yeah. [LR467]

SENATOR MELLO: And I think if we get... [LR467]

VIVIANNE CHAUMONT: Uh-huh. Uh-huh. [LR467]

SENATOR MELLO: ...we further get those documents and records... [LR467]

VIVIANNE CHAUMONT: Uh-huh. [LR467]

SENATOR MELLO: ...and e-mails, I'm sure that will explain it. One thing that...and it's probably just a small change in your testimony in regards to the percentage that changes from 100 percent to 95 percent. Your testimony says starting in 2016 the state decreases from 100 percent increased...enhanced FMAP to 95 percent, where a previous speaker, I don't mean to put...our previous speaker from NCSL's report said actually 2017 is when the state's enhanced FMAP percentage goes to 95 percent. So is that... [LR467]

VIVIANNE CHAUMONT: Well, I can check on that. That could be an error... [LR467]

SENATOR MELLO: An error? A small oversight? [LR467]

VIVIANNE CHAUMONT: ...somewhere. (Laugh) Yeah. [LR467]

SENATOR MELLO: That would just be...I think for the opportunity... [LR467]

VIVIANNE CHAUMONT: Yep, I can. Let me...let me check on that for you. [LR467]

SENATOR MELLO: ...to correct the record. [LR467]

VIVIANNE CHAUMONT: Yeah. Yep. [LR467]

SENATOR MELLO: I mean most other people I think we've heard from today, testifiers, also had 2014, '15, and '16 with the 100 percent... [LR467]

VIVIANNE CHAUMONT: Uh-huh. [LR467]

SENATOR MELLO: ...increased FMAP. One component that...and maybe if you can share more insight on page...bottom of page 2 regarding the eligibility, and it was a question I asked earlier as well to Ms. Wilson from NCSL, that the state has the authority starting in 2013 essentially. We can reduce eligibility for populations. And then in 2019, we as a state have the opportunity or the ability, I should say, to change eligibility for our Children's Health Insurance Program. That was a very small part, I guess, of your testimony. You just kind of breezed through it. Just to make sure that we're all clear, it says, "This requirement applies to adult populations until December 31, 2013, and to children in Medicaid and CHIP effective until September 30, 2019." [LR467]

VIVIANNE CHAUMONT: Uh-huh. Yep. [LR467]

SENATOR MELLO: Would it be safe to say that the Governor could introduce a bill to the Legislature, thus introduced by a senator, to reduce eligibility in Medicaid in 2011, 2012, 2013 that would take effect in 2014, prior to I guess the state either losing that 100 percent FMAP increase that starts to trend downwards in 2017? [LR467]

VIVIANNE CHAUMONT: Okay. I'm not sure I'm understanding your question. If your question is... [LR467]

SENATOR MELLO: Let me rephrase it. The state has the authority, thus, the legislative branch as well as the executive branch of the Office of the Governor, to reduce eligibility

for Medicaid, according to your statement here as well as the information we got from NCSL this morning. [LR467]

VIVIANNE CHAUMONT: Uh-huh. [LR467]

SENATOR MELLO: That first threshold we can start changing eligibility is January 1, 2014. [LR467]

VIVIANNE CHAUMONT: Yes,... [LR467]

SENATOR MELLO: That doesn't preclude... [LR467]

VIVIANNE CHAUMONT: ...for adults, uh-huh. [LR467]

SENATOR MELLO: ...that doesn't preclude the Governor or the Legislature to introduce legislation prior to that point in time to reduce eligibility if some of these cost factors that are associated with the Milliman report is true. To reduce the cost curve that's associated with Medicaid in the Milliman report, we could do that now. Is it safe to say that that's accurate? [LR467]

VIVIANNE CHAUMONT: If that's accurate within your legislative rules that you could adopt a bill that would be effective January 1, 2014, that would change something, yes. [LR467]

SENATOR MELLO: That is, and I believe we enact legislation all the time that takes place at a further date. [LR467]

VIVIANNE CHAUMONT: Okay. Yeah. [LR467]

SENATOR MELLO: So I'd assume that's safe to say. One I guess kind of a... [LR467]

VIVIANNE CHAUMONT: But...but here's the question, and I don't know the answer to it. But, okay, so you have a current group that's current...you have a group that's currently eligible. You adopt a bill this next legislative session to say those adults are not going to be currently eligible in January 1 of 2014, except I can tell you that pretty much every adult group will be under 200...under the pretty much 138 percent of the FPL so you will have to cover them because they'll be an adult. They'll be in a category that's under 138 percent and you'll still cover them at the regular match because they would have been eligible under your previous thing. So what would be to be gained? [LR467]

SENATOR MELLO: You could reduce...but I'm saying...I guess the point that I'm asking is you could reduce Medicaid eligibility from where we're at right now, 185 percent, to 138 percent. [LR467]

VIVIANNE CHAUMONT: We don't have any adults at 185 percent. Oh, pregnant women? [LR467]

SENATOR MELLO: Yes. [LR467]

VIVIANNE CHAUMONT: I don't know the answer to that. Yeah. [LR467]

SENATOR MELLO: Yes. If you could follow up with my office, I'd appreciate it. [LR467]

VIVIANNE CHAUMONT: Uh-huh. Uh-huh. [LR467]

SENATOR MELLO: I'm fairly certain our interpretation is, yes, that could be done, but it would be helpful to us. Thank you. [LR467]

VIVIANNE CHAUMONT: So we're going to add all these childless...the Legislature will be willing in 2014 to add all these childless adults and eliminate coverage for pregnant

women. [LR467]

SENATOR MELLO: If that's...I guess...I guess my question is whether... [LR467]

VIVIANNE CHAUMONT: Yeah. That, you're right, that may be possible... [LR467]

SENATOR MELLO: ...that was...that... [LR467]

VIVIANNE CHAUMONT: ...but is that in the slightest bit probable? [LR467]

SENATOR MELLO: Well, I...once again, I think in regards to some of the dialogue and some of the, I would say, rhetoric we've heard regarding this Milliman report, I think it's fair to say that there are options available, both to the executive and legislative branch, to look to bend the cost curve of Medicaid without simply shouting at the rain. And so you provide...if you can provide that information to my office... [LR467]

VIVIANNE CHAUMONT: Uh-huh. [LR467]

SENATOR MELLO: ...regarding the pregnant women population, that would be helpful. [LR467]

SENATOR CAMPBELL: Okay, we're going to take Senator Gloor's question, and then Hadley, and then Senator Nordquist. [LR467]

SENATOR GLOOR: This gives me an opportunity to thank your department for the great work they've done on the medical home pilot project that we have out there, as you once said, your little project, I think is how you referred to it, but... [LR467]

VIVIANNE CHAUMONT: (Laugh) It's one of the bright spots of my job. (Laugh) [LR467]

SENATOR GLOOR: Well, then this is going to be a good exchange. It is a state option, we know through the act, and we are at a stage now, and I'm serious that your staff along with the volunteer physicians have really worked hard and I think we're a year ahead of schedule from where we thought we would be. That speaks well, I think, to the effort that they've put into it. But we know it's going to be successful or it wouldn't be something that was built into the act. And the more we hear about medical home initiatives, the more that we hear that they actually have the opportunity to reduce significant cost and provide great care, better care and great patient satisfaction all because of the focus on primary care. How quickly could we move larger numbers? And I understand that you need to have and we as a Legislature would need to have proof that the pilot projects are doing what they're supposed to do. But assuming, you know, a year into it, and it's a two-year pilot, a year into it we're starting to get numbers back. Is this something that we'd be willing to proactively move a little quicker on to try to get larger population groups involved? [LR467]

VIVIANNE CHAUMONT: You know, I have to say one thing, and I don't mean to be a naysayer, but I have to be nervous about the statement that you made that if Congress passes a law that says something is good and will save money then it must be, because it's good and it will save money because I can probably point to all kinds of examples where that is not the case. But that said, I think that we are excited about the medical home. We are looking forward to seeing what it saves, and I think if, in fact, we find that the medical home model saves us money and provides, you know, better care, which is kind of the pitch of the medical home model, then I don't know why we wouldn't be interested in looking at that further. How quickly we could do that I don't know. And I would be very hesitant, I have to say, to move away from a model that we know saves money currently, and that's at-risk managed care, and that saves money without a doubt. But I think that if we get good results in that, and I'm excited because, you're right, we are ahead of schedule, if we start getting good results on that medical home model, I think that we need to start seeing where we could take that. [LR467]

SENATOR GLOOR: Well, and I did, you know, use the inference that we're from the federal government, we're here to help you, but the movement for medical home at the Medicaid level has been driven by individual states... [LR467]

VIVIANNE CHAUMONT: Uh-huh. [LR467]

SENATOR GLOOR: ...like North Carolina and Illinois... [LR467]

VIVIANNE CHAUMONT: Uh-huh. [LR467]

SENATOR GLOOR: ...and South Carolina. I mean there are a number of states that move their Medicaid Programs and are moving them very quickly now... [LR467]

VIVIANNE CHAUMONT: Uh-huh. [LR467]

SENATOR GLOOR: ...because all the things that we would hope would happen in ours seem to have been happening in theirs. So I, I mean, I think there is quite a bit of evidence out there to show that this is the right thing to do. But my concern, just to put a sharp edge on my concern, is risk-based managed care is a death spiral discounting. I mean if I... [LR467]

VIVIANNE CHAUMONT: Is what? [LR467]

SENATOR GLOOR: A death spiral at discounting. I mean I worry that eventually providers are going to say we don't agree with these fee schedules and we're going to refuse to take care of this particular patient population. And we've talked about this with individual providers before. We've got to change the ways the service and the care is provided, and that's what I like about medical home is it's not a financial model. It's a patient care model that has positive financial results. So I worry about a managed care approach, at some point in time, has its limits. When the price isn't right, pretty soon the

providers won't agree to sign contracts. [LR467]

VIVIANNE CHAUMONT: I think that's something that obviously we need. You can't do a managed care model in a Medicaid Program without guaranteeing access, so I am not as gloomy about that as you might be. But I also think that to say that the medical home model is just about care and there's no finance involved in it is not correct as well,... [LR467]

SENATOR GLOOR: There is, sure. [LR467]

VIVIANNE CHAUMONT: ...because as we developed this pilot, the help that we got from physicians and from other people, a lot of the focus of the advisory group and of everyone is, how much money is this going to...how much money are we going to make on this model? So, you know, and how are you going to reimburse that model? And I know Oklahoma put in a medical home model at some point and they had the model all set up and that took six months and it took them like two years to negotiate with physicians the finance of that. So the medical home model has a financial component... [LR467]

SENATOR GLOOR: Sure. [LR467]

VIVIANNE CHAUMONT: ...as well as a care...as a care component. I think it's another option that we need to look at that takes care of our clients in a fiscally responsible manner. You know, we can't take care of our clients if we don't have docs, so keeping docs happy is an important part of taking care of our clients, you know, keeping the providers, you know, engaged in providing access. So we can't deny that, but the medical home model is one way that we'll see, I think, at-risk managed care has proven itself. [LR467]

SENATOR CAMPBELL: Senator Hadley. [LR467]

SENATOR HADLEY: Thank you. Director Chaumont, thank you for being here. I have a different tact--the recovery audit contractor. I'm a recovering auditor. (Laughter) How do you...how do you audit Medicaid right now? Are there any...do we do a good job of making sure the right people are getting the right amounts and such as that? [LR467]

VIVIANNE CHAUMONT: You know, we can always...we can always do better probably. (Laugh) Any provider associations behind me would say, yeah, we audit the holy heck out of them. (Laugh) And you know, there's got to be a balance between auditing to where we know our tax dollars are going to the right places and not overburdening a provider so much that they just say, you know, the heck with you (laugh) from now on; we're not going to take your...you know, there's an audit or (inaudible). It's a lot of work for everybody. A lot of the latest things from the federal government is more and more audits, not just more and more audits of providers but more and more audits of clients and more and more audits of Medicaid Programs. So we have...I forget what they're called, you know, outliers and things that come up and then we go out and look at different issues. We have several federally required audit programs that we're doing right now, Medicare is doing as well. And then we have some federally required audits of eligibility, and then we have all of the audits that they do of us, so... [LR467]

SENATOR HADLEY: I guess one of the reasons I ask, I happened to see a program the other night about the insinuation of massive fraud in the Medicare...they were using the state of Florida as an example of, you know, storefront pharmacies, millions and millions and millions of dollars going. And you know, I can't imagine in Nebraska we would have that problem but I'm concerned about that. And the second question I have is it says that RACs are paid on a contingency basis. Can we pay on a contingency basis in Nebraska? [LR467]

VIVIANNE CHAUMONT: That will have to be clarified, I think. [LR467]

SENATOR HADLEY: It was my understanding that we can't,... [LR467]

VIVIANNE CHAUMONT: Uh-huh. [LR467]

SENATOR HADLEY: ...and so if you want this done that we... [LR467]

VIVIANNE CHAUMONT: No, I think...I think we have some statute now. [LR467]

SENATOR HADLEY: ...yeah, we might have to have... [LR467]

VIVIANNE CHAUMONT: Yeah. [LR467]

SENATOR HADLEY: ...you know, if we want to do that, we might have to have a statute to change that. [LR467]

VIVIANNE CHAUMONT: Yeah, we need to figure out first. I mean there's so much stuff that's in the ACA. This is just...I mean I am just skimmed, you know, some of the previous speakers, there's just a ton of things in there. And on the Medicaid side, CMS is trying to promulgate rules and guidance as quickly as they can but there's a whole bunch of stuff. So a lot of these things we won't know exactly what they intend for us to do until they promulgate rules and tell us. [LR467]

SENATOR CAMPBELL: Senator Nordquist. [LR467]

SENATOR NORDQUIST: Okay. First, I want to clarify. In the previous CHIP FMAP, I did find it. Milliman estimated it at $30.9 million additional federal over the 2014 to 2019 period, and the DHHS was an additional $52 million. So there is a little discrepancy there. And I don't know if you have the answer now but that's maybe something I'd like to look into, is why there's a $20 million discrepancy there. I see in the Milliman report there's also a difference in the costs of care for uninsured adults versus, I think it says,

nearly eligible parents, of $5,400 for uninsured adults versus about $4,800 for uninsured parents, and it says current and uninsured parents, I guess. Why the discrepancy between those two populations? [LR467]

VIVIANNE CHAUMONT: We have heard in...when I've gone to Medicaid director meetings that states who have done expansion, some expansion of care, that they had been under the assumption, when they did the expansion, that the average cost of the new enrollees would be something around what an ADC adult would cost. And they are finding that the costs are significantly higher than were the costs of the uninsured adult. And in one...one Medicaid director that I talked to said that they were much more similar to the costs of an ABD--an aged, blind, and disabled adult. I think the reason for that, and I'm speculating... [LR467]

SENATOR NORDQUIST: Sure. [LR467]

VIVIANNE CHAUMONT: ...is...will be that a lot of these folks haven't had medical insurance in so long that they're going to come in with a pent-up need and that happens in the Medicaid Program period. When you get a new eligible that, you know, that comes in, they haven't had insurance or they haven't...and so the first few months of a new Medicaid eligible are much more expensive than, you know, six months later or nine months later. So they're...so that's the reason why...that we thought it made sense to hike it up a little bit. And there's also the thought that part of those expenditures, part of the higher, is that you're going to get a lot more people with mental illness, which is expensive. [LR467]

SENATOR NORDQUIST: Uh-huh. Are there any states in particular that you know off the top of your head that I could look at? Just interested in that difference. [LR467]

VIVIANNE CHAUMONT: That thought that difference? [LR467]

SENATOR NORDQUIST: Yeah. Yeah. [LR467]

VIVIANNE CHAUMONT: Well, I was having breakfast with Arizona Medicaid director. (Laugh) I think that's when the conversation came up. [LR467]

SENATOR NORDQUIST: All right. All right. I guess in looking at some of the insurance provisions and their potential impact, do you see like the removal of lifetime limit cap potentially saving Medicaid money for people falling on to Medicaid once they've hit that private insurance lifetime limit cap? [LR467]

VIVIANNE CHAUMONT: I really don't know. [LR467]

SENATOR NORDQUIST: Okay. And then a couple quick, just a couple quick ones related to budget. (Laughter) First of all, was this paid for out of state dollars, out of your General Funds? [LR467]

VIVIANNE CHAUMONT: Was what? [LR467]

SENATOR NORDQUIST: The Milliman, sorry, Milliman study? [LR467]

VIVIANNE CHAUMONT: Yes. [LR467]

SENATOR NORDQUIST: Okay. And then are there going to be any ACA costs included in your budget recommendation coming before the Legislature or at least submitted to the Governor and then eventually to the Legislature? [LR467]

VIVIANNE CHAUMONT: The budget will be posted tomorrow. (Laugh) [LR467]

SENATOR NORDQUIST: Okay. All right. [LR467]

SENATOR CAMPBELL: Senator Mello. [LR467]

SENATOR MELLO: And it's a follow-up actually. Thank you, Senator Campbell. It's a follow-up to Senator Hadley's remarks regarding RACs in regards to what...the success they've had with Medicare. [LR467]

VIVIANNE CHAUMONT: Uh-huh. [LR467]

SENATOR MELLO: Can you provide, as the agency continues to look to...I know that because there's a state law that kind of forbids this or limits what can be done, can you follow up with our committee as the agency continues to look at that issue... [LR467]

VIVIANNE CHAUMONT: Uh-huh. [LR467]

SENATOR MELLO: ...in part only because I see it as a good government issue in the sense of trying to recover... [LR467]

VIVIANNE CHAUMONT: Uh-huh. [LR467]

SENATOR MELLO: ...state and federal funds that might be fraudulently being used. And if we have to look to make changes in working with the executive branch, it would be wise for us to know, I guess, sooner than later. [LR467]

VIVIANNE CHAUMONT: I'm sorry. To make sure I'm understanding about the contingency contract, to see if there's...the change that needs to happen on that? [LR467]

SENATOR MELLO: Yes. [LR467]

SENATOR CAMPBELL: Yes, Senator Cook. [LR467]

SENATOR COOK: Just one quick question. Thank you, Senator Campbell. [LR467]

SENATOR CAMPBELL: Go right ahead. [LR467]

VIVIANNE CHAUMONT: Hi, Senator Cook. [LR467]

SENATOR COOK: And thank you. Hi. How are you? [LR467]

VIVIANNE CHAUMONT: I'm good. Thank you. [LR467]

SENATOR COOK: And I'm looking at the pronunciation of your name. It's not the original French but who among us pronounces our name the way it was pronounced when we first got over here, or perhaps that's your spouse's name? I have a question. [LR467]

VIVIANNE CHAUMONT: No, it's not. [LR467]

SENATOR COOK: Okay. [LR467]

VIVIANNE CHAUMONT: It's my daddy's name. (Laugh) [LR467]

SENATOR COOK: I'm sticking with my daddy's name too. How about this? I have a morbidly curious question related to the degree to which the Medicaid costs were going to increase anyway... [LR467]

VIVIANNE CHAUMONT: Uh-huh. [LR467]

SENATOR COOK: ...based on the fact...let's say all those woodwork people just showed up at our regular 60-40, looking at our aging population, looking at immigrant

refugee with and without documentation, with and without birth emergencies. I'm guessing that with all the audits and with all the research--because we were already worried about this before the legislation came through D.C.--I would love to see what that looked like in terms of how we saw that wedge of the pie growing, status quo, and then as you describe a little early, worst-case scenario, if the woodwork people just said, forget it, I don't have any more money, I'm tapped out, I don't have any private insurance money and I'm going to have to suck it up and go on to Medicaid. I would love to kind of look at that and extrapolate and... [LR467]

VIVIANNE CHAUMONT: Well,... [LR467]

SENATOR COOK: Do you think you have one of those lying around maybe in the agency? They're so well-staffed and... [LR467]

VIVIANNE CHAUMONT: What... [LR467]

SENATOR COOK: ...hardworking. I know that much. [LR467]

VIVIANNE CHAUMONT: Okay, I can stipulate to that one. (Laugh) We...the only thing that I can think of that we have is the analysis that we do for the Medicaid reform report, which just came... [LR467]

SENATOR COOK: Okay. [LR467]

VIVIANNE CHAUMONT: ...the draft for 2010 just came out yesterday and I'd be happy to send e-mail. I know Senator Campbell has one, but I'd be happy to e-mail everybody else that isn't on the Medicaid Reform Council. [LR467]

SENATOR COOK: Okay. [LR467]

VIVIANNE CHAUMONT: And that's some time ago, maybe 2005, correct me, the department and the Medicaid Reform Council at the time did an analysis of the gap that was happening between the way our Medicaid Program was growing and what General Fund was going to be available. And so that has been updated. The gap has been shrinking some, although, you know, over the last few years and the economy are...I think we're close to 231,000 in August, which is up again from kind of two years ago when we were pretty much at 202,000--pretty flat. But anyway, so I can send you that. It has that. Now it has a lovely little asterisk, the chart that has that has a lovely little asterisk that says this does not include any changes due to health reform. [LR467]

SENATOR COOK: Okay. [LR467]

VIVIANNE CHAUMONT: But you will get some idea where we thought we were going... [LR467]

SENATOR COOK: All right. [LR467]

VIVIANNE CHAUMONT: ...and how much we thought we would be spending. [LR467]

SENATOR COOK: Okay. [LR467]

VIVIANNE CHAUMONT: Does that answer your question? [LR467]

SENATOR COOK: Yes, absolutely. [LR467]

VIVIANNE CHAUMONT: Okay. [LR467]

SENATOR COOK: Thank you. [LR467]

SENATOR NORDQUIST: One more quick one. [LR467]

SENATOR CAMPBELL: All right, one more quick question,... [LR467]

SENATOR NORDQUIST: Promise, last one. [LR467]

SENATOR CAMPBELL: ...because I haven't even got to my page of questions. [LR467]

SENATOR NORDQUIST: All right. [LR467]

VIVIANNE CHAUMONT: Do you have a page? [LR467]

SENATOR CAMPBELL: I mean, I've got...no, I don't. [LR467]

SENATOR NORDQUIST: All right. Just the...how does the benefits package for newly eligibles, do you have any inclination as to how that would compare? Because it is a different benefits package than what... [LR467]

VIVIANNE CHAUMONT: Uh-huh. Uh-huh. [LR467]

SENATOR NORDQUIST: ...the current Medicaid population gets. [LR467]

VIVIANNE CHAUMONT: Do I have an idea? No. The only idea I have is that it will be a benchmark and I gave you the criteria. We are looking to contract with a consultant to help us, to help us do that, to help us figure out what are the, you know, what are the options, what are the viable options specific to Nebraska based on our population, based on, you know, the prevalent Blue Cross plan, which is one of the options. And then we can make some recommendations as to... [LR467]

SENATOR NORDQUIST: Uh-huh. In general, would you...could you characterize that as generous, more generous or less generous than what the current Medicaid

population...? [LR467]

VIVIANNE CHAUMONT: You know, I think the idea is that it would be a less generous plan and I think it would be a less generous plan in ways such as dental not covered, vision not covered, audiology not covered, those kinds of things. [LR467]

SENATOR NORDQUIST: Okay. So even with that taken into account, we still think that the costs of that new population is still going to be higher? [LR467]

VIVIANNE CHAUMONT: Yes. [LR467]

SENATOR NORDQUIST: Okay. Okay. Thank you. [LR467]

VIVIANNE CHAUMONT: Yes. And don't forget that. You know, Senator Campbell and I have gone round and round on this one, but don't forget that when we say we don't cover dental for adults, that might mean we don't do a root canal,... [LR467]

SENATOR NORDQUIST: Uh-huh. [LR467]

VIVIANNE CHAUMONT: ...but dental issues that need to be medical... [LR467]

SENATOR NORDQUIST: Be medical, yeah. [LR467]

VIVIANNE CHAUMONT: ...yeah, medical dental issues have to be covered. [LR467]

SENATOR NORDQUIST: Uh-huh. [LR467]

VIVIANNE CHAUMONT: So if a client comes in with, you know, an infection caused by an abscess in their tooth, that's not considered a dental service. We have to take care of that. Now we might, you know, nowadays pull a tooth as opposed to do a root canal,...

[LR467]

SENATOR NORDQUIST: Sure. [LR467]

VIVIANNE CHAUMONT: ...you know, so...but... [LR467]

SENATOR NORDQUIST: Okay. [LR467]

VIVIANNE CHAUMONT: ...so it doesn't mean no dental,... [LR467]

SENATOR NORDQUIST: Sure. [LR467]

VIVIANNE CHAUMONT: ...you know, is covered. [LR467]

SENATOR NORDQUIST: Thank you. [LR467]

SENATOR CAMPBELL: And we have clarified that, exactly. [LR467]

VIVIANNE CHAUMONT: And we have quite a bit of that, uh-huh. [LR467]

SENATOR CAMPBELL: Senator Mello, you had one follow-up you say. [LR467]

SENATOR MELLO: One question follow-up, and I thought someone else asked it but I was going through my notes and they didn't. We had...the University of Nebraska Medical Center came in and provided some feedback and testimony as well, and one thing that was brought up was the primary care payments. And regards to the Milliman study, they included specialty care payments as well for those two years. Is that something that the department is looking to? And it was something that kind of caught most of our eyes. [LR467]

VIVIANNE CHAUMONT: Uh-huh. [LR467]

SENATOR MELLO: It was only the Medicare rates, was only for two years and it's only for primary care payments. But specialty care payments were included in the Milliman report. [LR467]

VIVIANNE CHAUMONT: I'm sorry, I don't remember that. [LR467]

SENATOR CAMPBELL: Senator Mello, do you remember where they were mentioned? [LR467]

VIVIANNE CHAUMONT: Yeah, what page? I know it's on here. Oh, here it is, I'm sorry, on page 5, bottom of page 5. The full participation scenario has the...so the worst-case scenario has...or the outer limits, I guess, I don't know, has the specialty things but the other scenario does not. And that was just based on discussion with a lot of states who were saying that they didn't think they would be able to get away with just increasing primary care and not specialty. So we wanted to say let's see what that would cost us. [LR467]

SENATOR MELLO: So somewhat problematic to some of the other full participation scenarios that we've discussed today is that it's...if the sky is falling and the worst-case scenario possibly could happen, this is the cost that would be associated with it. [LR467]

VIVIANNE CHAUMONT: Well, I think that what it is, you know, if depending on what the Legislature wants to do and what the Medicaid Program wants to do, I mean there's, you know, some talk that is it fair to pay these providers at 100 percent of Medicare and not pay these other providers at 100 percent of Medicare; that what we wanted to see was what was the outer limit of the cost. And so that's consistent with... [LR467]

SENATOR CAMPBELL: Director, I don't have a page of questions, but I am allotted time to ask you questions on the Reform Council. But one of the questions that I do think that we're going to want to spend some time really goes back on Senator Mello's comment of drawing us to page 2, at the bottom, in terms of the eligibility and what we have to have in place. Because one of the questions that we've talked about on Health and Human Services Committee, and Liz is here, is what do we need to look at in terms of the budget, the immediate that's going to come to us in the next couple weeks, and what do we need to make sure that we have in place for 2014? So it's really not a question to you today as much as it is, when you come to talk to us at the committee and we're looking at the budget, what do we need to be prepared for in terms of the eligibility? Because we offer a lot of optional services in Nebraska... [LR467]

VIVIANNE CHAUMONT: Uh-huh. [LR467]

SENATOR CAMPBELL: ...and, if I'm hearing the exchange correctly here, we would not be required to maintain all of those. [LR467]

VIVIANNE CHAUMONT: Well, currently that's the...okay, the prohibition in the act is about eligibility groups, not benefits, okay, so you can't say, you know, currently we cover pregnant women to 185, let's go to 150. That you can't do. Currently, we cover, you know, kids up to 200 percent--well, that's CHIP so that's different--up to whatever it is in Medicaid. Sorry, I can't remember. You can't change that. So...but you can...they've never said that you can't do anything about benefits. So, you know, you've heard my "dog and pony" before that there are really only three ways to cut a Medicaid Program: You cut clients, you cut rates, you cut services. Well, once you eliminate cutting, you know, any eligibles, you're left with really two major ways to cut the Medicaid Program and that's you cut rates and you cut services. So there are mandatory services that a state has to offer and there are optional services. Optional services for adults I'm talking about because kids are a totally different ball game. For adults, some of those optional services are things like dental, vision, you know, hearing aids, that kind of stuff. And I

can tell you, Colorado doesn't cover any of that when I was Medicaid director there. I didn't do that. That was that way when I started. So there are a lot of states, about half the states, that don't do it at all. So those you can cover...you can delete because they're optional. But then there's also mandatory services that you have to cover, like physician, inpatient hospital, nursing facilities, things like that. You can place limits on those but you cannot eliminate them. [LR467]

SENATOR CAMPBELL: Okay. So for instance, if you were offering 20 hours of treatment, you could go to 10. [LR467]

VIVIANNE CHAUMONT: Uh-huh. [LR467]

SENATOR CAMPBELL: You just can't rid of that whole population or that... [LR467]

VIVIANNE CHAUMONT: Some states, for instance, say you can only go...we'll only pay for, you know, 24 doctor visits a year,... [LR467]

SENATOR CAMPBELL: Right. Right. [LR467]

VIVIANNE CHAUMONT: ...that kind of thing. [LR467]

SENATOR CAMPBELL: Okay. [LR467]

VIVIANNE CHAUMONT: We'll only pay for 45 inpatient hospital days. [LR467]

SENATOR CAMPBELL: Okay. But that will be one of the issues that I think the committee will spend some time talking to you about. [LR467]

SENATOR HADLEY: Since everybody made fun of that one quick question, I do have one quick question. (Laughter) We had talked about it earlier. [LR467]

VIVIANNE CHAUMONT: A final, final question. [LR467]

SENATOR HADLEY: To your knowledge, are there any physicians in the state of Nebraska that will not see a Medicaid patient? [LR467]

VIVIANNE CHAUMONT: Yes. [LR467]

SENATOR HADLEY: Can you...is there any percentage you would come up with? [LR467]

VIVIANNE CHAUMONT: No. No, I don't know the percentage and I have to say that I think Nebraska physicians as a whole has a large percentage of Nebraska physicians step right up to the plate and take care of Medicaid clients,... [LR467]

SENATOR HADLEY: I think that's... [LR467]

VIVIANNE CHAUMONT: ...which is absolutely totally different than my experience in Colorado where Medicaid clients are taken care of in the federally qualified health centers and you do not see them in...which, you know, sets up that two-tiered, you know, healthcare system. [LR467]

SENATOR HADLEY: And I just worry that if we keep squeezing the physicians, potentially, in reimbursement, you can get, you know, if... [LR467]

VIVIANNE CHAUMONT: You know, there's that potential. I have to also tell you that Nebraska actually reimburses providers at a higher rate than most states. Our reimbursement rates are much more generous than a lot of states, so there's that as well. [LR467]

SENATOR CAMPBELL: Okay, a comment and then one last comment. [LR467]

SENATOR GLOOR: My comment will be brief. I think you're correct, Nebraska providers overall, certainly physician groups, do a good job of trying to take Medicaid patients. [LR467]

VIVIANNE CHAUMONT: Uh-huh. [LR467]

SENATOR GLOOR: But I think the challenge is they may take Medicaid patients, they may not take any more Medicaid patients. [LR467]

SENATOR CAMPBELL: Right. [LR467]

VIVIANNE CHAUMONT: Uh-huh. [LR467]

SENATOR GLOOR: And that goes back to how many people we have available to take care of patients, period,... [LR467]

VIVIANNE CHAUMONT: Uh-huh. Uh-huh. [LR467]

SENATOR GLOOR: ...let alone taking on a segment of the population. Reimbursement may be better in Nebraska than in other states. If you had a practice that was just Medicaid patients, I would dare say, from what I know, you couldn't pay your bills. [LR467]

VIVIANNE CHAUMONT: I think that's true. [LR467]

SENATOR GLOOR: And we know there's cost shifting. [LR467]

VIVIANNE CHAUMONT: I think that's true, but I also think that in some parts of the

state, probably not Lincoln and Omaha, that in some parts of the state a physician's practice wouldn't be able to stay afloat without Medicaid patients. Uh-huh. [LR467]

SENATOR GLOOR: Yeah, that's probably true. Those numbers are important (inaudible) patient. [LR467]

VIVIANNE CHAUMONT: Uh-huh, just because of the population there and, you know, just numberswise, so... [LR467]

SENATOR CAMPBELL: Senator Mello, you have a quick comment you said. [LR467]

SENATOR MELLO: Yeah, just in regards to...just a question in regards to maybe budgetary, how much do you know, and maybe you could direct it to Director Winterer if you can't provide it, how much money is available in the department's budget to do a report, departmentwide essentially, to show the cost savings that would be associated with the ACA? Because I know the Milliman report pretty much shows it's a report on the expenditures of what it's going to cost us, but what...how much money does the department have budgeted to do another report to show here's how much money we'll save departmentwide, possibly statewide with all the other agencies that might be involved in it, to give us, maybe this committee and the Legislature, the public at large maybe a more balanced perspective in regards to how much money we'll save in this process? [LR467]

VIVIANNE CHAUMONT: I will pass that along to Kerry Winterer. [LR467]

SENATOR MELLO: Okay. Thank you. [LR467]

SENATOR CAMPBELL: Before we disband today, I do want to give a plug for just a great report that the director puts together with her staff every year that is due to the Medicaid Reform Council and then to the full Legislature, in plenty of time for people to

know what the department and the director are proposing in Medicaid, and is on-line on the department. You can go back years and it's never too lengthy that you can't sit down in an evening and get through it pretty easily, very understandable. I would encourage all the senators here that if you have not looked at one in a while that you do so because it would give you a good idea about Medicaid maybe before we get into discussing the changes. [LR467]

VIVIANNE CHAUMONT: Uh-huh. Yeah, I'm going to e-mail it to all of you. [LR467]

SENATOR COOK: Thank you. [LR467]

SENATOR CAMPBELL: Because I think it's really good and I think it should be there. [LR467]

VIVIANNE CHAUMONT: And then I'll be asking you questions on it. No. (Laugh) [LR467]

SENATOR CAMPBELL: Just a reminder for everyone in the audience, the next time this group of people will be together is October 7 and 8 to take public comment. If you are from an association or an entity that wants to make comment, would you please see Michelle. We'll be setting up some idea of time slots so we can make the senators aware of how much time they need to set aside. It has been a great day as an introduction to a very long and arduous task ahead of all of us, so thank you, everyone, and we'll see you in October. Thank you, Director. [LR467]

SENATOR MELLO: We'll see you tomorrow. [LR467]

SENATOR CAMPBELL: Tomorrow morning, that's right. We have one more session. Senator Gloor, you should have reminded me of that. [LR467]

SENATOR GLOOR: I can't be here so... [LR467]

SENATOR CAMPBELL: Nine o'clock, the director of Insurance. [LR467]