[LR32 LR514]

The Committee on Health and Human Services met at 10:00 a.m. on Wednesday, October 19, 2016, in Room 1113 of the State Capitol, Lincoln, Nebraska, for the purpose of a briefing from Department of Health and Human Services. Senators present: Kathy Campbell, Chairperson; Sara Howard, Vice Chairperson; Roy Baker; Sue Crawford; Nicole Fox; Mark Kolterman; and Merv Riepe. Senators absent: None.

SENATOR CAMPBELL: (Recorder malfunction)...we felt that we wanted to accept Director Lynch's invitation to come and talk to us this morning. So while you're coming forward, I'll go through a few housekeeping things. A reminder, as always, on your cell phones, please turn them off or silence them so they don't bother anybody. This briefing there will be no other testimony because it's a briefing, not a hearing, so we don't need to sign in on anything. We will go ahead and do introductions so everybody knows us and we'll start. Senator, would you like to start us off?

SENATOR FOX: Senator Nicole Fox, District 7, downtown and south Omaha.

SENATOR KOLTERMAN: Senator Mark Kolterman, District 24, Seward, York, and Polk Counties.

SENATOR BAKER: Senator Roy Baker, District 30, Gage County, southern Lancaster County.

SENATOR HOWARD: Senator Sara Howard. I represent District 9 in midtown Omaha.

SENATOR CAMPBELL: And I'm Kathy Campbell, District 25, east Lincoln.

ELICE HUBBERT: I'm Elice Hubbert. I'm the committee clerk.

SENATOR CRAWFORD: Good morning. Senator Sue Crawford, District 45, eastern Sarpy County, Bellevue, and Offutt.

SENATOR RIEPE: Merv Riepe, Senate representative from District 12, which is Millard, Omaha, and Ralston.

JOSH HENNINGSEN: And I'm Josh Henningsen, committee legal counsel and legislative page.

SENATOR CAMPBELL: Yes. (Laughter) Multitask. Okay. Director Lynch, it's good to have you and I'm going to let you go right ahead and start. [DHHS Briefing]

CALDER LYNCH: (Exhibit 1) Thank you, Senator Campbell, and thank you, members of the committee, for allowing us the opportunity to be here today to brief you on some of the developments as it relates to changes that are happening in the Nebraska Medicaid Program with the upcoming implementation of Heritage Health, which is the state's new integrated managed care program. There's a set of slides that's been passed out before you that I'll talk though. They also exist as a resource for you as well, in addition to other materials I believe that we've made available to your office over the last several weeks. So I'm Calder Lynch, the director of the Division of Medicaid and Long-Term Care for HHS here in Nebraska. We are now just a little over two months away from the implementation of Heritage Health so I'll indulge...if the committee would indulge me, I'll just provide some basic background that I'm sure everyone is very familiar with. But you'll see in the first slide of course that Nebraska Medicaid is a health insurance program that covers a little over 230,000 Nebraskans; spends about $2 billion annually; covers about 12 percent of our state's residents and primarily covers children from birth through age 18, individuals who are blind and disabled, low-income parents and caretakers of children, and low-income elderly. And what we're here to talk about today are changes that are happening to the managed care delivery system. And what managed care is, is illustrated on the next slide. It is a system in which the state contracts with managed care organizations, or MCOs, or, as I'll probably call them mostly today, health plans. We use those terms interchangeably. But it's a system in which states contract with health plans to administer these services for our enrollees that are covered by Medicaid. So in that arrangement, the state, or DHHS, contracts with the health plan and then the health plan contracts with healthcare providers to deliver services for eligible members. And the health plan reimburses the providers for that care. However, what's important is the state retains its responsibility for eligibility determinations and enrolling individuals into the program. So that retains the state responsibility. We've had

managed care in Nebraska for about 20 years evolving from our first contract in the Omaha area in 1995 to where we are today. So currently, as illustrated on the next slide, we contract with three regional MCOs, or health plans, to administer physical or medical benefits for our members, and that would include things like doctors' office visits, inpatient hospital stays, medical therapies, those more physical health, traditional medical insurance type benefits. Those include Aetna, that currently operates statewide; Arbor Health Plan, that operates in greater Nebraska; and UnitedHealthcare that operates in the Lincoln-Omaha urban markets. We also have a separate contractor for behavioral health services for our members. That's currently Magellan, so we contract with Magellan to administer the behavioral health, which include mental health and substance use benefits for our members statewide. So everyone on Medicaid, for the most part, is enrolled in Magellan for purposes of their behavioral health benefits. And then separately we contract with a company to provide the claims processing system for our pharmacy benefit, and that's also a different arm of Magellan that administers the point-of-sale processing system for pharmacy claims, although the state is still directly responsible for that payment of those services. So depending upon who you are and what services you're receiving in Medicaid, today you're potentially having to navigate three different systems or three different contractors to access your benefits. And that include today about 82 percent of our enrollees. The majority are enrolled in one of those three physical health plans that I mentioned. So depending upon where they live, they choose between two of them, and that's 82 percent of our enrollees that choose one of those plans. But nearly everyone is enrolled in Magellan for behavioral health. So in some shape or fashion, nearly everyone on Medicaid today is touched by managed care. On the next slide we begin talking about the changes that are happening under Heritage Health. And under Heritage Health we have executed contracts with three health plans to administer a more complete array of services all on a statewide basis. So beginning on January 1, the three managed care plans or health plans that will administer Medicaid benefits in Nebraska are Nebraska Total Care, whose parent company is Centene; UnitedHealthcare Community Plan; and WellCare of Nebraska. So each of these three plans will operate statewide. They will serve members statewide and they'll have statewide provider networks. They'll also have a responsibility for the physical health benefits that our current health plans do as well as the behavioral health benefits that Magellan currently administers and the pharmacy benefits that the state administers. So we're bringing all three together into a more integrated service delivery system under Heritage Health where, as a Medicaid member, you'll choose one of these three

plans and that plan will be responsible for that more complete array of services, so having providers in contract paying claims and providing care management, and that begins on January 1, 2017. So as we've gone around the state to talk about the changes that are happening, you know, we get a lot of questions as to why the state is making these changes. And our goals for Heritage Health are listed on the next slide. Our first and foremost driving force anytime we look at making changes in our system is to try to improve health outcomes for our enrollees and really, to do that, looking at having a more integrated delivery system where we focus more on person-centered care and improving quality, so that really bringing together the physical, the behavioral, and the pharmacy benefit is really important because individuals don't access care in silos and those needs are often intermingled, in terms of co-occurring conditions. And certainly individuals that might have a mental health need and a physical health need, those different conditions impact each other, and so we need to be able to do care planning, care management designed around the whole person. And ultimately, that's focused on improving quality, improving outcomes, and through that reducing the rate of costly and avoidable care, like emergency rooms and avoidable hospital admissions, and to help over time improve the financial sustainability of the system. To do that we have contracted with the three health plans to take on some specific functions. First and foremost, they have to administer the covered benefits that are covered by Medicaid and for which they are contractually responsible. So that means having providers in-network to be able to provide care, being able to pay claims, being able to refer members to providers when necessary, and making sure members have access to services when needed. They also have responsibilities around providing care management to members that have chronic or high needs, and so identifying members through a health risk assessment and referring them into different levels of care management, depending upon their individual needs. They also have to have a program to improve quality and have a quality management program working with their provider community on performance improvement projects, identifying key metrics and reporting those up to the state on the things that we identify as priorities. They have a responsibility around utilization management to ensure that the services that are being utilized are appropriate or medically necessary, we're directing folks to the most effective, lowest cost setting of care when necessary, and that we're managing the system wisely. They have to have a provider network in place and manage that provider network to ensure that they have access and that they also have high-quality providers available to our members and, importantly, that there's continuity of care for members. So as individuals transition between health plans, come on or off

the program, or even just transition between settings of care as they're discharged from the hospital or to home or to another setting, that there's planning and follow-through to make sure that there's continuity. To do that, as on the next slide, "Benefits and Coverage," each health plan is responsible for the same package of benefits and services, and they will cover the same package of benefits and services. Health plans are not allowed to diminish the Medicaid benefit package below what their contractually responsible for covering. What they are able to do is offer extra benefits and services that are not historically covered by Medicaid as a way of differentiating between themselves and investing in care that might be cost-effective in the long run. So each health plan, as part of their proposal to the state, offered a set of value-adds or extra benefits and services, and they could take the form of benefits that aren't historically covered by Medicaid or waiving coverage restrictions that are imposed by the state, like copays or visit limits. And those are outlined in the plan comparisons that we provide members to help them choose the plan that's best for them and it's also a way for us to measure the effectiveness of providing some innovative approaches to care. So, for example, some plans have offered for the ability to provide hypoallergenic bedding for children with asthma or to provide car seats for moms if they complete all their prenatal care visits, and so incentives for healthy behavior and to access the healthcare system wisely. There's also one thing that is important is that while we're bringing the physical health, the behavioral health, and the pharmacy benefits together under Heritage Health, there are still some Medicaid-covered services that are not part of Heritage Health but are still covered by Medicaid and administered by the state, and those include dental services, nonemergency transportation, and all of our long-term services and supports, our long-term care services, either those provided in the community through a Home and Community-Based Waiver, or in a facility like a nursing home. And I'll talk a little bit more about some of our efforts around the long-term care redesign project as we wrap up the PowerPoint. What is important is that while we're continuing this...while they're not part of Heritage Health, members still have access to those services and we are still working on opportunities to improve how we deliver those services over time. For example, we're currently in procurement for a dental benefit manager to administer dental benefits for our members statewide and improve access to dental care. On the next slide, I think one of the most important and biggest pieces of the changes with Heritage Health is the integration of behavioral health benefits with the physical health benefit. And this is really designed to be able to better address individuals with co-occurring mental health, substance use disorders, and chronic health conditions by focusing on their individual

needs. It also creates a system in which the plans have more tools to address these needs. They're financially and contractually incentivized to invest in preventative and community-based care, whereas today with the carve-out model we have one plan that's responsible for behavioral health benefits, and so they're only paid for the cost of behavioral healthcare. So their only opportunity to reduce costs is to reduce behavioral health services or to manage behavioral health conditions. By bringing it together, we know that individuals with...the data strongly suggests individuals with a co-occurring mental health or substance use disorder, the costs of treating that individual who also happens to have diabetes, the cost of treating that diabetes can be five times higher than someone who might not have that co-occurring disorder. So bringing them together gives the plans more ability to invest in preventative and community-based care. And when that results in lower emergency room visits, lower hospitalizations, better managed chronic conditions, the financial incentives are there to reward that plan for managing that condition more effectively. So that's one of our main goals of bringing it together. But we also recognize that this is a huge shift for our provider community and for our members, so we have formed a Behavioral Health Integration Advisory Committee that's been meeting regularly since the spring to provide input and direction, to make sure that we're thinking through all the things that are necessary to make sure this is a smooth transition, like adopting common service definitions, planning for continuity of care for members, and also just making sure that we're reaching out to the provider community to make sure they're aware of these changes and that they're preparing for these changes. The other big change that's happening, as illustrated on the next slide, is the integration of the pharmacy benefit or the prescription drug coverage that are administered today by the state. So under Heritage Health, each plan will administer the prescription drug benefit through their pharmacy benefit manager, or PBM. We really think that from the member's perspective, this will be a fairly smooth transition as we've contractually required each of the plans to adopt and follow the state's preferred drug list. So there will be a common preferred drug list between the plans and the state, and we're working with them to align as much of our administrative policies as possible around prior authorizations and clinical coverage criteria. The plans are also required to accept any pharmacy in Nebraska that's participating in Medicaid today into their pharmacy network and what we've seen so far is very robust participation by the pharmacies in the state in each of the health plans' network. So if a member were to go into a pharmacy today to get their prescription drugs, we expect them to be able to continue to do so after January 1. A lot of the activity that's been happening over the last several months and it's continuing is

readying the provider networks for each of the plans. So each of the plans is out contracting with providers and credentialing them to be ready and have in-network status come January 1. One thing that we reminded providers as we've gone around the state and communicated to them is, just like it works today, all providers to contract with a Medicaid health plan must also be enrolled as a Nebraska Medicaid provider through the state system. The plans themselves have to meet our targets for network adequacy, which we'll be measuring as we get closer to go live. So we'll be comparing their provider networks against geographic standards based on their membership and based on specialties and subspecialties to make sure that they have adequate networks or, if they don't, that there's corrective action plans in place or that we recognize there may be a health shortage area, an area that we work together with them to address. Unfortunately, they don't have the ability to create providers where they don't exist, but they can be part of the strategy of working to address some of those disparities and some of those gaps. So we are working with them to get through that process. They're actively working with providers to get them contracted and credentialed. We did put in some safeguards in the contract, like that they have to accept common credentialing information from the CAQH system that some providers participate in, which is sort of a common credentialing application process, and they also have to provide decisions on credentialing applications, once they receive them, within 30 days to make sure that there's not a lag in getting that provider into the network and able to serve their members. So we're going to be continuing to report out on network adequacy as we get closer. Two of our plans are new so they've got a little bit more work to do in terms of getting all those providers in, but we fully expect the plans to meet network adequacy before January 1. The next slide begins talking about the changes from the members' perspective in terms of enrolling in Heritage Health. We recognize that historically we have been challenged with the rate at which our members are actively choosing their health plans under our existing managed care system. Nearly 80 percent of our members today are auto-assigned to their health plan. So to try to improve the rate at which we're engaging with members, we did go out and procure a new enrollment broker to work with the state through Heritage Health and ongoing, and that is Automated Health Systems that was...that won the contract, AHS. And they're responsible for providing written and telephonic member outreach to engage them proactively in making a decision about their health plan, to provide choice counseling to be able to answer questions and provide unbiased advice in terms of which health plan might be best for them and their family. They've also got new mechanisms for members to be able to choose their plan that I'll go through

on the next slide; the ability for members to search and compare provider directories between the plans to see which of their providers are participating in which plans. And then for those members that ultimately don't make a plan selection, they will be responsible for auto-assigning members to a plan based on an algorithm the state has determined. So for members that will be choosing a plan, which include nearly everyone enrolled in Medicaid, they will receive--many have already received--an enrollment packet in the mail from AHS that explains the Heritage Health Program, what it is and their responsibilities for choosing a health plan. There are four different ways for our members to choose a plan. They can do it on-line for the first time at NeHeritageHealth.com, which is the dedicated enrollment Web site. They can also call AHS Monday through Friday, 7:00 a.m. to 7:00 p.m., toll-free, and talk to them to choose their plan telephonically. They can return the form by mail that they receive in the mail from AHS and just...it's a postage-paid envelope. They can drop it right back in the mail and send it back in. Or they can return it by fax. So there's four different mechanisms for members to be able to choose their plan. Members have until December 1 to choose their plan. Those that don't choose a plan by December 1 will be auto-assigned based on an algorithm that looks at any other household members that that member might have, if they've chosen a plan, to try to keep families together under the same plan. And then we'll also look at their historic provider relationships based on our claim history to assign them to a plan in which their primary providers are contracted to ensure that there's continuity of care for them. Regardless of whether the member chooses their plan proactively or is auto-assigned by AHS, everyone will get 90 days after January 1 to change their mind and switch to a different plan if they wish to. After that, members will generally be locked into their plan for the calendar year. And starting next year, we're moving toward a consolidated open enrollment period each fall where all of our members will have the opportunity to switch to a different plan if they wish to or remain with their current plan by taking no action. So that's another change for us where we're going to be moving toward a calendar year plan enrollment process starting in 2017. The next slide just provides an illustration of some of the materials that are being mailed out to members as part of that enrollment packet. All of these are available for download on our Web site as well as the enrollment broker's Web site. But it includes a plan comparison chart, the member guidebook, and then the form to be able to select and choose the plan if you wish to do so by mail. One of the important things and important messages that we've been trying to communicate as we've been going around the state is that, in addition to the changes with the benefit structure under Heritage Health, there are some changes in terms of

who's enrolling in managed care. So there are some groups of eligible individuals who will be choosing a health plan and enrolling in a health plan for their physical health benefits for the first time under Heritage Health, and that includes individuals who participate in one of our Home and Community-Based Waiver programs, including the Aged and Disabled Waiver, the Traumatic Brain Injury Waiver, and the Developmental Disability Waivers, as well as individuals who reside in a long-term care facility like a nursing home or an intermediate care facility for people with developmental disabilities. But what's important is while these individuals are enrolling in Heritage Health for their medical, behavioral, and pharmacy benefits, those actual long-term care services and benefits are not changing under Heritage Health and will continue to be administered, provided, and reimbursed the same way they are today. No one can opt out of Heritage Health. All populations that are enrolling are mandatorily enrolled. And so if they do not choose a plan, one will be chosen for them. And that will include nearly all of our enrollees, starting on January 1. Only limited groups of individuals are excluded from Heritage Health and they include individuals who have intermittent benefits, like those that have spend down, so they come on and off Medicaid, depending upon when they reach those thresholds; as well as individuals for whom...that are Medicare dual-eligible, that we only pay premiums and copayments; and a few other small populations. But 99 percent, nearly, of our enrollees will be enrolling in a Heritage Health Plan beginning January 1. And while those long-term care services aren't changing under Heritage Health, we do recognize that we have lots of opportunity to improve our long-term care delivery system, so we have also launched a long-term care redesign initiative, which is briefly summarized on the next slide, which is occurring separate and apart from the Heritage Health implementation where we are actively studying and engaging with stakeholders, consumers, family members on ways they'd like to see the long-term care delivery system improve, challenges they face, things that are working well, things that are not working well. And from that, we'll be developing a set of recommendations which will be put out for public comment early next year. But as part of the Heritage Health implementation, we have formed several different groups to be able to meet with us continuously to provide feedback and input into how the program is being transitioned. One of those groups is our Administrative Simplification Committee, which is focused specifically on improving the experience from the providers' perspective. We recognize that for many folks managed care increases the administrative burden that they face as providers. We're increasing the complexity of their world. So where there are complexities or administrative burdens that are not adding value, we want to

work together with the providers in the plans to reduce or eliminate those. For example, by adopting common service definitions, looking at having a more common prior authorization process, and looking at ways that we can improve that experience from the providers' perspective. So that's the focus of the Administrative Simplification Committee. It's going to be an ongoing effort, even beyond implementation, to continue to identify and look for opportunities to improve that experience. The other that I've already talked about is the Behavioral Health Integration Advisory Committee that's been very active in meeting with us and working through the specifics of the behavioral health integration. And then finally, the Quality Management Committee which will be...which whose work will really gear up as we implement and move the program forward in looking at and guiding which performance improvement projects the plans are undertaking, which quality metrics they're reporting to the state, and which quality metrics they are financially incentivized to hit. That group will be chaired by our new medical director, Dr. Lisa White. And we've engaged a number of different provider, public health, and stakeholder, and consumer groups to be part of that, that group that's advising the program in terms of quality improvement. We have really endeavored to try to make sure folks know about these changes that are happening with Heritage Health, so earlier last month my team and myself embarked upon a statewide tour. We met. We did...I visited 14 of our local offices just to talk to local staff and make sure they were engaged and knew what was happening so as they interact with folks on the front line, they're able to answer questions. We also held eight provider seminars with provider organizations across the state and held seven town halls across the state, which were really well-attended I think for the most part. I got some really great feedback. I want to thank Senator Riepe for joining us for one of the town halls. I know some of this is probably a little repetitive for him but I really appreciate him being there. So it was a really good opportunity to engage directly with providers, with consumers, with family members, with members, and with advocacy organizations. We're not done. We know that there's still a lot of work to do with the provider community to make sure they're ready for this transition, so the three health plans have together agreed to host 14 provider training seminars across the state. Those actually kick off I think today or tomorrow and will continue through mid-November. So we've got a schedule of those posted on our Web site and we've also sent out a provider bulletin. But there will be 14 of those across the state, including 2 in Lincoln and 2 in Omaha. So with that, I would be happy to answer any questions that the committee has. [DHHS Briefing]

SENATOR CAMPBELL: Thank you, Director Lynch. One of the questions I'm going to start with is that we had a call in the office the other day and it was someone who was dually eligible, and total confusion. And I'm making the assumption that if they had...if they're on Medicare, that they would not have received a letter from your department. [DHHS Briefing]

CALDER LYNCH: That's not quite necessary because... [DHHS Briefing]

SENATOR CAMPBELL: Okay. [DHHS Briefing]

CALDER LYNCH: ...that's not necessarily true because we are, dual-eligibles are included in Heritage Health except for those who we only pay premiums and copayments. [DHHS Briefing]

SENATOR CAMPBELL: Okay. [DHHS Briefing]

CALDER LYNCH: So many of our duals will be enrolling in a Heritage Health Plan for their Medicaid-covered benefits. So Medicaid is secondary to Medicare, meaning Medicare has to pay first, but there are many benefits that Medicare...that Medicaid covers that Medicare does not cover. [DHHS Briefing]

SENATOR CAMPBELL: Okay. [DHHS Briefing]

CALDER LYNCH: And so in those instances, they will be enrolling in a plan. And we have published a fact sheet for both members and providers specifically for dual-eligibles that I'll make sure we disseminate to the folks on this committee and in the Legislature to make sure that you have that in case you get those questions. [DHHS Briefing]

SENATOR CAMPBELL: That would be helpful because she was all concerned about the physician and were they in the network. And whoever she was calling, and I don't know that she called the department, I have a feeling it was the provider,... [DHHS Briefing]

CALDER LYNCH: Okay. [DHHS Briefing]

SENATOR CAMPBELL: ...and just like nobody knows what's going on, nobody knows. And so it was...the message to her was that there's no information. So we forwarded them to you at the department through Bryson. But this is really helpful and the fact sheet would also help them. [DHHS Briefing]

CALDER LYNCH: Absolutely. We'll certainly, provided that AHS is also out doing engagement with stakeholders, we've worked with the SHIIP, the Senior Health Insurance (Information) Program, to make sure they're aware of these changes and so can answer questions. Unfortunately, the dual-eligible world, in and of itself, is very complicated and my hope is one day we'll have better integration between the state and the federal administration of these benefits. We're not quite there yet but we're continuing to look for those opportunities. [DHHS Briefing]

SENATOR CAMPBELL: Thank you. Questions, Senators, that you have? Senator Crawford. [DHHS Briefing]

SENATOR CRAWFORD: Thank you, Chairwoman. And thank you, Director, for being here today. So the committee members did receive an e-mail from someone who...a daughter who said that she did call the 1-888 number for her to tell...yes, well, that would be Monday when she called, and they said they hadn't received their package of information from the state of Nebraska so they couldn't assist her. So... [DHHS Briefing]

CALDER LYNCH: I saw that... [DHHS Briefing]

SENATOR CRAWFORD: ...yeah. [DHHS Briefing]

CALDER LYNCH: ...and we're following up on that. We're reaching out directly to that client... [DHHS Briefing]

SENATOR CRAWFORD: Okay. [DHHS Briefing]

CALDER LYNCH: ...because I didn't quite understand who she talked to, if it was the enrollment broker. Because the enrollment broker will allow them to enroll in a plan even if they haven't received their packet yet. And I'm not sure who she talked to then, so I want to follow up specifically on that case. [DHHS Briefing]

SENATOR CRAWFORD: So the packet of information that there's a picture of in here,... [DHHS Briefing]

CALDER LYNCH: Uh-huh. [DHHS Briefing]

SENATOR CRAWFORD: ...there's an open enrollment packet with information about each plan, that is available and... [DHHS Briefing]

CALDER LYNCH: It is. [DHHS Briefing]

SENATOR CRAWFORD: ...up on your Web site. [DHHS Briefing]

CALDER LYNCH: Yes. [DHHS Briefing]

SENATOR CRAWFORD: Okay. [DHHS Briefing]

CALDER LYNCH: Yes, Senator, it is. And what's also included in the packet is the ability for them to go on-line and create their account on the enrollment Web site, to be able to do that on-line, but they can...I mean we had folks that started choosing their plans before we had rolled the first packet out. So... [DHHS Briefing]

SENATOR CRAWFORD: Right. [DHHS Briefing]

CALDER LYNCH: ...we'll follow up specifically with that client and see what's happening there. [DHHS Briefing]

SENATOR CRAWFORD: Excellent. Thank you. Thank you. [DHHS Briefing]

SENATOR CAMPBELL: Senator Riepe. [DHHS Briefing]

SENATOR RIEPE: Thank you, Senator. Mr. Lynch, thank you for being here and thank you for all of the hard work that you and your staff have done to put this together to communicate it. And you probably, being from Louisiana, you probably know Nebraska better than many of us now that you've made your journey. [DHHS Briefing]

CALDER LYNCH: Beautiful state. [DHHS Briefing]

SENATOR RIEPE: Yeah. Well, good diplomacy on your part here. (Laughter) The question that I have is, you talked a bit about network adequacy. Do you anticipate any loss of providers of any category as you transition over to this new model? [DHHS Briefing]

CALDER LYNCH: Thank you, Senator. That's a great question. The plans are contractually responsible for having adequate networks and we have standards in their contracts based upon their membership and, you know, having certain numbers of providers within certain distances to their members in network. That's really just the first step. I mean we have to go beyond that to actually measure access in different ways, making sure members can actually get appointments, can get in. And that's going to be an ongoing effort on our part working with the plans. We're really hopeful to have very robust networks. The plans are not operating from a limited network mind-set. They're out there actively trying to recruit providers into their networks. Sometimes it is a negotiation. They are...sometimes providers are looking to negotiate different rate adjustments to the Medicaid fee schedule to participate, and sometimes those are appropriate and sometimes that's just part of that discussion between that plan and that provider. So there may be some variations between plans in terms of which groups or practices or hospitals might be participating. But our expectation is everyone meets those adequacy standards for their members to be able to access care, but that is one way that they're able to differentiate is in terms of how robust they're able to build their networks. [DHHS Briefing]

SENATOR RIEPE: Okay. Thank you. [DHHS Briefing]

SENATOR CAMPBELL: Any other questions? Senator Kolterman. [DHHS Briefing]

SENATOR KOLTERMAN: Thank you, Senator Campbell. Mr. Lynch, would you talk a little bit about Maximus,... [DHHS Briefing]

CALDER LYNCH: Uh-huh. [DHHS Briefing]

SENATOR KOLTERMAN: ...who they are and how they...because that has something to do with your networks as well, doesn't it, how you contract with the networks? [DHHS Briefing]

CALDER LYNCH: It does. Maximus is the state's contractor for provider screening and enrollment. So one of the many things the Affordable Care Act did was it increased the screening and enrollment requirements that state Medicaid programs had for our providers, and that includes conducting certain background checks and certain checks against registries where they might have been excluded by Medicare, other state Medicaid programs, and doing that on an ongoing basis. So in order to comply with that, we had to go out and procure a vendor to be able to manage that process for us, as it was something beyond what the state was doing at the time. And this was several years ago that this procurement was conducted. That system was implemented in December. Maximus at that point took over the process by which providers would enroll as a Medicaid provider with the state, which is necessary to do to be able to contract with a health plan. You have to be screened and enrolled by the state. And they're also responsible for the revalidation of providers every five years, to make sure that they're continuing to revalidate, re-up their agreements, and participate in the program. So it's a separate process. The state directly contracts with Maximus for that function and providers must be enrolled through Maximus in order to be able to contract with the health plans directly. [DHHS Briefing]

SENATOR KOLTERMAN: Okay. Thank you. And then talk a little bit about AHS brokers... [DHHS Briefing]

CALDER LYNCH: Uh-huh. [DHHS Briefing]

SENATOR KOLTERMAN: ...and their outreach, their 90-day open enrollment period and...I'm curious whether or not they can actually help qualify people for Medicaid or if they...just talk

about how that works and who they are and how many people you had apply for that (inaudible). [DHHS Briefing]

CALDER LYNCH: That's a great question. So we...one thing that's important to note is that we have in no way changed the responsibility for eligibility determinations for Medicaid. That process is still done through ACCESSNebraska. It's still done by state staff. So to get in the door to qualify for Medicaid, you still have to apply through ACCESSNebraska to be determined eligible. What happens then is enrolling in your health plan, and that's where AHS plays a role in assisting members. So we've had an enrollment broker for many years in Nebraska, the Medicaid Enrollment Center, who provided telephonic enrollment. And our system mailed them a letter but it was a pretty limited contract in terms of scope. And so as part of our effort to improve engagement with members but also as part of our efforts to comply with new federal regulations around providing member outreach and assistance, we issued an RFP earlier this year to select a new enrollment broker for managed care. I think we had five companies bid on that. AHS was the successful bidder and has stood up their system to be able to assist members. And what they're responsible for is mailing out the enrollment packets to members saying, you know, you're a Medicaid member, you're eligible to choose a plan, here are the plans, here's the process, call us, go on-line. They provide an on-line chat function for members. But their scope is limited to just health plan selection. They're not responsible for enrolling members into Medicaid or determining Medicaid eligibility. [DHHS Briefing]

SENATOR KOLTERMAN: So...can I continue? [DHHS Briefing]

SENATOR CAMPBELL: We'll do your question, then get Senator Howard, and then we will go on to our next hearing. So go right ahead, Senator Kolterman. [DHHS Briefing]

SENATOR KOLTERMAN: So for the process, you send out the kit. The people get the kit. There's an 800 number in there that they can call to access AHS brokers. [DHHS Briefing]

CALDER LYNCH: Uh-huh. [DHHS Briefing]

SENATOR KOLTERMAN: They help walk them through the process and decide which plan they want to go to. And then they send back the information or actually enroll them on-line or how do they do that? [DHHS Briefing]

CALDER LYNCH: So it's working a little differently today as we're gearing up for the January 1 start date and that Heritage Health doesn't begin till January 1. So everyone will have until December 1 to choose their plan. Then on December 7 we'll run the auto-assignment process for those that have not chosen a plan. And then shortly thereafter we will send each plan a file of their members, saying this is who chose you and this is who is assigned to you. And then from that, the plans take that and mail out welcome packets and member ID cards, like, you know, your health insurance card, to the members before January 1 so they have those in hand. Process will change once we are actively enrolled into Heritage Health after January 1. That will happen as members are enrolling in Medicaid for the first time. They'll be assigned into a plan and then they'll have the opportunity to choose a different plan if they wish to after that point, but that will happen at the point of eligibility going forward. [DHHS Briefing]

SENATOR KOLTERMAN: And so as I understand the process, there's three different companies that you've contracted with. [DHHS Briefing]

CALDER LYNCH: Uh-huh. [DHHS Briefing]

SENATOR KOLTERMAN: One company...is it possible that one company could get the bulk of the business and the other two get ancillary parts of it, because if I see this correctly, all three companies operate in all...the whole state. Is that correct? [DHHS Briefing]

CALDER LYNCH: That's correct. [DHHS Briefing]

SENATOR KOLTERMAN: So as an example, if you've got a bad network out in western Nebraska, they probably wouldn't choose to go to that network and... [DHHS Briefing]

CALDER LYNCH: Right. [DHHS Briefing]

SENATOR KOLTERMAN: Okay. [DHHS Briefing]

CALDER LYNCH: So we could see some variation in plan membership. Our goal is to try to start on relatively...start the program on relatively even footing with the plan, assuming they're able to, you know, meet network adequacy standards and be prepared for that. Members can choose any plan at any time. The auto-assignment process will attempt to balance membership, to try to at least give everyone a viable number of lives to operate. And then going forward we can make adjustments to that auto-assignment process to look at things like quality outcomes to preference plans that might meet certain metrics going forward. And that's an option going into the future. [DHHS Briefing]

SENATOR KOLTERMAN: But isn't network adequacy the most important thing for those people? [DHHS Briefing]

CALDER LYNCH: And it will look at that member's providers and make sure that they're assigning them to a provider of a health plan which that provider is enrolled with. [DHHS Briefing]

SENATOR KOLTERMAN: Okay. Thank you. I'll have some more questions but... [DHHS Briefing]

CALDER LYNCH: I'm happy to follow up, you know, in a more-detailed conversation. [DHHS Briefing]

SENATOR CAMPBELL: Senator Howard. [DHHS Briefing]

SENATOR HOWARD: Thank you. I wanted to talk about long term...the long-term care redesign. Is your intention with the long-term care redesign that we'll move into a managed care situation for our long-term services and supports? [DHHS Briefing]

CALDER LYNCH: So we state in the concept paper that we published in January that the state believes that a system of MLTSS, when we're able to offer a fully integrated package of benefits

with the medical, the behavioral, the pharmacy, and the long-term care together to really, truly look at that whole person's needs, has a lot of advantages. It is the system that we've identified, at least at this point, as the more ideal solution. However, recognizing that there's still a lot of work that has to be done to get us to that point, we've kind of taken a step back. And as part of this redesign we say we want to look more completely at how do folks enter the system, what do our waiver authorities look like, what services are covered, how do we measure quality, how do we assess need, and really try to look at this from a much more comprehensive perspective versus just handing the system over to health plans. We need to kind of take ownership and redesign the system in a way that makes sense before we make that decision to move into a more integrated MLTSS environment. We've now seen a tremendous amount of movement across the state. I think there's now maybe 18 states that have some form of managed long-term care. So we're able to draw from a wide set of experiences, lessons learned, good and bad, to determine what the best course for Nebraska is. So we've not made any final decisions on that front and, as part of this redesign process, we're getting feedback from folks about, you know, if we do move toward an MLTSS system, what are the things that you're concerned about, what are things you'd want to see, and what are the things that...what are other options you think we should consider. [DHHS Briefing]

SENATOR HOWARD: I guess my concern is more financial. [DHHS Briefing]

CALDER LYNCH: Uh-huh. [DHHS Briefing]

SENATOR HOWARD: Have other states seen a financial benefit in moving into managed care for long-term services and supports? [DHHS Briefing]

CALDER LYNCH: Yes. I think we can see some really good examples and I'm happy to share some of those with you. It's really not so much about cutting services but it's more about making the system more sustainable by addressing individuals' needs sooner and helping deflect away from costly care. We're able to generate not just savings but a more sustainable glide path of growth. When we look at our budget right now, 24 percent of our enrollees receive some form of long-term care services, but together they account for about 67 percent of our spending. So we're really trying to address their needs, as the population continues to age, to make sure that we're

managing the system to try to manage the growth of costs in the program overall. [DHHS Briefing]

SENATOR HOWARD: And two more. [DHHS Briefing]

SENATOR CAMPBELL: And to be... [DHHS Briefing]

SENATOR HOWARD: I apologize. [DHHS Briefing]

SENATOR CAMPBELL: To be mindful,... [DHHS Briefing]

SENATOR HOWARD: Oh, yes. [DHHS Briefing]

SENATOR CAMPBELL: ...we do have a hearing that we're going to need to move on. My suggestion would be that we have another public hearing coming with Senator Bolz's bill... [DHHS Briefing]

CALDER LYNCH: Yeah. [DHHS Briefing]

SENATOR CAMPBELL: ...in November and we'll schedule another hour ahead of that, if that's okay with the director, because by then you're going to know a lot more. Would that be accurate? [DHHS Briefing]

CALDER LYNCH: I think that would be a perfect opportunity to have a deeper conversation on long-term care. [DHHS Briefing]

SENATOR CAMPBELL: Yes. So we will bring him back at that point. If you have a quick question, because I'm trying to be mindful of people who came for the BSDC. [DHHS Briefing]

SENATOR HOWARD: No, it is not quick, so I'll save it for November. [DHHS Briefing]

CALDER LYNCH: Okay. [DHHS Briefing]

SENATOR CAMPBELL: Okay. All right. Thank you, Senator Howard. [DHHS Briefing]

CALDER LYNCH: Lots of discussion in November. [DHHS Briefing]

SENATOR CAMPBELL: We appreciate that. Thank you, Director Lynch. [DHHS Briefing]

CALDER LYNCH: Thank you. [DHHS Briefing]

SENATOR CAMPBELL: Okay. And we'll take just a teeny break for anybody that wants to leave, and we're going to change chairs. We want Senator Coash to have a microphone. [DHHS Briefing]

BREAK

SENATOR CAMPBELL: We'll say good morning to everybody once again and we will go into our next hearing and briefing. And Senator Coash is going to start us off with some comments and then have some invited testimony, I believe. [LR32]

SENATOR COASH: That's correct. Thank you, Senator. [LR32]

SENATOR CAMPBELL: So, Senator Coash, go right ahead. [LR32]

SENATOR COASH: (Exhibits 1, 2, and 3) Thank you, Senator Campbell. Thank you, members of the HHS Committee and also the LR32 Committee, of which there are some overlap here. I've got some things to hand out to you because I want you to kind of get some history here of what we're going to be talking about. Well, several years ago the Division of Developmental Disabilities lost its federal match for BSDC and that was kind of a big hit to the state budget at a time when we couldn't really afford that kind of a hit. That was north of $70 million. We got recertified. The federal match has been reinstated. Things at BSDC are moving along fairly well in that regard. As a reminder, one of the bills that was passed by the Legislature this year through this committee requires a report on a plan for BSDC. That report is not due to be completed until next year. However, I would encourage the committee to keep an eye out for that. The census at

BSDC continues to go down and admissions still for years have not happened. With that said, that's just a little bit of background of what's going on at BSDC. But the real purpose of today's hearing is to talk about a similar problem that the department has had that I want this committee to be aware of because it could impact significant budget things going on next year, but it's also impacted the provider community who the state relies on to provide services to adults and children with disability. What I'm being...having passed around to you is three articles from the local media. One of the articles, dated from September, outlines pretty well the source of what caused me to request this hearing today. There were some billing problems that this administration discovered that were put into place during the last administration that have the potential for a big impact, and when I say big impact I mean a $32 million payback to the federal government. Sounds a lot like what happened a few years ago, right? That $32 million is something that the department found on their own, reported it to the federal government, and are working to negotiate that down. But that's where we started. HHS has been diligently dealing with that, and as early as today it looks like they've got some updates for us. And so the timing of this hearing is appropriate because we can get kind of an update of where they are. But worst-case scenario, the federal government was asking for a pretty large check. So I've asked the department to come and talk about that, to give this committee an update of how we got there, where we're going, and what could possibly happen. In the short term, this realization of a billing problem had a large effect on the provider community, some providers more than others. But when the billing problem was discovered, the providers took a brunt of that issue. This is a system that is struggling for some stability. Its rates are always a challenge for any kind of provider. And this additional burden has certainly been a challenge for them. And I've asked a member of the provider community to come and talk about that. So I only have two testifiers today: one from the department, one from the provider. So there's kind of some short-term issues based on this billing issue, but long term there are some provider rate issues that tie into this. And I think those...the newspaper articles that I've passed around kind of illustrate those but we'll get a little bit more of an idea from the department. So we need to look at the stability of the system that we're operating in, and we certainly cannot afford to be paying back the federal government again for challenges that could have been prevented and with a little bit more forethought, well, could have been prevented. These challenges, particularly with the billing, are not anything that the department...the leadership in the department today had anything to do with, but it is certainly something that they're dealing with and it is something that many of you

will have to deal with as well. So to that end, I'd like to end my opening and let the department give you a briefing. [LR32]

SENATOR CAMPBELL: Okay. Thank you, Senator Coash. We'd like to also note that Senator Bolz has joined us. Senator Bolz, Senator Coash, and Senator Baker are all members of the special committee on BSDC. The remaining members are from the Health and Human Services Committee. So with that, I'll turn over the meeting to Senator Coash. [LR32]

SENATOR COASH: Thank you, Senator Campbell. As I mentioned in my opening, we are going to hear from two testifiers only. We're going to start with a representative from the department. So, Courtney, if you want to come on up. And we'll have you just kind of start with kind of where we were, where we are, and see what kind of questions we have, go from there. [LR32]

COURTNEY MILLER: Okay. [LR32]

SENATOR COASH: Thank you. [LR32]

COURTNEY MILLER: (Exhibit 4) Good morning, Senator Coash and members of the Health and Human Services Committee and the Developmental Disabilities Special Joint Committee. My name is Courtney Miller, C-o-u-r-t-n-e-y M-i-l-l-e-r, director of the Division of Developmental Disabilities with the Nebraska Department of Health and Human Services. I appreciate the opportunity to come before you today and provide a brief update regarding our Home and Community-Based Services Waivers through the Centers for Medicare and Medicaid Services, and our rate methodology. A lot of good work has been happening since I appeared before you in December of 2015. As noted within the DHHS business plan that was released in June of 2016, the Developmental Disabilities Division began our process on consolidating and renewing our Medicaid waiver services. Currently, the division has three approved waivers--Adult Day, Adult Comprehensive, and a Children's Comprehensive--providing services to individuals with intellectual and developmental disabilities. Two of the waivers--Adult Day and Adult Comprehensive--expired in December of 2015 and are currently on approved temporary extensions from CMS. We have been working diligently over the last year to renew these three

waivers into two: the Adult Day Services and a Comprehensive Waiver. This change was made based on town hall input. This strategy streamlines the process of service delivery throughout an affected individual's life. The division has been collaborating with CMS through bimonthly conference calls as well as additional technical assistance calls as needed. Drafts of the two waivers have been regularly shared with CMS for input and feedback prior to our public comment period. In addition, the division has been building relationships with stakeholders through seven work groups comprised of roughly 420 members, 18 town hall meetings across the state, and a monthly stakeholder meeting with 154 participants to date to gather input. The division is anticipating that these two new streamlined waivers will be in effect in early 2017. Once the draft application has been fully vetted and the public comment process has been completed, the DD Division will submit to CMS for final approval. Our goal is to have full implementation of the two HCBS Waivers completed by March 31 of 2017. Part of the waiver renewal process also required the division to unbundle the existing services and rate methodologies developed in 2010 and 2011 and implemented in July of 2014. Many of our current services include multiple billable services within one billing service code. Navigant Consulting, Incorporated, was retained by the division to begin assisting us with this process. As part of this process, it was determined that an existing billing practice implemented in July of 2014 was in conflict with federal reimbursement requirements. CMS subsequently informed the division that the billing document did not match the approved rate methodology if, in fact, residential providers were billing for day habilitation services that were already factored into the residential rates, and said that a reimbursement for claims submitted must occur. All residential rates assume a participant's sick leave and holidays at 15 days per year. In addition, all daily residential rates assume that a participant is outside the home in a day habilitation program 35 hours per week. All claims involving residential rates must be reviewed. I am currently negotiating with CMS on a claim review methodology. I anticipate that this process and all claims will be concluded by the end of the first calendar year of 2017, roughly in March. At this time, there is no clear way to quantify the total number of claims that CMS will characterize as overpayments that have been made to providers. I revised the agency's billing guidelines for all providers effective October 1 of 2016. These new billing guidelines will continue to reimburse providers at the state General Fund portion of their payment--is at 48.15 percent--for any excess hours of day habilitation that are not allowable for federal reimbursement through Medicaid. Upon approval from CMS of the Medicaid waiver renewals with new rate methodologies we will

be able to return to full federal claiming at that time and reimburse providers the full General Fund and the full federal fund dollars. To obtain CMS approval for the waiver renewals for the new rate methodology, a corrective action plan will be required to re-base our existing payment structures. The requests for proposals, or RFPs, for this process is in development. Again, I appreciate the opportunity to come before you today and provide an update, and I'd be happy to answer any questions that you may have. [LR32]

SENATOR COASH: Okay. Thank you, Director Miller. I'm going to start by getting a few clarifying questions here on the record. As I mentioned in my opening, the potential impact of that conflict with the federal reimbursement requirements was up to $32 million. That was kind of...that was the worst-case scenario, $32 million. [LR32]

COURTNEY MILLER: Thirty-two million is the universe of claims that we have to dive into to review. [LR32]

SENATOR COASH: Right. So we have to dive into $32 million. The World-Herald, let's see, you've been working with the federal government to try to review those claims to see if it's actually $32 million but something south of that, right? [LR32]

COURTNEY MILLER: Correct. [LR32]

SENATOR COASH: And in your testimony you said you hoped to have all that review done by the end of next year. Is that...? [LR32]

COURTNEY MILLER: The first quarter of this coming year, yes. [LR32]

SENATOR COASH: By the first quarter of 2017,... [LR32]

COURTNEY MILLER: Yes. [LR32]

SENATOR COASH: ...you'll have all those reviews done... [LR32]

COURTNEY MILLER: Yes. [LR32]

SENATOR COASH: ...and you...but we don't know what the result of that review could be with regard to how much those...what those claims will say about what is owed back to the federal government. [LR32]

COURTNEY MILLER: Correct. [LR32]

SENATOR COASH: Is that right? [LR32]

COURTNEY MILLER: Yes. [LR32]

SENATOR COASH: But the federal government has given you the guidance on how to review those claims and approval on that? [LR32]

COURTNEY MILLER: They've indicated that they've reviewed the waiver and they've reviewed the billing guidelines. What we're having discussions with about is how deep of a dive do we need to do to satisfy that we've conducted a thorough review. Is it a stratified sample of 2014 and 2015, or do we have to review every single claim that's involved? That's what we're discussing with them. [LR32]

SENATOR COASH: Okay. So there's no finality yet on the methodology... [LR32]

COURTNEY MILLER: That's correct. [LR32]

SENATOR COASH: ...to review those claims, but... [LR32]

COURTNEY MILLER: Uh-huh, that's an active conversation with CMS. [LR32]

SENATOR COASH: ...we expect some finality on that which will allow you and your team to dive into those claims based on whatever methodology is agreed upon... [LR32]

COURTNEY MILLER: Yes. [LR32]

SENATOR COASH: ...to figure out how much of that $32 million is actually going to be...we'll have to pay back. [LR32]

COURTNEY MILLER: Yes. [LR32]

SENATOR COASH: Is that...that would be accurate? [LR32]

COURTNEY MILLER: Yes. [LR32]

SENATOR COASH: Would you want to hazard a guess where...what number that would be or do you...? [LR32]

COURTNEY MILLER: I would not. (Laughter) [LR32]

_____: Yeah, that's smart. [LR32]

SENATOR COASH: Smart answer. Does your budget that you've submitted to the Appropriations Committee reflect a need for any additional money to cover what...this unknown number? [LR32]

COURTNEY MILLER: No, because it's an unknown number. [LR32]

SENATOR COASH: Okay. So if, depending on what that number is, you'll either have to find the money within existing budget or come back to the Legislature and ask for. Whatever...let me ask it this way. Whatever number it ends up being, somewhere between zero and $32 million, is the process then the state of Nebraska has to go talk to the Treasurer and say, write a check back to the federal government, or do they withhold it from reimbursement that's coming in the future? How will that go once that final number is arrived at? [LR32]

COURTNEY MILLER: That is...it's a process with CMS. It can be done a number of ways. Essentially, we have quarterly reporting that we conduct or utilize through the grant system that CMS has. We can open up prior years and pay it back in increments. We can do it...we can wait/not wait for the disallowance letter and then if there are any...if we don't agree with their methodology that they're asking us to do, we can dispute that and ask for an appeal. So there's a lot of options I think. First, it's just negotiating the process of which claims we'll review and how is the most important on the forefront right now. [LR32]

SENATOR COASH: Okay. Can you talk a little bit in more detail about what this realization of this billing problem has done with regard to the providers of service and what they are...the providers have had...what are they having to do as a result of this reduction in federal money into the system? [LR32]

COURTNEY MILLER: I think we're still taking the time to react to the change. It was unexpected that we were requested to do this and to stop the claiming immediately. We've worked through CMS on several issues, so this was a first in which we were asked to do this. And so we have worked with providers. We brought the issue to their attention in July, started having the conversations about what was discovered. It wasn't until September that CMS gave the directive to tell us to stop billing that immediately. There's definitely an impact. But right now we're asking for detailed information from the providers that collect that information to see what the level, the reduction, has caused on providers and to see what our options are, to work through that with them. [LR32]

SENATOR COASH: And although the federal match with regard to this particular service has gone away, the state continues to pay the state portion of that? [LR32]

COURTNEY MILLER: Yes, we did make the decision to continue on with the state portion to ensure that that money was allocated, those dollars were allocated for the services, so we continued that. [LR32]

SENATOR COASH: So we've got half the payment. Now does that...it's about half, right? [LR32]

COURTNEY MILLER: 48.15 percent. [LR32]

SENATOR COASH: Yeah, 48 percent. So does that 48 percent of what providers were used to getting for that particular service, that carries us through the end of this year? Is that accurate? [LR32]

COURTNEY MILLER: It's until we receive approval through CMS. CMS has approved in writing to us that they will allow a temporary residential rate increase in, as a bridge, in the waivers with a corrective action plan to do a complete re-basing. And so it's upon approval of those waivers we'll be able to claim the federal matching again for that. [LR32]

SENATOR COASH: So that temporary rate is kind of the bridge between now and the time that the rates are... [LR32]

COURTNEY MILLER: No, the temporary bridge is from the date the waivers are approved until we do a re-base. They would not allow--we asked--they would not allow the bridge from October 1 until the waiver was...or basically October 1 through the re-base. They were not inclined to do that for us. [LR32]

SENATOR COASH: So that temporary rate increase really hasn't taken effect yet then. [LR32]

COURTNEY MILLER: It went into effect October 1. [LR32]

SENATOR COASH: Okay. So October it did. So the temporary rate goes into...went to effect the beginning of this month. [LR32]

COURTNEY MILLER: Yes. [LR32]

SENATOR COASH: And it will stay in effect until the new rates are finally approved? [LR32]

COURTNEY MILLER: Till the waiver renewals are approved at the beginning of the year. [LR32]

SENATOR COASH: At the beginning of the year. And the CMS has said that they will approve those or we're still wondering if that's the case? [LR32]

COURTNEY MILLER: They said they will approve an increased temporary rate to the residential rates. [LR32]

SENATOR COASH: Okay. In the...I just want to talk about the relationship between the department and the providers. It was reported that all the current providers agreed to accept about half of their previous payments for providing that day programming beyond 35 hours a week. That was the service that was affected by the billing problem. So the providers who were currently providing that service have agreed to take less, less payment for that service? [LR32]

COURTNEY MILLER: We have worked with providers to...we did contract amendments and amended the billing guidelines that indicated that we created a new code for day programming for this 36-hour and above that would be available for the state fund portion of that rate. [LR32]

SENATOR COASH: So how does that go, I mean, just between the department and the providers? I mean you say: Here's your contract; it's going to be about half for this particular service; go ahead and sign it. Right? I mean that's a contract amendment is what you're talking about? [LR32]

COURTNEY MILLER: Yes. There were discussions prior to the contract amendment. We've met often with providers to discuss the change and to answer any questions that they have as we work through what it means and the impact on the providers. It certainly wasn't an enjoyable conversation, but it is something that if we don't have the federal match to pass on, the state General Funds are what's available for the rate. [LR32]

SENATOR COASH: Was it an option to kick in the difference from state General Funds? [LR32]

COURTNEY MILLER: Not within the current appropriations that I have for the (Program) 424 DD budget in fiscal year '17. [LR32]

SENATOR COASH: Okay. I guess I'm just kind of picturing being on the provider side saying, well, here's half the money; sign it or don't. [LR32]

COURTNEY MILLER: Uh-huh. [LR32]

SENATOR COASH: Because if you don't sign it, you don't provide service, right? I mean you have to have... [LR32]

COURTNEY MILLER: We don't disagree that there's not an impact. There is an impact. [LR32]

SENATOR COASH: Okay. All right. Thank you for being here today. I'll see if the committee has any questions. Senator Riepe. [LR32]

SENATOR RIEPE: Thank you. Thank you, Director Miller. It was not lost on me when you referred to CMS approval in writing, you said, which I think is a key element at this point. [LR32]

COURTNEY MILLER: Yes. [LR32]

SENATOR RIEPE: I'm also a fan of Will Rogers who said, everything I know I read in the paper. And this morning's Omaha World-Herald had an article on this $32 million, that there was some negotiation. [LR32]

COURTNEY MILLER: Uh-huh. [LR32]

SENATOR RIEPE: And obviously, in driving, I didn't have a chance to read it. So is there anything in there that could bring more light to us today (inaudible)? [LR32]

COURTNEY MILLER: I think the article correctly indicated that we were able to negotiate the bridge of that temporary enhanced funding for the residential rate within the waiver wait methodology to get that full federal match upon approval. From what I've seen, that's unprecedented for a state to accomplish, so it was a victory for us... [LR32]

SENATOR RIEPE: Okay. [LR32]

COURTNEY MILLER: ...in writing. (Laughter) [LR32]

SENATOR RIEPE: Always. Thank you. [LR32]

SENATOR COASH: Senator Bolz. [LR32]

SENATOR BOLZ: Thanks for your work, Director Miller. Just a couple of clarifying questions. [LR32]

COURTNEY MILLER: Uh-huh. [LR32]

SENATOR BOLZ: Can you tell me a little bit more about this bridge or temporary payment? Is it an increase to residential providers within the cost-neutral budget? Or is it a temporary increase to residential providers that's above and beyond the expected cost neutrality? [LR32]

COURTNEY MILLER: So cost neutrality, let's make sure we're on the same page. Cost neutrality in CMS terms is the cost to provide institutional care for an individual versus community-based services. And they absolutely will not approve a waiver that is not cost neutral. So we have to remain within that cost neutrality. [LR32]

SENATOR BOLZ: So in my oversimplified terms, we have the same bucket of money but the residential providers are going to be provided a temporary bridge rate that will help them bridge the gap basically. Is that...? [LR32]

COURTNEY MILLER: Yeah. Essentially, it's the same dollars, but rather than billing a day habilitation code for the weekends, holidays, sick days, it would be included in a residential rate that has a factor or an amount in that rate that accommodates for those days. [LR32]

SENATOR BOLZ: Uh-huh. And because we have that in writing, that helps providers have some assurances that in January things will be in a little bit better place and that helps them get through October to December,... [LR32]

COURTNEY MILLER: Yes. [LR32]

SENATOR BOLZ: ...hopefully. (Laugh) [LR32]

COURTNEY MILLER: Hopefully. [LR32]

SENATOR BOLZ: Hopefully, okay. [LR32]

COURTNEY MILLER: Yes. [LR32]

SENATOR BOLZ: That's helpful. And my other question was just a question about timing. If the claims negotiation is completed by March, does that mean that the payback will have to begin in March or is that just a question mark? I'm just wondering whether we can expect to see an impact in this year's budget or will it be delayed to next year's budget? Do we know at this point in time? [LR32]

COURTNEY MILLER: There is...there's no deadline at this point from CMS of when we accomplish the claims review. I think, because we've had the conversation and we're negotiating with them, their priority is reviewing our appendices for our waiver to go out for public comment for us to move forward. But we are intermittently having those conversations with a different area of CMS--their finance division--on the methodology of the claims review. We are hopeful that we would have that, the claims review, accomplished by March and to be able to determine what that dollar amount is. But then we could...then we start entering into negotiations with CMS of when they can expect to see those dollars. [LR32]

SENATOR BOLZ: Okay. That's helpful. And maybe just a last final comment is I really appreciate the idea that we will be re-basing the provider rates. And just from an appropriations perspective, I think we have a lot of rates in the state that are out of date. And your willingness to

work on that to address minimum wage increases and health insurance increases I think is really constructive. So thank you for that work. [LR32]

COURTNEY MILLER: Thank you. [LR32]

SENATOR COASH: Senator Howard. [LR32]

SENATOR HOWARD: Thank you, Senator Coash. Thank you for coming to visit with us today. I appreciate it. I, like most of my colleagues, don't love it when we are fined or have to return money, and so I want to ask you a few questions about how we conduct oversight within the department. And specifically, how long have you known about this billing issue? [LR32]

COURTNEY MILLER: The billing issue was discovered when Navigant was on-site in July. I guess July, July was the time that we learned that there was a discrepancy between the service definitions, the new service definitions from the unbundling and trying to assign a rate to those services based on our claims data. And Navigant had done the study in 2011 and 2010. [LR32]

SENATOR HOWARD: Okay. [LR32]

COURTNEY MILLER: So based on what was approved, they were working with what was approved in the waiver. And there was that discrepancy where essentially there was a bucket of money that we couldn't identify. Why did it show a cost savings, because that wasn't our intent? It was to utilize the dollars that were appropriated in the system. It wasn't...it was basically a budget-neutral exercise and that it wasn't coming out to be budget neutral. And so in July is when we started to dive in and have the conversation with providers to determine this is what we're seeing or this could be it, this could be a factor. And so through July and August is when we had the conversations with CMS to say this is what we're seeing; we need your assistance on how to proceed, of how to adjust the residential rate or a supplemental payment or something to ensure that those dollars remained in the system to sustain the system until we could do the re-base. That's how the conversation started. [LR32]

SENATOR HOWARD: So tell me about how do you audit or monitor these waivers, because this waiver went in, in 2014? [LR32]

COURTNEY MILLER: Uh-huh. [LR32]

SENATOR HOWARD: And so for two years we were billing inappropriately based on incorrect service definitions. So who's keeping track of that? Who's keeping an eye on that sort of thing? [LR32]

COURTNEY MILLER: I don't know that it was an incorrect service definition. It was just the billing guidelines introduced additional billing units that could be billed for. So, for instance, it said the residential providers may now bill for weekend days and holidays and sick days when an individual was not participating in a day habilitation program. And so those units, the budgets, the system was actually designed around that billing guideline because an individual's budget was based on...a residential individual was seven days of residential habilitation and seven days of day habilitation. [LR32]

SENATOR HOWARD: So I go back to the original question which is, how are you monitoring, how are you maintaining oversight over your own waivers? [LR32]

COURTNEY MILLER: I think as we move forward we have developed someone that's responsible for policy and compliance. That wasn't a position that was present before. And I think that that is critical to ensure that the waiver applications, the regulations, the billing guidelines, the provider enrollment process all align together, as well as the operational guidelines for our service coordination staff, to ensure that what we say that we're doing is actually what we're doing in the end. [LR32]

SENATOR HOWARD: So when was this position created? [LR32]

COURTNEY MILLER: This position was created about a month ago. I'd have to get back to you on the exact date. [LR32]

SENATOR HOWARD: And has it been filled? [LR32]

COURTNEY MILLER: Yes. Yes. Tony Green has joined us from the Division of Children and Family Services as the deputy director for the Division of Developmental Disabilities over policy and communication. [LR32]

SENATOR HOWARD: And then... [LR32]

COURTNEY MILLER: And he's a key asset, too, with the policy experience to ensure compliance. [LR32]

SENATOR HOWARD: He's a jack of all trades. [LR32]

COURTNEY MILLER: He is. [LR32]

SENATOR HOWARD: We've seen him in multiple places. Is that a position that we're going to see in other divisions? It seems like something that Medicaid would appreciate or Children and Family Services. [LR32]

COURTNEY MILLER: I think in some...in one way or another, it actually exists in other divisions. [LR32]

SENATOR HOWARD: Okay. [LR32]

COURTNEY MILLER: Tony was in that position for CFS... [LR32]

SENATOR HOWARD: At CFS. [LR32]

COURTNEY MILLER: ...policy and communications. Correct. [LR32]

SENATOR HOWARD: Okay. [LR32]

COURTNEY MILLER: Yes. [LR32]

SENATOR HOWARD: Okay. All right. Thank you. I appreciate that. [LR32]

SENATOR COASH: Any other questions for...? Senator Campbell. [LR32]

SENATOR CAMPBELL: Just a comment, Director Miller, that all of these funds are Medicaid funds correctly. Is that correct? [LR32]

COURTNEY MILLER: Of the line item, the 424 budget, I would say 99.9 percent of them are matched by Medicaid dollars. Most of our program...most of the individuals that we serve are receiving the Medicaid Home and Community-Based Waiver service. [LR32]

SENATOR CAMPBELL: Okay. So for a while I think there were some people who thought that we got special dollars from the federal government that were just DD dollars, but these are Medicaid dollars. Correct? [LR32]

COURTNEY MILLER: No. When we apply for federal grant dollars through Medicaid, it's for...it's to serve the Medicaid population, whether it's through state plan services or waiver services. [LR32]

SENATOR CAMPBELL: Okay. [LR32]

COURTNEY MILLER: Uh-huh. [LR32]

SENATOR CAMPBELL: To comment, I mean we went through this in the child welfare side having to unbundle, if you will remember, and we had disallowances that came because we had...I'm sure that's what we're seeing now with what you're going through. In that situation, the disallowances could be negotiated with the federal government once the figure was determined whether you were going to pay the whole thing at once or whether you were going to stretch those payments out over a period of years and you paid in interest. And I'm looking at Senator Bolz because, to some extent, that was a question out of the Appropriations Committee, was why

are we just not paying these rather than accruing the interest? So for my colleagues here, once that's determined, that will be a key question, I assume, that will be asked of the federal government is will...do we have to pay these all at once or would we negotiate something? And the last time on some of the larger disallowances, we did negotiate a payment over time to try to even that out for the department's budget. Just a comment of what you may see coming. [LR32]

COURTNEY MILLER: Thank you. [LR32]

SENATOR COASH: I've got just a follow-up question. We've kind of talked about how this will affect providers, and, of course, the budget is of concern. I want to get a little deeper in here to the effect on services and people...citizens of our state who rely on these services. With the short-term issues and with what we see coming down with new rates, are we asking providers to, in essence, do what they've been doing but for now less reimbursement? [LR32]

COURTNEY MILLER: Yes. The billing guidelines in the contract for the service definitions and those requirements remain because those are also what's mirrored in the waiver. So if there's a reduction or a change in service, you would have to ask for an amendment to the waiver. The concern with that is that you cannot amend an expired waiver, so we're kind of between a rock and a hard place on what our options are. Health and safety and quality of services is a forefront concern as we work through providers to weather through this process and what our options are. [LR32]

SENATOR COASH: Have you...are you aware of any issues with regard to providers with these changes saying, I can no longer serve this individual for this new rate or this amended rate? [LR32]

COURTNEY MILLER: It's not... [LR32]

SENATOR COASH: My concern is the people with disabilities, if they're going to lose services because of these changes. [LR32]

COURTNEY MILLER: Absolutely. I have...nothing has been brought to my attention that a provider would close its doors or reduce services to an individual or will no longer serve a particular individual. That has not been brought to my attention. [LR32]

SENATOR COASH: Okay. All right. Thank you. Well, we have some providers that will...can speak to that too. Any final questions for the director? Thank you for being here today. [LR32]

COURTNEY MILLER: Thank you. [LR32]

SENATOR COASH: Appreciate it. Okay. We've also asked a representative of a provider. There he is. (Inaudible) come on up. [LR32]

MARK MATULKA: Afternoon. [LR32]

SENATOR COASH: Welcome. [LR32]

MARK MATULKA: (Exhibit 5) Senator Coash, Senator Campbell, members of the Health and Human Services and LR32 Committees, my name is Mark Matulka, that's M-a-r-k M-a-t-u-l-k-a, and I'm the vice president of government relations for Mosaic. Thank you for the opportunity to provide testimony today on the recent changes to waiver services in Nebraska. Mosaic is a mission-driven organization serving 3,700 people with intellectual and developmental disabilities throughout ten states, including 753 people in our home state of Nebraska. Together, Mosaic staff members, volunteers, and the people we support work as partners providing services that are personalized to their wants and needs. In Nebraska, Mosaic provides day services, employment services, extended family homes, residential services, intermittent services, and affordable and accessible housing. The changes to the billing of day programming hours by the Nebraska Department of Health and Human Services' Division of Developmental Disabilities will adversely impact Mosaic by reducing funding for its critical community-based services. We are currently working with the department to figure out the exact reduction and funding for the October to January period, and conservatively estimate it to be approximately $400,000. Mosaic's 103 extended family home providers will realize an average decrease of about $424 per month, and some will see reductions over $1,000, which is unfortunate since many families have

made accommodations to their homes out of their own pockets to meet a person's needs. If the reductions are annualized into the future, the cost to Mosaic and its extended family home providers is estimated to be about $4.7 million. People with disabilities, their loved ones, and the greater community, including the state, rely on human service providers to implement personalized services and promote meaningful lives in the community. This change in policy, regrettably, reduces valuable resources to an already stressed system and will lead to decreased financial stability for providers, fewer program choices for the people in service, negative impacts on staff wages and benefits, and the potential reduction of group homes and extended family home providers in Nebraska. Human service providers are price takers. We have no ability to set our prices, increase reimbursement rates, or shift cost burdens to a non-Medicaid funded constituency. The change in funding is compounded by federal rules increasing providers' costs without any funding increase to implement the provisions. The rules require greater community integration, person-centered planning, and a push towards competitive employment for people with disabilities. Mosaic supports these initiatives, but the fact remains that more staff members will be required to continue achieving positive outcomes. For years, direct-support workers have been filling the roles of teacher, social worker, and community connector, in addition to providing personal care so that people with intellectual disabilities can live meaningful lives. Like a Nebraska state senator, a direct-support job boasts long hours, irregular schedules, and low pay, yet it is satisfying, fulfilling, and provides an opportunity to make a significant difference in people's lives. Even though support workers are critical to the success of community-based services, the rates provided by the state and federal Medicaid partnership have not allowed salaries or benefits for these workers to reach a level to adequately compensate them for their work. Mosaic does struggle with recruitment and retention of staff because current rates preclude competitive wages. Exacerbating this are increasing costs related to health insurance, the minimum wage increase, and the U.S. Department of Labor's overtime final rule. Mosaic appreciates that the committee and the department are committed to exploring options that will help providers continue operating and maintaining services for people with disabilities. The Nebraska Association of Service Providers has been in discussions with the department and the administration, and has requested that the department work to find resources to make the rates whole through the end of the year and delay the rate change to allow providers time to adjust to a reduced rate. We do truly appreciate the efforts made by the department, especially Director Miller and her team, to work with the Centers for Medicare and Medicaid Services to secure

temporary funding to alleviate some of the financial strain to providers. As you know, reimbursement rates are directly connected to quality services; however, rates seldom reflect the actual costs of providing services to people with intellectual disabilities since the increasing costs of doing business usually outpaces Medicaid rate adjustments. It is imperative that the Legislature and the administration recognize the value of these services and partner during the upcoming legislative session to ensure Medicaid rates are sufficient to continue providing critical community-based services for people with intellectual disabilities. Thank you again for the opportunity to speak with you all today. I am more than happy to answer any questions you may have. [LR32]

SENATOR COASH: Thank you, Mr. Matulka, for being here. I don't know how to phrase this question, so I'll do my best. Director Miller talked about this, the rate adjustment that we're...or the billing code, excuse me, that we're picking up the pieces on now, started back in 2014 and we just caught it this year. So we've got...you know, we've marched down the track two years with an improper billing code where providers were doing something that they had built their budgets on and now that's... [LR32]

MARK MATULKA: Uh-huh. [LR32]

SENATOR COASH: ...been backed down to a significant extent in some cases. If the department had caught this when they were adjusting rates back in 2014 and said, okay, hang on a second, we can't do it this way, we have to change our billing code so it matches the federal reimbursement requirements, what would you have done as a provider back in 2014 knowing that...knowing what you know now? I mean would you have said, no, we can't do it for that, try to negotiate something different? Because in 2014, even with the erroneous billing code, you know, you and other providers signed a contract and said, yeah, this is what we'll do and this is what we'll do it for. Can you speak to that, because I don't want to guess, but if it's $400,000 maybe back then you would have said, hang on a second, that doesn't work for us. Can you comment on that? [LR32]

MARK MATULKA: You know, yes, I can. Hindsight is always a benefit and knowing what today, if we would have known then, it would have been a different situation. And whenever

Mosaic does receive a rate or looks at the costs of what it is going to cost us to provide service, before we enter a contract we do evaluate the service to be provided, whether or not we can provide that service effectively, lead to positive outcomes for what we're contracted to do. And if there would have been a discrepancy between the cost for us to provide it and what the department was asking, yes, we would have worked with the department and ultimately the Legislature to ensure that funding was adequate to provide that service. [LR32]

SENATOR COASH: Okay. Seems like we're still in kind of a negotiation phase between providers and the department. Is that...would that be accurate from your standpoint? Or is...or do we know...we now know, you've signed this temporary increase and we know what rates will be, I mean, or are we still negotiating? [LR32]

MARK MATULKA: I would say that it's an evolving process, Senator. As I mentioned in my testimony, we are price takers. The department did present us a contract and at the end of the day our mentality at Mosaic is that our mission trumps our margin and that, you know, we're not blind to the economics. But at the end of the day, we need to serve people. And you know, at this point in October, coming to January before the Legislature convenes and a new budget is proposed, we're, as Director Miller said, in a rock and a hard place. We know the department can't pull money out of thin air to make it happen. But we feel that, you know, the original billing guidelines that came out that were referenced in our contract and a subclause that we signed that indicated how much money we would be paid to perform a service, that they do everything in their power to uphold that end of the contract. [LR32]

SENATOR COASH: Out of the 753 people that your organization serves right here in Nebraska, are any of them in danger of...do you see the potential of having to say to any of them, I'm sorry, for what we're being reimbursed we cannot be your provider? Is that discussions you've had? Is that decisions you've made? [LR32]

MARK MATULKA: It's not discussions that I have been privy to. I, you know, we have...we're spread about...across about seven agencies throughout the state, all the way as far west as Holdrege, up north to Norfolk. So, no, we have not had those conversations at this point. But again, we are...I don't like to...I don't use the term "crisis" lightly, but I would say our direct-

support work force is nationally in a crisis. If you look at the increasing demand for direct-care staff for people with intellectual disabilities, it is increasing fast. And you know, throughout our organization, I think we're operating at about a 37 percent vacancy rate. So in your personal lives at your business, imagine if 37 percent of the people you work with just weren't filled and the strain that that would put on your operations. And again, dealing with a vulnerable population, we want the state...we want to uphold our end of the contract and ensure that the state and the people of the state are receiving a good service for the money that's spent on it. [LR32]

SENATOR COASH: How are you making up the difference? Through charitable...you're a nonprofit, correct? (Inaudible). [LR32]

MARK MATULKA: We are, yes, we are a 501(c)(3). We are 96 percent Medicaid funded. The other 4 percent comes through our fund-raising efforts. We tell our donors, you know, you help stand in the gap, but it's...they help fill a gap. They are not the answer to the gap. [LR32]

SENATOR COASH: Right. My guess is--I've learned this from Senator Campbell over the years--is that your donors don't want to be in the position of doing what the state should be doing. [LR32]

MARK MATULKA: I think we both have... [LR32]

SENATOR COASH: They want to help, they want to contribute, but they're not in the business of... [LR32]

MARK MATULKA: I think we both have the same goal of providing meaningful supports to people with disabilities. [LR32]

SENATOR COASH: Okay. So where...you've got a gap here of $400,000. How are you...I mean, and you don't have to give...open (inaudible). [LR32]

MARK MATULKA: I'm a political scientist, sir, not (inaudible). [LR32]

SENATOR COASH: But I mean are you...are...something has got to give here, right? You can't raise your prices. You have to go out and ask your donors for money. You have to do more with less. You have to... [LR32]

MARK MATULKA: We do. We do. There will be a shortfall. We will look at reducing expenses within our operations. So Mosaic, being a national organization in ten states, we're headquartered in Nebraska, we have a national office. And then throughout our ten states we have about 37 agencies that provide the actual services. So we'll look at ways that we can reduce our costs while not sacrificing the quality of services that we are providing. And then we will work with our foundation and our foundation board, but not to speak for any other provider in the room. I would say Mosaic is the exception and not the norm to having the resources of a national organization and a foundation with very generous donors that support our work. [LR32]

SENATOR COASH: Thank you for your testimony. We'll see if we have any questions from the committee. I don't see any. I appreciate your time. I'd encourage you and your peers within the provider organization to make sure this committee is aware of where you are and how it's going so that those can be part of discussions when they talk about budgets, services contracts, all those kinds of things. [LR32]

MARK MATULKA: Definitely. And please feel free to reach out to me with any information or any questions you may have about providing services. I know Senator Crawford has been to our Omaha agency and some others, Senator Fox as well. So we'd love to show you what we do firsthand. So I appreciate your time today. [LR32]

SENATOR COASH: All right. Thank you for your testimony. [LR32]

MARK MATULKA: Thank you. [LR32]

SENATOR COASH: That will close the briefing. [LR32]

SENATOR CAMPBELL: Okay. And that concludes the hearings for today. Thank you for coming and have a good weekend. [LR32]

The Committee on Health and Human Services met at 1:30 p.m. on Wednesday, October 19, 2016, in Room 1510 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public hearing on LR514. Senators present: Kathy Campbell, Chairperson; Sara Howard, Vice Chairperson; Roy Baker; Sue Crawford; Nicole Fox; Mark Kolterman; and Merv Riepe. Senators absent: None.

SENATOR CAMPBELL: Good afternoon, and welcome to the hearing of the Health and Human Services Committee. I'm Kathy Campbell, and I represent District 25. We're very glad to have you here this afternoon. Before we do the introductions, just a couple of reminders: Make sure that you have turned off your cell phone or silenced it so it doesn't bother anybody. If you are testifying today, we do need you to complete the orange sheets. Senator Bolz has informed us that there will be four testifiers, so we are not going to use the lights; we're going to count on your not going an hour and a half, please. We may not all be here if you're doing that. Let's (inaudible). So I think that's all of the housekeeping, so we will do our introductions, and we'll start on my far right.

SENATOR FOX: All right. State Senator Nicole Fox, District 7: downtown and south Omaha.

SENATOR KOLTERMAN: Mark Kolterman, District 24: Seward, York, and Polk Counties.

SENATOR BAKER: Senator Roy Baker, District 30: Gage County and southern Lancaster County.

SENATOR HOWARD: Senator Sara Howard, I represent District 9 in midtown Omaha.

JOSH HENNINGSEN: Josh Henningsen, committee legal counsel.

SENATOR CRAWFORD: Good afternoon. Sue Crawford, I represent District 45, which is eastern Sarpy County, Bellevue, and Offutt.

ELICE HUBBERT: I'm Elice Hubbert; I'm the committee clerk.

SENATOR CAMPBELL: And coming in is Senator Riepe, representing...

SENATOR RIEPE: I apologize.

SENATOR CAMPBELL: District...I can never remember...

SENATOR RIEPE: 12.

SENATOR CAMPBELL: Thank you.

SENATOR RIEPE: That's Millard, Ralston, Omaha.

SENATOR CAMPBELL: Very good. And will the page introduce herself?

BRIANNE HELLSTROM: Hi, I'm Brianne Hellstrom.

SENATOR CAMPBELL: Good to have you. Okay. So that I don't forget like I usually do, we do have a letter, right, Elice? [LR514]

ELICE HUBBERT: (Exhibit 15) Yes, we do; and it's passed out. And there's also one on the Google drive, a letter from Doug Lenz who's the director of Central Plains Center for Services. [LR514]

SENATOR CAMPBELL: Okay, excellent. All right, Senator Bolz. Today we are hearing the LR574 (sic: LR514), Senator Bolz's. It's an interim study to examine the availability of transition services for youth who will leave or have left the juvenile justice system while in an out-of-home placement. So go right ahead. [LR514]

SENATOR BOLZ: Thank you. I am, in fact, Senator Bolz, that's B-o-l-z, and I'm glad to be here with you this afternoon. Those of you who remember the last time we discussed these issues, you may remember the story that inspired my interest in serving this population, and I'll refresh your memories. Last summer, I received a phone call from a colleague in the human services

field who had a particularly troubling case that she was working with. She had a young woman she was worried about who was on the verge of turning 19 and who had a developmental disability, a history of trauma and abuse, and was currently being served in a treatment center. She could not return home because she had previously lived with elderly grandparents who were not in the physical condition to manage her in their home with her...with them. And so my colleague and I scrambled for resources and scrambled for assistance and looked for ways to help this young woman. And, thankfully, with the help of some community organizations, she is in a fairly stable position now but is not as stable or as successful as she has the capability to be. And so this interim study is built on, not just that story, but on the story that we hear from many, many others who are in the juvenile justice system and turn 19 and are looking for supports and services to transition successfully into adulthood, including employment and education. I found this particularly challenging because, in other policy areas, we have a commitment to positive transitions and supports. Specifically, we have our Bridge to Independence program which provides foster care services to individuals aging out of the child welfare system. And we have a robust and growing reentry system for individuals who leave our prison system. And so, to me, it seems as though we have a gap for the youth that are served through the juvenile justice system and that, by supporting them, we could increase not only their transition to education and adult success, but also prevent recidivism, which is another important goal. So today's hearing...we'll discuss not only the importance of filling that gap, but we'll also discuss some of the specifics of the population that we believe is most appropriate to be served and some of the details of the program design that we think is most appropriate to meet these needs. Not every individual who's in the juvenile justice system needs additional support, but many do and it's a need in our community that I think is appropriate to respond to. So I'll wrap it up and I'll answer any initial questions or leave it to the rest of the testifiers. [LR514]

SENATOR CAMPBELL: Questions, anyone? Okay. [LR514]

SENATOR BOLZ: Very good. [LR514]

SENATOR CAMPBELL: Will you be staying? [LR514]

SENATOR BOLZ: Yep. [LR514]

SENATOR CAMPBELL: All right. Our list of invited testifiers will begin with Juliet Summers. And while Ms. Summers is getting ready, colleagues, there are four testifiers. Okay. I know you like to know that (laughter). [LR514]

JULIET SUMMERS: And we're all very quick, speak very quickly (laughter). [LR514]

SENATOR CAMPBELL: We don't want you to be too quick (laughter); make sure you can tell your story. [LR514]

JULIET SUMMERS: (Exhibit 1) Thank you, Chairperson Campbell and members of the Health and Human Services Committee. My name is Juliet Summers, J-u-l-i-e-t S-u-m-m-e-r-s. I am here on behalf of Voices for Children in Nebraska to address you on LR514. For young people exiting our child welfare and juvenile justice systems on the cusp of adulthood, the sudden transition from structural supports and requirements to complete independence can be a difficult path to navigate safely. Thankfully, on the child welfare side, Nebraska has an excellent extended foster care program, Bridge to Independence, to assist young adults leaving the foster care system who haven't achieved permanency in a family setting as they find their way into adulthood. I am happy to be here today on behalf of my organization, which is one of a coalition of child-advocacy organizations that have come together through this interim study to examine how this program might be extended to young people aging out of our juvenile justice system who are similarly alone in the world and without the support of family. As the senator said, that's absolutely not every young person exiting our juvenile justice system, but there are some and we've heard many stories to that effect. So a brief background: When the Legislature passed LB216 in 2013, creating Bridge to Independence, it required that the Children's Commission examine and report on ways to extend the program to other populations that would benefit from it. And last year the Bridge to Independence Advisory Committee of the Children's Commission formed a task force to examine this question and make recommendations. Focus groups were held with youth and adult stakeholders across the state. I think there were over 100, maybe even more, individuals statewide who were part of the focus group process. And the task force itself was comprised of a broad set of state experts in either probation and how things work on the juvenile justice side or Bridge to Independence and extended foster care or, in some cases, both. We had experts in both to come to a set of recommendations for how this could look or who it

should operate for. In short, what we learned through the process is that there is a broad consensus among stakeholders supporting a voluntary program of extended services for young people who are aging out of the juvenile justice system without a stable system of family supports already. The resulting recommendations from this group went to the Children's Commission and were approved and forwarded to the Legislature. And the primary one was to open up Bridge to Independence, as it exists, to a small population of young people aging out of the juvenile justice system in out-of-home placement who are at risk of homelessness because they don't have a home or family to return to. This recommendation came out of substantial evidence that, though they may have come to the attention of the system or the courts through a criminal act or misbehavior, there are youth who are lingering in placement on probation not because they, themselves, have failed to rehabilitate, but because they don't have a family who's willing to take them home or because they don't have a family who can take them home. However, child welfare proceedings, for one reason or another, have not been initiated, often due to their advanced age. The data show that there are probation youth leaving out-of-home placement not to return to family, but to go into independent living. And we heard directly, in focus groups, from probation officers who, literally, had to drop off young people at homeless shelters on their 19th birthday. Because jurisdiction was ending, probation could no longer provide services or be on the case, and yet there was nowhere else for that young person to go. So today you will hear testimony to this effect both from Jeanne Brandner, deputy director of juvenile probation administration, and from a young woman named Meshka Waya, who has experienced what it is like to transition out of our juvenile justice system. I'm still in the history on this. So last session, Senator Bolz brought LB866, the Transition to Adult Living Success Program Act, as a step toward implementing the recommendation. And, thanks to this committee, it was voted out but, without a priority, it didn't get heard on the floor. And you know, actually in hindsight, this has actually been ultimately of benefit, because it's provided, through this interim study that senator offered, an opportunity for some very detailed legal and technical research into federal funding streams, as well as further collaborative discussion among partners to take place. So the core team that has continued the work of the task force includes: Voices for Children, Nebraska Appleseed, Nebraska Children and Families Foundation, DHHS, and Probation...have all been at the table with Senator Bolz to, kind of, talk through these issues and what this could or should look like, and try to get the right language around eligibility so that we can extend transitional support, so the population who need it without being over- or under-

inclusive, and best setting up Nebraska to be able to draw down federal funding in order to support expansion of our program as it currently exists. So this proposal that the group has worked on has essentially two criteria for juvenile justice eligibility for Bridge to Independence: that a young person aging out of the juvenile justice system must be in a court-ordered, out-of-home placement, and that, prior to...on their 19th birthday and prior to aging out, the court has to hold a hearing and make a finding that such placement is necessary because returning to the home would be "contrary to the welfare of the child." Because the population we're trying to assist with this has not had a formal child welfare finding, last year we ran into really sticky legal issues regarding parental rights that are still intact. So trying to find the right language to express that these are young people who, as a matter of fact, don't have a home to return to when, as a matter of law, parental rights are still intact, was a really, you know, difficult road to navigate. And I think there's consensus among the group that this language gets there and it gives the court, sort of, the ultimate responsibility to make the finding, in the right cases, that these are young people who are eligible and would benefit. So we felt that this, contrary to the welfare language, is a strong proxy. And, in part, this is because it mirrors the language required by the federal government on the foster care side to draw down federal IV-E funds to cover foster care. So Kate Gaughen is here, with Mainspring Consulting, who has also been assisting us in this process. And she is going to testify, I believe, following me, regarding a fiscal analysis they've prepared, based on this proposed eligibility criteria, and also based on really great data that Probation has been generous to provide about their young people aging out of out-of-home placement. The hope is that, providing a system of supports to young people who would otherwise be sent adrift as they turn 19 after significant system involvement, Nebraska can ensure their safe transition to a productive and healthy adulthood which, again, as Senator Bolz said, benefits our community as a whole. So with that, I'd like to thank this committee for all your time and commitment to ensuring our systems serve and protect Nebraska's vulnerable populations and, especially, to thank Senator Bolz for her dedication to this issue and to helping young people through this work. So I'd be happy to answer any questions that I can about our process or the resulting recommendation or proposal. Otherwise we do have a couple other testifiers following me. [LR514]

SENATOR CAMPBELL: Questions, Senators? Senator Riepe. [LR514]

SENATOR RIEPE: Senator Campbell, thank you. Juliet, thank you for being here; good to see you again. [LR514]

JULIET SUMMERS: You, too, Senator. [LR514]

SENATOR RIEPE: Question that I have, trying to come along with some balance on this thing, do you have a projected, you know, fiscal note on this thing over a year or...and maybe over a ten-year period of time? [LR514]

JULIET SUMMERS: We have a projected fiscal that Mainspring has, Mainspring Consulting has been working on. It only covers the first three years, but I think she could extrapolate from there for you, Senator. I have it here. [LR514]

SENATOR RIEPE: Three years is a long time to plan it out anyway. [LR514]

JULIET SUMMERS: Three years is a long time. So the estimated cost is, in the first year, would be over $1 million, so $1.2 million; and then in fiscal year 2018, $2.6 million; and in fiscal year 2019, $2.78 million estimated. She's got better numbers than me, and she can tell you how...what their methodology was to get there. It's based on the cost of the current population in Bridge to Independence, as well as estimates from data we have from Probation about who we would expect to be entering the program, based on (inaudible). [LR514]

SENATOR RIEPE: Um-hum. Would this be the state's contribution, or is this the entire federal/state cost? [LR514]

JULIET SUMMERS: I believe this is the state's...oh, no, Senator, that's the total cost. The state's cost is less than that, based on estimated Title IV-E revenue that we could draw down from the federal government, which is low in this analysis, I will tell you, because our current IV-E penetration rate for the current Bridge population is still hanging around 15 or 16 percent. So we estimated our IV-E penetration rate on that relatively low number, percentage, comparatively. But that draws it down a hundred thousand to a couple hundred thousand for each year. And she

has...she'll give you the report itself, so you can dig through all the numbers that she used. [LR514]

SENATOR RIEPE: Am I hearing that correct, that the state's obligation might be $100,000 a year out of the million? Is that not... [LR514]

JULIET SUMMERS: No, no, no. The federal, the federal...the state's obligation is estimated at $1,182,575 for the first year, based on an estimated IV-E revenue of $112,881. [LR514]

SENATOR RIEPE: Okay, thank you. [LR514]

JULIET SUMMERS: So we're not talking small numbers; I will say that. [LR514]

SENATOR RIEPE: We're not used to small numbers, are we? (Laughter) [LR514]

JULIET SUMMERS: But, yes, in this committee we say we'll bring as high a number as we think we think we can get away with, Senator Riepe. [LR514]

SENATOR CAMPBELL: Senator Baker. [LR514]

SENATOR BAKER: Thank you. How many people...with these dollar estimates, how many people do you, would you be serving, based on that? [LR514]

JULIET SUMMERS: Yes, so, Senator, I'm looking at...I wish I had more copies to pass around; she'll give them to you in a minute. So the...she's estimating the numbers based on probation data of how many young people were aging out of an out-of-home placement on their 19th birthday. And then, from there, it's sophisticated. They do an uptake rate of how many young people from that eligible population they would expect would take advantage of the program. And that number for 2017 is 85; and then 2018, 89; 2019, 94. And I will say that these numbers are fairly in line with, back in 2013 in the original Bridge to Independence legislation, this population was initially included. And the numbers are fairly well in line with what those estimates were, back in the day, and also in line with the estimated cost per participant. [LR514]

SENATOR BAKER: So we're looking at $30,000 per person. [LR514]

JULIET SUMMERS: I am not the math person, Senator, but I... [LR514]

SENATOR BAKER: I just did a little quick math. [LR514]

JULIET SUMMERS: Yeah, yeah. I trust you in that equation. [LR514]

SENATOR BAKER: Isn't that a little high? [LR514]

JULIET SUMMERS: Well, I think it depends on how we look at it. So it's not really about just giving people $30,000, but about investing in a group of young people who are at risk of either, you know, making the transition to a stable and successful adulthood or not, and we've certainly seen this investment working with our current Bridge population, so young people aging out of foster care who don't have that family support. The vast majority of them are either in higher education, pursuing, you know, GED or pursuing college. Or they're working; they're employed. And so our hope would be that, by making that investment in this group of young people, that we could see similar successes in getting them to a stable and productive adulthood rather than, you know, the risk of recidivism or homelessness. [LR514]

SENATOR BAKER: Thank you. [LR514]

SENATOR CAMPBELL: Other questions? To be eligible for this, you have to be in probation when you're aging out, correct? You cannot have been in probation and then left, and difficult situations arise. You can't get back in. [LR514]

JULIET SUMMERS: Yes, Senator. [LR514]

SENATOR CAMPBELL: Okay. Is there any concern that the judge would just keep someone in probation in order...say, well, I think they need the services? I mean, part of the thing that I think for Probation that they continue to work on, and Jeanne is, no doubt, going to talk about this, in

terms of trying to find the mix of programs, services that are offered on the child welfare side, so any national thought about that? And I can probably ask the next speaker that question. [LR514]

JULIET SUMMERS: Absolutely. So this actually, this has been a big piece of our discussion, over the past year or longer, with the task force and focus groups, is wanting to...is a concern about balancing the need of getting the right population who are aging out without anything versus not wanting anybody to be artificially extended in probation or in out-of-home care in order to get access to a great program. Nationally it's hard to say, Senator, because Nebraska is a little unique in how we have, you know, bifurcated our system, in terms of Probation/DHHS. So most of the other states that offer an extended foster care program for juvenile justice youth, those juvenile justice youth might be in the care of the state's DHHS. So it's a little harder, it's a little harder to draw those comparisons. Kate Gaughen, after me, may have a better answer than that. What I will say is that, in our system, on the juvenile justice side of things, if the young person doesn't want to stay on probation, doesn't want to stay in out-of-home care, they are able to advocate that, for that, in the courtroom. And they should have an attorney, a defense attorney, whose mandate is to be advocating zealously for, you know, the child's expressed desires, as opposed to, on the child welfare side, when the attorney is a GAL who has the dual role of, you know, the expressed interest, but also the best interests. So there's going to be conflicting pressures in a juvenile justice case or courtroom that might not be there in the child welfare side where, if the young person really doesn't want to stay on probation, that's at least going to get heard in the court. There's going to be a lawyer arguing for that. There's also, as I said before, on the juvenile justice side, sort of the whole point of this is there are parents involved. So we also, part of the task force's work, last year we looked at maybe setting eligibility younger, so that, you know, to try and head off kids staying in care until they're 19. But because parental rights are still intact, we came into, sort of, another tricky legal question which was: Can a young person even voluntarily sign themselves into foster care, if they have parental rights that are intact? I don't think so. So we need almost to keep it at 19, when they are becoming an adult, so legally there's not, you know, there's not a parent who can exert their right and say, I want to, you know, want you to give me that money from the state maybe; I don't even know. You know, and certainly we don't want the court to make a finding that a young person can sign themselves into foster care, if there's a parent who, you know, who has legal rights intact, whether that parent is practically in the picture or not. [LR514]

SENATOR CAMPBELL: At what age can someone become...an appeal to the court to become emancipated? I'm sure you thought about that today. [LR514]

JULIET SUMMERS: I have thought about that because Senator Howard has another interim study, actually, on that question. [LR514]

SENATOR CAMPBELL: Would you like me to hold my question? [LR514]

SENATOR HOWARD: No, no. [LR514]

JULIET SUMMERS: And do you know what, Senator? The answer is in Nebraska there's not a mechanism currently for a young person to approach a court and request emancipation. Nebraska is a state where emancipation is governed by case law predominately. So really, the only way for a young person to emancipate themselves in Nebraska is to get married or to live so separately from their parent and with, what seems to be, sort of, the parent's permission to do so that, retroactively, a court might come in and make a finding that, as a practical matter, they were emancipated, so, yeah. [LR514]

SENATOR CAMPBELL: The first year I was in the Legislature, there was a lot of discussion on the floor about youth emancipation and whether that could be and of an oddity of...all the discussion started with being able to get your own phone. I mean, it had to do with the practical parts of life, and it wasn't resolved at that point, I mean, because there was so much debate as to what we should do that, I think, they held the bill at that point. But we'll look forward to the next step. Any other questions, Senators? Thank you very much. [LR514]

JULIET SUMMERS: Thank you so much for your time. [LR514]

SENATOR CAMPBELL: Our next testifier is Kate Gaughen. Am I saying that correctly? Probably not. [LR514]

KATE GAUGHEN: (Exhibits 2 and 3) I believe you all already have my report in front of you now, which is great. [LR514]

SENATOR CAMPBELL: We do. Thank you. And so, for the record, we need you to state your name and spell it. [LR514]

KATE GAUGHEN: Yes, my name is Kate Gaughen, K-a-t-e G-a-u-g-h-e-n. [LR514]

SENATOR CAMPBELL: Go right ahead. [LR514]

KATE GAUGHEN: Thank you. Thank you, Chairperson Campbell and members of the Human Services Committee. It's an honor to be here today. I'm a consultant with Mainspring Consulting. We're a small firm that specializes in providing technical assistance and facilitation, as well as conducting high-quality research and analyses around funding and financing strategies for programs that support children, youth, and families. We've developed fiscal analyses regarding extended supports and services in many states across the country, including: Michigan, Indiana, Iowa, Connecticut, Florida, Georgia, and Hawaii. So we have a lot of experience doing this work. As Juliet stated, in the fall of 2015 the Bridge to Independence Advisory Committee contacted us about facilitating a series of in-person meetings with critical stakeholders, regarding supports and services for young people transitioning out of the Office of Probation. Nationally, we know that young people transitioning from the juvenile justice system have worse outcomes than their peers in the general population, and worse outcomes than their peers in the child welfare population. One study showed that 12 months after their release from institutional placements, only 30 percent of those young people exiting from juvenile justice were either involved in school or employment. So this is a group of young people that are really at risk. So in the fall of 2016 the Bridge to Independence Advisory Committee contacted us again and asked us to participate in a series of phone calls to update our recommendations for 2015 and to do a fiscal analysis attached with those recommendations. With the support of the Jim Casey Youth Opportunities Initiative, I was able to provide the fiscal analysis in front of you, based on their final recommendations. The fiscal analysis assumes that Bridge to Independence would be available on a voluntary basis to any young adult who has attained age 19 while in out-of-home placement, under the care of the Office of Probation and, as Juliet stated, has a court order finding that it would be contrary to their welfare to return home. The young person in our calculations must also meet eligibility criteria for Bridge to Independence, which includes participation in education or employment activities or being incapable to do so because of a

documented medical condition. The analysis assumes that the Bridge to Independence program itself would remain unchanged, which then means there would be monthly face-to-face visits by a caseworker, there would be a young person to case worker ratio of 1:16. Young people would have access to direct stipends the way young people do in the current Bridge to Independence Program and that they would be receiving bi-annual reviews from the Foster Care Review Board (sic: Office). So given this program, we calculated a total cost to the state of $1.26 million in the first year of implementation, and that grows to $2.78 million by fiscal year 2019. The reason you see the growth between those years is in the first year we are only calculating 19-year-olds; the second year out would be 19- and 20-year-olds. So really, after that second year, you would see minimal cost growth, just sort of dependent on cost of living increases. And we assume slight increases in the population that would be participating. So the costs do include an assumption that the eligible population would grow by 5 percent annually. We feel that this is a conservative estimate because there are initiatives within the Office of Probation to lower the number of young people in out-of-home placement settings. But again, to be conservative, we thought it was right to include a 5 percent increase. The analysis also assumes a 3 percent annual increase in salaries and benefits for caseworkers and supervisors, and it assumes that young people exiting from the Office of Probation would voluntarily opt in to the Bridge to Independence program at the same rate that young people in the child welfare system are currently doing so. So that's, sort of, the total state costs. To partially offset these costs, the Office of Probation could enter into an agreement with DHHS to draw down the federal Title IV-E dollars, which we discussed a bit earlier, to support the population; and these are the numbers that Juliet quoted earlier. To do so would have leveraged $113,000 in the first year of the program when you're only looking at the 19-year-olds that would be in the program. And that would grow to about $248,000 in the third year of the program. Again, the reason that IV-E drawdown is so low is because of the very low IV-E penetration rate for young people in Bridge to Independence right now, which is 18 percent. So that's the percentage we applied when we were doing the fiscal analysis. In addition, the young people, if the state opted to draw down IV-E dollars, those young people who were IV-E eligible would also be eligible to receive Medicaid from 19 to 21, and so that would be an estimated cost of about $33,000 per cohort of young people. And so that would put, then, the total estimated state cost, if you drew down the IV-E but then had the added Medicaid cost, to $1.18 million in 2017 and growing to $2.6 million in fiscal year 2019. So that

is the broadest overview of the fiscal analysis. Would it be helpful for me to walk through the table, or how...do folks have questions that I can answer about the analysis? [LR514]

SENATOR CAMPBELL: I think we'll start with their questions, to see if we get to the tables. So, questions? Do you want her to go through the tables, Senators? I'm assuming you're talking about page 5. [LR514]

SENATOR CRAWFORD: And 6. [LR514]

SENATOR CAMPBELL: Or... [LR514]

SENATOR HOWARD: Or 6, (inaudible). [LR514]

KATE GAUGHEN: Page 6 or there's also a one-page document and it's on the back of that, but... [LR514]

SENATOR CAMPBELL: Oh, okay. [LR514]

KATE GAUGHEN: ...it's the same as on page 6. [LR514]

SENATOR CAMPBELL: We'll give them a minute. Don't have (inaudible). [LR514]

KATE GAUGHEN: Sure, that's a lot of numbers. [LR514]

SENATOR CRAWFORD: Yeah. [LR514]

SENATOR CAMPBELL: So you've done this for a number of other states--while they're looking, we'll let them look at the chart here--for a number of other states. [LR514]

KATE GAUGHEN: Yes. [LR514]

SENATOR CAMPBELL: I'm sure you heard my question about if someone left an out-of-home placement and went home or whatever, and then, you know, had difficulty later on, could they...do any states allow somebody to come back then? [LR514]

KATE GAUGHEN: So I should say that Nebraska is really pioneering in looking at this for the juvenile justice population. Again, as Juliet said, some states have both the juvenile justice and child welfare in one agency which is, for example, the case in Indiana. And so in that sense, we have not done one just for young people aging out of the juvenile justice system. I will say that all of the states that we've worked with, the young person must leave care--generally it's at 18 was the age of majority in those states--and that there isn't an option for a young person to leave prior to that date and then enter the extended-care program. I should also say that we do...we have a fair amount of ongoing contact with the states we've worked with and, to date, I have never had a report that that was of concern that young people were being held in the system and able to access extended supports. I mean, I would certainly not say that never happens. I'm certain, from time to time, you get an active judge or lawyer that would like that to happen, but it's not been reported to me as a significant issue in the other states we've worked with. [LR514]

SENATOR CAMPBELL: Were you making the assumption on the additional caseworkers and that, that the caseworkers would be located in the Office of Probation Administration or in the Department of Health and Human Services? [LR514]

KATE GAUGHEN: We made the assumption that the caseworkers would be located in the Department of Health and Human Services and used their salary data and their caseload ratios to do all of the calculations. [LR514]

SENATOR CAMPBELL: Okay. So there would be a hand off from the probation officer to the caseworker at that point. [LR514]

KATE GAUGHEN: That's correct. [LR514]

SENATOR CAMPBELL: Okay. [LR514]

KATE GAUGHEN: And I believe in the focus groups with young people, they also reported that there was a desire to feel like they had completed probation, that they still were not in that system and to, sort of, start a new day by entering the Bridge to Independence program. [LR514]

SENATOR CAMPBELL: So if they're no longer in probation, then the court review that, you know, that the Bridge to Independence uses would all be written in statute, and they would have to go before court, correct? [LR514]

KATE GAUGHEN: Correct, yes, especially in order to access the IV-E dollars. You would need a court finding. [LR514]

SENATOR CAMPBELL: So they're basically leaving the door of Probation and they're going in the door of Bridges. [LR514]

KATE GAUGHEN: That's correct. [LR514]

SENATOR CAMPBELL: Okay. All right. Any questions, Senators? I don't see any questions. Thank you. [LR514]

KATE GAUGHEN: All right, thank you. [LR514]

SENATOR CAMPBELL: Okay. Our next testifier is Jeanne Brandner. Good afternoon. [LR514]

JEANNE BRANDNER: Good afternoon. [LR514]

SENATOR CAMPBELL: I see you so seldom and then, all of a sudden, here we are, almost twice in a week. [LR514]

JEANNE BRANDNER: I know. [LR514]

SENATOR CAMPBELL: That's good, that's good. [LR514]

JEANNE BRANDNER: (Exhibits 4-13) Thank you; I'm glad to be here. Good afternoon, Chairperson Campbell and members of the Health and Human Services Committee. My name is Jeanne Brandner, J-e-a-n-n-e B-r-a-n-d-n-e-r. I am employed by the Nebraska Supreme Court Administrative Office of the Courts and Probation as the deputy probation administrator, overseeing juvenile services. As has been said several times today, a special thank-you to Senator Bolz for last year's proposed legislation, which was LB866, and this interim study to examine the feasibility of transition services for youth who leave the juvenile justice system. As professionals in the state have come together to examine the extended services and supports, a lot of which you've heard about this afternoon for the juvenile justice youth, it was certainly reassuring to see such great advocacy for Nebraska youth. However, as some have commented today, this work has not transpired without criticism. Individuals call out the question: How is it that we should provide a benefit to children who have done wrong? I'm here today to provide a simple answer for you; and that is: humanity. It is said that children are our future but, honestly, without the adult leadership, these children may not have adequate future opportunities. For many individuals involved in the juvenile justice system, while their most recent incident may be delinquent or status in nature, more often than not, they likely first became system-involved at a much younger age, in the child welfare system. This means that they, too, have suffered abuse and neglect by the ones who should have been their biggest champions and/or struggled to gain that permanency that we've talked about. When a youth enters the teenage years, there is often a culture that assumes that they can fend for themselves and protect themselves, which limits their opportunity to enter the child welfare system. And for those, as we've heard about as well, that fall between that age gap of 18 and 19 years of age, this option is not even available. This, for many youth, seems to be when things fall apart. The youth we are talking about lack that family support and meaningful relationships that greatly assist them to successfully transition to adulthood. A legislative effort to address this vulnerable population would give us a foundation. Those of you who were here when the original Bridge to Independence legislation was enacted might remember that that legislation did initially include the status offense population, and they were ultimately removed, due to budget and fiscal constraints. So in Nebraska we must continue to improve the outcomes for youth who transition from out-of-home placements and return to their communities, regardless of which system that they are involved in. As we hear, in other juvenile justice related policy discussion, children aren't miniature adults and, while the physical differences are obvious, the psychological ones are not, particularly as youth appear more

sophisticated than in previous generations. It is our job to respond to youth in developmentally appropriate ways, hold them accountable, and provide resources to overcome barriers as they transition to adulthood and reintegrate within our own communities. Attached to my testimony today, you also have a handful--I believe about eight letters from some of the Probation staff across the state that have, over the transition time, have experienced some of these cases, the real-life cases, as Senator Bolz had mentioned, that really have transpired this work. I am not going to read those letters to you; they're...you know, you can read them at your leisure. But I just wanted to call out a couple of the common themes, as we've talked about today: the lack of family support and stability; oftentimes mental health issues that are ongoing; developmental disabilities; and, certainly, risk of homelessness and exiting into shelter-care programs. As we've heard today, this is a very vulnerable population and, if we don't act in some way and put some investment, we will be paying in the State Pen for these youth. And so, either way, there will be dollars allocated to these youth. It's just to get ahead and find that support for them so they can reintegrate into their communities. With that, I would take any questions that you might have. [LR514]

SENATOR CAMPBELL: Questions, Senators, that you might have? Ms. Brandner, at this point, the kinds of services that are talked about through Bridges are not really available yet in Probation, are they? [LR514]

JEANNE BRANDNER: That is correct. [LR514]

SENATOR CAMPBELL: Even ahead of that age...I mean, you're still working on those programs. [LR514]

JEANNE BRANDNER: Correct, yes. [LR514]

SENATOR CAMPBELL: Okay. Would we have very many people, do you think, who would be in this system and then went home, and it didn't work, and then they would try to come back to get some services? [LR514]

JEANNE BRANDNER: Well, I think that's an interesting question. And that's one that we've been grappling with throughout this work group, is, what does that number look like? And we've looked at, you know, is it a large population? Is it a small population? I've even said many times at the table, even if we put a...now, of course, there's funding caveats that we have to consider as well, but one of the things is: Even if we put a cap on this and said ten kids a year that could benefit from this, it would be ten more kids than we're helping today. And so I think we guess that the numbers are not super large, as they've been alluded to, less than 100 kids per year across the state. But again, until we can get to that full implementation, we have the stories and we have the youth. And really, again, as was alluded to, the youth that we serve predominately have parents involved, they have already been adopted, most have some permanency. But we're talking about the select few individuals that just have fallen through the gaps and have the loopholes that have not gained that permanency and do not have that support. [LR514]

SENATOR CAMPBELL: For the youth that would be duly adjudicated, they would be eligible for the Bridges program, would they not? [LR514]

JEANNE BRANDNER: That is correct. [LR514]

SENATOR CAMPBELL: Okay. [LR514]

SENATOR CRAWFORD: There's another question. [LR514]

SENATOR CAMPBELL: Oh, sorry, Senator Crawford. [LR514]

SENATOR CRAWFORD: Yeah, that's fine; that's fine, thank you. Thank you, Senator Campbell, and thank you for this testimony. I just wanted to bring attention to one point you raised. You mentioned that those youth who are between 18 and 19 particularly are vulnerable. I know in the earlier discussion we were talking about limiting it to people who were in the system until they were 19. [LR514]

JEANNE BRANDNER: Um-hum. [LR514]

SENATOR CRAWFORD: So would you see a concern about that, in terms of...or a need to look for ways to include those youth who are 18, as well? [LR514]

JEANNE BRANDNER: Well, it's definitely something we've talked about and, if that did happen, it would be a change to what's currently happened on the child welfare side, so not something we were quite ready to explore at this time. [LR514]

SENATOR CRAWFORD: Okay. [LR514]

JEANNE BRANDNER: What I was particularly calling out, within that reference, is the fact that once a youth reaches that age of 18, they no longer can have an abuse/neglect case opened at that point. [LR514]

SENATOR CRAWFORD: Oh. [LR514]

JEANNE BRANDNER: So we have this limbo age here where, even if we had some pretty substantial things that were going on, they cannot become involved in the child welfare system. And so a lot of times, as was alluded to in the case that really brought this legislation forward, the young gal had the history but didn't have an active case. And because she was past the age of 18, there was nothing further that could happen within that system. [LR514]

SENATOR CRAWFORD: They can't be eligible for the other system if they're 18. [LR514]

JEANNE BRANDNER: Correct, yes. [LR514]

SENATOR CRAWFORD: Okay, thank you for clarifying that. [LR514]

SENATOR CAMPBELL: Okay, any other questions? Thank you for your testimony today. [LR514]

JEANNE BRANDNER: Thank you. [LR514]

SENATOR CAMPBELL: Our last invited testifier is Meshka...I'm not going... [LR514]

MESHKA WAYA: Wa-ha (phonetically). [LR514]

SENATOR CAMPBELL: Wa-ha (phonetically)? [LR514]

MESHKA WAYA: Waya...the "Y" is pronounced as an "H." [LR514]

SENATOR CAMPBELL: I kept trying to write it phonetically, and I wasn't doing a very good job. [LR514]

MESHKA WAYA: That's okay; nobody ever gets it right. You're good; it's not your fault. [LR514]

SENATOR CAMPBELL: Welcome. [LR514]

MESHKA WAYA: (Exhibit 14) Thank you. Good afternoon to senators and Chairperson Campbell and people at Health and Human Services Committee. Thank you for the opportunity to speak on LR514. As I said, my name is Meshka Waya, it's M-e-s-h-k-a W-a-y-a, and I speak to you today as a former state ward. I'm here to share my support of expanding services to youth aging out of our juvenile justice system without a stable support system. And I'm here to provide the perspective of a young person who aged out of the juvenile justice. I'm here to give you my story and raise awareness about those who these supports would help. I'm one of many cases where I went into the system as a juvenile case, but then I was put into care for foster system due to child welfare reasonings with my...I'm sorry; I lost my spot on here. I'm very nervous, if you can't tell. [LR514]

SENATOR CAMPBELL: You're doing just fine. [LR514]

MESHKA WAYA: Where did I...I'm here to give you my story and raise awareness about those who these supports could help. I am one of the many cases where I went into the system as a juvenile case and then put into the foster system due to child welfare reason without my case

being transferred. I would like to share a few reasons why I support extending supports and services to youth aging out of the juvenile justice system in out-of-home placement. I aged out of the juvenile justice system in 2012, and I moved into the dorm and started attending the local community college. But by the end of 2013, I was seven months pregnant and looking for a place to stay, due to homelessness. I feel that, if I had had the opportunity of Bridge to Independence when I aged out, moving when I was pregnant would have been a lot easier--definitely. Having someone to call when I was struggling and the additional funds to make, like, a security deposit just may have prevented my homelessness, because I wouldn't have been alone. College is definitely a hard transition for all young adults. The difference for those like me is that we have to do it alone. When I aged out of the system, I was a part of the Former Ward Program, which helped with school. Unfortunately, it didn't help me transition into the world of adulthood. I didn't have the resources to be able to keep a home. I had the dorm, but in between semesters I had nowhere to go; I had nowhere to live. I had no money to afford temporary housing, and it was hard for me to juggle going to school, doing homework, holding a job without support. By 2013, when I became pregnant and was having to figure out what I was going to do about housing, I was not allowed to live in the dorms with a child. And I didn't want my daughter to come into the world while living in a homeless shelter. My parents lived in another state, so I couldn't live with them. My daughter's other bio parent wasn't in the picture, and I didn't have a job where I could afford housing for even a one-bedroom apartment. I was fortunate to have a friend in Grand Island that allowed me to move in with them. That meant that I was moving to Grand Island with no job, no money, and no clue what to do next. I would have still moved to get away from an unhealthy environment, either way. I feel that if Bridge to Independence was an option for me, maybe I would have been able to save money before my daughter was born, had my own place, possibly had a job to help support my beautiful little girl. Unfortunately, Bridge to Independence would have never been an option for me, due to my case not being classified as a child welfare case. Well, I went into my first placement. I had already been in court system due to a stupid mistake of hanging out with the wrong crowd. However, I went into my first placement due to continuous verbal, mental, and physical abuse from a parent. The system tried to help my parents and I, but the situation was 17 years of problems that they could not fix in a year. Through all of this "help" that we were receiving, my case never became classified as a child welfare. I want to know why the system never fixed this error or thought that my case was not important enough to be classified as a welfare case. Due to this mistake, I became ineligible

for Bridge to Independence program. Expanding Bridge to Independence would make sure that youth like myself in the Probation system get the support they deserve. I do not understand why, when the program was passed for only those who were in the child welfare system, why those under juvenile not just as important. What makes those in juvenile justice cases who don't have support systems different from a child welfare case? So I ask you today to make a difference and help make this program open to more of our children aging out--they deserve to have the opportunity to achieve their highest goals--by supporting efforts to put every youth in our systems who need the support in the same category. Doing that makes sure one kid doesn't feel like they're not important because they were in the system due to mistakes that they made, even though they were survivors of abuse or neglected, or because they were unfortunate, like me, to not have a transfer happen that should have. Again, I thank you, Senators, for allowing me to speak today to you on LR514. And if you have any questions for me today, I can do my best to sincerely answer. Thank you. [LR514]

SENATOR CAMPBELL: Thank you; you did a great job. It's not... [LR514]

MESHKA WAYA: I have no idea why I'm crying. I'm just going to blame it on pregnancy hormones (laughter). I apologize. [LR514]

SENATOR CAMPBELL: It's not easy to tell one's own story. [LR514]

MESHKA WAYA: It's not. [LR514]

SENATOR CAMPBELL: So we very much appreciate it. Are there questions from the senators? Did you ever find out, was it just an error that you weren't? [LR514]

MESHKA WAYA: I have no idea. I actually didn't even find out that my case wasn't transferred until Bridge to Independence actually got passed and we tried to put me into it. [LR514]

SENATOR CRAWFORD: Hmm. [LR514]

MESHKA WAYA: So I don't know. [LR514]

SENATOR CRAWFORD: Um-hum. [LR514]

MESHKA WAYA: I don't know if it's just...something just didn't get filed or what, but... [LR514]

SENATOR CAMPBELL: The question that we're discussing up here is: Were you ever represented by an attorney? [LR514]

MESHKA WAYA: No, I just had a guardian ad litem and, other than that...and my guardian ad litem never even came into my home or talked to me. And I would maybe see her for, like, five minutes before my case. So I think I met my guardian ad litem like three times and that was it. Sometimes I didn't even see her until I was up in front of my judge. [LR514]

SENATOR CAMPBELL: We have heard that story before, unfortunately. [LR514]

MESHKA WAYA: Yes, yes. [LR514]

SENATOR CAMPBELL: Any other questions? Thank you, and we wish you the very best. [LR514]

MESHKA WAYA: Thanks. [LR514]

SENATOR CAMPBELL: Thanks for coming today. Senator Bolz. [LR514]

SENATOR BOLZ: I just want to close very briefly in saying that I appreciate the questions about the fiscal analysis, and I promise that we will do our due diligence in cooperation with the Legislative Fiscal Office to get the numbers right. But my final comment is just, going back to the policy analysis, this is an evidence-based program. It has proven outcomes, and I think there is a clear consistency with our other public policy in promoting these kinds of strategies as preventative strategies and as strategies that help transition into successful community living out of any, sort of, institutional or state-supported care. And so I just wanted to wrap up by saying I think this is good public policy. [LR514]

SENATOR CAMPBELL: Any further questions, Senators, that you'd like to ask? I think we've all tried to put this bill forward. Unfortunately, we have not gotten to that priority stage for it. And perhaps, in a longer session, there might be an opportunity to share more information about it. [LR514]

SENATOR BOLZ: I promise you'll see it again. Thank you. [LR514]

SENATOR CAMPBELL: Okay, thank you very much, Senator Bolz. That concludes our hearing for today. Thank you; have a great weekend. We are complete with our (recorder malfunction). [LR514]