[BRIEFING]

The Committee on Health and Human Services met at 1:00 p.m. on Tuesday, November 15, 2016, in Room 1113 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a Department of Health and Human Services briefing. Senators present: Kathy Campbell, Chairperson; Sara Howard, Vice Chairperson; Roy Baker; Sue Crawford; Nicole Fox; Mark Kolterman; and Merv Riepe. Senators absent: Sue Crawford.

SENATOR CAMPBELL: (Recorder malfunction).

SENATOR FOX: (Recorder malfunction)...District 7: south Omaha and downtown Omaha.

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

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

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

JOSH HENNINGSEN: Josh Henningsen, committee legal counsel.

SENATOR CAMPBELL: And Elice Hubbert is the committee clerk, and she's trying to get the computer up and going. Senator?

SENATOR RIEPE: I'm Senator Merv Riepe from District 12, with laryngitis.

SENATOR CAMPBELL: Oh, that could not bode well for you. And would you like to introduce yourself?

JORDAN SNADER: I'm Jordan Snader. I'm the page this evening...or this afternoon, whatever it is (laughter). I am a student at the University of Nebraska-Lincoln, studying advertising and public relations.

SENATOR CAMPBELL: We will certainly hope that Jordan is not prophetic and that we're still here at dinnertime. I think Senator Howard is going to help us out there, not be there till dinnertime.

SENATOR HOWARD: It will be very fast.

SENATOR CAMPBELL: I would like to remind you to turn off or silence your cell phones this afternoon. During the first hour of our briefing today, there's only going to one person coming to testify so you don't need to worry about that. If you are staying for the second part of our agenda today, and I think all the testifiers are invited testimony. Correct, Senator Howard?

SENATOR HOWARD: Yes.

SENATOR CAMPBELL: And so if you are an invited testifier, we'll need to have you complete one of the sheets, which I don't see out, which we'll have to put out for the second one. And I think those are all the housekeeping duties, so, Director Lynch...Director Lynch is the head of Medicaid and Long-Term Care for the Department of Health and Human Services and was here, what, about a month ago?

CALDER LYNCH: Um-hum.

SENATOR CAMPBELL: ...at one of the hearings. And we started questions, and there were a lot of questions yet to be covered, so we scheduled another hour with Director. So thank you very much for coming back. And I know that you want to address several things before we go to questions, correct?

CALDER LYNCH: Absolutely.

SENATOR CAMPBELL: And so we will...once Director Lynch has completed his opening comments, we'll start with Senator Howard, who had a question and just couldn't get it in. And then I'll go to Senator Kolterman, who had, he told me, a lot of questions. And then we'll, you

know, go to the rest of the senators, but they did not get a chance to finish their questions. So Director Lynch, start us out this afternoon.

CALDER LYNCH: (Exhibit 1) Thank you, Senator Campbell and members of the committee. Calder Lynch, director of the Division of Medicaid and Long-Term Care, and very happy to be here again this afternoon. I do have a few slides, which have been distributed out to the committee members to provide some updates from our discussion last month, hopefully answering some of the questions that, maybe, didn't get answered last time, but then certainly have...we'll have plenty of time to answer any other questions that the committee may have. Just to quickly recap, I'm not going to cover much of the same material as last time. But you'll see, on the first content slide, we're here today to talk first about the implementation of Heritage Health, which is the new, integrated managed-care program for Medicaid in Nebraska, bringing together physical health, behavioral health, and pharmacy services under one delivery system for nearly all of our enrollees. As part of Heritage Health, we have contracted with three health plans or managed-care organizations to administer those benefits, and those are: Nebraska Total Care, UnitedHealthcare Community Plan, and WellCare of Nebraska. This is a repeat slide--just going to level set with Heritage Health. I think it's always important to remember that each of the plans offers the same package of benefits and services that are covered by Medicaid. No plan can diminish in any way the services that are covered by Medicaid for which they are contracted to administer. Each plan, though, may offer a variety of extra benefits and services also called value adds for services that aren't part of the Medicaid benefit package, or they may waive restrictions that are part of the Medicaid program, like copays or service limits. And that's one of the ways they differentiate between the plans for purposes of member selection. There are also some Medicaid-covered services that aren't part of Heritage Health, and so they continue to be administered by the state or through another contractual vehicle, and those include: dental services, non-emergency transportation, and long-term supports and services, which include personal assistance services, long-term care in a facility like a nursing home, and all of our home and community-based waiver services that are administered through one of the HCBS waivers, either administered by Medicaid or the Division of Developmental Disabilities. However, many of the people that receive those services are coming into Heritage Health for their acute care, their physical health, behavioral health, and pharmacy services to be administered by their health plans. On the next slide, just a quick recap of the time line of what's brought us to this point. A

little over a year ago, we released the RFP for Heritage Health to choose the health plans that we are contracting with; those contracts were awarded in April. We immediately began a series of implementation, as well as stakeholder meetings to prepare for that implementation. Over the summer, began outreaching to providers, to stakeholders, about the changes that were coming. In September began and launched our new enrollment broker, to begin enrolling members and giving them the opportunity to choose what health plan is best for them and, since that time, have been an ongoing readiness review status, where we have been doing both desk audits of health plan policies and procedures, as well as, for the last several weeks, having staff go on-site to each plan and do an in-depth review of their readiness of both their staff, their policies, and their systems, to ensure that we're going to have a smooth launch on January 1. We continue to be in the member choice period until December 1, and then Heritage Health will actually begin, and the health plans will begin administering services with dates of service effective January 1, 2017. So we're a little over 45 days out from implementation. So a couple of the follow-ups from the last briefing that I'll touch on today: first, some of the updates of the work that's been going along with the behavioral health integration work group--that's been a lot of our focus recently as we look at integrating behavioral health benefits, moving from just having Magellan to having all three plans administer those; our update on enrollment and where we are with member selection; update on where we are with outreach and education to make sure folks are ready for the change; we received some questions about the budget and financing of Heritage Health, so I'll touch on some of those pieces, as well as what we're doing to measure performance of the health plans in year one and then some of our plans moving forward. After that, I'll briefly touch on long-term care redesign and some of our efforts that are underway, sort of separate but related initiative of looking at those long-term supports and services in the future. So first, as you'll see on the next slide, behavioral health integration, we have been meeting monthly since May, and then with breakouts, work groups, as necessary. Some of the key outcomes of that work effort have been the standardization of service definitions for behavioral health. That was one of the concerns we heard early on from providers was that we had service definitions that the Division of Behavioral Health was using, the service definitions that Magellan was using, and Medicaid had never adopted a common set of Medicaid service definitions. So we brought together a work group including DBH, Magellan, Medicaid, the new health plans, and providers and stakeholders to work together to develop and comment upon a set of service definitions. Twenty-eight of those have now been finalized and are posted on our Web site, but it's been an iterative process of

releasing draft to the work group, receiving comments, releasing it to the greater committee, receiving comments, and then finalizing those. Each of the plans has the ability to, sort of, set service definitions within the Medicaid state plan, but this a concerted effort by the department to have all the plans work together toward a common set, to provide some continuity for providers and for members. So that's been, I think, a promising outcome of that process. They've also worked together to create a common prior authorization form for certain behavioral health services that each of the plans has agreed to use to try to ease some of the administrative work of the providers and behavioral health that have, you know, are used to only dealing with one plan, as well as some focused effort in the readiness review process, getting feedback from providers about the things that we need to be looking for to ensure that the health plan systems are ready for continuity of care, as services transition over from Magellan to the health plans. And we've got some defined work effort that's coming out from that in the form of guidance to both the plant and the providers over the coming weeks. On the next slide, just a quick recap--there are four different ways that members can choose their health plans: on-line, by phone, by mail, or fax. Everyone has until December 1 to make that selection, after which members will have 90 days to, after January 1, to switch to a different plan if they're...do not like the one that they are in, for whatever reason, they have unfettered ability to change plans, after which they'll be locked in for the calendar year, until an annual open enrollment period. And, as you see on the next slide, as of this week, a little over 36,000 of our members have chosen their health plan. They've primarily done so through phone and mail to HHS. We've also had a number of folks who have done it on-line or who have done it through the phone IVR system, which is an automated voice response system. So there are several different ways that members can choose a plan. We're really focused, over the next few weeks, over the remainder of this month, to push this number as high as we can. And some of the ways that we're doing that in partnership with our enrollment broker is they've launched a new dedicated Web site for community organizations and stakeholders that are interacting with our members in the community to get resources and tools to help provide assistance to members who are navigating this process. As part of that, they've scheduled a series of lunchtime webinars. They've done, I think, a couple of those and they have a few more coming up over the next week or two, for community organizations that want to learn more about the enrollment process and be able to help members through that process that they are working with or patients that they're working with. We've also, over the last few weeks, AHS has started doing outbound calls to members that have not chosen a plan, warm calls where they

pick up and there's a person on the other end of the line to offer assistance and see if they can help them make a plan selection at that point, as well as reminder letters going out via mail. One of the things we're very excited--or very proud of is that, prior to the implementation of Heritage Health, we did a concerted effort within ACCESSNebraska and our eligibility system, to really clean up our demographic data, including mailing addresses for our members. And AHS has only reported about a 3 percent returned mail rate, which is very, very good. In fact it exceeds most national averages as it relates to returned mail for this population. So we're very excited about that we're at least reaching folks and that they know about the opportunities that they have. AHS is also doing direct outreach to HCAN and FQHCs across the state, since they are interacting with members out in the field very regularly. So they've set up some dedicated, you know, webinars for those centers and their staff who are assisting members with enrollment in both Medicaid as well as the marketplace. We've published a number of materials and resources for members and providers, as part of the Heritage Health implementation; you'll see a list of examples of those on the next slide. They're all available on our Web site, including: open enrollment materials; fact sheets for specific high-need populations like Medicare/Medicaid dual-eligibles; highlights for long-term care providers for which some of these changes are new to and need to understand how they need to interact with that; provider bulletins that we've issued; all of the past webinars that we've hosted or recorded and placed there; all of the past presentations, including the ones that we've given in this committee, out in the community and our town halls, are posted there; any press releases related to Heritage Health; you can go view the actual contracts and the RFP for the health plans; and more. There's a lot of resources there that are available, so we've really pushed folks there to get access to that information. There's also been a coordinated outreach effort from the department, along with our plans and the enrollment broker, to work together so that folks aren't hearing different messages from different entities. So we've been coordinating with them any requests for presentations out in the field, which we get almost daily; and we're working to field those out, either between the enrollment broker, the health plans, or state staff, to go out and meet with providers, advocacy groups, facilities, and members, to engage them on the changes that are happening. Last time I was here, I briefed you on the sort of roadshow that we undertook in September what, with the town halls and provider meetings. The health plans, also at our direction, agreed to co-host a series of 14 provider orientation sessions across the state. Happy to report that those have had tremendous participation, and we've gotten very good feedback from those. Over 1,000 providers and

provider staff have attended those so far; there are still a few more remaining. So we really have had a wonderful participation there. We're going to be recording one of those and posting that on-line after the completion of the tour, for those who weren't able to make it. But that's really focused on more of the administrative issues surrounding claims, prior authorizations, contracting, and then specific focus on behavioral health and pharmacy, since those services are being integrated. We did receive some questions from the committee on, you know, sort of how is Heritage Health being financed and what's the budget for the program? So, like our existing managed-care program, the managed-care organizations that are part of Heritage Health will be paid essentially what we call a take-it-or-leave-it capitation rate, or per member per month, that is set and determined by our actuaries. So they look at all the data from the fee-for-service program, from our past managed-care experience, look at national and state trends and any other relevant data that we put forward, and they develop a set of rates that we pay the plans; and we present those to the plans. They have the opportunity to review the data behind it, ask questions, but it's essentially a take-it-or-leave-it rate, and it's set by the state. One of the things I think that's important to note that...is that the rate is a prospective for the months that they begin delivering service. So none of the Heritage Health plans, at this point, have been paid a dime by the state for the Heritage Health program. So the money does not begin until the actual month of the health plan enrollment. As part of their contracts, the health plans are also required to meet an 85 percent medical loss ratio, which is consistent with new federal managed-care regulations. And if they do not meet that medical loss ratio, they have to return that money to the state. They're also capped on their profit at 3 percent, per their contract. And they're also, for the first year, capped on their losses at 3 percent, after which we intend to remove that from the contract, recognizing that in the first year with such a new program, there is some uncertainty as it relates to rate setting, so that gives us a chance to reconcile that. But we don't anticipate any issues at this point. The total capitation payments for Heritage Health for year one are budgeted at $568 million in total funds. It is not a significant difference from what we would have spent otherwise, absent Heritage Health, as we bring all these services together. There is a one-time impact called claims lag in the first year. Essentially what that means is that under...as we bring new services and populations from fee-for-service into managed care, there's an overlap in paying for those services. Whereas, under fee-for-service, we don't pay for it until after the provider delivers it and then, sometimes later they submit the bill to us, and then we pay the claim sometimes several months after that service was delivered, where under a risk-bearing, capitated, managed-care

model, we pay it up front by paying the prospective rate to the health plan for that month. So there's a one-time overlap which we budgeted for in the current fiscal year, estimated at about $7.4 million in the current year. But we still anticipate only spending about $3 million more, overall, than what we would have spent otherwise, so there are a small amount of savings built in. But savings was not, in the year one, was not the primary goal of Heritage Health. It was really bringing the delivery system together, getting the provider network stood up, and creating a framework from which we can work with the plans to reduce the cost of the program and the cost growth of the program. And so there are some strategies that are merging now, as we look to future rate setting, of how we can work with the plans to reduce unnecessary hospitalizations and care. But we're not expecting a significant difference in what we would have paid absent Heritage Health, with Heritage Health, at this point. And just a quick example to, kind of, demonstrate the complexity of the rate-setting process: We divided...our actuaries looked at the data and, based on the data, determined that there would be best served by having two rating regions in the state, one primarily the eastern part of the state, the other the western part of the state. And it's because there's some differences in costs and utilization, based upon those geographic differences. And then we further divide the Medicaid recipients into categories of assistance, based upon their eligibility, and then each of those categories has its own separate per member per month, based upon past utilization and cost. So for example, individuals who are aged, blind, and disabled adults obviously have a higher per member per month than healthy children. So one of the reasons that this is important is it prevents any incentive from the plans to cherry-pick membership and only try to have the healthiest members to ensure that they're adequately reimbursed for the costs associated with the membership mix that they do end up with. We'll take this a step further, beginning in year two of the contract, where we will begin assigning a risk adjustment score to each plan that looks at the relative membership mix of each plan--does the one plan have a sicker population than the other--and make aggregate adjustments to their reimbursement, based upon that relative risk. So that's a best practice in terms of managed care, and we anticipate beginning risk adjustment, and our contract contemplates beginning risk adjustment, in year two of the contract, so 2018. We were also asked about performance metrics for the plans. We, in the RFP, defined the year one performance metrics that the plans would be financially accountable for. The MCOs are required to hold back 1.5 percent of their aggregate payments, so 1.5 percent of every dollar we pay them, they have to hold back and have to earn that back by hitting these performance targets. The first year metrics are very

operationally focused, you'll see, as we collect base data under Heritage Health to understand where we want to move, sort of, more the outcome-based metrics but really want the plans to be focused on making sure they're able to pay claims, they're able to assist members, they're able to, kind of, ensure the operational readiness of the program. So you'll see the year one performance metrics include: timely claims payments to providers; timely pharmacy claims payments to providers; that they're submitting encounter data back to us at a rate that we can accept and that's complete and accurate; that they're not having abandoned calls in their provider member call centers; that they're answering calls quickly; that they're resolving appeals quickly for many members that appeal a denial or an adverse action; same thing with grievances, any grievances that are filed, that those are handled timely; and that they comply with the state's preferred drug list, which they're required to do. So those were the metrics that we defined, in year one, for them to meet and earn back that 1.5 percent. For future years, we'll be setting these metrics on an annual basis, with the recommendations and the input of our Quality Management Committee, which our medical director, Dr. White, is chairing. So she's convening a broad array of provider, academic, public health, another is consumer, and family member, sort of, stakeholders to come together and meet, regular basis, to review the performance improvement projects that the plans are undertaking and make recommendations about which quality metrics we want to focus in on. In addition to these performance metrics, for which they are financially accountable, there's also dozens of other metrics that they have to report to us on, identified in their contract. And we have the ability to go back and add additional metrics as we see fit. So, shifting focus a little bit to long-term care redesign, this has been a project that we're very excited about that we kicked off back in January with the publication of a concept paper that broadly outlines some principles for which we wanted to engage providers and stakeholders about the future of our long-term care delivery system. We outlined, in that concept paper, six guiding principles that you'll see on the next slide--very broad, you know: that we want to improve the quality of services; we want to promote independent living; we want to strengthen the access and the coordination and the integration of care; improve our ability to match resources with needs, especially as we look at the aging population that we're faced with; try to decrease the amount of fragmentation that members and providers experience; and rebalance the system for sustainability over a time. So very broad principles that we outlined...the scope of that was really looking at the, primarily, the Medicaid-funded services you'll see on the next slide, including services that are administered by our division, the State Unit on Aging, and the Division of Developmental Disabilities, but also

recognizing that many individuals receiving long-term care rely on other natural community supports that aren't funded through Medicaid that need to be taken into account--so really looking very broadly across the system. I won't read each of the next bullets, but the next slide just outlines the six realms in which we actively sought feedback from that concept paper and that really guided our stakeholder engagement efforts over the summer, but really have not limited us in the fact that we have heard other input from folks. And so we have taken that into account as we work through this process. As part of the redesign, we contracted--we published an RFP to bring in a technical assistant/consultant to be able to guide us in evaluating our current system by looking at both how we're performing today, national best practices, what other states' models are emerging, as well as to go out and directly engage with consumers, family members, and providers across the state. So that's been happening over the summer. We had our first listening tour in September and October. There were quite a few stops across the state both, sort of, the more traditional public town hall meetings, as well as going directly into assisted living facilities, adult daycare facilities, senior centers, to talk with folks and family members about the services they receive, their perceptions of the system, barriers that they faced, what they fear about change, and have been pulling that feedback together into a stakeholder engagement report that we anticipate publishing in the coming days. And that will better inform our overall plan for how we want to redesign the system across a much more broad array of metrics, looking at how people enter the system, what services that they...how we determine their level of care, how we develop plans of care for individuals, how providers are brought into the system, how they're incentivized to come into the system, how they're reimbursed--metrics and quality metrics that we measure across the system, as well as how we deliver and pay for the services that folks receive, looking very broadly across the system. So we anticipate receiving some preliminary recommendations from the consultant in the coming months and then putting that out as a draft redesign plan, in the spring, for comment. We'll do another round of stakeholder listening, similar to what we did in September/October to get feedback on that plan, and we're going to attempt to put that plan out well in advance of that to give folks a chance to digest that before that gets finalized next summer. We're not...we don't have any final decisions, at this point, that are made about what direction we're moving in or our things that we definitely want to adopt. We laid out some principles in the concept paper that we thought made sense for Nebraska, but we wanted to get feedback on. And we don't anticipate anything to begin being implemented, as a result of this effort, until at least 2018. So lots still to come on that piece, anticipate a lot of really

good discussion once we publish the draft redesign plan of what that might look like. But really it looks very broadly across our waivers, the structure of our waivers, the structure of our programs, and the structure of even how our agencies are set up to administer this program. So I think it's one of the things we've really committed to, as part of this process, is to be very careful, be very deliberate, be very inclusive, and move slowly. I think, as we look across the country, as states have embarked upon some of these changes, moving too fast can be very disruptive in people's lives. So we want to be thoughtful and avoid, you know, some of those lessons that have been learned by others. So with that, I'd be happy to answer any questions that the committee has. [DHHS Briefing]

SENATOR CAMPBELL: So, Senator Howard. [DHHS Briefing]

SENATOR HOWARD: Thank you, Senator Campbell. Just to take us in a completely different direction, my question from last time was, I was hoping you would give us an update on the MMIS implementation. [DHHS Briefing]

CALDER LYNCH: Oh yes, yes. [DHHS Briefing]

SENATOR HOWARD: And then my next question is about an outline of your provider enrollment strategy which, I believe, Senator Kolterman will also have some questions about. [DHHS Briefing]

CALDER LYNCH: Yes. [DHHS Briefing]

SENATOR HOWARD: Do if you could start with the MMIS, and then we can get into the weeds on the enrollment, that would be great. [DHHS Briefing]

CALDER LYNCH: Yes, absolutely. On MMIS, I'll say that we are in active procurement, so I do have to be a little careful about, you know, what we say. But I think I can give you a sufficient update, in terms of where we are. So we have been working for, as you know, many years on replacing the legacy systems that we have that support our Medicaid program. In fact, I think we're on the third attempt to replace the legacy MMIS that we have. We, when I arrived in

March, a lot of work had already been done in this vein in terms of looking at assessing the current structure of the system, what the market offerings look like, what the different alternatives were, so we had a really good road map to work from, from that point. And what we did at that point was try to analyze where were we headed with our delivery system and what Medicaid would look like in the future, and try to bring those together to make sure that whatever systems or strategy we were pursuing, as part of MMIS replacement, would not be outdated or out of touch by the time we implemented it. And the other piece that's important here is that CMS, who funds the vast majority of these projects, has really been pushing states in a new direction, in terms of looking at modularity, looking at breaking, kind of, the pieces off to try to get best of breed instead of these single, monolithic vendors that have historically dominated the landscape in this market. One of the things that was clear to us was that the central component of replacing our MMIS system would not be focused on claims payment, because the state has been moving for some time out of the business of paying claims, as we've moved more and more into a managed-care environment and instead our focus has very much about taking in the data from our health plans and from other systems and to be able to do better analysis and analytics around that to understand the overall performance of the system. And so we really shifted our focus in that regard and refocused our central efforts around the data management and analytics. So I would say that very much of what I've talked to you today about, with regard to the implementation of Heritage Health and long-term care redesign, are all part of our MMIS replacement strategy, as we continue to look in how to revolve our delivery system. And one of the things that we benefit from in Nebraska is that we are one of relatively few self-administered MMIS states, meaning the system itself is administered by state's personnel; it's a state-owned and operated system, even though it's old. I think it's well run; I think there's very good people that we have in partnership within our department that work with us, and they give us a lot of really good resources as we look at replacing the system. So the central component became the data management analytics, so we released an RFP back in...earlier this spring to procure what we call the DMA, the data management analytics vendor. And this includes a data warehouse to be able to processing and count our data from the health plans, to be able to do program integrity analytics in case management, and to be able to do all of the reporting, report carding in analytics for the program as a whole. And we believe it can also serve as a foundation for the department overall, in terms of how, looking at future...a future platform for which other programs and systems can come into in a much more modern data

system that supports the overall goals of the program. We received five bids on that RFP, and we are actively evaluating that. We anticipate bringing a number of those bidders in, in December, for oral interviews, after which we'll be able to tally the final scores and announce an intent to award. From there, we'll go through the contracting process, which may or may not include protests that we've come accustomed to and then hopefully can begin work in the spring in earnest, with the vendor. Now that's not to say that work is not already beginning internally, in terms of our staff developing our data management strategy, making sure that we have the right governance in place for managing the vendor and the project, once they come on-board. And that includes participation from Medicaid, as well as our IT division, as well as other divisions that administer Medicaid program...Medicaid services like the Division of Developmental Disabilities. So that's the central component of the MMIS. There are other components of the MMIS that exist today that we're also working to replace or modernize. One of those is the payment of the capitation rates to the health plans. So every month we calculate how much each health plan should be paid, based on their membership and the current rates that are in place. That was actually one of the scopes of work that was included in our enrollment broker contract with AHS; it's phase 2. So now that we've got the enrollment stood up, we're beginning to work with AHS to begin working on a road map for them to take over the payment of capitation rates to the health plans. That's another functionality of the MMIS that will shift over. Another piece is provider enrollment. So we had to quickly come into compliance with the Affordable Care Act screening enrollment requirements that went into place last year and, to do so, we did an RFP a couple of years back to bring in somebody to do the up-front screening and enrollment of providers to be compliant with the ACA requirements. Maximus was, as you're familiar, was the vendor that was awarded that contract, and that system launched on December 1. And we've been working with them since that time to continue to look for improvements in that system. But the back end of that provider enrollment system is still the MMIS in terms of the system of record for providers. So now we're turning our attention to the long-term strategy as it relates to provider management. And you asked about this question, as well. So we've scoped a team together to begin working on scoping out an RFP for what we're calling, at this point, centralized provider management, to replace both what Maximus is doing in terms of screening enrollment today, as well as what the MMIS is doing in terms of the system of record for providers. We're in the early stages of that, so I don't yet have a time line of what that looks like; but we're beginning to work on the procurement now. And that will also decommission a portion of what the MMIS

is doing today. There are also still going to be some residual fee-for-service claims that, even as we move into more of a managed-care environment, that the state is still responsible for reimbursing because, for various reasons, those services aren't a good fit for risk-based managed care. So we included, as a scope in the Heritage Health procurement, the ability to award to one of the Heritage Health plans to eventually take over as our claims broker services contractor; and that was awarded to UnitedHealthcare. So we can't really engage with them yet, since they're also affiliated with a potential procurement in the data management analytics procurement, but once that's resolved, we'll begin working with them in earnest, in terms of looking at when we would plan to phase in their taking over some of those residual fee-for-service claims that exist in the system. Depending upon policy decisions that have yet to me made, the number of claims can vary from 10,000 to over 100,000 a year. So we're looking at...but, relatively we'll be small, compared to what the traditional fee for service claims volume has been. Overall, this strategy, we believe, will cost less than half as much as a traditional MMIS procurement, based upon the different components that we've laid out and, ultimately, there will still be some work to be done with our IT division, to look at remaining components of that MMIS and ensure that they have some plan, in terms of how those get replaced and how those get resourced going forward; and we're working with them on that, as well...but a lot of different pieces, moving through this. And we're actually beginning to get some national attention relative to the model that we're pursuing. I've had a number of states that are watching over our shoulders very carefully to see how things proceed. CMS has been very supportive of the approach we're taking and has granted us some leeway in terms of allowing the state, for example, to act as our own systems integrator, rather than procuring that as a separate contractor, because they have the faith in our history of execution and the structure that we have in place. So I think some very positive things will come from this, and we'll hopefully be able to serve as a model for other managed-care states. [DHHS Briefing]

SENATOR CAMPBELL: I'm going to go to Senator Kolterman, if he has follow-up questions. [DHHS Briefing]

SENATOR KOLTERMAN: Thank you. [DHHS Briefing]

SENATOR CAMPBELL: Any follow-up questions? [DHHS Briefing]

SENATOR KOLTERMAN: Thank you, Senator Campbell. Yeah, I've got quite a few questions, and it deals primarily with the enrollment and the new companies and things of that nature. [DHHS Briefing]

CALDER LYNCH: Um-hum. [DHHS Briefing]

SENATOR KOLTERMAN: Can you tell me, Calder, what kind of...are we getting an equal spread amongst the companies as it pertains to that 36,000, you know, enrollees? [DHHS Briefing]

CALDER LYNCH: Not at this point, no. We're seeing the predominant number of members choosing UnitedHealthcare. [DHHS Briefing]

SENATOR KOLTERMAN: All right. [DHHS Briefing]

CALDER LYNCH: They're our only incumbent vendor, and so they had a little bit of a head start, in terms of provider network. They're also a well-known name, both in terms of their work here in Nebraska and nationally, but we anticipate that we'll begin operations with a relatively even numbers of members, once we get through the auto-assignment process. So our goal is to ensure that each plan has a viable membership to begin operations on January 1. [DHHS Briefing]

SENATOR KOLTERMAN: Okay. And then, do you know...do all three of the companies have large claim-management programs in place so that if somebody ends up in dialysis or has to have a kidney transplant, somebody is overlooking that? Is that all part of that negotiated agreement? [DHHS Briefing]

CALDER LYNCH: Oh, yes. Claims is an entire section of their contract, in terms of what our expectations are around service levels and their ability to comply with the state requirement. It's also a significant focus of our readiness review process, and a whole day of our on-site readiness review is dedicated to reviewing their claims systems. We provided them with dozens of different claim scenarios: Long-term care member in a facility receives this specific DME; show us how

that claim will process. And I actually sat in for several hours as part of one of the plan's demonstration of their claims system last week. And they would run it through their claim system, they would show how that claim would adjudicate, and we compared against how it should have adjudicated. And some of them were right, and some of them they needed to make some changes. But that's why it's important for us to, kind of, do that, that readiness review process with them. And we're going to be going back in December to follow up, to make sure all of those different pieces are ready to go. But they each are operating Medicaid programs in a number of states, and they are processing millions of claims each month. So they have the capacity to do it; it's just making sure they've got their systems programmed to comply with the Nebraska-specific rules. [DHHS Briefing]

SENATOR KOLTERMAN: Okay. And then the next question deals with the networks; you alluded to that a little bit already. You said that UnitedHealthcare had the...probably the broadest network thus far. And I remember a couple of years ago, when the state went with UnitedHealthcare just as an employer. [DHHS Briefing]

CALDER LYNCH: Um-hum. [DHHS Briefing]

SENATOR KOLTERMAN: The networks were an issue. Has that improved? And what kind of...the last thing I'd, like, hate to see is somebody in Scottsbluff/Gering not be...have a really good network available to them. How is that process coming along? [DHHS Briefing]

CALDER LYNCH: It's coming along well. We are monitoring that on a weekly basis, and we've seen some significant progress, in terms of contracts getting signed and loaded, including some very large systems with some of the newer plans in the last few weeks, which have significantly broadened their networks. We have network adequacy standards in their contracts that, based upon their membership, we're comparing, you know, how many PCPs do they have within certain geographic radiuses of where their members live, and then others, those specialties--hospitals, behavioral health. And all are very close to meeting those adequacy standards. In fact, we were due to receive attestations from each of the plans this week regarding their network adequacy, and we're going to continue to monitor that up until go live and put them into corrective action necessary. But I don't anticipate any major disruptions, in terms of network,

because there's also provisions where they're required to pay out of network over the first 90 days of the contract so that there's...if there's still time, if there's still issues of getting some contracts loaded, there's time for that before that occurs, and members can also have the ability to switch plans, if necessary, because of those issues. But this is not going to be something where you're seeing narrow networks. Each of the plans has really adopted nearly (inaudible) any willing provider, at least for the first year effort, where it's really up to the providers to get those contracts returned and loaded back to the plans. And most are contracting off of the Medicaid fee schedule at this point. So we're working hard, I think, having these provider orientation sessions across the state is urging folks to get those contracts in. And some of the large systems were caught up in some lengthy negotiations with the plans but, at this point, those seem to have concluded. So I'll hopefully be able to report back with some concrete numbers once we get past the attestation period, in terms of what exactly we (inaudible) for the networks. [DHHS Briefing]

SENATOR KOLTERMAN: Do you know...you alluded to the fact that some of the networks could be pretty narrow, and your goal is not to have narrow networks. But isn't it accurate to say that the narrower the network, the better cost savings you're going to have? [DHHS Briefing]

CALDER LYNCH: So Medicaid is a little different in that regard because, at least at first, everyone is going to be operating off of the Medicaid fee schedule, where you'll start seeing differences, in terms of costs of how members are being managed...you know, readmissions to the hospital, emergency room visits, things like that, as we keep moving to some of these value-based payment arrangements. I think our goal is not to have narrow networks at the beginning, but I think we want the plans, especially considering that we have...and I don't think we'll ever want to have narrow networks by any means. We're going to make sure that plans meet our network adequacy standards for Medicaid. The plans, especially for the ones that are new to our market, need to develop relationships with our provider community, and so they need to have some baseline from which to operate. If there are issues with members of those networks because of quality or cost concerns, they can then work through their provider education channels to work with that provider, hopefully get them in a place where they're meeting those targets and, if not, you know, can review their network status. But we want members to have choice, and we want to have broad networks, at least as we begin the program, and then give the

plans the opportunity to work with the providers to look at improving that...the overall quality of that provider network. [DHHS Briefing]

SENATOR KOLTERMAN: Okay, thank you. I have some more, but I'll let somebody else ask, if they have some questions. [DHHS Briefing]

SENATOR CAMPBELL: Okay, we may come back to you. Other questions, Senators? I have one question before we go back. To...you said that you got 36,000 people enrolled. How many people are left then? [DHHS Briefing]

CALDER LYNCH: Um, probably a little less than 190,000. [DHHS Briefing]

SENATOR CAMPBELL: Okay. [DHHS Briefing]

CALDER LYNCH: So they have until December 1. I'll have to go back and check that number, but I think that's off the top of my head. [DHHS Briefing]

SENATOR CAMPBELL: It's getting close. [DHHS Briefing]

CALDER LYNCH: We're seeing, we were seeing about 10,000 a week but, hopefully, that's ticking up, because we want to get as high as we can which, historically, we've not had a very high self-selection rate in Nebraska--only about 22 percent of member have historically proactively chosen their plan. We want to improve that, so we're working hard to try to do that. And then, of course, members still have that 90 days after January 1 to say, oh, wait, I actually did want to pick and switch to a different plan. [DHHS Briefing]

SENATOR CAMPBELL: So on December 1 then, however many are left from the 190, you will then put them in a plan. [DHHS Briefing]

CALDER LYNCH: Correct. [DHHS Briefing]

SENATOR CAMPBELL: So that's how you intend to equal out the numbers. Would that be accurate? [DHHS Briefing]

CALDER LYNCH: Correct. But we'll also be looking to make sure that we're assigning members to plans in which their providers are contracted. [DHHS Briefing]

SENATOR CAMPBELL: Okay. [DHHS Briefing]

CALDER LYNCH: So that will be part of that algorithm as well, and it won't just be based on equalizing membership between the plans. So they still do have to get their provider networks in place. [DHHS Briefing]

SENATOR CAMPBELL: Okay. Senator Kolterman, I think you're up. [DHHS Briefing]

SENATOR KOLTERMAN: Thank you, Senator Campbell. Are you familiar with what pharmacy benefit managers, PBMs? [DHHS Briefing]

CALDER LYNCH: Oh yes, very. [DHHS Briefing]

SENATOR KOLTERMAN: Just out of curiosity, do they all have separate PBMs and do we get any of the rebates that are coming back from those PBMs? [DHHS Briefing]

CALDER LYNCH: Yes on both of those points, with some nuances. So each of the plans has a pharmacy benefit manager to manage their pharmacy benefits. UnitedHealthcare has an affiliated company within their umbrella of...called OptumRx that serves as their PBM; Nebraska Total Care and WellCare both use Caremark as their front end PBM. But all three plans retain, sort of, benefit policymaking decisions within their health plan that they really use the PBM more as a claims processing and contract, network contracting tool. Regardless of who their PBM is, my contract is with the health plan. And that health plan, that contract, has certain requirements that we expect them and all of their subcontractors to meet. And in fact, we review and approve all of their subcontracts, including their subcontract to the PBM, to ensure it meets that compliance standard. And we'll be working, we'll be holding the plans accountable for any actions that their

PBM takes, as it relates to how they administer the pharmacy benefit, ensuring that they're complying with the specific requirements of our contract and our program. And then, what was the second part of your question? I'm sorry. [DHHS Briefing]

SENATOR KOLTERMAN: Well, the rebates. [DHHS Briefing]

CALDER LYNCH: Oh, the rebates, yes. So all drugs are, per our contract, are rebatable exclusively to Nebraska Medicaid. They are not allowed to negotiate secondary supplemental rebates outside of that. That's one of the reasons we mandated that the plans follow our preferred drug list, which enables us to do that. So for federal rebates, the process will continue as it is today, where we invoice the manufacturers for the rebates for drugs that are administered through the managed-care plans. We get that data from their encounter data, which then enables us to go and rebate for those, invoice for those rebates. The same thing will continue for our state supplemental rebates, which we have a contractor who does that on our behalf; they'll continue to do that. They're having to make some systems changes to be able to intake the MCO encounter data, but they will continue to rebate for those drugs as well. [DHHS Briefing]

SENATOR KOLTERMAN: Can I keep going? [DHHS Briefing]

SENATOR CAMPBELL: You bet. I'm going to watch the clock but, so far, you're good. [DHHS Briefing]

SENATOR KOLTERMAN: All right. Next question deals with per member per month rates. Are the rates higher in the rural areas than they are in the metropolitan areas and, if so...and I've looked a little bit at that, but my...I just got this and my sight isn't very well anymore. And do you get...I don't know how to say this...do you pay more for services in the rural areas because they're primarily dealing with critical access hospitals? [DHHS Briefing]

CALDER LYNCH: That is part of it, the pricing for the critical access hospitals is higher because it's a cost-based reimbursement versus a DRG, which we pay to more of the community hospitals in more of the urban and suburban markets. So that's, I think, probably the most significant portion of the difference between the urban and rural rates. [DHHS Briefing]

SENATOR KOLTERMAN: And where does...you talked about Region 1 and Region 2. Physically, on a map, where does that break? [DHHS Briefing]

CALDER LYNCH: The yellow is Region 2...sorry; the red is Region 1. So it's almost a straight line about two-thirds of the way over. And that was what the actuaries recommended, based upon their analysis of the data. [DHHS Briefing]

SENATOR KOLTERMAN: Okay. [DHHS Briefing]

CALDER LYNCH: And I'd be happy to share this with you. [DHHS Briefing]

SENATOR KOLTERMAN: Yeah, I'd like to have a copy of that, if possible. [DHHS Briefing]

CALDER LYNCH: Absolutely. [DHHS Briefing]

SENATOR KOLTERMAN: And then...make sure I get them all here. Inside the managed-care programs that you developed, and I know we don't have it yet, but is there any area for patient-centered medical home or direct primary care? And is anybody, to your knowledge, looking at utilizing those programs? [DHHS Briefing]

CALDER LYNCH: There is. Within the contracts of the plans, there are specific requirements as it relates to patient-centered medical homes, And all the plans, the new Heritage Health plans, have been participating, so far, in the multi-payer collaborative. They've come and have been part of that conversation. They're also...in their requirements, their health contracts require to produce to us a work plan for increasing PCMHs in the state and how they plan to engage providers in that regard. The other piece, as it relates to direct primary care, is that there are specific targets in their contracts for percentages of their provider network that need to be in a value-based contract and, certainly, a direct primary-care-like arrangement, because it would have to be a little bit different for Medicaid, just given the structure of the Medicaid program, would certainly qualify as a value-based arrangement. So as they work with providers on looking at different ways of contracting and reimbursing for services, sort of these fixed payment rates and taking on some risk, essentially, as a primary care practice or system, is one of those types of arrangements along

a whole continuum of potential value-based type of arrangements. So we would expect to see some of that. We're starting to see early signs of that, even in the first year of the program in that one of the plans, I know, has signed with one of the large systems, a contract that includes an upfront care management fee for members who are assigned to PCPs within that system. So they're taking on some responsibilities as it relates to care management for their members. And we expect that to continue to evolve as we move along that continuum of potential payments. And that's something we're seeing, and we're looking at the changes that are happening with Medicare under MACRA and some of the changes that are happening with other types of multi-payer, value-based payment design initiatives to make sure we're not out of alignment with those. [DHHS Briefing]

SENATOR KOLTERMAN: So, so as you develop the criteria for quality and value based, are you including Dr. White and the providers in that? [DHHS Briefing]

CALDER LYNCH: Oh, yes. [DHHS Briefing]

SENATOR KOLTERMAN: Or how is that coming together? [DHHS Briefing]

CALDER LYNCH: So we're really only beginning that effort at this point. [DHHS Briefing]

SENATOR KOLTERMAN: Okay. [DHHS Briefing]

CALDER LYNCH: Year one is very much focused on: let's make sure everyone has got their networks; can pay claims; folks get enrolled; there's not, you know, disruptions. And then we're really shifting our focus to: okay, let's establish some baselines; let's look at, you know, where we want to move the system, set some targets, look at what our year two metrics need to look like. Some of the work right now is looking at each plan is required to undertake some performance-improvement projects and making sure that those are coordinated and are matched up against what our goals are as a state, from both the Medicaid division, as well as the department overall, as well as what other providers and stakeholders are working on, to make sure that we're in alignment. We're looking at forming some specific subcommittees to that quality-management group, focused on things like maternal and child health, social determinants

of health, value-based purchasing designs, to help guide some of those efforts moving forward. So, yes, but that hasn't really begun yet. [DHHS Briefing]

SENATOR KOLTERMAN: All right. One last question. [DHHS Briefing]

SENATOR CAMPBELL: All right, I'm right on the target. [DHHS Briefing]

SENATOR KOLTERMAN: I'm going to go to long-term care. [DHHS Briefing]

CALDER LYNCH: Those are great questions, by the way. Okay. [DHHS Briefing]

SENATOR KOLTERMAN: I know that that's a work in progress. [DHHS Briefing]

CALDER LYNCH: It is. [DHHS Briefing]

SENATOR KOLTERMAN: Is there anything in your request proposal to address the subrogation issues, as people utilize? [DHHS Briefing]

CALDER LYNCH: I want to make sure I understand the question. [DHHS Briefing]

SENATOR KOLTERMAN: Well, okay. So let's say that somebody wants to qualify for long-term care benefits. They have to spend down. [DHHS Briefing]

CALDER LYNCH: Oh, okay. [DHHS Briefing]

SENATOR KOLTERMAN: And then they spend down but, in the process, they've given a farm away or moved a lot of assets someplace else. Is there any attempt, inside the process, to look at how we go after some of those dollars that have been given away? I mean, I know there are some federal guidelines as look-backs and things like that. I'm just curious. We had some bills last year that addressed that, or... [DHHS Briefing]

CALDER LYNCH: So I would view that as, sort of, a function of our eligibility programs as well as...you know, we were in close partnership with our legal department, because it was getting very complicated. So it is something we're looking at. I wouldn't say it's part of the work we're doing around the delivery system reforms that we're doing, but spend-down and, you know, I'm sure you're talking about a state recovery and those pieces. Yeah, I mean, we're constantly looking at: What do our statutes say? What do our processes look like? We actually have recently reconfigured that team internally under a new, sort of, combined cost-avoidance team under a new manager who's doing a phenomenal job. So we're expecting to see some of those recoveries improve, just based upon some of those internal process improvements that we're making, but then from a policy perspective and it's an annual, sort of, perennial review of our statute to see, you know, or do we need to make adjustments, based upon best practices or federal changes? And so I know that that's something we're looking at now. And then, as it relates to spend-down specifically, the folks that are, whose eligibility is intermittent because of their spend-down, meaning they come on and off the program, depending upon their cost each month--are not part of managed care, just because of the difficulty of getting them in and out of a plan that frequently. But the folks whose eligibility are continuous because they're in a facility and the cost of that facility every month meets that requirement and, therefore, their eligibility is continuous, those are being enrolled into Heritage Health. So that's the only impact, really, right now, in terms of spend-down as it relates to some of these changes. [DHHS Briefing]

SENATOR KOLTERMAN: So long-term care will be funded by Heritage Health as well. [DHHS Briefing]

CALDER LYNCH: No, the long-term care populations are enrolling in Heritage Health for their physical, behavioral, and pharmacy services. [DHHS Briefing]

SENATOR KOLTERMAN: Okay. [DHHS Briefing]

CALDER LYNCH: But the LTSS services aren't changing; that's part of our redesign initiative. [DHHS Briefing]

SENATOR KOLTERMAN: All right, thank you. [DHHS Briefing]

CALDER LYNCH: Thank you. [DHHS Briefing]

SENATOR CAMPBELL: I guess I get the last question here, and I'm kind of looking into the future, because there has been some discussion by the new administration to go to a block grant for Medicaid. Just give us a little bit of your thoughts about how that might impact our program and managed care. [DHHS Briefing]

CALDER LYNCH: I would say that the...I anticipate that there will be many changes, as it relates to federal healthcare policy in the coming months and years, related to the outcome of the election last week. And, you know, many opportunities, as well, for states to look at some additional flexibilities that maybe didn't exist before. How the Medicaid program is financed today, I think you'll be hard-pressed to find anyone who says it's a perfect system. The FMAP calculations are based upon per capita income, which is an imperfect measure of poverty. I've often joked that if we could get Warren Buffett to move out of the state, our FMAP would jump up five points but, in reality, you know, it really is an imperfect measure that can be influenced by outside options. So I think that the debate and discussion of looking at ways to improve how Medicaid is financed and how the federal versus state participation is determined is a welcome dialogue; the devil is in the details. And so in forecasting whatever impact would be on Nebraska would be very difficult without knowing exactly what that looked like. There's a different form...block grant is, sort of, a ubiquitous term that gets used a lot, but there's been a lot of different proposals under that headline, from a straight-up look at how much you get today and you're just going to get block-granted that, to more-nuanced, per capita caps, where you look at--similar to how we develop our PMPMs for the health plans--you look at your historical cost for certain groups of eligibles and come up with a per capita cap, so that you at least have some funding flexibility as membership goes up or down. I think there's going to be a lot of debate and discussion about what some of those changes might look like. And certainly we'll be happy to weigh in on what those impacts would be for Nebraska, once we have those details. [DHHS Briefing]

SENATOR CAMPBELL: Okay, thank you. [DHHS Briefing]

CALDER LYNCH: Thank you. [DHHS Briefing]

SENATOR CAMPBELL: Okay. Director Lynch, always appreciate the good information that you bring to us. And, from a personal standpoint, thank you very much for always keeping us in the loop; that's appreciated. [DHHS Briefing]

CALDER LYNCH: Thank you, Senator Campbell. And I want to thank you for your leadership of this committee over the last several years, but certainly since I've been here. It's certainly been a pleasure to work with you. [DHHS Briefing]

SENATOR CAMPBELL: Thank you very much; I appreciate that. [DHHS Briefing]

CALDER LYNCH: Thank you. [DHHS Briefing]

SENATOR CAMPBELL: That concludes our briefing today. So if you are leaving, you have to leave very quietly. [DHHS Briefing]