[LB552 LB649]

The Committee on Health and Human Services met at 2:00 p.m. on Friday, March 17, 2017, in Room 1510 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public hearing on LB649 and LB552. Senators present: Merv Riepe, Chairperson; Steve Erdman, Vice Chairperson; Sue Crawford; Sara Howard; Mark Kolterman; Lou Ann Linehan; and Matt Williams. Senators absent: None.

SENATOR RIEPE: For those of you who have just joined us, we'd like to welcome you once again to the Health and Human Services Committee. We've had introductions and I think some of the senator and staff people, they know who the players are here. I did want to go through...you're welcome, Senator Pansing Brooks, to take the seat. I want to go through just a few rules of engagement. We'll be taking up the bills in the order that they're posted at the hearing today, and we encourage participation. This is your opportunity as Nebraskans and visitors to engage in our legislative process. At times you will see some of our committee members having to leave and sometimes they're introducing bills or testifying and so it's nothing personal on your particular bill. You'll also see some of our members working on computers, laptops, and some working with paper and it's...they're still paying attention to what is going on. Other parts of rules of engagement are we'd ask you to please silence or turn off your cell phones. If you are going to testify, in order that we move it along, we'd ask you as it gets closer to move up to the front seats. And the process here is the senator who's introducing the legislation will be introducing and that senator has unlimited time to make comments. Following that then will be we'll ask for proponents of the legislation, followed by opponents, followed by some that might be testifying in a neutral capacity. We'll read in some letters if we have some. And then we'll ask the senator who's introducing or at least affording them an opportunity to come back and to make any closing remarks that they would like to. We ask anyone that's coming forward to please spell your name, state your name so that we can get it into the record. And the way that the clock works, we said that the introducing senator is unlimited. But testifiers, we are on a five-minute clock in the Health and Human Services Committee. It's four minutes on the green, one on the amber, and then we go to a red light. All we ask is should you get to the red light, please try to pull it together. It doesn't mean that you have to abruptly stop at that very second. And quite possibly if you're testifying, you may have a question from one of the committee members that will afford you an opportunity to expand. If it goes over too far, I will try to be polite but to try to ask you if you can pull it all together and so that we can move along. If you will not be testifying at the microphone but want to go on record as having a position on a bill being heard here today, there are white sign-in sheets at each entrance where you may leave your name and other pertinent information. These sign-in sheets will become exhibits in the permanent record at the end of today's hearing. Should you be testifying, we ask all of the testifiers to bring up their orange sheets if you will. And if you have some handouts, we would ask you to provide us with ten copies for the committee members. If it so happens that

you've shown up and you do not have your ten copies, our wonderful pages over here will lickety-split go and get those copies and get them back and get them to us. With that said, we are going to open today's hearing with LB649 and Senator Pansing Brooks. [LB649]

SENATOR PANSING BROOKS: (Exhibit 1) Thank you, Chairman Riepe. And the best news for a Friday afternoon is that I'm not going to take an endless amount of time to do the opening so that's good. Thank you, members of the Health and Human Services Committee and Chairman Riepe. For the record, I'm Patty Pansing Brooks, P-a-t-t-y P-a-n-s-i-n-g B-r-o-o-k-s, representing District 28 right here in the heart of Lincoln. I come before you today to introduce LB649, a bill that would require a critical evaluation be performed before any additional long-term care services are added to the Medicaid managed care program, known as Heritage Health. I have prepared for your consideration as well an amendment specifying that this bill is referring only to long-term care services. My office has received some inquiries that programs that are not long-term care and are currently in process for being added to Medicaid managed care may be affected. That was not the intent of our bill so the amendment corrects that oversight. This bill, if passed, would not obstruct the inclusion of long-term care services in Medicaid managed care as currently scheduled for January 2019. It would require that a critical evaluation be performed to determine if doing so would likely be successful. I would like to share with you why I agreed to cosponsor this bill. I believe that when we are asked to listen to a community that is to be covered by the expansion of any program that has grave concerns and evidence of likely challenges and problems that ultimately hurt the individual for whose care we are responsible, we should, as legislators, listen. And I believe it is our role as legislators to review and question significantly transformative programs as they are being developed to better understand them. I brought this bill because long-term care providers in my district have expressed deep concern about our ability to ensure that needs are met moving forward under managed care. I understand that even though long-term care services are currently not in the Heritage Health Program, the providers have participated in the meetings and conference calls that have been held preparing the program for the other services. The long-term care community has been active in understanding the DHHS vision but are, and I believe legitimately, concerned that their needs may be overlooked. There are testifiers behind me who bring the right expertise to answer your questions, including Nebraska long-term care providers, so they will be in a much better position to answer any questions you might have, and I'm sure that you'll have them. So with that, I will end my opening and I will waive closing because I need to get back to Judiciary for something. [LB649]

SENATOR RIEPE: Okay. So if we have questions for you we need to get them to you now. [LB649]

SENATOR PANSING BROOKS: Okay. Uh-oh, yeah, that's a good point. [LB649]

SENATOR RIEPE: Senator Williams. [LB649]

SENATOR WILLIAMS: Thank you, Chairman Riepe. And thank you for being here. My question, whether you answer it or others that can follow you, is what do you perceive being involved with what is described in the legislation as a critical evaluation? [LB649]

SENATOR PANSING BROOKS: I'd really appreciate it if you'd ask the people behind me, so. This is... [LB649]

SENATOR WILLIAMS: I will do that. (Laughter) I will do that. [LB649]

SENATOR PANSING BROOKS: I can answer some Judiciary questions but not quite as efficient on these, so. [LB649]

SENATOR WILLIAMS: I'm sure one of them will build it into their testimony, right? [LB649]

SENATOR PANSING BROOKS: I bet so. Thank you for that heads up. [LB649]

SENATOR RIEPE: I have a question and that is how does this bill relate to the soon to happen second tour of the state about long-term managed care? Is this an evaluation along with that? It's a complement? Or does it... [LB649]

SENATOR PANSING BROOKS: Again, I'm going to let the people behind me answer that. [LB649]

SENATOR RIEPE: You're trained as an attorney, aren't you, Senator? (Laughter) [LB649]

SENATOR PANSING BROOKS: That's why I'm running back to Judiciary. [LB649]

SENATOR RIEPE: Okay. Are there other questions? [LB649]

SENATOR PANSING BROOKS: But it's good to get them out so that people are prepared to answer those. [LB649]

SENATOR RIEPE: We appreciate you being here today. [LB649]

SENATOR PANSING BROOKS: Okay. Thank you very much. Everybody have a good weekend. [LB649]

SENATOR RIEPE: You too. Thank you. We'd like to hear from proponents of LB649, please. [LB649]

MICHAEL CHEEK: Good afternoon. [LB649]

SENATOR RIEPE: If you'd be kind enough to give us your name and spell it. [LB649]

MICHAEL CHEEK: (Exhibit 2) Michael Cheek, M-i-c-h-a-e-l, Cheek, C-h-e-e-k, representing the American Health Care Association and the National Center for Assisted Living. Mr. Chairman and Senators, I'm happy to be here today to testify on this particular matter, and I want to be specific in regard to the preceding comments that I'm only here to speak to the managed long-term services and supports component onto the proposal. The other components, No Wrong Door, a single-assessment tool, and others are all laudable efforts that can be completed without Medicaid managed long-term care. While I recognize the value and importance of what the department is attempting to do with managed long-term care, I would encourage caution and some consideration of other options. I think that there are a number of issues in flux, both at the federal level as well as issues among states that have implemented Medicaid managed long-term care that merit consideration before Nebraska pursues this course of action. First and foremost is our Congressional efforts to reform Medicaid in the coming months. As I'm sure you're aware, Congress is considering a piece of legislation to repeal and replace the Affordable Care Act, which would include Medicaid reform. We've completed a Congressional Budgeting Office scoring effort of that bill and to complete state-by-state impacts. Based on our scoring of the Medicaid reform legislation, as currently drafted, Nebraska stands to lose $700 million in federal funds over a ten-year period. States with deep experience in Medicaid managed care, including Arizona and Minnesota, stand to lose money in the billions from the federal government based upon Medicaid managed care, based on the Medicaid reform efforts in terms of how the federal government calculates its matching. Additionally, in a letter from Secretary Price to the Governors, he has alluded to restructuring the existing Medicaid managed care regulation upon which most of what we've been discussing this afternoon would be based, so again something else that's in flux. Irrespective of those two changes based upon what's happening in other states, I would highlight four areas that I think that Camille alluded to in her comments and are worth due diligence within any state to explore thoroughly. First, contracting out does not solve problems. The plans inherit issues that are inherent in the service system that is already in existence. If there are no qualified providers with whom to contract or there are no providers with whom to contract, the plans have no one to deliver the services. In regard to state staff implications, the states typically have to add staff rather than streamline government when they

privatize managed care. In terms of homogeneity and creating a consistent experience with healthcare coverage across healthcare plans for consumers and providers, creating that kind of alignment among administrative responsibilities for providers where they have to submit different types of claims to different plans, beneficiaries have to call different plans to understand how they perform their services, this is all extremely difficult as well. Difficult for the state as well as for legislators is understanding how the plans are operating internally. Encounter data is extremely difficult to unpack and understand how the plans are operating, and often negotiated rates and care models are proprietary and not public...subject to public scrutiny. And third, plans often are difficult to replace or rein in line if they're having problems. It is my opinion that when plans...when states add too many services to too many plans or too much to too many plans that they're creating a "too big to fail" scenario. Finally, I think that in regards to savings and costs that there are considerable questions about whether or not that is feasible in terms of Medicaid managed care. The evidence to date is poor. And then finally I would encourage exploration of an option that's in place with a couple of different states. It's a particular approach to managed fee for service where fee for service rates are still paid but services are coordinated with the state agency using an administrative services organization. This latter piece is something of a hybrid between a full-scale move to Medicaid managed long-term care before moving on to...rather than staying with pure fee for service. So in conclusion, I would urge additional study, potentially a comparative study on something like an administrative services organization combined with managed fee for service, and to contrast that with what the implications would be for beneficiaries and the state before moving on to full-scale Medicaid managed long-term care. Mr. Chairman, I conclude my comments. [LB649]

SENATOR RIEPE: Thank you. Very efficient, but we're going to have some questions so we'll give...I know you did come from out of state and we want to take advantage of your knowledge while we have you here. Okay? [LB649]

MICHAEL CHEEK: Certainly. [LB649]

SENATOR RIEPE: Are there questions from the committee members? Senator Williams. [LB649]

SENATOR WILLIAMS: Thank you, Chairman Riepe. I guess...could you provide us with a little more about your background and your experience in making these recommendations? And then the second part of that question is it appears that managed care has worked successfully in certain areas of managing people's health. Why is this one different, in your judgment? [LB649]

MICHAEL CHEEK: Sure. My background is I've worked for several different state government associations, including the Medicaid Directors Association, the State Aging Directors, the State

Developmental Disability Directors. I was the Medicaid Long-Term Care director in the District of Columbia for four years, where I had the privilege of working with Camille when she was at CMS. And then after that I consulted with about 30-35 states, their Medicaid agencies as well as with managed care plans, on operations and integrated services for persons with disabilities and older adults. And your latter part of your question? I apologize. Oh, right. [LB649]

SENATOR WILLIAMS: Talking about why managed care has worked in some areas and your... [LB649]

MICHAEL CHEEK: Certainly. [LB649]

SENATOR WILLIAMS: ...questioning its ability here. [LB649]

MICHAEL CHEEK: I think that in my experience, both with consulting with states, working in a state, as well as working at examining operations as a consultant, that there are two ways of looking at healthcare. One is what I refer to as transactional healthcare where someone goes in for a doctor's...a doctor appointment. They go in for a procedure and it is completed. Long-term care is just that. It continues in perpetuity. I think that many plans, not all of them, but many insurers struggle with coordinating care for people who need it in perpetuity. There is a built-in efficiency incentive to how plans operate often in their contracts with the states and by design of the program in terms of a capitation rate. A fixed fee is paid to the plan for the delivery of care. So there are incentives to rein in utilization. That is very difficult to do in long-term care. If someone needs six hours or eight hours of personal care services, they need six hours or eight hours of personal care services. Finding efficiencies in that regard are very difficult. You can't reduce the hours. When I worked for D.C. Medicaid, we went through a budgeting exercise where we were told we had to cut the hours from eight hours to six hours of PCA due to a budgetary shortfall. I received calls from residents to whom I was answerable--we were directly operating the personal care services program--and was asked: What would you like me to do? My PCA tells me I can get up and bathe or my PCA tells me that I'll have to make my own dinner when I'm not capable of doing that. So I think that trying to create efficiencies within a service delivery system where efficiencies are hard to find is very difficult. I think that home and community-based services and the shift thereto from institutional services plays a role in that, but I think that choice for older adults is important. They have different perspectives on where they like to receive services comparative to...compared to persons with disabilities. And also, I think it's important to understand that for older adults often the circles of natural support, which are available to persons with disabilities in the community, for older people who may not longer live near their families or their families have moved away also may play a role in where someone is best suited to serve. So I think HCBS is important but not the linchpin to this. [LB649]

SENATOR WILLIAMS: One final question and just a quick answer to this if you can. It seemed like in the previous information that we were getting, not in the hearing but the information, that there have been those states that have successfully done managed care in the long term and those that haven't. That seems to fly in the face of your comments about the difference between long-term care in some areas than others. [LB649]

MICHAEL CHEEK: I think that we're down to a definitional issue with the word "successful." From my perspective, representing a provider association, I think that our members struggle with managed care in virtually all states. Some good examples I think are in Florida, where they went through extensive readiness review activities. Readiness review is the ramp up where the plans and the states work together to test how provider interaction works, how the call center for beneficiaries functions. And despite considerable readiness work conducted in states like Florida, Virginia, and Ohio, those were integrated Medicare and Medicaid managed care initiatives but the point remains the same. Extensive readiness review activities: They experienced full claims failure for the first two months of the program and had to switch back to fee for service. Florida had in place a long-term care provider plan state work group to solve payment and coordination issues, not the least of which was eligibility for people for the program. They were unable to solve those even in the six-month ramp up, and that committee is standing still addressing layer after layer of operational issues. Tennessee has additional...has issues as well with this. They have a standing working committee as well. And to the point earlier from the gentlewoman to my left regarding state legislature involvement, the CHOICES in Tennessee is required to submit to the legislature a quarterly report on the fiscal performance of CHOICES as well as some quality indicators, which were designed by the legislature. Those are delivered I believe on a calendar basis as opposed to state, but that might be worth exploring as well in terms of oversight if and when the state of Nebraska elects to pursue this course. [LB649]

SENATOR WILLIAMS: Thank you. [LB649]

MICHAEL CHEEK: Certainly. [LB649]

SENATOR RIEPE: Senator Kolterman. [LB649]

SENATOR KOLTERMAN: Thank you, Senator Riepe. And thanks for coming. I know you've come a ways. [LB649]

MICHAEL CHEEK: Sure. [LB649]

SENATOR KOLTERMAN: I have some questions about how it would actually work and some of the challenges. And maybe you can help address these. So let's say, since he's a little older than I, Senator Williams ends up in the nursing home. (Laughter) And his wife says, well, we're going to put you with company A. And then the next person that comes along is Senator Riepe and he goes with company B. And then we got a third person, probably I'd be the last one so myself with company C. So we have three companies now working inside that nursing home. [LB649]

MICHAEL CHEEK: Uh-huh. [LB649]

SENATOR KOLTERMAN: And they're all on different contracts with our state or...you know, I don't know how exactly that works. But would we then have three portals to report to every month? I'm just dealing with the challenges that I see because then all of a sudden the nursing home or the assisted-living facility is dealing with three different companies on a regular basis all trying to do that same thing. Is that how it works or am I mistaken as to how it might work? [LB649]

MICHAEL CHEEK: In most places that is how it works. States can take steps in the contracts with the plans to specify that they use the same sorts of billing portals and the same sorts of assessment tools and other operational activities, but at the end of the day you are interacting with three payers, rather than one, with three different processes. Despite what it may say on paper, that creates a substantial amount of confusion and operational expense. And I think often it may impact the beneficiaries' experience with service delivery. In general, our members tell us that for every plan with whom they add a contract with they have to add at least one full FTE to do nothing but manage the relationship with the plan to ensure eligibility, to move claims along, to make sure that they are paid in a timely fashion, to make sure that they are stable as a provider in the community for the people and families that they serve. [LB649]

SENATOR KOLTERMAN: Then to take my question one step further, could the state or the people...the state, because they're paying the bill, could they say, well, nursing home A, all of yours are going with company A; nursing home B, all of you...and do like they did when they rolled out our managed care for Medicaid? Everybody got somewhat equal amount, all three providers got a somewhat equal amount of participants. Could they do that? Would they have the flexibility to do that so at least the home that we're dealing with only has one provider to deal with? I'm just asking because it would make things easier, I would think. [LB649]

MICHAEL CHEEK: What some states have done, at least in the initial period of implementation, is come at your issue but from a slightly different direction, and that is to require that the plans follow what's called "any willing provider." They have to enroll any

provider in their coverage region into their network to make sure that everyone in the building has the opportunity, that anyone in the building or that's being served by a long-term care provider is not displaced for some reason, because there's always the chance that if you didn't do that and the plans had some limitation on out-of-network payment, that the person might have to change providers, which to your question, Senator Williams, is another piece that makes long-term care quite different from acute where if someone has to change providers due to issues with provider network on the long-term care side relative to acute, it's quite a bit more traumatic for a person with a disability or an older adult to change a long-term care provider, be it in-home supports or a residential setting, than to change a doctor, which also can be an issue. [LB649]

SENATOR KOLTERMAN: And just so you understand where I'm coming from,... [LB649]

MICHAEL CHEEK: Sure. [LB649]

SENATOR KOLTERMAN: ...I hear statistics that over 50 percent of our population in the facilities are Medicaid. I mean we're not talking small dollars here. We're talking huge amounts of money. And I don't...and a year ago I think we had three nursing homes close down and we were scrambling to find places for them. So it's a concern with my constituents as well as everybody else sitting around this table. [LB649]

MICHAEL CHEEK: And it should be. The most of the...there are two private long-term care insurance carriers still issuing new policies. It's virtually impossible to purchase private long-term care...private long-term care insurance. Reverse mortgages, private resources typically are not available, to be brief, for long-term care, so reliance on Medicaid is absolutely essential. And we are on the cusp of the aging demographic where we are going to see a substantial increase in the proportion of over-85 adults relative to the overall over-65 population. That over age 85 population, as I'm sure you know, are far more likely to need significant supports. So thinking through adequacy, which is I think is what you're getting at, and ensuring that there's sufficient financing for that population is something that every state should be thinking about right now. [LB649]

SENATOR KOLTERMAN: All right. Thank you. [LB649]

MICHAEL CHEEK: Sure. [LB649]

SENATOR RIEPE: I wanted to back to rewind a little bit because I think when you started your testimony you were talking about a cost to Nebraska of $700 million. [LB649]

MICHAEL CHEEK: Uh-huh. [LB649]

SENATOR RIEPE: I'm trying to go back. Were you referring to the existing changes in the ACA that's in front of Congress? [LB649]

MICHAEL CHEEK: That's correct. [LB649]

SENATOR RIEPE: But they're not primarily dealing with long-term care. They're dealing with acute care. [LB649]

MICHAEL CHEEK: That is my... [LB649]

SENATOR RIEPE: And still, it's a long way from a final edition. [LB649]

MICHAEL CHEEK: Absolutely, but that is the overall...that is the aggregate total impact across. The model that they're using is called "per capita cap." There are five population groups for all services, acute and long-term care. [LB649]

SENATOR RIEPE: But as you know, the CBO has been challenged all over the place on that number. So I don't think there are any good numbers out there yet... [LB649]

MICHAEL CHEEK: Certainly. [LB649]

SENATOR RIEPE: ...and there may not be for a number of days. I might have some more questions. Senator Crawford, I know you do. [LB649]

SENATOR CRAWFORD: Thank you, Chairman Riepe. [LB649]

SENATOR RIEPE: Thank you. [LB649]

SENATOR CRAWFORD: And thank you for being here today, sharing your expertise. [LB649]

MICHAEL CHEEK: Sure. [LB649]

SENATOR CRAWFORD: So when...your alternative approach that you mention is the administrative services organization. [LB649]

MICHAEL CHEEK: Uh-huh. [LB649]

SENATOR CRAWFORD: Is that a single organization for the entire state or...is that what that is? [LB649]

MICHAEL CHEEK: Typically, yes. [LB649]

SENATOR CRAWFORD: Okay. [LB649]

MICHAEL CHEEK: It's a single organization that takes over many of the administrative responsibilities that a state agency might currently be responsible for: provider network management, claims payment, eligibility management. They can take on some care coordination activities as well. Connecticut's administrative services organization, for example, also has some quality metric measurement responsibilities in regard to their providers in the state of Connecticut, and part of that is their oversight responsibility for the providers in the state. Their monthly payments are withheld by 7.5...7.5 percent are withheld based upon being able to demonstrate that the quality metrics have been hit, both for the administrative services organization as well as the providers in the state of Connecticut. [LB649]

SENATOR CRAWFORD: And so what is the advantage of this single ASO versus a department doing that oversight and quality measures? [LB649]

MICHAEL CHEEK: If the focus in Nebraska, and in no way would I presume to tell the state what to do, if there's interest in privatizing certain functions of government then this is a reasonable step in that direction to privatize large functions of the existing DHHS Medicaid functionalities, moving those out of house, possibly in preparation for managed care in the future, but by taking...but taking a smaller step in that direction. Managed fee for service is just that. It's a care coordination function that overlays fee for service. They control, to some degree, what people receive and when, and they help connect them to those services. So it is managing the services they receive under fee for service. But it is all simply not risk based and wrapped up in a single contract. [LB649]

SENATOR CRAWFORD: If I could ask another question... [LB649]

SENATOR RIEPE: Absolutely. [LB649]

SENATOR CRAWFORD: So in the long-term care plan draft that we have in front of us, one of the alternatives to...that's discussed briefly is expand the Medicare ACO model to include long-term care. Could you explain for us the difference between an ACO and an ASO? [LB649]

MICHAEL CHEEK: A Medicare accountable care organization is a CMS, or Centers for Medicare and Medicaid Services, initiative. It is an arrangement among providers, not with the state, where they come together contractually to develop certain targets with CMS for a given population. [LB649]

SENATOR CRAWFORD: Okay. [LB649]

MICHAEL CHEEK: There is target pricing, which is established for delivering services to the given population that they're going to serve, and they share in any bonus payments that are available from savings that they achieve for the Medicare program. Very few ACOs have started to take downside risk, which is to incur penalties for not hitting their targets. Of note I think for additional consideration, if you took a third leg of study in addition to MLTSS, a Medicaid ACO or an ASO or an accountable care organization or ASACO, is that CMS still is entertaining interest from states on integrated Medicaid/Medicare accountable care organizations, which can be provider led, working with the state. And there are three states that have submitted...that have submitted applications to do that. [LB649]

SENATOR CRAWFORD: Thank you. [LB649]

MICHAEL CHEEK: Sure. [LB649]

SENATOR RIEPE: I have a question. Seems to me like it's a question of risk management and whether you have an ASO that's managing your fee for service with that. If that was the state contracting for that, then the state owns the risk. [LB649]

MICHAEL CHEEK: Uh-huh. [LB649]

SENATOR RIEPE: If you contract out to a managed care organization you transfer the risk over to that firm with motivation and incentive for them to come in with some more efficiency. [LB649]

MICHAEL CHEEK: Uh-huh. [LB649]

SENATOR RIEPE: I don't want to say a cheaper product because I don't believe that's always the case. They just have better systems, better processes, maybe better base. And I'll afford you an opportunity to respond to that, challenge it, say I'm goofy. I don't care. [LB649]

MICHAEL CHEEK: I would not say you're goofy, Senator. [LB649]

SENATOR RIEPE: Well, that's all right. You wouldn't be alone if you did. (Laughter) [LB649]

MICHAEL CHEEK: I think that red light would come back on. (Laughter) I think that I would look to states where the plans have come back to the state and said your capitation rates are insufficient, we are not willing to participate in this program any further unless you increase the capitation rates, which brings me back to my "too big to fail" scenario, which is where you might have two plans or in a rural state like Nebraska one plan that says we don't want to play anymore unless you pay us more to cover this population. And that creates a very high-risk situation for people, families, and the state, and you as policymakers answerable to your constituencies. [LB649]

SENATOR RIEPE: One of my major concerns is that individuals who cannot, and maybe into the future, cannot afford long-term care. [LB649]

MICHAEL CHEEK: Uh-huh. [LB649]

SENATOR RIEPE: On the other hand, the state can't either. [LB649]

MICHAEL CHEEK: Sure. [LB649]

SENATOR RIEPE: So we're in a dilemma, if you will, in terms of particularly with a graying tsunami... [LB649]

MICHAEL CHEEK: Absolutely. [LB649]

SENATOR RIEPE: ...coming on the state of Nebraska. [LB649]

MICHAEL CHEEK: Yes, sir. [LB649]

SENATOR RIEPE: And I was concerned about an issue on long-term care. We've often...we've pushed to try incentives for people to buy long-term care insurance. But if it's not available or...I know it's pricy. [LB649]

MICHAEL CHEEK: Absolutely. [LB649]

SENATOR RIEPE: We also have some issues about trusts that protect capital assets that people can then skirt the issue, so just a couple problems. Are there other questions? Comments? [LB649]

SENATOR CRAWFORD: I have another question, if I (inaudible). [LB649]

SENATOR RIEPE: Yes, Senator Crawford, please. [LB649]

SENATOR CRAWFORD: Thank you. Thank you, Chairman Riepe. In one of your comments you mentioned that there sometimes were successful oversight structures in a state. And I wondered if you wouldn't mind telling us about one or two oversight structures that you've seen that have been successful... [LB649]

MICHAEL CHEEK: Sure. [LB649]

SENATOR CRAWFORD: ...and why you see them as successful. [LB649]

MICHAEL CHEEK: Sure. I think one in particular in terms of oversight for Medicaid managed long-term care that's been helpful, it's not without its challenges, and that's the Office of the Ombudsman in Minnesota. That is an office dedicated to Medicaid managed long-term care and it is a place where...an entity where both providers and beneficiaries can go with issues to the state that is neutral when they have exhausted all options with the plan in terms of solving problems, including issues with beneficiaries securing prior authorization for services, issues with eligibility redetermination, or for providers potentially with claims that have been substantially backlogged. Florida's Integrated Task Force of Providers' Plans in the state around solving payment issues, eligibility, and benefits, that was supposed to have sunset after the first year of implementation. It's now been extended in perpetuity. So I think that that's also helpful. The Tennessee CHOICES reporting requirement to the state legislature I think is another helpful aspect in terms of reporting on metrics and holding them accountable for how they performed with...both fiscally as well as in terms of outcomes for families and beneficiaries. So I think if you pull those three together that those would be helpful structures to evaluate as Nebraska DHHS considers options. [LB649]

SENATOR CRAWFORD: Those seem to be addressing different kinds of oversight. Am I hearing you correctly? The Ombudsman's is more kind of a personal solving problems. The Integrated Task Force is solving operational problems, where the Tennessee CHOICES is perhaps that policy question of is this... [LB649]

MICHAEL CHEEK: Correct. [LB649]

SENATOR CRAWFORD: ...the right direction to go and are we getting... [LB649]

MICHAEL CHEEK: One is more prospective, one is retrospective, and one is in real time in terms of solving issues. [LB649]

SENATOR CRAWFORD: Okay. Thank you. [LB649]

MICHAEL CHEEK: Sure. [LB649]

SENATOR RIEPE: Do you have any supporting information that says a high level of bureaucratic state override is more effective than putting a provider at risk, and if they don't get the job you fire them...get the job done? [LB649]

MICHAEL CHEEK: I think that a balance between privatization and government oversight with people that have a vested responsibility in the efficient use of taxpayer dollars is something that's well worth exploring and should be. But that balance is difficult to strike. [LB649]

SENATOR RIEPE: Yeah. People would take issue with your trust in politicians but okay. (Laughter) Are there other questions from the committee? Thank you very much. [LB649]

MICHAEL CHEEK: Thank you all very much. I appreciate it. [LB649]

SENATOR RIEPE: We appreciate you coming in and for you testifying. [LB649]

MICHAEL CHEEK: Yes, sir. [LB649]

SENATOR RIEPE: Additional proponents, please. [LB649]

CINDY LUXEM: (Exhibit 3) Hello, Senator Riepe and committee members. I am Cindy Luxem, and that's C-i-n-d-y L-u-x-e-m. I am the CEO and president of the Kansas Health Care Association and Kansas Center for Assisted Living. My counterpart sits right behind me here in Nebraska. We, of course, in Kansas, as you probably know about our Health Care Association, we're the oldest trade association that represents long-term care in Kansas. And I represent, we are an association who represents about 250 providers: skilled, assisted living, residential healthcare, Home Plus. I was asked to come up here to share some hard lessons that we've learned in Kansas and I really hope that I can share some thoughts with you as decision makers and that you really take some things into consideration in whatever direction you decide to go. Number one, we call our managed care KanCare in Kansas, and I've just realized that you call yours Heritage Health, so I caught on to that not too long ago. But our managed care access really began to limit the access that seniors had for options. And I'm going to...I've laid out several points in my testimony that you can read later on, but I want to hit on some that are more important than others. You know, the managed care, as we've heard today, is supposed to give options, more options. It's supposed to decrease utilization of institutional care, and in our fifth year of KanCare it's not happening. And you know I'm not going to sit here and say that it isn't any one person's fault or another. It all gets back to that topic again that our elders and the population we are dealing with in our skilled and long-term care world often is a different population and that's why it's been so difficult all along to kind of figure things out anyway. But quite honestly, we have had a very vibrant "money follows the person" program in Kansas and we still do, but it is limited because we don't have enough workers. We don't have enough care coordinators among the three managed care companies to get out to all of the folks that need to talk to someone. You know we have close to 10,000 people in our skilled nursing centers on any given month. We have about 4,000 in the frail elderly waiver, 4,000 to 5,000. We have between 4,000 and 5,000 in the PD waiver. We have probably 6,000 to 8,000 in the DD waiver,and there's about 800 in the TBI waiver--traumatic brain injury, developmentally disabled, physically disabled, frail elderly, in case you're not familiar with all those various buckets. Quality improvement was touted as something that they were going to...that was going to be a caveat of this. And I will tell you in the packet that I gave you, I gave you a copy of the Leavitt report and we didn't...our association doesn't have enough money to go in and be a part of something like this, but the Hospital Association did and you will see that it really doesn't show a very good picture of quality measures in Kansas. And I don't believe it is necessarily...because even some of the quality measures that the state officials from Kansas might present to you, those are quality measures that our providers, our long-term care providers were already working on and had been working on for many years, the reduction of rehospitalization, because those are the things that cost us money as providers also. So I get a little frustrated when the managed care companies start coming in...or the state start coming in--and, really, it's the state coming in, not the managed care companies--and taking credit for the quality improvement measures because we had been working on those long before this program went into effect. And then, quite honestly, one of the things that I will lay at the feet of the managed care companies, and I don't

really know how else to do that, the insurers, is that the perks are not there for seniors. You know all of the things that...the prepaid money cards, the advantages to go to the health clubs, those are not things that are things that our seniors can participate in. We were rolled out without any...it was just rolled out. Yes, they did the ready readiness and all that kind of stuff, but it was just rolled out. People weren't ready. Provider manuals weren't ready. There was...we just weren't ready. I want to make sure. The last thing I want to hit on which I think is the absolutely most important thing is oversight by the Legislature. If you choose to go down this route, in Kansas they are putting $2.1 billion in the hand of three for-profit companies. I believe it is behooving on the folks that elect us to make sure that you're good stewards of those dollars. And we do have oversight committees. But I have to tell you something kind of funny, because up until August 2016 at the primary election, where we lost quite a few legislators, the committee became a little more active after that. I would love to stay up here for hours--the red light has come on--because, let me tell you, we have lots to talk about. But thank you so much for having me come. This is only the second Capitol I've been in and it's very exciting to be here today and I'm glad I'm sitting down because my knees would be shaking so bad I probably couldn't stand up. [LB649]

SENATOR RIEPE: Well, welcome. We have our own budget problems but I'm not sure that they're as great as Kansas. We do have, we have thought through an oversight piece and we see that as the accountability of the Health and Human Services Committee, and so we will have oversight in terms of our managed care organizations without creating undue levels of bureaucracy, if you will. That said on my part, I would look to committee members if they have any questions. Senator Williams. [LB649]

SENATOR WILLIAMS: Thank you, Chair. And I just have one quick question. Can you list for us the managed care companies that you do business with in Kansas? [LB649]

CINDY LUXEM: We have Sunflower, which is a Centene affiliate; we have United HealthCare; and we have Amerigroup. [LB649]

SENATOR WILLIAMS: Thank you. [LB649]

SENATOR RIEPE: We have two of those same three. [LB649]

CINDY LUXEM: I'm aware of that. [LB649]

SENATOR RIEPE: Very good. You seem to know your facts. Are there other questions from the committee members? Senator Crawford. [LB649]

SENATOR CRAWFORD: Thank you, Chair Riepe. And I was just trying to find things quickly. You had mentioned something about quality measures and some challenge in moving on quality measures, and I just wasn't finding if that's something you have given to us, or if you just want to explain a little bit more about your point on that front. [LB649]

CINDY LUXEM: I think some of them are on the back. [LB649]

SENATOR CRAWFORD: The back, okay. Okay. [LB649]

CINDY LUXEM: But one of the things, as I was reviewing some of the recent PowerPoints that the state provided back in February when we had our last KanCare oversight meeting, they were showing things like the reduction of rehospitalization. Kansas traditionally has been low in rehospitalization. That's one of our quality measures in the managed care world for our folks. And they're showing a great reduction in that and that was already well on its way prior to the managed care folks coming into play. [LB649]

SENATOR CRAWFORD: Okay. [LB649]

CINDY LUXEM: The managed care companies all have...each have their own quality measures that they have to abide by and then the various populations also have quality measures that we're held to. [LB649]

SENATOR RIEPE: Senator Crawford. [LB649]

SENATOR CRAWFORD: On your written testimony you indicate that CMS has not approved Kansas' application to extend managed care into 2018... [LB649]

CINDY LUXEM: No. [LB649]

SENATOR CRAWFORD: ...calling our program not just substantially but substantively out of compliance. What are some lessons we need to learn to avoid that same fate? [LB649]

CINDY LUXEM: Well, number one, better oversight. And also the thing was is that what they...what basically happened within the state of Kansas was they kind of stopped giving the reports that CMS was requiring at various places of the process, and they were thinking they could send one kind of complete letter that would cover everything. And CMS also was in our state from August of last year until the end of the year doing on-site visits, visiting with people,

and they were out there finding out, as I say in my testimony, that the consumer was very dissatisfied and that they were very upset. And they were not believing that people were accessing. Things also came up that consumers were saying that their plans of care had been altered. I mean there was just a lot of kind of divisiveness that I think CMS was saying, no, we're going to figure this out before we move down further, is what I understand. But when they came back, there was a significant amount of work. There are four different work groups going on right now within our program with the lieutenant governor to try to straighten things out between now and the end of April. [LB649]

SENATOR CRAWFORD: So just to clarify, so the patient satisfaction, recipient satisfaction is an important criteria for compliance? [LB649]

CINDY LUXEM: I think access is the...access. [LB649]

SENATOR CRAWFORD: Access is the key. [LB649]

CINDY LUXEM: Yes, access is the key. [LB649]

SENATOR CRAWFORD: So if they're unhappy with their access, that becomes an important issue that CMS evaluates. [LB649]

CINDY LUXEM: Yes. [LB649]

SENATOR CRAWFORD: Thank you. [LB649]

SENATOR RIEPE: So that's access in part because of your geography is not unlike Nebraska. [LB649]

CINDY LUXEM: Correct. [LB649]

SENATOR RIEPE: So that it's just a matter of trying to get providers in those locations. So you know, it's not a matter of an opportunity to receive the services. It's that there's no...not enough incentive to have those services in some of these remote communities, if you will. The other one that I look at in here is your senior population. You must be the, what, dual eligible, because many of these would be under Medicare Advantage or Medicare. Medicare Advantage should have a lot of choices for them. [LB649]

CINDY LUXEM: You know, in Kansas we actually only have about a 10 to 12 percent saturation of Medicare right now. [LB649]

SENATOR RIEPE: Of Medicare. [LB649]

CINDY LUXEM: And Medicare Advantage, very low. [LB649]

SENATOR RIEPE: What do you buy? What's your thoughts? Youngsters down there or what? (Laughter) Okay. Do you have... [LB649]

SENATOR CRAWFORD: Yeah, one more,... [LB649]

SENATOR RIEPE: Senator Crawford. [LB649]

SENATOR CRAWFORD: ...just to clarify. So are the access issues that were a concern in these evaluations, were they because of a lack of providers and services available or a lack of approval and payment for those services? [LB649]

CINDY LUXEM: I'm going...we have 105 counties in Kansas, and I don't know how many counties you have here. A hundred and four of those counties have either a nursing home or a long-term care unit of a hospital, the most expensive kind of service. In only 60 of those counties is there anything other than that opportunity. So to say you want to drive services, we have home health agencies stopping service because they cannot get paid in a timely manner. So when you start losing community capacity in an area that really only has institutional care, you have no other options. So it can be both the lack of...you know, in Washington County, which is up in the northwest county of Kansas, if you only have a nursing home or a hospital unit, you don't have a choice. And guess what? Senator Williams lives in Washington County. He doesn't want to go to six counties over where there are home and community-based services for him over there. And that's...that's... [LB649]

SENATOR CRAWFORD: Okay. Thank you. [LB649]

CINDY LUXEM: We just have the issue in rural,... [LB649]

SENATOR CRAWFORD: Just trying to understand (inaudible). [LB649]

CINDY LUXEM: ...yeah, with this. It's a mess in rural Kansas too. [LB649]

SENATOR RIEPE: Senator Kolterman. [LB649]

SENATOR KOLTERMAN: Thank you, Senator Riepe. [LB649]

CINDY LUXEM: You're way too young to go in a nursing home, but I will take your address down just in case (inaudible). (Laughter) [LB649]

SENATOR RIEPE: Now he's forgotten his question. [LB649]

SENATOR KOLTERMAN: No, I didn't. [LB649]

SENATOR RIEPE: Oh, okay. [LB649]

SENATOR KOLTERMAN: You lost me on the low population of Medicare and Medicaid. [LB649]

CINDY LUXEM: Well,... [LB649]

SENATOR KOLTERMAN: You say it's only, what did you say, it was 10 percent? [LB649]

CINDY LUXEM: Yeah, we have about...yeah, we have a very low saturation of Medicare right now. [LB649]

SENATOR RIEPE: Did they all move to Arizona? [LB649]

SENATOR KOLTERMAN: Yeah. Why would that be? [LB649]

CINDY LUXEM: Linda, do you have an idea? Linda is my...she's probably got the technical answer. [LB649]

SENATOR KOLTERMAN: That's all right. She can't speak to (inaudible). [LB649]

CINDY LUXEM: Oh, I'm sorry. [LB649]

SENATOR KOLTERMAN: That's all right. [LB649]

CINDY LUXEM: Can you whisper in my ear? (Laugh) You know, I don't know why it is, to tell you the truth. But you know we...our state is aging a little slower, you know, as far as, I mean I just turned 60 in January but our state, truly, is aging a little slower than they kind of anticipated when we first started talking about how all these people were going to come into the, you know, into that Medicare world sooner than later. But we just don't have a very high saturation of Medicare or Medicare Advantage, bottom line. [LB649]

SENATOR KOLTERMAN: All right. [LB649]

CINDY LUXEM: Opportunity, huh? [LB649]

SENATOR KOLTERMAN: Yeah. Thank you. [LB649]

SENATOR RIEPE: Senator Linehan, please. [LB649]

SENATOR LINEHAN: Thank you, Chairman Riepe. And thank you for being here. This is very helpful. So did it actually save any money? I mean I understand there's problems. I get all that and that's very problematic, especially...well, in all areas. But did the state actually appropriate any less money? You're spending less money or...? [LB649]

CINDY LUXEM: I think we're appropriating exactly the same if not more. And I tell you why. Because we had a debacle. We privatized our Medicaid system and we had to go back to fee for service because we've had over...we've had some providers that have been in arrears for 18 months of Medicaid payments. So there are parallel issues going on. [LB649]

SENATOR LINEHAN: But originally they thought they were going to save money. [LB649]

CINDY LUXEM: Yes. And the thing is that I don't believe, I think some of your insurance companies that are here could...I don't know whether they can respond about Kansas or not, but I don't think any of them ever got any of their incentives that they were supposed to get if they kept things under wraps. But I think the state would say they showed savings. But showing savings and showing the capacity to do, you know...yeah, maybe they're showing savings but there are also a lot of people that aren't getting services. [LB649]

SENATOR LINEHAN: Okay, but I...so I understand that they're show...they're not getting services but you don't have an idea what the state thinks, claim they saved? [LB649]

CINDY LUXEM: I can...I will tell you what I'll do. I'll follow up with some information and give it to Heath and let him... [LB649]

SENATOR LINEHAN: Okay. [LB649]

CINDY LUXEM: ...he and Shannon deliver it to you, if you don't mind. [LB649]

SENATOR LINEHAN: Oh. No. That would be wonderful. [LB649]

CINDY LUXEM: Okay. [LB649]

SENATOR LINEHAN: Thank you very much. [LB649]

SENATOR RIEPE: I have just one question. It seems to me whether it's public or private, if you have a capitation model as opposed to a fee for service...you had talked a little bit about ability and access to use adult day care and use of other services. There's every incentive for that capitation provider to make sure that they're at the right level of care as opposed to with a negative incentive to have them in a nursing home. I mean all the incentives are right and they're all wrong under fee for service, in my opinion. [LB649]

CINDY LUXEM: Did you ask me a question? (Laugh) [LB649]

SENATOR RIEPE: Well, I'm don't know. I'm inviting you, just like I did before. If you think I'm wrong on this then fight with me with a little bit. [LB649]

CINDY LUXEM: Well, see, the thing...the way...so this is what happened, okay? Providers, you know, if the, number one, if our providers understood about working insurance companies... [LB649]

SENATOR RIEPE: Working them? [LB649]

CINDY LUXEM: Working with them. [LB649]

SENATOR RIEPE: Oh. [LB649]

CINDY LUXEM: So a hospital understands, you know. In fact our lieutenant governor is a physician. He says he works with 8 to 12 different insurance companies. Our providers have never worked with an insurance company other than a state Medicaid program. So now, all at once, they're dealing not only with three insurance companies, and they are three very different. They all have different processes. They all have different portals. Everything thing is different. So you have three. If you are talking about a single owner nursing home and we do have any willing provider in Kansas, you do not want to not have that because all at once you start picking and choosing who gets the business. You want all providers to be able to participate in this kind of program. But my thing is that if the insurance companies understood about billing and our providers understood about how you work with an insurance company, we actually in Kansas, our nursing home providers, had to change how they get their rates reviewed to go to a twice a year rather than four times a year to keep up with the insurance companies, because they couldn't keep up with our rate changes. [LB649]

SENATOR RIEPE: Well, I will assure you that there are people that disagree with any willing provider because that's the only way you're going to get a price advantage. You got to leverage. It's just the way it is. [LB649]

CINDY LUXEM: And so the thing is, Senator, what I try to tell our providers is go out there and use your resources to your benefit. If you can do an extra service, then ask them for that. But the thing is our folks, they don't understand that. So all I'm saying is that please don't rush into anything and please, you know, this little study was very exciting but just don't rush into anything because there's so many circumstances that you might not think about. [LB649]

SENATOR RIEPE: We're government. Do you think we'll rush into anything? (Laughter) [LB649]

CINDY LUXEM: Well, the only thing I'd like you to rush to is there's a basketball game tonight about 6:00 I'd really like to watch. [LB649]

SENATOR RIEPE: I don't think Nebraska is playing. [LB649]

CINDY LUXEM: Oh, I'm sorry. (Laughter) [LB649]

SENATOR CRAWFORD: Creighton is playing. [LB649]

SENATOR RIEPE: Oh, Creighton. (Laughter) I'm sorry. For all the Creighton people, I apologize. Are there any other questions from the committee members? Thank you very much. [LB649]

CINDY LUXEM: Thank you, Senator. [LB649]

SENATOR RIEPE: You're very engaging. We appreciate that. More proponents. [LB649]

HEATH BODDY: (Exhibit 4) Good afternoon, Senator Riepe, members of the committee. I am Heath Boddy, that's H-e-a-t-h B-o-d-d-y. I'm here on behalf of the Nebraska Health Care Association and we're a family of associations that represent nursing homes, assisting living, hospice and palliative care, and licensed practical nurses. Thank you so much for taking your Friday afternoon, long week, St. Patrick's Day, end of the day, but we appreciate you letting us talk a bit about LB649. I want to give special thanks to Senator Pansing Brooks, even though she had to step out. We appreciate her, her willingness to work with us to shine a light on managed care and specifically our concerns related to managed care. Our association represents 430 nursing facilities and assisted-living facilities across the state and their services today are not included in managed care but the people who live with them are as of January 1, and they've got some experiences around that. And I think we hear some more about that behind me. I also want to express appreciation to Director Lynch. He's had a real willingness to have open communication with us and talk through issues. And while we may not always agree on the vehicle or the decisions, we do appreciate the open dialogue and the willingness to talk about issues. And I think we heard from the people that gave the review earlier that that will...regardless of what direction Nebraska moves, that will be critical. It's important also that the director has been clear with us of their intent to move long-term care into managed care. That helps frame things a little differently and I truly appreciate that. You had a lot of testimony already. We've had some great conversation. I think I'm just going to point out a few things, lots of which I hear from my colleagues who experienced long-term care managed care in other states. Nebraska experiences a really good cash flow scenario right now with Medicaid. It's just a touch over a week, when things are done right, they can turn around and get claims paid in Nebraska with Medicaid. My colleagues tell me in other states that that grows, 30, 60, 90, much differently. And while that's not necessarily anyone's intent, cash flow to a lot of our single rural providers on--hopefully we can last the 30s, the 60s, and 90s--we'll have a lot of providers that will not be able to operate in that manner. I think talking about reasonable rates would be a concern. Director Lynch, we've had conversation around the state's intent. At least in the first contract period, they would be interested in setting the rates and we would have an interest in that. I am a little concerned about the rate that we have now in that it's going to be hard to maintain a level of quality. Today we're $25.06 per day underfunded in capped cost in the nursing facility world. And if there's some assumption that we have the same amount of dollars to work with and yet we're going to have more fingers in the pot, I'm concerned that it's going to

be hard to keep a level of quality that Nebraska has now. And as you heard a couple...or I think you...you'll probably hear--I probably read some testimony--you'll hear some people talk about Nebraska has got...has good quality. We're good quality providers, not in every aspect but generally we do things well. We've talked about access. I won't beat a dead horse. I am concerned, however, that as the operation, the business model that is Medicaid gets ratcheted down from the ability to cover cost, there is no profit margin in Medicaid for Nebraskans, and I want to be clear about that. There is when we talk about managed care for insurance companies. There is not today for providers. But as we ratchet that down, access has got to be a discussion that we have. There will likely be some effect. And my colleagues in other states share that with me as well. And I think that you asked some questions earlier about administrative burden so I won't work on that, and Cindy just alluded to that as well. The last point I would just make from a concerned standpoint is I think, going back to this question about critical evaluation, Senator Williams, how will we know critical evaluation, I think we have to be clear and transparent and public about what our baseline is, where is the data now, what are we measuring about. The discussion about this early was improve the quality of care, improve access, and originally it was save money. Now we talk about controlling costs and that's fine. That might be a great place from a critical evaluation perspective. What's the baseline data? How will we know what success looks like from a data perspective? You might tell that our association is not sold on a managed care, that it's the best plan for Nebraska at this point. But we do continue our commitment to work with DHHS, to have open dialogue, to work with this committee to find the best path for Nebraska, whatever that may look like. I thank you very much for taking your Friday afternoon and this holiday afternoon to listen to our concerns and to hear us out. We do ask you to advance this bill and I would be happy to answer questions if you have any. [LB649]

SENATOR RIEPE: Senator Kolterman. [LB649]

SENATOR KOLTERMAN: Thank you, Senator Riepe. Heath, would you talk a little bit about you indicated...well, first of all, what percentage of the population of the homes service Medicaid? [LB649]

HEATH BODDY: Thank you. Nationally, 62 percent of the nation in the nursing facility is Medicaid. Nebraska is 53 percent. And in assisted living it's just a touch under 25 at 24 percent and change. [LB649]

SENATOR KOLTERMAN: Okay. And along those same lines then, you said something about $25 below what? [LB649]

HEATH BODDY: So Nebraska, on average, and that's an average rate over the whole state, a provider in Nebraska is reimbursed, based on the analysis that we have, $25.06 per person under the capped cost of care. There's no margin in that from a net profit perspective. [LB649]

SENATOR KOLTERMAN: Okay. [LB649]

SENATOR RIEPE: So we bring a new meaning to the word not-for-profit. [LB649]

HEATH BODDY: Or great deal or discount, which we do bring a new. [LB649]

SENATOR RIEPE: Senator Kolterman, did you have a follow-up question? [LB649]

SENATOR KOLTERMAN: No, that answered my question. Thank you. [LB649]

SENATOR RIEPE: Do others have a question? I'll go to Senator Williams. [LB649]

SENATOR WILLIAMS: Thank you, Chairman Riepe. And thank you, Heath, for being here. Thank you for writing a bill that only takes two minutes to read. I appreciate that. (Laughter) [LB649]

HEATH BODDY: I'd love to take credit for that. [LB649]

SENATOR WILLIAMS: Oh, I bet you had a hand in it someplace. I am a little bit mystified because...and I really appreciate your comments about Director Lynch, because in my conversations with him on this topic he has, I think, worked very hard to try to do this. The dates that the director has talked about and talked about earlier seem to match the dates that are in the bill, being the January 2019, with the exception of the critical evaluation. I find it hard that...to say that the Department of Health and Human Services would try to roll something out like this if they had not fully done a critical evaluation on their own. So I'm not sure we're not talking about a bill that is already being done, but I would like to hear your comment about that and what you really think a critical evaluation is. [LB649]

HEATH BODDY: Sure. Thank you, Senator. I appreciate the question. You're correct, Director Lynch has been fantastic with us with open dialogue and I think has the best intentions for what he sees for the plan going forward. I have not seen, nor have I been shown, information in Nebraska nor in this country that says this is a model that makes sense for Nebraska. Now I realize there's a matter of perspective to that. But when I went back to the initial three points--

save money, improve care, and improve access--I even asked our earlier testifier, Mike Cheek, Mike, show me another state that's doing this well. I'd be glad to talk to the members about what that looks like. I've not see it. So in my mind, from a critical evaluation perspective, we need to understand what do we see now in Nebraska that's an issue or at least just even where we are. We know the spend is an issue. We realize the dollars that are going out are something that we want to put some controls around. And then what are we going...what are we going to be measuring or how are we going to measure that, and said differently when will we be able to see, to see that that makes sense? Now I realize they probably have data that they see that gives them some comfort and the contractors have data they see that gives them comfort. I don't see it. And it's not just that I don't see it. I don't see it in Nebraska and I don't see it in other states. And so we see actually quite the contrary, that there are states that rolled it out--you heard from our colleague in Kansas, we could talk about Iowa, there's many other states. And I'm really worried for access and for the providers and the Nebraskans that get that care in this state, if this isn't done well, what that's going to look like. So... [LB649]

SENATOR WILLIAMS: Thank you. [LB649]

HEATH BODDY: ...I'm not sure if that's helpful. [LB649]

SENATOR RIEPE: I'm not sure whether you're the person. Are we looking at a pilot project? [LB649]

HEATH BODDY: Are we looking at...? [LB649]

SENATOR RIEPE: At a pilot project so that we don't...it's not all in? And that's probably a Director Lynch question but... [LB649]

HEATH BODDY: I think that is. I would just say we would support that discussion. You know, that would make a lot of sense if there's a way for us to look at this in a smaller amount. [LB649]

SENATOR RIEPE: Senator Linehan, go ahead. [LB649]

SENATOR LINEHAN: Thank you, Chairman Riepe. And thank you, Heath, for being here. This might not be a question for you but it's a question that's been going through my mind since I came in here. What do we do as a state or the industry do to keep people? Are we paying enough attention to keeping people in their homes so they don't have to go to assisted? Is there enough

robust Meals on Wheels, occupational therapists, nurses checking in? Are we doing that well enough? [LB649]

HEATH BODDY: Thank you, Senator. I appreciate the question. I think my answer is no. I think there are pockets, especially in urban areas, that have opportunities based on people's business models that do that well. A couple things jump in mind. When we get outstate and we talk about who reimburses for those kind of things, there's some real challenges with that, whether that be a private pay. I don't know of insurance companies that do a lot of payment. Maybe they're out there. And then the other part would be Medicaid and there that's not necessarily a readily available option for those providers. The other side of that, which is problematic in our work from a regulatory perspective, is the regulations really don't give a lot of leeway for a healthcare provider to branch out in these other things without going down a bunch of different paths with more regulations and more surveys. Said differently, it would seem to me that a nursing facility or an assisted living already licensed in the Health Care Facility License Act would be able to say, as an example, home delivered meals or adult day care or those things. We've seen some members in our state. We've got a couple of examples that I could share with you offline of members that are doing some neat things with that and it's definitely an opportunity. But I think generally that is not something we do well. And then I would go back to what I think Mr. Cheek talked about or maybe it was Cindy Luxem, the work force. Work force is going to be an issue. This state struggles. You guys know that. That's not new. We especially struggle in the health space. [LB649]

SENATOR LINEHAN: But we could do better. [LB649]

HEATH BODDY: We could absolutely do better. [LB649]

SENATOR LINEHAN: Thank you. [LB649]

SENATOR RIEPE: I guess Senator Crawford and then I'll come back over here. [LB649]

SENATOR CRAWFORD: Thank you, Senator Riepe. And thank you, Mr. Boddy, for being here and talking about your concerns, what you'd like to see examined. I think that I picked up from your comments that the current model moving forward is one where the managed care organizations have a guaranteed profit margin, while at the same time the providers are currently operating below cost. Is that one of the issues that you would like to have us examine and figure out how to adjust that moving forward? [LB649]

HEATH BODDY: Thank you, Senator. That's a great question. I think that would be a great opportunity for us to discuss things. We have a lot of providers that are businesses, you'll hear from some today, here in Nebraska now and in this business do not have an opportunity for a profit margin or a bottom line. The contracts that we've seen for managed care offer an opportunity for profit or for a bottom line. That by itself seems a little uneven. One of the discussions we had early in this with DHHS is let's talk about a model that gives the businesses that are already hear in Nebraska, that have been partnering with the state of Nebraska for all these years with Medicaid, let's give them the opportunity to create efficiencies, to bring costs down, to get things more in line, but to let them have the opportunity to have a margin. And that's just not a path we've down yet. [LB649]

SENATOR CRAWFORD: What do you mean by that, that you don't have an opportunity to create a margin? What keep...what does that mean? [LB649]

HEATH BODDY: Because Medicaid pays less than the cost of...the capped cost of care, there's no opportunity for a margin in Medicaid work. They have to lean over to Medicare or private pay or, in a very limited sense, long-term care insurance to get that. There is no, in Nebraska, at least I'm not aware. If there's somebody that's smarter than I am in that way, I'm not aware of a way under the Medicaid umbrella to do that because they use your cost, and a cost report. It's capped and then it's less than that cost. [LB649]

SENATOR CRAWFORD: And when you say, just to clarify, I think you clarified it as an opportunity for a profit for the managed care organizations. They're at...I mean when we say they're at risk, don't they have...aren't they at risk really or are you saying they're not really at risk from what you've seen on the contracts? [LB649]

HEATH BODDY: So I'm going to have to plead a little ignorant. My understanding of the first round of the theory, the first round of contracts, and I'm not sure on the Heritage Health side. I'm going to be speaking about the long-term care. I understand because of the implementation side, the at-risk part is lessened a bit in the first year but then it becomes more at risk going down. But we would have to...I'll find that information out, Senator, and have that shared with you. I apologize. I'm not an expert on that. [LB649]

SENATOR CRAWFORD: Okay. Thank you. [LB649]

SENATOR RIEPE: Senator Kolterman. [LB649]

SENATOR KOLTERMAN: Yeah. Thank you, Senator Riepe. Heath, talk...do you have...how many nursing homes are there in the state that are a member of your organization? [LB649]

HEATH BODDY: We have 205 nursing homes out of about 225 in the state, and 235-238 assisted livings at about 285 in the state. [LB649]

SENATOR KOLTERMAN: Okay. Now my question is, out of those, do you have occupancy numbers? I mean are assisted living on average running 75 percent, 80 percent full? [LB649]

HEATH BODDY: I don't have occupancy numbers for assisted living. On the skill side I'm drawing a blank. I'll get them for you. I think this... [LB649]

SENATOR KOLTERMAN: Skilled would be your nursing homes, correct? [LB649]

HEATH BODDY: I'm sorry. Yes, the nursing homes. [LB649]

SENATOR KOLTERMAN: Full-blown nursing homes. [LB649]

HEATH BODDY: And I think that occupancy rate is around 80 percent, but let me get that for you, Senator, so that I don't tell you wrong. [LB649]

SENATOR KOLTERMAN: Well, it all plays into what's profitable and what isn't profitable. [LB649]

HEATH BODDY: It does, absolutely. The less amount of people living in your environment, absolutely the higher cost for the things that you can't control. [LB649]

SENATOR KOLTERMAN: Thank you. [LB649]

HEATH BODDY: No question. [LB649]

SENATOR RIEPE: Are there any additional comments or questions? Seeing none, thank you (inaudible). [LB649]

HEATH BODDY: Happy St. Patrick's Day. [LB649]

SENATOR RIEPE: Happy St. Patrick's Day. More proponents, please. [LB649]

TIMOTHY JUILFS: (Exhibit 5) I brought along some reading material today. (Laughter) I know you don't get very much and so...thank you for giving me this opportunity, Senators and Senator Riepe. My name is Timothy Juilfs, T-i-m-o-t-h-y J-u-i-l-f-s, president of Ambassador Health. I thank you again for this opportunity to speak in support of LB649. I've been in the nursing home field for 43 years and I have seen the good and the bad, but now may be witnessing the ugly should the MCOs have control over the nursing home industry. My question to the committee today is, why the state is so inclined to provide three MCOs, in particular, taking over the nursing home industry with $50 million, and the discussion you just had that we're under water about $25 a day, but there's no discussion to have us review $50 million a year? The calculation that I have from that you'll find in the book on the second page. On the line items from 2009 until 2016, the Nebraska Legislature's budget has shown in 2016 that $327 million is the line item for a nursing home. In my quest to find, in the 2017 and 2018 budgets I was not able to find the exact line item for the nursing homes in that. So taking off then 2016 of $327 million in the contract, and I furnished that, I believe it's under...I didn't have enough tabs so it's the second to the last tab, excerpts of the managed care contract, and you can go through that at your leisure. But in there it states that in the first year the MCOs are allowed 3 percent profit and they're allowed a 12 percent management fee. If you take $320 million times 3 percent, that's $9.8 million; $327 (million) times 12 percent is 39.2 million. That's $49.15 million, so I rounded it off, $50 million. We'd jump through fire to have that opportunity to discuss that with our industry. We've been a cost-based system since...well, when we first started and when I first started in the state in '78, '79, '80, Continental Cares, many nursing homes back then were able to provide a dollar-a-day profit. I believe it was probably the early '80s that most of that got taken away from us and we've had capped cost reports and things that Heath just talked about. So I think that's probably...and you can read the rest of my presentation. I talk in the presentation about articles from other states. Iowa, 11 months into their managed Medicare program, received a letter from one of the MCOs--the article did not mention the name--that the state had offered them $127.7 million and the exec said that's not even close, it's unacceptable, you need to do more--eleven months into it. Kentucky, Kaiser Health wrote an article, I believe, off the top of my head, it talked about the...entitled "Cautionary Tale For Other States." The article shows that one of the MCO companies left the state because they lost $120 million. The remaining two MCOs received a 7 percent increase. We'd take a 7 percent increase if we could get one. Another article is Illinois, Health Alliance leaving the state. I've added other articles from a global standpoint in terms of how it talks about, in one of the sentences in the article, is how MCOs have been started by insurance companies in their belief that there's a pot of gold at the end of the Medicaid rainbow. Over the years the department has hired several groups that have tried to improve...help us improve our program in the state. At this point I just simply don't understand. We're about $1.1 billion, as I understand it, with the new revenue forecast. Maybe I'm off. I don't read the paper every day, but if we're that shortfall I don't quite understand the ability to provide

these types of contracts, that's number one, and I still don't...and again, I'm not...I'm a nursing home person so that's what I try to do every day is run the facilities. But I just don't know what the Governor and the department wants other than less, is what I thought, and caring for the population that we have. I've been in the field, again, for numerous years and it's been a rarity to see a patient that shouldn't have been there. It's not like we have a lot people get up every morning and go, hey, I'm going to go to the end of the road nursing home because Medicaid is going to pay for it. People don't want to go to a nursing home, I can tell you. You know, it's not a sexy business. But the individuals that end up in our facilities, cared for by fabulous staff, really need to be there. [LB649]

SENATOR RIEPE: Thank you very much. Maybe we can turn it over. Are there any questions? Senator Williams. [LB649]

SENATOR WILLIAMS: Thank you, Chairman Riepe. And thank you for being here. And you heard Mr. Boddy testify to how quickly you were receiving...your industry is receiving payments from Medicaid. [LB649]

TIMOTHY JUILFS: Correct. [LB649]

SENATOR WILLIAMS: Does that fit with your experience that... [LB649]

TIMOTHY JUILFS: Correct. Yeah, and it's been awesome all in all. [LB649]

SENATOR WILLIAMS: ...a week, something like that? And I know that... [LB649]

TIMOTHY JUILFS: Even though we're $1,500...$15 under water, we get paid. [LB649]

SENATOR WILLIAMS: I know that your facility is one of the...I think would be defined as a larger facility compared to the ones that are in my legislative district that I am concerned with. And I don't know if any of those will be able to testify today. My question is that cash flow element. What would it do to your organization, a larger organization, to have a delay in cash flow? And what do you expect it would do to a smaller organization to have that kind of a delay? [LB649]

TIMOTHY JUILFS: We just have gone through a software conversion and that did complicate some issues for cash flow. And I'm telling you, in a 90-day window it...we finally went out and got our first line of credit this last month. Just going through that was our own doing it to ourselves, but it didn't take long for things to go south on us a little bit like that. So we, in Omaha

particularly, we've worked with the managed...Medicaid managed care programs over time. Particularly, we have long-term care pediatric and ventilator patients. We...insurance companies, in the past, because I think we've been a smaller population to work with, we've received some payments from them. But to give you an example at UHC, I've been negotiating with them since 2004 to establish a rate and still don't have it signed. Now they paid us my old rates, but we have not been able to...we're getting close now. We've been working weekly with them since last October and we think we'll be able to get that finally, you know, wrapped up, but it's been a... [LB649]

SENATOR WILLIAMS: Okay. [LB649]

TIMOTHY JUILFS: For a small company it's a heavy load. [LB649]

SENATOR WILLIAMS: Thank you. [LB649]

SENATOR RIEPE: Senator Williams, do you have another? [LB649]

SENATOR WILLIAMS: I'll let it go then. [LB649]

SENATOR RIEPE: I guess one of the questions I think you said, well, instead of looking at the managed care companies, why don't they take care of us, or something to that effect. My question would be is, as a major provider, are you in a position...because as a state we like predictable cost. Therefore, when you have a capitation rate, you have predictability. Would you be willing as a nursing home provider to provide a capitation rate that you would provide services for the residents? [LB649]

TIMOTHY JUILFS: There are some elements of it, if we were negotiated correctly. [LB649]

SENATOR RIEPE: Just curious. Are there other questions? Thank you so much for being here, taking your time. We appreciate it. [LB649]

TIMOTHY JUILFS: Thank you. [LB649]

SENATOR RIEPE: More proponents? If you'd just state your name and spell it, please,... [LB649]

JAY COLBURN: Thanks. [LB649]

SENATOR RIEPE: ...and proceed. [LB649]

JAY COLBURN: (Exhibit 6) Good afternoon. I'm Jay Colburn and that's spelled J-a-y C-o-l-b-u-r-n. I'm from York and I work for York General currently, and specifically York General Hearthstone, which is a 129-bed skilled nursing facility or nursing home there in York. So our organization has a hospital, my facility, assisted living, dialysis, home health, and low-income senior housing. So in the state we're not a big deal, but in York or York County we're...we like to think we're pretty big stuff. So today has been pretty humbling. So overall I'm just trying to come and share my concerns about the potential of managed care coming into the state overall. You know, we hear the worst-case scenarios; there might be better case scenarios. But I think the big thing that I want to promote is that we as providers would like to be engaged in the conversation. I think we have some ideas of how we could help save costs or maybe even look at ways to lean out rates a little bit or maybe improve some of those measurements or if we knew what the department wanted to look at for quality measurements or if we knew what their target was. You know, what do you want to save? Maybe we can just help you get there. And I don't feel like we've had that opportunity yet. And maybe that's like asking the fox into the henhouse. I don't think so. We operate at about a 3 percent margin and we're a not-for-profit organization. We really need to be more around 5 percent. I hope to get there by the end of the year to have some comfort zone, but that's where we're at. A Mercer plan, read through it. I've participated in the meetings. I've listened on the telephone calls. The plan has lots of good information in it. Mr. Lynch has been very good about communicating with us as providers and the provider group. He's been very open. He's made some good changes in the department, as well, which we appreciate, so I think we all have some trust that we would like to extend, but as providers I guess we're asking for some help in verifying how managed care is going to proceed. And why is that important? I already kind of mentioned our margin. And then the frail elderly folks that we're caring for, you know, I couldn't bring my resident president here today to testify to you. They're not able to travel or to hang out this long. I'm no longer a certified nurse's aide. I couldn't help them to the bathroom while they were here. They need the services. But they really...they have a limited ability to have a voice that's heard, so I'm trying to be here today to accomplish that. The other things that concern me in general is some of the contracting issues that we've seen on our acute care side and even getting our facility, while we're not full-blown managed care, long-term care services, we still had a contract with the MCOs and we had some things occur during contracting. They seem like minor issues, probably sounds like I might be whining about them or they're not that big of a deal. But really, they were concerning to me. The one issue, we had a request for a piece of documentation from one of the MCOs and, you know, that information has been posted on-line by Medicare for years. So they either weren't willing to pull it or they didn't have the knowledge to just go pull the information. That concerned me. That was on January 5, 2017. What really concerned me is after we told them where to find it on-line and provided the information, they circled back around on March 10 and requested the same piece of information, which I know it sounds trivial. It's not a big deal. But it's concerning when you

think, well, these folks are who maybe we're going to entrust the future of our frail elders to. The CEO of the hospital in Albion has a pretty interesting story. They took four tries to get contracted with one of the managed care organizations, finally got the contract approved. It was pretty ornery deal to work through and then when they finally did receive a check, it bounced. You know, in a hospital setting that's kind of a funny story you tell over a green beer in...on a day like today. In long-term care, our rural facilities, some of the facilities have gotten close to the edge that I've had to go out and help pull back from the edge or try and help get them turned around. You can't take a Medicaid bounced check on your services. You won't make payroll. And then you hope that you have a local bank that will help you on an operating loan. And then your margin that you were making just got ate up by an operating loan. I think the final thing is if Medicaid managed care for long-term care follows the performance curve we've seen in the states around us, again, we've heard of that unicorn managed care system that has worked well. I still don't know where it's at. We don't know what model it falls under. I don't know what state it's at. I hope it has reciprocity with licensure for Nebraska. [LB649]

SENATOR RIEPE: Okay. [LB649]

JAY COLBURN: But that's, you know, the concerns I have is it will cause facilities to close. My neighbor facility at Exeter closed and it was painful for those family members and those residents. And that community is still reeling. I was involved... [LB649]

SENATOR RIEPE: Can you kind of pull it together so we can get on with some questions? [LB649]

JAY COLBURN: Yep, sure. I was involved with Lyons, Nebraska, who also closed, and trying to figure out how to help that facility reopen and just had heard from the family members and residents of how difficult that was. [LB649]

SENATOR RIEPE: Okay. [LB649]

JAY COLBURN: It's just...it's a scary proposition. So I appreciate your time. Sorry I ran a little long. [LB649]

SENATOR RIEPE: Are there some questions from the committee? I have a couple questions, being an old recovering hospital administrator. Do you think that the hospitals have an easier go at negotiating with managed care companies than long-term care? [LB649]

JAY COLBURN: I don't know because all of my service has been to the elderly in healthcare so far. Our organization does have a hospital and what I've seen from the hospital side is they do have deeper pockets to lobby. And oftentimes that goes further when they're trying to work on contracts. I don't know. That's more anecdotal than hard evidence, so. [LB649]

SENATOR RIEPE: Second question I would have is, do you think Director Lynch would be easier to negotiate with than a managed care company? [LB649]

JAY COLBURN: I don't know. I like that he's in Nebraska and I like that we're trying to work towards helping Nebraska and I like that he is not incentivized to cut my payment... [LB649]

SENATOR RIEPE: Okay. [LB649]

JAY COLBURN: ...and to kick residents out of my facility who don't have a different place to go. [LB649]

SENATOR RIEPE: But you do understand that all the managed care companies, at least in the acute care side, are also Nebraska based now? [LB649]

SENATOR KOLTERMAN: Question. [LB649]

JAY COLBURN: So they're based, they're headquartered in Nebraska and the profits will stay here with ownership or...? [LB649]

SENATOR RIEPE: Well, they have subsidiary corporations here, so I'm just curious. And Senator... [LB649]

JAY COLBURN: For me it seems a little different than having to be in a community and serving your elders. But maybe it's all six one way, half-dozen the other. [LB649]

SENATOR RIEPE: Well, CHI is based in Denver and everybody is based all over every place. Senator Kolterman, please. [LB649]

SENATOR KOLTERMAN: Thank you, Senator Riepe. Jay, thanks for coming today. You talked about Exeter. [LB649]

JAY COLBURN: Yeah. [LB649]

SENATOR KOLTERMAN: Did you pick up a percentage of that business or do you know where it transitioned to? [LB649]

JAY COLBURN: I don't know where the bulk of their residents went. I think we ended up picking up one as their direct neighbor because we had limited beds available. [LB649]

SENATOR KOLTERMAN: And was that... [LB649]

JAY COLBURN: And one of my staff members had family members there that we could make room for, so. [LB649]

SENATOR KOLTERMAN: Was that a locally owned, small home or was that a part of a smaller chain or do you know? [LB649]

JAY COLBURN: They're owned by I think it was Deseret out of Utah, a smaller chain I believe. [LB649]

SENATOR KOLTERMAN: So it went down when the rest of them went down last year. [LB649]

JAY COLBURN: Yep, the whole chain sank. That was part of Lyons, as well, as I understand; maybe Atkinson was also in that. [LB649]

SENATOR KOLTERMAN: Yeah. Yeah, I know what you're talking about. [LB649]

JAY COLBURN: And there was one other facility. I'm not remembering which one. [LB649]

SENATOR KOLTERMAN: Okay, thank you. Have a good weekend. [LB649]

SENATOR RIEPE: Do we have another question? Were you finished, Senator? [LB649]

SENATOR KOLTERMAN: I was just telling him to have a good weekend. [LB649]

SENATOR RIEPE: Oh, well,... [LB649]

JAY COLBURN: Well, you do the same. [LB649]

SENATOR RIEPE: ...I have another question. Do you have a limited number of Medicaid beds out of your total occupancy that you are available for Medicaid? [LB649]

JAY COLBURN: Currently we...all of our 129 beds are licensed for Medicaid. [LB649]

SENATOR RIEPE: But do...but on your acceptance level though. [LB649]

JAY COLBURN: Right now we have to maintain a balance where we can maintain our margin. [LB649]

SENATOR RIEPE: Which is what? What's the number? Do you have that number? [LB649]

JAY COLBURN: Yeah, we have been running and we typically budget for about 43 to 45 percent Medicaid residents, and that works out to right about 45 to 47 residents. [LB649]

SENATOR RIEPE: I know some of the nursing homes have a policy, and I want to see if that's your policy, that you have to have been a paying patient or resident for two years before you can become a resident at their facility on a Medicaid basis. [LB649]

JAY COLBURN: I don't. We're not for profit and we really try and just take care of our community members that are there. If we're going to accept additional private-pay residents, then our out-of-town residents or extended communities, that's where we would look at accepting those residents, and we can't really accept Medicaid from across the state or we wouldn't...or we'd...I don't know. We'd have to figure out some different funding. [LB649]

SENATOR RIEPE: Okay. Are there other questions? Seeing none, thank you. Thank you for being with us today. [LB649]

JAY COLBURN: Thanks for your time. [LB649]

SENATOR RIEPE: Thank you. Additional proponents? Appears you are dressed for the occasion on St. Patrick's Day. [LB649]

JULIE KAMINSKI: (Exhibit 7) Yeah, that's right, a little green. [LB649]

SENATOR RIEPE: If you would just state your name and spell it. [LB649]

JULIE KAMINSKI: Yes. Julie Kaminski, J-u-l-i-e K-a-m-i-n-s-k-i, and I'm the CEO of LeadingAge Nebraska and we represent the nonprofit providers of senior housing and services across the state. And I'm not going to read through my testimony because much of what is in it has been said. But really we support LB649 on two points: one, the continued thoughtful dialogue on implementation, time line. When you look at managed care across the United States, 22 of the 50 states have rolled out managed care. And I think there's times when Nebraska wants to be an innovator and I think there's times when we want to kind of stand back and learn a few more lessons from those around us to make sure when this is implemented that it's done well and it's done thoughtfully. So I would just...if we move forward with managed care, that that January 2019 time frame maybe look at being pushed out even further. I hearken that back to Heritage Health with implemented January 1 of this year. And even though long-term care was not a part of that specifically, it did impact our members and the residents through DME, which is durable medical equipment, pharmacy, and some rehab pieces. And due to really no fault of anyone's, there's been significant challenges with that for our members and the beneficiaries around prior "auths" and authorizations, but I cannot echo enough how well Director Lynch and his Deputy Director Heather Leschinsky have worked at trying to resolve these issues. So I don't think there's fault in there; it's just when you transition any program to managed care, there's going to be bumps along the road. So the implementation time frame, we would request that even further beyond 2019, so that's the first one. And then second, which we've talked about, is I have not seen any quantifiable data that managed care improves care and saves money. So those are my two points and if there's any questions. [LB649]

SENATOR RIEPE: Okay. Are there questions of the committee? We're going to make sure that Courtney Miller and the Governor receive a copy of this transcript of this hearing for Director Lynch's benefit. (Laughter) [LB649]

JULIE KAMINSKI: And don't forget Heather too. [LB649]

SENATOR RIEPE: Oh, and Heather, okay. Thank you very much. Next proponent. [LB649]

VIRGINIA LEACOCK: (Exhibit 8) Good afternoon. My name is Virginia Leacock, V-i-r-g-i-n-i-a L-e-a-c-o-c-k. [LB649]

SENATOR RIEPE: Thank you. [LB649]

VIRGINIA LEACOCK: Thank you for allowing me to come today and provide comments. I am currently the administrator of Tabitha Nursing and Rehabilitation Center here in Lincoln, Nebraska. And just to give you a little bit of information about Tabitha, we are a non-for-profit organization that serves the elderly in 28 counties. We have an urban and a rural footprint for our

business. We provide complex continuum of elder care services that includes in-home support, innovative and creative living communities, rehabilitation services, skilled nursing, assisted living, and hospice. We also employ 1,000 individuals. I have worked in long-term care in Nebraska for 19 years. My career in long-term care spans 28 years. Just before coming to Tabitha I spent three and a half years in Arizona which is one of the first managed Medicaid states. A lot has been said today that reflects my concerns, so I'll just focus on a couple of areas that were experiences I had in Arizona as sort of a preview of what could possibly occur for providers and elders here in Nebraska. In short, administrative costs for providers went up and services for elderly were diminished. Insurance companies in Arizona chose to eliminate coverage for dental care, hospice, podiatry; essential transportation through an approved Medicaid provider was frequently unavailable; and probably most disheartening for me was the long waits that the elders experienced in utilizing mental health services. Much of the added cost, the administrative cost which for my largest facility in Arizona was upwards to $200,000 per year, were to deal with the administrative cost for requirements of documentation and reporting. And just a few of those requirements, but certainly not all of them, I have listed in my testimony and they include: prior authorization for services; weekly reports of beneficiaries' health status; frequent meetings with insurance companies to determine care plans and levels of care, and then frequent hearings to debate those determinations--even with appropriate documentation of caring services rendered to an individual, it was not uncommon to be approved for a level of care and payment lower than services that were rendered; rounding with nurse practitioners of the plans to determine care plans; annual compliance surveys in addition to the annual compliance surveys already conducted through the Health Department; complaint surveys on reportable items for APS and the Health Department even though those agencies already conducted their own investigations and surveys; quarterly quality measure reviews for these organizations; authorizations for speciality items such as DME, specialty beds, mental health services; and prior authorization for every resident transport event. Depending on a facility's size, the number of Medicaid recipients that they served, and the number of contracts that they had, case managers were frequently required to deal with on-site visits daily. The increased documentation and survey activity was expensive, it was oppressive, and it was overwhelming. As a provider at Tabitha, a facility based in home-based services, Tabitha is already on the front lines of managed Medicaid changes and it has been difficult. Long-term care providers want to be a part of this conversation, we want to be a part of the solution. We believe support of LB649 allows us that opportunity to look at the issues that have risen in other states, as well as our own, and to design a solution that addresses those issues. I would just like to add, in 2016, 58 percent of Tabitha Nursing and Rehabilitation's services were elders that needed Medicaid reimbursement. Tabitha as a whole utilized 40,239 Medicaid days in 2016. Tabitha is underfunded $30.06 per day which created in excess of $1 million loss for Tabitha in 2016. Again, I respectfully request that you advance LB649 to allow time for us to stabilize current issues while allowing providers to work with the department to evaluate those issues and create a service system that addresses payment and addresses access of services. My contact information

is included. Please feel free to utilize myself and Tabitha as a resource to answer questions, and I'm available for questions now. [LB649]

SENATOR RIEPE: Thank you, Ms. Leacock. Are there questions? Seeing none, thank you very much for testifying. [LB649]

VIRGINIA LEACOCK: Thank you. [LB649]

SENATOR RIEPE: We appreciate it. Other proponents. [LB649]

KARL BIEBER: (Exhibits 9 and 10) Good afternoon, Chairman Riepe and members of the committee. My name is Karl Bieber, K-a-r-l B-i-e-b-e-r. I am the public relations and communications coordinator at Vetter Health Services in Nebraska. Many of you know our CEO and founder, Jack Vetter. He founded the company in 1975 and, believe me, would have been here had it not been for just things that he could not arrange differently. So he sent me. I'm honored to be here in his behalf and to represent Vetter Health Services. Vetter Health Services provides services and living options for rehabilitation, independent living, assisted living, and skilled nursing across 30 locations. Twenty-four of these are in Nebraska, from Omaha to Grand Island, Hooper, Norfolk, Lincoln, North Platte, Alliance, Gering, Seward, Broken Bow, Loup City, Red Cloud, and on. Based on our experience in other states--other states that we also operate include two in Iowa, one in Kansas, and two in Missouri, and we also manage one in Wyoming--based on our experience in other states, we have concerns about including nursing facilities in managed care and the impact this may have on the quality of care and continued access to services for older Nebraskans. Skilled nursing facilities have helped coordinate and integrate the care of residents for years. We know these individuals, their needs, and their wishes, and are committed to providing person-centered care that recognizes and supports their choice and preferences. Our residents' outcomes and our facilities' successes at providing their care are publicly reported and readily available. That's why we, Vetter Health Services, and others are unclear why there is a need for the state to pay additional funds to insurance companies to duplicate the work already being done essentially by our facilities. Although the managed care organizations may have the best intentions, they do not know our residents as we do. Even reviewing their clinical records would not give them the complete and accurate picture of the individuals. Our teams know those individuals residing in our facilities as whole and complete people. They're in the best position to coordinate and integrate their care in collaboration with the individual and with their family. Vetter Health Services supports LB649. Thank you for your consideration of the bill, and we hope you will advance it to General File. [LB649]

SENATOR RIEPE: Thank you very much. Questions from the committee? Senator Linehan. [LB649]

SENATOR LINEHAN: Thank you, Chairman Riepe. Thank you for being here very much. What percentage of your client base is Medicaid? [LB649]

KARL BIEBER: In the state of Nebraska, I can't give you an accurate estimate. [LB649]

SENATOR LINEHAN: That's okay. That's fine. I'm just... [LB649]

KARL BIEBER: It varies from facility to facility and I would venture to say it is under 60 percent, under 60 percent. [LB649]

SENATOR LINEHAN: Okay. All right. [LB649]

KARL BIEBER: I could...I definitely will get a more accurate figure for you. [LB649]

SENATOR LINEHAN: No, no. That's fine. That's fine. I could just stop by because you're right next to my house. But thank you very much for being here today, appreciate it. [LB649]

KARL BIEBER: Absolutely. I also have submitted a letter from Mr. Vetter to the Chair. [LB649]

SENATOR LINEHAN: I saw that. [LB649]

SENATOR RIEPE: Senator Williams. [LB649]

SENATOR WILLIAMS: Thank you, Chairman Riepe, and thanks, Karl, for being here. [LB649]

KARL BIEBER: Absolutely. [LB649]

SENATOR WILLIAMS: I asked the question, you heard me ask the question earlier, and you represent and your institutions are those, many times, those smaller facilities and communities like Broken Bow. [LB649]

KARL BIEBER: They are. [LB649]

SENATOR WILLIAMS: What would that cash flow difference do to you... [LB649]

KARL BIEBER: For... [LB649]

SENATOR WILLIAMS: ...if that were to come to pass? [LB649]

KARL BIEBER: Well, I believe there is a budget proposal right now in the state of Nebraska for a 3 percent reduction in Medicare. Are you referring to that? And... [LB649]

SENATOR WILLIAMS: No, excuse me, the... [LB649]

KARL BIEBER: For Medicaid? [LB649]

SENATOR WILLIAMS: There was testimony earlier that right now the reimbursement period, how quickly you're getting paid for Medicaid... [LB649]

KARL BIEBER: Yeah. [LB649]

SENATOR WILLIAMS: ...is in that week to eight days... [LB649]

KARL BIEBER: Yes. [LB649]

SENATOR WILLIAMS: ...versus what might be longer than that. How does that cash flow affect an organization like yours? [LB649]

KARL BIEBER: Okay, Senator, that...candidly, we have the advantage of being a large organization. We turn the majority of our profits back into our facilities but we do have a cushion, so we could adjust accordingly for a short amount of time. It would hurt some of our smaller facilities but, because we have 30 facilities, we could adjust for it. [LB649]

SENATOR WILLIAMS: You have that capacity, okay. [LB649]

KARL BIEBER: It would not have an immediate devastating impact but it would definitely cause an adjustment of funds for things that we'd already thought we'd planned for. [LB649]

SENATOR WILLIAMS: Thank you. [LB649]

SENATOR RIEPE: Senator Kolterman. [LB649]

SENATOR KOLTERMAN: Thank you, Senator Riepe. Thanks for coming today. [LB649]

KARL BIEBER: Absolutely. [LB649]

SENATOR KOLTERMAN: Are Vetter...we appreciate what you do in Seward, as well. Are Vetters...is that a not-for-profit or a for-profit corporation? [LB649]

KARL BIEBER: Currently it is a for-profit organization owned by Jack and Eldora Vetter. [LB649]

SENATOR KOLTERMAN: Okay, thank you. [LB649]

SENATOR RIEPE: I think Senator Erdman had a question. [LB649]

SENATOR ERDMAN: Thank you, Senator Riepe. Thank you for coming. Your facility in Gering, can you tell me which one that is? [LB649]

KARL BIEBER: In...oh, in Gering? [LB649]

SENATOR ERDMAN: Gering. [LB649]

KARL BIEBER: Our facility in Gering, Nebraska, is Heritage Estates care center. [LB649]

SENATOR ERDMAN: Okay. Did you used to have one in Bridgeport as well? [LB649]

KARL BIEBER: We did years ago. We had one in Bridgeport. [LB649]

SENATOR ERDMAN: And you sold that to the city. [LB649]

KARL BIEBER: I believe so, yes. Yes. [LB649]

SENATOR ERDMAN: Okay, thank you. [LB649]

SENATOR RIEPE: Okay. Are there other questions? Seeing none, thank you very much for being here. [LB649]

KARL BIEBER: Thank you, Senator. [LB649]

SENATOR RIEPE: Additional proponents, please. Welcome. [LB649]

MARK INTERMILL: (Exhibit 11) Good afternoon, Senator Riepe and members of the Health and Human Services Committee. My name is Mark Intermill, M-a-r-k I-n-t-e-r-m-i-l-l, and I'm here today on behalf of AARP. Based on the draft report prepared by the consultants, it appears as though the intent of the administration is to pursue capitated managed care for Medicaid long-term care services. We're skeptical about the advisability of capitated managed care in Nebraska. We're willing to be convinced but we have yet to see compelling evidence that there's a problem in the long-term care system that can effectively be addressed by capitated managed long-term care. We do appreciate the planning process that the department has engaged. We have reviewed the report and find good information about the long-term care system as it currently stands. It reminded me of a long-term care planning process that took place back in 1997 that set in motion the events that produced the long-term care system that we currently have. The major initiatives of that process were to increase access to home- and community-based services through the aged and disabled waiver, and also the development of assisted-living facilities as a residential long-term care option. In terms of making the system more efficient, which was a motivation back in 1997, there is evidence that it has been successful. In the ten years leading up to 1997, the average growth in Medicaid was, the average annual rate was about 12 percent. Since 1997, the average rate of growth has been less than 3 percent so we have substantially contained the cost of Medicaid by employing some of these tactics. If Medicaid's 65-plus spending had grown as fast as General Fund revenue from 2000 to 2015, we would have spent an additional $120 million for Medicaid services for people over 65 in 2015. We do support actions to make the system more efficient and effective. We support this bill because it calls for evidence that there would be a net advantage to moving to a capitated managed long-term care system prior to starting it. I'd be happy to answer questions. [LB649]

SENATOR RIEPE: Thank you very much. Are there questions? Seeing none,... [LB649]

MARK INTERMILL: Thank you. [LB649]

SENATOR RIEPE: ...thank you very much. Are there more proponents? Okay. [LB649]

BRETT HOOGEVEEN: (Exhibit 12) Thank you very much. Brett Hoogeveen, B-r-e-t-t H-o-o-g-e-v-e-e-n, director of provider relations for Quality Living, Inc., or QLI, in Omaha. [LB649]

SENATOR RIEPE: Thank you. [LB649]

BRETT HOOGEVEEN: I'll try to keep this concise. We appreciate the committee hearing our testimony today. I think most of you are familiar with QLI and hopefully most of you I think have visited our campus. And so you're aware of the high-quality, cost-effective, specialized services that we provide for folks with brain and spinal cord injury primarily. We hope you also know how much we value the partnerships that we've had over the last 27 years with the state, the Department of Health and Human Services and the Legislature alike. With that in mind, I'd like to endeavor today to not be a self-interested stakeholder. I'd like to approach this with common goals in mind, and then we hope that some of our expertise can be helpful as we move this forward. We know the state budget needs to be balanced and that long-term spending definitely needs to be curbed to make that happen. So QLI is the preeminent center of our kind in the whole country and we serve patients from coast to coast that come into Omaha for our specialized services. We're contracted with nine states for Medicaid reimbursement, and those are states that send their state tax dollars out of state to QLI for the unique and remark...the efficient services that we provide. It's been our experience in working with a lot of...several of those states and managed care systems that the managed care system for Medicaid may just not be capable of appropriately managing care with true long-term interest in mind. And I want to speak to a conflict of interest that we've seen in our unique, specialized setting. But we see that the MCOs are certainly incentivized to control costs in the short term but don't have any real obligation to consider the long-term picture, the true long-term picture. Long-term when it comes to the types of injuries that we see are folks that, you know, have long rehabilitation periods and long, complicated discharge plans for life. And the MCOs aren't incentivized to account for long-term care services in the short term, say the year or two that that member might be on their plan, but not necessarily the next 20, 30, 40, 50 years with the types of individuals that we serve. They're not likely to stay with that MCO over that period. In just the two and a half months that Heritage Health has been in place, we have seen a few of our folks adversely affected, our long-term care clients, in cases where we've had unnecessarily long hospital stays due to troubles with authorization and getting people to our lower level of care. We've seen a fairly complete "unacknowledgement," basically, of cognitive and behavioral issues. So physical, medical issues the MCOs are very comfortable with, but more complicated cognitive and behavioral issues that can have significant long-term effects is not their speciality. And we've seen that they have an inability in most cases to look at the big picture and they're not able to do what makes sense for each individual in the same way that the state has been able to in the past, in our experience. We've talked with most of the MCOs and it's our impression that several of these issues are not nearly short-term bumps in the road but, instead, are part of the unintended consequences of a system to which there is currently no solution and no discussion of a solution to some of those issues. It's been our experience with previous managed care systems, and now with Nebraska's Heritage Health, that we are quite concerned that managed care might do the opposite of what it was intended to do and will actually increase spending, especially for some of these specialized long-term care populations. I do want to echo some of the comments that we've heard earlier that in our experience and my experience the Department of Health and Human

Services and their team have done a good job managing the complex needs of this population and I would submit they've made good decisions in a timely manner. And I think a couple of the reasons are for that is their staff really knows and understands us as a specialized provider here in the state. We've worked very hard with the MCOs at home for several years and in other states that have worked with us, and we've not been able to get them to understand us as a specialized provider in the same way that our own state does, and understand how to utilize us. And the state has also over the years not just looked at data in very strict and rigid rehabilitation or level-of-care tools. They've been willing to look at each person individually and see what makes sense for that individual. So with that being said, we're asking you to approve the LB649 and also to designate a reasonable period of time where solutions, potentially other than managed care, might be explored. Thank you. [LB649]

SENATOR RIEPE: Okay, thank you. Are there questions from the committee? Seeing none, thank you very much. Additional proponents. Have we...everyone that's in favor testified? Those in opposition, the opponents, please. [LB649]

CALDER LYNCH: (Exhibit 13) Well, good afternoon, Mr. Chairman, members of the Health and Human Services Committee. My name is Calder Lynch, for the record that's C-a-l-d-e-r L-y-n-c-h, and I'm the director of the Division of Medicaid and Long-Term Care at DHHS and I'm here to testify in opposition to LB649. You're receiving copies of my written testimony; however, I'm going to not read that and, instead, take a moment just to hit a few high points and maybe respond to some of the concerns that have been raised here this morning. I first want to say that our concern and opposition to the bill is not because we don't believe that this issue deserves careful study. And in fact, we've been engaged in a process to do that over the last year and a half. My concern is primarily around some of the language that's used around the conducting of a critical evaluation until such time that the success of that program can be proven. And I just am very uncertain as to what that means in terms of what a critical evaluation looks like and what it means for it to be proven, and proven to who. You know, we certainly, regardless of what happens with this legislation, are committed to remaining engaged with this committee, with the providers, with the stakeholders and advocates in designing a program that does work for our state. I want to take a few minutes just to hit a few high points. I think we've heard some really great testimony today, some real issues that need to be put on the table and examined and explored. We're all here together to be good stewards of the dollars that are entrusted to us to care for the folks that are entrusted to our care and to do so well. I think that we...there's a lot of...there were a lot of concerns raised today specifically regarding nursing facilities, and nursing facilities are a critical part of our long-term care system. We have over 18,000 people that receive long-term care services funded through the Medicaid program. Of those, about 37 percent do so in nursing facilities. So while that's a critical component, it's not the only component. And our job and role and responsibility as the department is to take that big picture approach at looking at our long-term care system. And a lot of our goals with regard to the long-term care redesign is to

create a system that looks like it was designed on purpose, that provides a front door for folks to be able to come in and get consistent assistance and help in guiding them to resources that help them live as independently in the community for as long as possible. It costs about half as much to serve someone in the community than it does to serve someone in an institutional setting like a nursing facility. And I think it's everyone's goal to help individuals live where they want to live and do so in the most cost-effective manner. Today we have a health...a Medicaid program in which nearly all of our enrollees are enrolled in one of three managed care organizations, and nearly all of their services are delivered through that MCO, meaning they have a more integrated approach to developing care plans and helping that member navigate the system. The long-term care sits in isolation to that. And that's really our goal with regard to moving forward is to create a system that is integrated, that is able to serve the whole needs of the individual, to look at that big picture and help develop plans and provide assistance to navigate individuals to the settings of care that they want to be in and that are most effective and deliver the best outcomes. You know, we heard a lot about privatization and it's true that there are functions as part of this that the MCOs would take that are currently being done today, claims payment, for example. But I can tell you, while we may be fast, we're not always good. And we have a claims payment system that was built in the 1970s and it's difficult to manage and to update and modernize, and we have to replace it one way or the other. So whether it's through shifting toward MLTSS, in which we're integrating this with our other programs, or through another means of purchasing the services from, for example, United HealthCare, who is our currently contracted claims broker, to eventually take over that...the fee-for-service claims processing from the state, the way claims are being paid are going to have to change. And that's a big change and we need to be "planful" and thoughtful and make sure it's well tested and providers can get paid in a timely manner, in a predictable way, and we don't impact the cash flow. And that's an important commitment that we have to make and we are making, no matter how we move forward. We have three plans that operate in Heritage Health. Other states have many more, so I think that's important to think about that. We've not budgeted savings related to this. We know this is about bending the cost curve and helping improve outcomes and serve members more effectively. We have explored other options. That's part of the paper. I don't think it's by accident that we've gone from ten states with MLTSS in 2010 to 22 today. It is becoming the best practice and we are learning a lot from lessons from other states and intend to incorporate those. And I think, you know, there's other models that have been put out there, the ASO model. Certainly I think there's conversations we can have about that. I can tell you that under the federal regulations, as mentioned I think by you, Senator Riepe, you know that that's not...the state is still retaining that risk. We're still bound by the federal regulations around payment and service reimbursement and they don't...and that model doesn't provide the flexibility that the MLTSS model does. There does need to be protections in place. We do have a long-term care ombudsman in the department. There is an ombudsman here in the Legislature. And we think there's roles and responsibilities for those entities as we move forward in this model. We heard a lot about specifically two other states--and I'll wrap up, Senator--near us, and perhaps they don't provide the best examples of a

well-executed implementation. And that's really got to be our commitment that no matter how well the policy is designed, the execution is what's critical and taking our time to be thoughtful and "planful" of that and have these dialogues to make sure that it is a well-designed and well-implemented program so there's not disruption. And so we're going to have some testimony I know after me from some plans that have brought folks in that do have some other examples to share. I've asked them to please keep that brief and concise because I know everyone has had a long day. But this is a very important topic and I appreciate all the time that the committee has taken to hear this dialogue and look forward to answering your questions. [LB649]

SENATOR RIEPE: Do you have other key information that we need to hear? [LB649]

CALDER LYNCH: I would just say that, you know, for us, this really is about looking at the big picture. And we heard...you know, I think it's interesting. I'd just note that, you know, while we heard a lot of testimony, I think it was from a perspective that is not the whole perspective of the program. You know, there's a lot of other pieces to the long-term care delivery system that have to be taken into account. You know, the...and I think one in particular area I would say is that, you know, there's a lot of concern about payment and profits and being able to be sustainable, and those are important conversations. Our health plans are capped in their current contracts at 3 percent profit for the first year. That drops to 2 percent thereafter. But the way we build the rates, we only build in an assumption of 1 percent and they have to, well, for one, run the program well in order to achieve that. And I think the issues that exist on the rate side for the providers is something we need to address independently or coinciding with this discussion with regard to our current methodology that's been in place for many years. And I'd open that dialogue and really appreciate everything the associations have done to bring their members to the table for the conversation and participate in this discussion. And I do share that feedback that it has been a very collaborative process, and even though we might not always agree, we've enjoyed that dialogue. And, you know, I think there's evidence that it is working because in the July rates that we're in the process of setting for the current Heritage Health plans, we're forecasting a 1 percent reduction in those rates based on recent utilization. So, you know, we do ratchet down when necessary. It's not an "evergrowth" for that and I think that does demonstrate some of the evidence that managed care can work. And I think we heard testimony that the growth rate in the Medicaid program dropped in 1997 from 12 percent down to 6 percent. I don't know. I can't validate those numbers off the back. But I can tell you that we implemented managed care in 1996 in Nebraska, starting in the Omaha area, which were the majority of...or the urban markets, which were the majority of our clients. So I do think that there is a correlation to that. [LB649]

SENATOR RIEPE: Okay, very good. Other questions? Seeing...oh, Senator Kolterman. [LB649]

SENATOR KOLTERMAN: Go ahead. [LB649]

SENATOR RIEPE: Senator Williams. [LB649]

SENATOR WILLIAMS: Thank you, Chairman Riepe. And thank you, Director, again. Two things I wanted to touch on. One is you mentioned the caps and the profit in that cap. Can you tell me what the administration fee portion would be in those contracts that's a cost to the state? [LB649]

CALDER LYNCH: Absolutely. So first I would say that it's not an additional cost because, as we develop the rates, you're taking that whole cost into account. And we...and it's difficult. You know, one of the things we've...I've been asked for is to show us, well, what did it look like before managed care and after? Well, we've had managed care for so long in Nebraska that that baseline data just isn't relevant to the experience today. But I can tell you that growth rate has been low in those services. You know, those rates, those are built around a cost of care and then an administrative component which includes efforts to do case management, improve quality, measure outcomes that I think add a lot of value. We have an 85 percent medical loss ratio in the current contracts, which means that 85 percent of every dollar has to go directly to qualifying, you know, activities and reimbursing for care, essentially. So then there's administrative quality activities and any profit that's associated with that. I think there's value in those dollars. You know, we've often heard that states have incredibly low administrative costs in the Medicaid program, 1 to 3 percent, and that that's somehow a success, a sign of success. I don't agree. I think, you know, as a payer, as an insurance company, which we are essentially, it's worthwhile to invest in some of those activities around making sure that we are developing good contracts with providers, managing a good network of providers that can deliver quality access to our members, measuring quality and doing quality improvement projects, performance improvement projects, employing case managers to work with members, to do outreach with members, and make sure they're navigating the system effectively and getting the assistance they need, getting help getting into appointments when necessary, following up when they've been in the emergency room to see why they may have perceived a barrier to going to a primary care setting and helping them establish that connection. Those are things I don't have the resources to do within the state government apparatus that I operate. [LB649]

SENATOR WILLIAMS: And the final thing, it was brought up by the opponents the argument of too big to fail. I happen to work in an industry that has to deal with that on a daily basis. You have had the experience and Nebraska has had the experience of working in managed care in some other areas, and you're dealing with a few companies there. Would you give me your view on the concept of too big to fail and whether you would feel uneasy only having that many providers or that few providers. I'll put it that way. [LB649]

CALDER LYNCH: Thank you, Senator Williams. The choice of three plans is not by accident. You know, we're balancing the, you know, administrative complexity that is added to the system by the fact that there's multiple payers. And there's a lot of things that we can do to help address that through the work of our administrative simplification committee and the state ensuring that there's consistent policies and practices between the plans. But to go fewer than that would put us I think in a more challenging position. By having three plans, I can kick one out, frankly. You know, if there's a need and a reason for a quality or a performance issue or a financial issue, or they're coming in and saying that I can't make it on these rates, where the other two plans can, I can balance that by terminating that contract, redistributing membership, and re-procuring a third plan. We're required under federal regs to have choice for our members, so you've got to have more than one. But when you only have two, then you're put into that untenable position. So having three is purposeful. That's very rare. You know, contract terminations and those types of activities doesn't happen often. And I think it's the role of the state to have a positive and productive business relationship with their plans, but we also need to hold them accountable and hold them compliant to their contract and we do that by having good rate setting, good contractual terms, and employees that are managing and monitoring their performance on a daily basis. [LB649]

SENATOR WILLIAMS: Thank you, Director. [LB649]

CALDER LYNCH: Absolutely. [LB649]

SENATOR RIEPE: Very good. Senator Kolterman. [LB649]

SENATOR KOLTERMAN: Thank you, Senator Riepe. Calder, thanks for coming and giving us a briefing earlier. And I won't talk to you about my concerns about the rollout of Heritage because we've already talked about that. But I do have a couple questions that I feel need to be answered. First of all, LB649, as I understand, and this was raised earlier, runs simultaneously to what with your rollout. So if we were to approve this bill and we get to the end of the time and we discover that this just isn't going to work, will we have invested a lot of money for naught? And if so, would we be better off waiting before we go any farther with managed care and let this work its way out? [LB649]

CALDER LYNCH: Uh-huh. [LB649]

SENATOR KOLTERMAN: And then the second part of my question is, would you be open to some sort of a pilot project? And my rationale behind that is several years ago I was not serving here but they tried to privatize behavioral health and HHS and aspects of that, and in my district I watched them set up an office, back the office out, two years later they came back and put the

office in, and there was chaos. I don't want to see that happen to nursing homes like it happened there. So would it make more sense to walk cautiously? When we used...when we tried a single payer health program, can't think of the name of it now, but it was out...there was two pilot projects. One was in Lexington, Nebraska. And we tried those before we went any farther and that seemed to work. And all the managed care companies were involved in that project. Any thoughts along those lines? [LB649]

CALDER LYNCH: Thank you, Senator. To address the first part of your question, you're right in that the time line is not inconsistent with our draft proposal of bringing in the aged and adults with disability population in 2019, in January of '19. My concern is I think it puts the state in a questionable, even legal, position perhaps of what does it mean for us to prove that the program is going to be, and let me find the exact language, that the success of the program is proven? And who is going to determine whether that burden of proof has been met? And what, you know, is or is not a critical evaluation? And certainly I think our intention of doing that, of continuing this dialogue with the draft plan, taking feedback, addressing those concerns, you heard earlier that the folks that have been working with us as our consultants are also doing a separate research project to demonstrate some of the value and outcomes of MLTSS programs in gathering some of that data from other states. And we're certainly excited about making that information available and using it to inform, you know, our policy design around this process. But I think putting this language in statute could put us in a difficult position where maybe the department believes that we've proven it but maybe others don't. And it's unclear who gets to make that decision of whether that's happened or not. And so I think that's concerning to me. And I think rather, we believe that we'd like to continue in the efforts that we've employed of having this dialogue and we'll be back next session, before anything is implemented, where I expect we'll continue to have this dialogue with regard to how these plans are unfolding. [LB649]

SENATOR RIEPE: Okay. Satisfied? Any more questions? [LB649]

SENATOR KOLTERMAN: Well, I...yeah, I just want to finish up... [LB649]

SENATOR RIEPE: Go ahead. [LB649]

SENATOR KOLTERMAN: ...with that. I appreciate your response, but wouldn't it be easier to prove if we had a pilot project go with that? [LB649]

CALDER LYNCH: Oh, sorry, the pilot project, yes. I'm sorry. I forgot to respond to the second part of your question. You know, this is a draft plan and so everything, you know, in that regard is still under review and we're still accepting that feedback. And I think to put it forward, that's something we'd have to look at seriously and consider whether it makes sense to phase in an

implementation. There are challenges with that as well. So you've got to evaluate the pros and cons of doing that. You know, starting in a region, for example, means you're operating two different systems simultaneously and you've got to have an administrative framework in place to be able to do that, and that could add some cost. So we would just need to evaluate and look at and come up with what the best decision would be. [LB649]

SENATOR KOLTERMAN: Okay. Thank you. [LB649]

CALDER LYNCH: Thank you. [LB649]

SENATOR RIEPE: Okay. Senator Crawford. [LB649]

SENATOR CRAWFORD: Thank you, Chairman Riepe. And thank you, Director, for being here. I have two questions. The first comes back to the question of making sure we're ready. And I do appreciate your attention to having the plan, being very transparent about that; having these stakeholder meetings and getting input. I think that's great. So...and I understand your concern about the language in the bill about what does it mean to prove. (Laugh) So I guess I'm going to ask you: What do you see as a key readiness factor that will make you feel comfortable to say, yes, this time line is appropriate and we should continue? [LB649]

CALDER LYNCH: Uh-huh. [LB649]

SENATOR CRAWFORD: Is it...or is it pretty much driven by the time frame and at this date we're just...we're going to make sure we're ready? Or do you have in your mind a few things that you know we have to have these things in line before we hit that date, before we can say it's an appropriate date? And what proves to you that you think we're ready? [LB649]

CALDER LYNCH: Absolutely. Thank you, Senator. I would say...you know there's a lot of different pieces to that. You know, as outlined in the draft report, we believe that there are some critical steps that the state needs to take to prepare for a shift in the delivery system, you know, improving that front...the entry into the system, that "no wrong door" approach; addressing some of the challenges. You know we didn't talk much at all today but we've got some enormous challenges with regard to the in-home services that we're providing in our state, the Personal Assistance Services Program. We've got over 3,000 individual providers, many of whom are relatives of the folks that they're providing care for. And I'm not against relatives providing care, but we've got to have an infrastructure there that can support that member and that provider and make sure that care is being delivered effectively. And just handing that situation over to the

MCOs without some work to stabilize that I think would be a mistake. So we've got some work to do... [LB649]

SENATOR CRAWFORD: Okay. That's good. [LB649]

CALDER LYNCH: ...to get ready for that. And there are some things in the budget related to that, of putting a fiscal agent in place to help manage some of that claims processing for us--right now it's very manual--you know, because I don't want to hand these problems over to the MCOs and then have the program or the plans be blamed for the disruption related to trying to get those addressed and fixed. And so that's got to be a more thoughtful and "planful" approach so we have to have time to do that. We have to have time for this dialogue. I think one of the benefits of the approach we're taking under the recommendations of the plan is that we've already got contracts with these three health plans in place. We're not necessarily going to go back through another procurement process which could further delay. There's always protests and whatnot. So we can start working now, knowing who those partners are, working with the providers and the plans to make sure that they understand the specificities of what billing is going to look like, what prior authorizations are going to look like, what making sure that providers are ready and understand how they need to work with those plans, submit claims, figure out where there may be some of those things we didn't think about that need to be addressed before we pull the trigger and making the switch over so that there's a long and "planful" opportunity for that. I think this gives...I think the year and a half, you know, more than a year and a half that's currently proposed allows that. But that time line is up for input as we put it out there. And if we need to tweak that or make adjustments to it based upon what we discover as we move through this process, we're absolutely willing to do that. [LB649]

SENATOR CRAWFORD: Great. And the last question is really a question I get from constituents in terms of explaining what we would be doing or the advantage that we would have in moving to managed care. And that's just a question of, if we're currently providing this care at a very low margin, how do we add an opportunity for managed care organizations to make it worth their while to come to our state and offer these services and save money, because it feels like, seems like that that's...adds a layer of things that you have to pay for? And so how would you explain that to my constituents in a simple way? (Laugh) [LB649]

CALDER LYNCH: And I will...let me try, let me do that. So there is value in some of the activities that the plans take on that states haven't historically done in fee-for-service environments, and that happens in multiple different levels. So we recently...we're in the process, rather, of doing an analysis with our actuary of running our claim data history through some advanced algorithms and looking at where there might be avoidable episodes of care,... [LB649]

SENATOR CRAWFORD: Okay. [LB649]

CALDER LYNCH: ...so preventable hospital readmission or admission or waste in the system because they ended up back in the ER with something that was an avoidable complication, for example. And there's a lot of really good data that helps to determine what those are and can mine the data and extract those episodes. Based on some preliminary analysis, we've got about 6 percent of our total spend through the MCOs that they can trigger to potentially avoidable episodes of care. So there's some opportunity for efficiency there. But...and they're working on, in another state, for example, that's 100 percent fee for service today, they're at over 20 percent of their spend attributable to potentially avoidable episodes of care. [LB649]

SENATOR CRAWFORD: Interesting. Okay. [LB649]

CALDER LYNCH: So I think that demonstrates some of the value the plans have brought to us historically of avoiding some of those unnecessary costs. From the long-term care perspective, it's different,... [LB649]

SENATOR CRAWFORD: Right. [LB649]

CALDER LYNCH: ...although it's still relevant. These members are in those plans today so they're already working with them to look at how do we avoid hospitalizations, because they are on the hook for those costs... [LB649]

SENATOR CRAWFORD: Uh-huh. [LB649]

CALDER LYNCH: ...and things of that nature. We're going to continue to see a growth in our long-term care spending, no doubt, just from the fact that we've got a population that's continuing to age and more and more people every day who are needing services for long-term care. So this is I think more about creating a system, that can help deflect some of that cost growth by moving upstream and trying to help individuals before they get to that critical level where they need that level of care necessarily in an institutional or 24-hour type assistance but better, rather, connecting them to those resources earlier, getting them a little bit of help maybe that keeps them in the home for longer and helps get them back into the community sooner after a hospitalization and a skilled stay by putting together the necessary discharge planning and care planning and connecting those different resources to help that individual return to that setting of care. I think those are some of the pieces that are missing today that if we design it right this program can help us achieve. [LB649]

SENATOR CRAWFORD: Great. Thank you. [LB649]

CALDER LYNCH: Thank you. [LB649]

SENATOR RIEPE: Okay. Thank you. Are there other questions? Director Lynch, thank you very much. [LB649]

CALDER LYNCH: Thank you. And I will note that while they won't be coming back to testify, the folks from Mercer NASUAD are still here if the committee has additional questions for them. [LB649]

SENATOR RIEPE: Okay. Thank you, sir. [LB649]

CALDER LYNCH: Thank you. [LB649]

SENATOR RIEPE: Opponents. [LB649]

LORI CETRINO: (Exhibit 14) Good afternoon. My name is Lori Cetrino, L-o-r-i C-e-t-r-i-n-o. [LB649]

MARION SMAYDA: (Exhibit 15) Marion Smayda, M-a-r-i-o-n S-m-a-y-d-a. [LB649]

LORI CETRINO: Marion and I are nurses and we're from WellCare Health Plans of New Jersey. Our testimony is a little bit different. We just want to explain our model up in New Jersey and why we felt it was successful. I'm here today because the Nebraska market invited us to speak to you because of our success with the MLTSS program. For many years the state managed the MLTSS population through the waiver programs. They "vendored" it out and along had in-house care managers. There was a time... [LB649]

SENATOR RIEPE: Can you make sure you talk into the mike? [LB649]

LORI CETRINO: Oh. I'm sorry. [LB649]

SENATOR RIEPE: And thank you. That will be helpful for our transcribers. [LB649]

LORI CETRINO: So a few years ago the state recognized that this design needed to have some tweaks and they decided to put it out to the MCOs. So presently there are five MCOs in New Jersey that have MLTSS and we call ourselves "The Five Families." What we have together is more of a partnership with the state. They are very involved with what we do. We each have the same contract, so no matter what MCO is in a nursing home or in the community, we're all doing the same thing. As far as WellCare's New Jersey MLTSS program, I'm just going to highlight a few points. So our program has designed an infrastructure that wraps services not only around the member but the caregiver as well. This meets the needs of our most vulnerable population with a member-centered approach to care planning and service delivery. MLTSS services and care management help to decrease hospitalization and ED utilizations while allowing our members to stay in their homes longer, which in turn can decrease unnecessary institutionalization. For many members the scope in services have increased as a result of the MLTSS program. MLTSS also allows the care manager to have complete, comprehensive view of each member, such as the ability to see gaps and fill those gaps, to see any duplications and eliminate the same; single point of contact, all questions answered and outcomes facilitated by the same person; elimination of the administrative burden to the state as each MCO will incur these activities; allowing the state to offer training, collaborative meetings, workshops, and oversight of the MCOs. The actual model of care can be designed by the state based on their needs. Our commitment to reshape long-term care to align with the state's goals, to ensure every member receives the highest possible quality of life and remains safely in their own homes or the least restrictive environment of their choice. In conclusion, I want to say that MLTSS works in New Jersey because we have a great relationship with the state. They are our partner and very involved, like I said, with all the MCOs. Also, the MCOs aren't in competition with each other as far as MLTSS. We meet monthly with all the MCOs and the state. We have a quality workshop. We discuss what works, what are our challenges, maybe things that need to be tweaked. We're very transparent. We also have twice-a-month phone calls with the state, each MCO does. We discuss our enrollment, where we feel it's going, where we think that maybe there's room for improvement. I think that in New Jersey, and I'm going to say this off the record--well, on the record here (laughter)--this isn't in my script, Marion and I both came from home care so neither one of us really thought about ever working for an MCO. I hate to say that, but that was the truth. In home care, it wasn't even a possibility. But when I heard about the MLTSS program starting, Marion and I felt really intrigued. And when we started to see what it was that they were building, I have to be really honest, I wouldn't go anywhere else and this would probably be the job that I would retire from. [LB649]

MARION SMAYDA: Uh-huh. [LB649]

LORI CETRINO: So I just want to allow you to present one success story, very shortly. SP is a 28-year-old female currently living in an apartment set up through the MFP program. This is the "money follows the person." This member has a history of depression, rheumatoid arthritis, and

MS that progressed very quickly around 2013. She was living with her brother who can no longer care for her so she was placed in a long-term care facility for approximately two years. She spoke with her care manager about wanting to go back into the community. And after multiple interdisciplinary team meetings with the state, the facility, and WellCare, we were able to furnish her with an apartment, build ramps, and expand openings to doorways to make mobility easier for her. Along with this, the care manager was able to get her a computer table so she could work. SP now works for the Department of Human Services, Division of Developmental Disabilities work force program. She's absolutely thrilled to be back in the community. Thank you. [LB649]

SENATOR RIEPE: Okay. Thank you very much. Let's see if we have some questions. Are there any questions from our committee? Well, thank you and welcome to Nebraska. [LB649]

MARION SMAYDA: Thank you. [LB649]

LORI CETRINO: Thank you so much. [LB649]

SENATOR RIEPE: This is typical weather here. (Laughter) [LB649]

LORI CETRINO: I have to tell you...and we were in time for the party last night, so it was great. [LB649]

SENATOR RIEPE: We have people from San Diego moving here all the time. (Laughter) [LB649]

LORI CETRINO: We'll come back. Love it. Thank you so much. [LB649]

SENATOR RIEPE: Okay. Thank you. [LB649]

MARION SMAYDA: Thank you. [LB649]

SENATOR RIEPE: Thank you very much. Other opponents, please come forward. Sir, if you would just state your name and spell it and then proceed on. [LB649]

PAUL SOCZYNSKI: (Exhibit 16) Good afternoon. Thank you for the opportunity to address you today. My name is Paul Soczynski, P-a-u-l S-o-c-z-y-n-s-k-i. My wife is Irish and today she tells me that's an Irish name regardless of its origin. (Laughter) I'm the executive director for Complex

Care for United HealthCare Community and State. We currently support the needs of members living in nursing homes and those living in the community with the support of home and community-based services through managed long-term care services in 13, soon to be 14, states. This rewarding and humbling experience serving LTSS individuals is not new for United HealthCare. In fact, we've been partnering with states to serve these individuals for more than 30 years, the longest standing of which is Arizona, known as the Arizona Long-Term Care or ALTCS. So over those three decades we've worked with our state partners to provide, to create, an approach that is member-centered, helping our members achieve their individual goals. For some of them that means living independently in the community regardless of the complexity of their needs. For others it means finding and keeping a job that increases their independence and meaning of life. And for some that means living in a nursing home where they feel safest and most secure. The personal nature of the care we provide is founded on a robust practice of assessing individual needs for physical health, behavioral health, functional limitations, and social needs. This assessment information, along with personal relationships with the member and their families, as appropriate, with their care manager serves as the basis for development of personalized care plans centered on monitoring alignment with their goals. Managed long-term care services and supports, particularly when designed as envisioned here to serve Nebraskans, creates a foundation of accountability to comprehensively address the needs of individual members, anticipate future needs, and align services that are best suited to achieve member-centered goals. States can achieve financial predictability for their long-term care services in two ways: first, by transitioning the cost of long-term care services and supports to capitation; and second, by creating financial incentives and early identification of individuals who may be at risk for institutional care. Capitation, as you know, is a financial approach for which states pay a set amount to a managed care organization for the care of a specified population. The set amount is the total liability that the state incurs and the costs for that population are paid over a monthly basis. The state is not liable for any...is not liable, as it is today in the current model. Through the use of capitation, the state limits its financial exposure by transitioning the risk to the managed care organization. In addition to assisting states and addressing financial pressures associated with complex care populations, managed care, long-term care services and supports can help states improve outcomes and quality. At their core, these programs are intended to reduce the numbers of individuals who need institutional care, which is a goal held by most of our members in our 13, soon to be 14, states. They're also designed to reduce reliance on hospitals and emergency rooms and improve the management of chronic conditions, like diabetes and high blood pressure. Improvement of traditional measures is extremely important to us. We believe that improving the quality of life for our members is equally as important. To that end, in collaboration with a group of national experts, united through its Complex Population National Advisory Board, have developed and deployed a set of quality metrics to help us determine if our model of supports are positively impacting members' quality of life. These measures include things like monitoring members and where they're living, where they choose to live, and have the ability to participate in their community and support...including supportive employment.

Managed long-term care services and support programs are fundamentally different than most understand managed care to be. We support our members' life goals, such as living independently, like going to church and volunteering. During our years of serving individuals in need of long-term care services and supports, we have had the privilege to support our members in countless ways. We've got some examples from some states. In Texas, 83.6 percent of our members rate our plan an 8, 9, or 10 on a scale of 1 to 10. And in Arizona, that rate is 84.5 percent on a scale of 8 to 10. Consistent with national experience, we have supported traditional long-term care providers to diversify their businesses to meet the growing needs of the population that we are jointly serving. Through more than three decades of experience we know that managed care, supports, and service programs do work and improves the predictability for the state Medicaid program and improves the quality of life for members. [LB649]

SENATOR RIEPE: Okay. Thank you. [LB649]

PAUL SOCZYNSKI: Thank you. [LB649]

SENATOR RIEPE: Are there questions from the committee? Senator Crawford. [LB649]

SENATOR CRAWFORD: Thank you. Thank you, Senator Riepe. And thank you for being here to share your experience. In your testimony you note, and I appreciate, that you've worked with national experts to come up with these quality measures, and you are already in 13 states. Could you provide for us some of those measures? Are they publicly available measures? Is there a way we could see what this looks like in terms of some of the other states where you're already measuring these quality outcomes? [LB649]

PAUL SOCZYNSKI: Yes. I can actually share. It's a quality framework for LTSS. I can share that document with you. This happens to be one of my projects. It is my life, which some people would say I need to get a life, but (laughter)...so there are 54 measures in five domains, and 30 of those measures are surveyable. We have to actually survey the members. Those include things like: Are you living where you want to live? Are you able to interact with your family when you want to interact with them? Can you get a job and is it a meaningful job? So those kinds of elements, really, we have to go back to the member and ask what their experience is. Then there are others that are really more about the process: Are the assessments happening on time? Are the care plans being managed? So we're really looking at the process of care. [LB649]

SENATOR CRAWFORD: But you'd be able to share... [LB649]

PAUL SOCZYNSKI: Yes. [LB649]

SENATOR CRAWFORD: ...some results from some of the states. I appreciate that. [LB649]

PAUL SOCZYNSKI: And actually for those 13 states I am in the process of collecting all of that data so we can make a comparison for each of those elements. [LB649]

SENATOR CRAWFORD: Great. Thank you. [LB649]

SENATOR RIEPE: Okay. Thank you. Are there any other questions? Senator Kolterman. [LB649]

SENATOR KOLTERMAN: Thank you, Senator Riepe. You talked about quality of life issues, so bear with me here for a minute. I know you're sincere about that. My wife, who's got terminal cancer and we're on a United HealthCare policy, and you've done extremely well in taking care of her. So I just want the people here to know that I appreciate that. And you do fulfill what you promise in that regard. Irregardless of how I might vote on this bill, thank you. (Laughter) [LB649]

PAUL SOCZYNSKI: Thank you, I think. (Laughter) I guess I'll just comment because I think that's a heartfelt reality of...I mean we're talking about people's lives and you're living it very directly now. My wife is a three-time cancer survivor, so I get it personally. I mean I get it, looking in her eyes and having that experience. So I mean I think in as much as this is an insurance company, we're human, we have family issues. And so I think we bring that to the table everyday when we work with our members. [LB649]

SENATOR KOLTERMAN: You do. [LB649]

SENATOR RIEPE: Thank you very much for being here. And we'll now go on to the...is there another opponent? Please come forward. If you would, just give your orange slip over here. If you'll give us your name and spell it, please, and then proceed. [LB649]

RICHARD FREDRICKSON: (Exhibit 17) Yes. I'm Richard Fredrickson, Richard is R-i-c-h-a-r-d, Fredrickson is F-r-e-d-r-i-c-k-s-o-n. I'm the senior vice president for long-term services and supports for Centene Corporation. We're the parent for Nebraska Total Care. So you've heard all the testimony from the other health plans on person-centered care and I want to talk about one of the critical factors for success that I think. And we've implemented...I've been with the company 15 years and have been in long-term services and supports for over 30 years, starting one of the original waiver diversion programs on the nonprofit side. But as we've...these past 15 years and have implemented the nine programs, we've learned a lot over time, but each program is

different. Each program is significantly different. And what's really different is the current safety net--the waiver providers that exist today. And here we've met with the Area Agency on Aging folks, the League of Human Dignity, the CILs, who really serve people with physical disabilities, and I think it's really critical and our plans for implementation really are to include those folks--and I'm sure the others are, the other two plans are, too--to include them in the provision of service delivery, both for the consumer and for the providers, so to engage what's there today and take advantage of and build a program for Nebraska. And that's the way we've really approached things in each of the individual states that we work in. The second thing I really want to talk about is...and Heath and I have met and the nursing homes are a critical component. Are there claim problems? Yes. I think it's based on the lack of standardization so I'd like to promote, with your...it's one of the best Medicaid directors I've ever met, so you guys are lucky to have him so for sure. Oh, there we go again, he needs a raise. [LB649]

SENATOR RIEPE: And there we go. [LB649]

RICHARD FREDRICKSON: But I think if we move towards a standardized process, we all get together and work through this. This is a long implementation time. You heard about Kansas. I mean I was up in Iowa where we implemented in three months. It's impossible. So I think having this time period but really taking advantage with it and working together through test claims, through the associations. We just were successful in Pennsylvania with the procurement. They're moving 450,000 duals in, and there's three of us statewide. But one of the cornerstones of our proposal was but working with, and there's three nursing home associations, working with them, standardized contracts, standardized processes; very strict and penalty ridden, if you will, interest for late payment of claims, period. Really put a big stick out there. And I know from our company, we're willing to take that on. But work together on a system so that these folks get paid correctly and quickly, very quickly. The second point is to create some incentives. There's a great opportunity, especially in the rural areas, and you heard some testimony about licensure problems. We find...I was out in Arizona. We were the sole source, one MCO in some of the rural counties out there and we were actually funding home health agencies taking nursing homes, working with them to expand, move into personal attendants, assisted living, to expand that because they are one of the major key employers in a lot of the rural communities. So there's an opportunity there for step downs and alternative services for them to further advance their revenue streams. But again, everybody working together. I think if you heard a lot of stories, and I know Cindy well, you know, which MCO is it? And we're all defending ourselves. If one MCO goes bad, we're all bad. It hurts the program totally. So I think we're all together, the three of us, in terms of developing a program that looks the same so that all of us can have a high level of performance in the program. There isn't one that you have to hear all (inaudible) come back and hear all these nightmare stories for. So that's what I had to say. Thank you for having us. It was very interesting. [LB649]

SENATOR RIEPE: Thank you. Let's see if we have some questions. [LB649]

RICHARD FREDRICKSON: Yes. [LB649]

SENATOR RIEPE: Are there any questions from the committee members? Senator Williams. [LB649]

SENATOR WILLIAMS: Thank you, Chairman Riepe. And thank you for being here. Maybe a series of questions here. There's been talk, at least a concept may be brought up about a pilot plan. It would seem to me--correct me where I'm wrong here--that if we endeavor on this, with the number of participants that we have and the dollars that are going to be flowing, a company like yours will be required to make a significant investment of people, training, time, even brick and mortar in the state of Nebraska. [LB649]

RICHARD FREDRICKSON: We're all local. [LB649]

SENATOR WILLIAMS: So that's a yes to that, right? [LB649]

RICHARD FREDRICKSON: Yes. Yes, sir. [LB649]

SENATOR WILLIAMS: Can you do that to make a pilot project work? [LB649]

RICHARD FREDRICKSON: We would obviously prefer, because of those implementation costs, and I think some of the issues of selection in the pilot program having...and part of the insurance concept is having the whole scale of a number of different lives. But we're here to serve you. You're our customer. So whichever path you decide to go down,... [LB649]

SENATOR WILLIAMS: Okay. [LB649]

RICHARD FREDRICKSON: ...that's the path we will follow, so. And again, we're not bringing you a cookie-cutter approach here. It's a Nebraska program with Nebraska people in a Nebraska way. [LB649]

SENATOR WILLIAMS: Your company's name was one of those listed by the Kansas person. And your experience there that they have not, is the difference between what happened in Kansas and what has been successfully, is it the rollout time period, the planning, the structure of that? [LB649]

RICHARD FREDRICKSON: Yes. You know, she pulled me out before the hearing so I'm very close to her, sir. I think it was...there's a number of different issues there. And first of all, they don't have Calder Lynch, in my mind, so. The timing was relatively short. There was, and Cindy mentioned it, there was some issues with the sequencing of the reimbursement for the facilities I think that caused some consternation and confusion in the beginning, and again the implementation time frame, and again this mandate that everybody get on the same page with a standardized way of doing things. Either we're willing to do that or we walk from the state. That's just my opinion and I think... [LB649]

SENATOR WILLIAMS: And you heard my question earlier and the comment that was made about the "too big to fail" issue. Have you ever seen a circumstance in the...because you do this and other forms of managed care in many states. I think there is a fear that with the "too big to fail" concept that there can be collusion between the companies; that they just come in and flat say, hey, we all get together, it's not working very good for us, instead of $400 a month we need $450 a month, whatever. Have you ever seen that happen? [LB649]

RICHARD FREDRICKSON: Not the collusion, no. I'd say there's not enough togetherness. I really enjoyed the New Jersey testimony because I often don't see that. That was heartfelt and that's a very unique situation. I think there's an opportunity for us all to work together. But, no, I don't see that. We go in it with our eyes open. They're actuarially sound. I mean Mercer is a great firm. I haven't seen any of that, where there's collusion between MCOs. [LB649]

SENATOR WILLIAMS: Okay. And a specific... [LB649]

RICHARD FREDRICKSON: And we certainly wouldn't participate in it. [LB649]

SENATOR WILLIAMS: ...a specific question that I asked Director Lynch and he was very careful to answer the question about the administrative fee portion of the cap in a way demonstrating, which I agree with, that the significant amount of work that goes into it and the amount of work that would be eliminated from DHHS. But in your experience in other states, give me the percentage of what that cap normally is. [LB649]

RICHARD FREDRICKSON: In LTSS? [LB649]

SENATOR WILLIAMS: Yes. [LB649]

RICHARD FREDRICKSON: It would depend upon the requirements of the program, anywhere from... [LB649]

SENATOR WILLIAMS: Would it be in their...okay. [LB649]

RICHARD FREDRICKSON: Anywhere from 5 to 9 percent, somewhere in that range. [LB649]

SENATOR WILLIAMS: Okay. In that kind of a range. [LB649]

RICHARD FREDRICKSON: Yes. [LB649]

SENATOR WILLIAMS: Okay. [LB649]

RICHARD FREDRICKSON: And in some states they actually bid the administrative portion of the rate. [LB649]

SENATOR WILLIAMS: You probably heard my question very early about the comment that was made by...during the presentation that the person said, I think this will work in Nebraska. The question I've got is about a critical evaluation. I think we can go through a critical evaluation and figure out all the timing of the whole thing and be perfect. But how do we answer the question about are we really going to work from a financial perspective that it covers the state on the thing but doesn't penalize the participants? And do you think a critical evaluation could address that? [LB649]

RICHARD FREDRICKSON: I think there's a great opportunity here. I've spent some time here with the folks that are working in the community and there's an opportunity for flexibility, creativity, a unified view, getting in front of people in the preventative care and their ability to live in the community should they so choose. That's the opportunity. It's very real here, from my experience. You know sometimes, walk in and it's...you don't feel that way. But I don't know what...I would agree with Calder's comment back to you about that critical...you know, who's defining that, how do you define, is it consumer satisfaction? In my mind, that's everything, the consumer and the providers being satisfied. That's a real outcome, I think. The financial piece comes with that but that's the real outcome, is taking care of the residents and the taxpayers of the state that we're entrusted the care of. So that would be the critical, if you wanted to look, and I don't know how you get there through a study ahead of time other than just ensuring all these pieces are put in place, so. [LB649]

SENATOR WILLIAMS: I don't either. That's why I asked the question. (Laugh) Thank you, Mr. Fredrickson. [LB649]

RICHARD FREDRICKSON: Yeah. Thanks. [LB649]

SENATOR RIEPE: Are there additional questions? Thank you very much. [LB649]

RICHARD FREDRICKSON: Thank you. [LB649]

SENATOR RIEPE: We do appreciate it. [LB649]

RICHARD FREDRICKSON: Thank you. [LB649]

SENATOR RIEPE: Are there more opponents? Seeing none, are there any that are testifying in a neutral capacity? Seeing none, Tyler, I'm going to go to you. Do we have letters? [LB649]

TYLER MAHOOD: (Exhibits 18, 19, 20, 21, 22, and 23) Yes, I have a letter...the following letters are in support: Kristen Mayleben-Flott of the Nebraska Planning Council on Developmental Disabilities; Dennis Loose, Nebraska Association of Area Agencies on Aging; Diana Rohrick of the Nebraska Home Care Association; Marc Brennan of the Nebraska Speech-Language-Hearing Association; Steven Freese of the Community Pride Care Center; and Dr. Todd Pankratz of the Nebraska Medical Association. And that is it. [LB649]

SENATOR RIEPE: Thank you very much. Senator Pansing Brooks, if you would. [LB649]

SENATOR PANSING BROOKS: Thank you. I waived but I do want to thank you all for your patience and your good questions and really thinking this through. I know it's a long afternoon on Friday and I'm sorry about that. [LB649]

SENATOR RIEPE: Yes, and we have one... [LB649]

SENATOR PANSING BROOKS: But thank you for...thank you very much. [LB649]

SENATOR RIEPE: We have one more hearing too. Thank you very much. [LB649]

SENATOR PANSING BROOKS: I know. I'm very sorry to Senator Walz as well on (inaudible). (Laughter) [LB649]

SENATOR RIEPE: It was very interesting. Thank you all, and this concludes the Health and Human Services public hearing on LB649. We will take a five-minute break and we will come back on LB552. [LB649]

BREAK

SENATOR RIEPE: In the interest of time, and we appreciate everyone is here. I truly appreciate the committee members giving their time. And, Senator Walz, thank you for your patience as well. We would like to now open the hearing, public hearing, on LB552 with Senator Walz. Please. [LB552]

SENATOR WALZ: All right. Thank you. You know it's weird being on that side. Everybody always says, gosh, thanks, you guys, for, you know, sticking around, but these guys are the ones we need to thank because they've stuck around a long time. So I want to thank my testifiers. We have about, oh, I think there's like 20 outside that are going to be coming in here pretty soon. (Laughter) [LB552]

SENATOR RIEPE: Would the Red Coats lock the doors. [LB552]

SENATOR LINEHAN: That's really funny, Lynne. You have to stay till the end. [LB552]

SENATOR ERDMAN: Here's the deal: We're fine with that if you want to stick around till closing. (Laughter) [LB552]

SENATOR WALZ: Okay. All right. Thank you, Chairman Riepe and members of the Health and Human Services Committee. For the record, my name is Lynne Walz, L-y-n-n-e W-a-l-z, and I proudly represent Legislative District 15. LB552 would establish a Children's Connection program to expand mental and behavioral health services to children throughout the state. I have the privilege to serve on the Education Committee with a couple of other people who are on this committee, and this year we have heard many bills on how to handle students with behavioral problems and ideas to help students who are struggling in the classroom. We've heard testifier after testifier tell heart-wrenching stories about their children or their students that need help. It is unimaginable what these kids go through, and you and I can't even begin to understand the trauma they go through. Whew! But yet, we expect them to do well in school. So for a minute I'm going to stop looking at my paper and just give you a little idea of my experience since I've been here. As you all know, I was a teacher and since...for the last two months, since I've been here, my eyes have really been opened to just the very many serious things that are happening to kids. As a teacher, I didn't even have an idea about the amount of kids who are going through or who have mental health issues. So, you know, first of all I want to say that I know we don't have a lot of money, but I also want to let you know that we have to start somewhere. We have to start to break that pattern of mental health problems for people, and it has to start today. And it's going to take time. You know, really, it's going to take a good 20 years to see a big difference, but it's something that has to start today. So I just wanted to let you know that before I went on with

my testimony. So one of the biggest things that I've learned since doing this job are there are people out there who are hurting. We, as lawmakers, need to think about what we hear and what we see happening in our communities and throughout the state, even though it really doesn't affect us personally. I have found a sense of responsibility and a sense of urgency to improve areas in education, including nutrition, early childhood education, and increased access to behavioral and mental health services for students and their families. Therefore, I am proud to introduce LB552 to you today. This bill would establish a Children's Connection program that is modeled after a program that serves Omaha, Millard, Bellevue, whew, Papillion, La Vista school districts. Currently, the program is privately funded, but we want to make it more sustainable and expand it to the outside of the Omaha metro area. This bill is very important to me and to the long-term success of our children in our state. There are very few mental health practitioners that focus solely on children. In fact, most don't even have training for how to deal with children. If you get outside the Omaha and Lincoln...if you get outside Omaha and Lincoln, the specialists for children are almost nonexistent. We receive support from school districts, teachers, and parents to expand this program outside Omaha based on the success of Project Harmony and all involved with...and all of the parties...and all of the involved parties have had. LB552 would allot money to the behavioral health regions covered under the Department of Education. Under this bill, schools would be able to identify and refer students to behavioral health regions. These students, especially if they live in rural areas, are not likely to get the help they need otherwise. The bill also allows for professionals to meet with families to address concerns or problems that the child may face at home that is affecting them in the classroom. I've designed this bill to be a first step that hopefully we can continue to expand upon. I have asked for $2 million that would be divided or...that would allow for ten schools in each regional district to get these services. I feel the money we spend today is more than worth it to help these children and, by saving costs in the long run, problems these children may have down the road if issues are not addressed. I urge you to advance LB552 and address this need for our students in Nebraska. I am happy to work with the committee on any concerns you may have. This is an important issue and we need to be on the same page, so let's meet and let's figure out what we can do to get this done. I'd be happy to answer any questions the best I can. Thank you. [LB552]

SENATOR RIEPE: Thank you, Senator Walz. Are there questions from the committee? Senator Howard. [LB552]

SENATOR HOWARD: Thank you, Senator Riepe. Thank you, Senator Walz, for bringing this bill to us. I wanted to ask some intention-based questions. So why is it only for schools serving children in kindergarten through grade 8? [LB552]

SENATOR WALZ: I think that it's because those are the years that they are most able, if they are able to diagnose that, that they're going to be able to help them down the road. I think those are just critical years that they're looking at. [LB552]

SENATOR HOWARD: And then the reporting requirements through the regions or the reporting requirements go through the regions and then would that be part of their regular reports to the state? [LB552]

SENATOR WALZ: I'm going to allow somebody else to answer those questions. [LB552]

SENATOR HOWARD: Good. I'll follow up with Ms. Jurjevich about that. Yeah, and then is it your intention that some of these services would be able to be billed through a Medicaid or a CHIP program or a third-party payer? [LB552]

SENATOR WALZ: I believe so, yeah. [LB552]

SENATOR HOWARD: Okay. Great. Thank you. [LB552]

SENATOR RIEPE: Okay. Any...Senator Erdman. [LB552]

SENATOR ERDMAN: Thank you, Senator Riepe. Thank you for coming. Sorry it's so late. So you know it talks about on the bottom of page 2, line 30: Solicit annual program plans from each behavioral region to ensure the plans meet initiative requirements. What are the requirements? Who's going to determine what the requirements are? [LB552]

SENATOR WALZ: Again, I think I'll let the Connections program or the people who are here. There's a program that's already in place, and I think I'll let them answer those questions. [LB552]

SENATOR ERDMAN: So they will also be the people...they've got a method to train these people? [LB552]

SENATOR WALZ: Yes. [LB552]

SENATOR ERDMAN: Someone will have to do that. On page 3, line 28, it says: the budget including a local match of at least one-fourth of the total cost. Is there going to be a contribution by the local school system or who's that local match from? [LB552]

SENATOR WALZ: I'm going to have to look that up. Can I find that answer and then... [LB552]

SENATOR ERDMAN: Yeah. [LB552]

SENATOR WALZ: ...let you know at the end? [LB552]

SENATOR ERDMAN: I just...you know, when you see that, I wondered one-fourth of the total costs. So... [LB552]

SENATOR WALZ: Uh-huh. [LB552]

SENATOR ERDMAN: ...the fiscal note says $2 million and a fourth of that is another $50,000 from somebody. [LB552]

SENATOR WALZ: Uh-huh. And I'll look it up... [LB552]

SENATOR ERDMAN: Or $500,000, excuse me. [LB552]

SENATOR WALZ: ...so we don't have the... [LB552]

SENATOR ERDMAN: Okay. Thank you. [LB552]

SENATOR WALZ: Yeah. [LB552]

SENATOR RIEPE: Any further questions, Senator Erdman? [LB552]

SENATOR ERDMAN: No, thank you. [LB552]

SENATOR RIEPE: No? Senator Linehan. [LB552]

SENATOR LINEHAN: Thank you, Mr. Chairman. Thank you for bringing this. Is somebody behind you going to explain what mental health issues we're talking about? I mean descriptions of...I mean behavioral health, mental health, that's a huge term. [LB552]

SENATOR WALZ: That's a huge term. [LB552]

SENATOR LINEHAN: So is somebody going to actually kind of describe to us here? [LB552]

SENATOR WALZ: I think what they'll do is they'll give you an idea of, you know, what they've been doing so far and who they've been working with. [LB552]

SENATOR LINEHAN: Okay. Okay. [LB552]

SENATOR WALZ: What kind of support services they're providing. [LB552]

SENATOR LINEHAN: All right. Thank you very much. [LB552]

SENATOR RIEPE: Okay? [LB552]

SENATOR WALZ: I'll find out that number. [LB552]

SENATOR RIEPE: No other questions? Thank you very much. We assume you'll be staying around for closing if you stayed this long. [LB552]

SENATOR WALZ: Absolutely. [LB552]

SENATOR RIEPE: Okay. Proponents, please. [LB552]

KRISTIN WILLIAMS: Chairman Riepe, members of the Health and Human Services Committee, my name is Kristin Williams, K-r-i-s-t-i-n W-i-l-l-i-a-m-s, and Senator Walz asked me, invited me to come here today to share some of the background of the Connections program and why the Sherwood Foundation started the Connections program. So before I begin I just want to tell you a little bit about the Sherwood Foundation. For those of you that don't know, we're a family foundation in Omaha, Nebraska, and we make grants all over the state in probably almost every county on a variety of different areas. We focus on communities large and small to improve the quality of life of Nebraskans and we do that through early childhood education, K through 12 education, human services, rural leadership development, affordable housing, and community revitalization, just to name a few of the areas that we work on. We work in partnership--and by "partnership" I mean both strategy, data analysis, and match funding--with the Nebraska Department of Health and Human Services on several issues, including foster care, child welfare, systems of care for children's mental health. And I am personally honored to have served on the Unicameral's Intergenerational Poverty Task Force in 2016. I was invited again to explain the background of why the Sherwood Foundation began investing in the Connections program at Project Harmony in Omaha. We know from the National Institutes of Health that approximately one in five youth struggle with a mental health issue while they're children. And because of our investments in K through 12 education, we were hearing from teachers and principals and counselors. They were struggling with how and where to make referrals for children who are struggling in the classroom, but they don't qualify for a 405 (sic--504) or an IEP plan where the district would need to attend to that. So they were really relying upon the

community-based services and there wasn't any meaningful infrastructure there for handling referrals. There was a lot of dialogue and data gathering going on in Omaha about children's mental health quite a few years ago, but the models that would come forward were medically based and not necessarily the best first step for children to receive appropriate care, sort of akin to sending someone to a surgeon before they've seen a primary care physician. We also know that a majority of the community-based therapists are essentially generalists in practice. They graduate with the ability to sort of a treat a wide variety of issues and may not be trained in the best practices for treating and supporting children, and those are different modalities that get used for children. Our goal in starting Connections was threefold. First, we wanted to invest in prevention. We wanted to help youth learn the coping skills for managing issues like anger and depression and anxiety while they're young so that we could reduce the need for intensive interventions, like psychotropic medication and even hospitalizations that will occur in those older populations in middle school up through high school and college. Second, we know students who are acting out are usually telling us something is wrong at home. We believe that families must be involved in the treatment solutions for their children, and Connections is working hard to make that happen. Third, we want to make sure that youth are getting the most up-to-date interventions by helping build a cadre of providers who are trained in evidence-based techniques for children. Real quickly, I just...I'm sure you're all aware the Behavioral Health Division received a SAMHSA grant to implement systems of care for children across the state for severe and extremely disturbed children. The Sherwood Foundation is pleased to provide matching grant to the state's work of $1.6 million for this important endeavor. And my hope is eventually there will be a creative way to expand access to the community-based mental healthcare for children with the less extreme needs across the state. Thanks for your time. I'm happy to answer any questions you might have. [LB552]

SENATOR RIEPE: Thank you. Are there questions from the committee? Senator Howard, please, go ahead. [LB552]

SENATOR HOWARD: Sorry. Thank you, Senator Riepe. Thank you for visiting with us today. You mentioned that the Connections program is housed within Project Harmony. So is it that Project Harmony sort of owns the therapists and they go out to the school, or who do the therapists work for? [LB552]

KRISTIN WILLIAMS: The therapists work for either community providers, so maybe someplace like Heartland Family Service, or their private practitioners. I was nervous to say this but I'm going to say it anyway, given the last testimony. But effectively what we've created is a managed care system for mental health for children and it's obviously, you know, run by a nonprofit but they have staff who act as care coordinators, and that's what's making this work for people. So we get a referral and then that family has immediately got someone they can connect with to help them navigate the system, to plug in with them and make sure that they are getting

their needs met and getting referred to the appropriate kind of therapists. And then we've got a feedback mechanism that tells us how effective those therapists are. We have systems in place, the therapists themselves, you know, get them signed up for if they need Medicaid or if they have health insurance. All those things are taken care of. And then Connections itself is the payer of last resort and they also have a pool of resources for burial...burial...barrier removal. (Laugh) Sorry. So if someone has transportation issues or it could be that the therapist finds out the family doesn't have a washer and dryer, there are things that we can do to sort of help step things up for that family, the idea being again preventing them from more severe mental health issues, preventing them from entering the child welfare system. [LB552]

SENATOR HOWARD: So... [LB552]

SENATOR LINEHAN: Go ahead. [LB552]

SENATOR HOWARD: I apologize. [LB552]

SENATOR LINEHAN: No, I'm sorry. [LB552]

SENATOR HOWARD: So in our considerations of alternative response and the pilot there, is this something that would sort of be a precursor to alternative response or a better version of alternative response? [LB552]

KRISTIN WILLIAMS: I...some of my colleagues in the field are saying it's going to end up becoming part of the alternative response system. We...and probably already is to some extent. What Connections can't do is provide services to youth that are already a part of the child welfare system... [LB552]

SENATOR HOWARD: Okay. [LB552]

KRISTIN WILLIAMS: ...because we don't want to be supplanting... [LB552]

SENATOR HOWARD: Okay. [LB552]

KRISTIN WILLIAMS: ...where government should be covering costs. So this isn't your higher need population. This is kind of the in the middle. [LB552]

SENATOR HOWARD: Okay. Thank you. [LB552]

SENATOR RIEPE: I think Senator Linehan had one, then I'll come back, Senator. [LB552]

SENATOR ERDMAN: Okay. [LB552]

SENATOR RIEPE: Please. [LB552]

SENATOR LINEHAN: Thank you. Can you give me an example of what we're talking about here? Who decides when the child...the parents need to be called, what? Give me an example of how this works. [LB552]

KRISTIN WILLIAMS: Sure. It's the school. So whether that's a teacher saying there's a challenge here, refers that student maybe to the student counselor... [LB552]

SENATOR LINEHAN: Okay, but what's the challenge? [LB552]

KRISTIN WILLIAMS: Acting out in anger in the classroom. Sometimes they're withdrawn actually, quite introverted, might be some depression going on, not engaging in the school work. Could be bullying behavior. [LB552]

SENATOR LINEHAN: So then what happens? The teacher refers them to who? [LB552]

KRISTIN WILLIAMS: So a school counselor will be involved or a principal or if there's a school social worker, and then they make the determination to refer that family to Connections. [LB552]

SENATOR LINEHAN: Okay. And then...so are there psychiatrists at Connections? [LB552]

KRISTIN WILLIAMS: I think we have psychiatrists available, yes, so if that is determined as the actual need of the student, that's an option. [LB552]

SENATOR LINEHAN: Well, that's what I'm kind of (inaudible). Who's doing this determining about when you're saying behavioral health, and there's less...I'm not an expert on this at all, but behavioral health, mental illness, or families...I'm just...I'm very...I'm confused about the line we're drawing here. What is behavioral health and what is a family that's struggling? [LB552]

KRISTIN WILLIAMS: You know, there are assessment tools that are used by Connections to determine that issue. And so they use I think three of them. I'll let Debbie Anderson from

Connections tell you what those are because I have a terrible memory for those kinds of things. [LB552]

SENATOR LINEHAN: Because they're here? [LB552]

KRISTIN WILLIAMS: Yeah, she's here. [LB552]

SENATOR LINEHAN: Okay. Okay. That's good. [LB552]

KRISTIN WILLIAMS: So she can probably help you understand that part a little bit more. But it isn't your extreme stuff like where the...if it's pretty extreme and an IEP is needed or a 504 plan,... [LB552]

SENATOR LINEHAN: Well, that's all about cognitive ability. That's not about mental health. [LB552]

KRISTIN WILLIAMS: Well, right, but if the mental health is interfering so severely with the classroom, this is kind of like that squishy, in-the-middle place. [LB552]

SENATOR LINEHAN: Well, I think we need...okay. Okay, but there's going to be...is there going to be a psychiatrist here? [LB552]

KRISTIN WILLIAMS: I don't believe we have a psychiatrist here. [LB552]

SENATOR LINEHAN: So who's the behavioral health expert that's here? [LB552]

KRISTIN WILLIAMS: So we have...Debbie Anderson will be. [LB552]

SENATOR LINEHAN: Okay. [LB552]

KRISTIN WILLIAMS: Yeah. [LB552]

SENATOR LINEHAN: All right. Thank you much. [LB552]

KRISTIN WILLIAMS: Yeah. [LB552]

SENATOR RIEPE: Aren't psychiatrists often there for the medications? [LB552]

KRISTIN WILLIAMS: They're there for the medications. And, frankly, we were looking at...there are programs in place where they get kind of right to a psychiatrist and we wanted to prevent the use of psychotropic medication through this program if it's not absolutely necessary. [LB552]

SENATOR RIEPE: Senator Erdman, you had... [LB552]

SENATOR ERDMAN: Thank you. I was following up on what Senator Linehan asked. So these young people get somehow worked over to your side by someone who's supposed to know something about mental health. How long are they there? Are those people there for a long extended period of time in your organization, in your managed operation, or how does that work? [LB552]

KRISTIN WILLIAMS: The client? [LB552]

SENATOR ERDMAN: Yeah, the kid. [LB552]

KRISTIN WILLIAMS: So they're averaging, I believe it's...we're trying to work on that but about 6 to 12 months that they're getting seen by a therapist. [LB552]

SENATOR ERDMAN: So then does that continue on into summer break? [LB552]

KRISTIN WILLIAMS: Yes, it does, but we do see a dip in the summertime. [LB552]

SENATOR ERDMAN: Okay. Okay. So would this program be available all across the state? [LB552]

KRISTIN WILLIAMS: According to the bill, I believe it would start that process, yes. It's going to be a little bit more challenging in rural areas because we don't have quite the large number of professionals available. The foundation is willing to help with things like training, help get people up to speed on how to work with children. [LB552]

SENATOR ERDMAN: You may be right. Maybe zero is a better number. [LB552]

KRISTIN WILLIAMS: Zero? [LB552]

SENATOR ERDMAN: People available. [LB552]

KRISTIN WILLIAMS: That makes me sad. The School of Social Work actually at UNO is working with the School of Social Work at Kearney to try to bring more practitioners to the rural communities. [LB552]

SENATOR RIEPE: Do you also see telemedicine, telehealth in there quite a bit? [LB552]

KRISTIN WILLIAMS: Yeah. Yeah. [LB552]

SENATOR RIEPE: The other question I would have is looking at the court order, I believe you've been talking about school kids but there's a preschool element as well under the concept catch it early, treat it, you're better off. [LB552]

KRISTIN WILLIAMS: Yep. Yeah. [LB552]

SENATOR RIEPE: How do you respond to that? Is that a consideration or was it intentionally not to include... [LB552]

KRISTIN WILLIAMS: This was intentional so we were very Omaha focused when we started this. My colleagues at the Buffett Early Childhood Fund work with the Sixpence Fund and they started that really early intervention. And so where we were coming in is the Sherwood Foundation is already funding some work with the mental health needs of high school students in the Omaha Public Schools district only and so we were looking to fill that gap in the district. And then to our surprise or not, the surrounding districts were asking for Connections to support them, and so we provided the funding to allow that to happen as well. [LB552]

SENATOR RIEPE: Our office has been made aware that a lot of the kids that are in trouble, if you will, foster kids, has grown significantly in the last few years. That's an alarming piece. [LB552]

KRISTIN WILLIAMS: It really is. We do work with the foster care system as well at the foundation and are very supportive of the older youth population that age out of the system in helping meet their needs across the state. [LB552]

SENATOR RIEPE: Are there other questions? Well, thank you for being here and thanks for your patience. [LB552]

KRISTIN WILLIAMS: Thank you for your time. [LB552]

SENATOR RIEPE: We do appreciate it. Other proponents, please. [LB552]

DEBRA ANDERSON: (Exhibit 1) So I'm giving you each a PowerPoint, but I realize as I'm looking it that even my old eyes can't see it, so I can send it to you in another format later. Good afternoon, Senator Riepe and members of the Health and Human Services Committee. My name is Debra Anderson, D-e-b-r-a A-n-d-e-r-s-o-n. I am the senior director of the Early Intervention at Project Harmony and I oversee the Connections program. So I'm here today to represent that program which is the prototype for LB552 and which is to provide for a statewide Children's Connection program. I'm going to talk about what we do in the program and hopefully answer some of the questions that you may have about how we deliver the services in an evidence-based manner. Launched in January of 2015, so we're just slightly over two years old, Connections was founded on the idea that when mental health problems are identified early in a child's life, we can prevent a wide range of more serious problems from developing later in life. Connections is designed to help the child and family who are early in the development of a problem before outside systems such as child protective services or juvenile justice has to be involved. We have one goal in mind and that is to improve access to high-quality mental health services for children and families. Since 2015, the Connections program has increased access to mental health services for over 1,200 children, their siblings, and parents. And I want to take a few minutes to explain how the Connections program works and what makes it successful. When Connections began we were pretty naive. We thought all we needed to do was connect children to community mental health providers and the process, we thought, would be very straightforward. A school would identify a child in need, they'd contact us, we would meet with the family and get their consent, and then we would know which provider would be best and we'd make a match and that would be the end of the story and, you know, all would be good. And we were very wrong when we started that way. We learned that to be successful we must intentionally, purposely, and steadfastly work with three groups. First, of course, are the children and families that we serve. We use evidence-based screening and assessment tools to assess a child's symptoms and identify barriers to therapy, such as transportation or high deductibles or copays, and sometimes no insurance at all, and then we pay for those barriers. Then we match the child to the community mental health provider that's most appropriate and who can best address their needs. We remain involved with the child and family throughout treatment and we help bridge communication between the family, the child's school, and the mental health provider. One of the things we heard from schools is that we often make referrals for children to get therapy and we don't know after that what happens. We don't know if the child went, didn't go, is getting help, is not getting help, what we can do to support that child here at school. And we'd like to know that so that we can work together. And incidentally, we view the child as a gateway to services. If the child's sibling or parent has a mental health need, they also can receive our services. The second group that we work with are the schools. Currently, we serve 90 elementary and middle schools in

Omaha Public Schools, Millard Public Schools, Papillion-La Vista Public Schools, and, Senator Crawford, we're in three Bellevue schools. Each of these districts has recognized that violence and trauma can lead to behavioral health problems which can affect academic performance. And each is also interested in addressing the social and emotional needs of their students but, generally, they don't have a background or experience in mental health service delivery. As a result, we needed to learn their way of thinking and they needed to learn ours. We needed to learn which evidence-based models of practice work for schools and which do not. And we needed to work together to create processes and protocols that met the mental health needs of children while also ensuring protective instructional time, which is so important to the school districts. The third group we work with are mental...are community mental health providers. We recruit experienced and licensed providers employed by agencies or working in private practices. We select those who have interest and skill in working with children, grades kindergarten through 8, and then we provide them with high quality, nationally recognized, evidence-based practice training. The trainings we have coordinated include individual models, such as Trauma-Focused Cognitive Behavioral Therapy, and Motivational Interviewing; and group models, including Cognitive Behavioral Intervention for Trauma in Schools, called CBITS, and Support for Students Exposed to Trauma, called SSET. The Adverse Childhood Experiences Study, or the ACEs study, has demonstrated that children exposed to interpersonal violence or household dysfunction suffer devastating consequences, both short term and over a lifetime. Exposure to violence and trauma affects how children feel, how they act, and how they learn. Our first two years have shown us that Connections has increased awareness to children, parents, teachers, and others about the devastating impacts of the ACEs study. It's increased mental health service capacity to children who otherwise would not have received it, and we've improved the quantity and quality of evidence-based trainings for community mental health providers. I know Project Harmony employees, our partners and our donors would agree that Connections has been a wise investment in children and families in the Omaha metro area and I urge you to support LB552 to continue this momentum and better serve children and families, schools, and mental health providers throughout Nebraska. Thank you for this opportunity to provide testimony and I can answer any questions. [LB552]

SENATOR RIEPE: Thank you. Are there questions? Senator Erdman. [LB552]

SENATOR ERDMAN: Thank you, Senator Riepe. So you said you're in 90 schools. [LB552]

DEBRA ANDERSON: Ninety schools. [LB552]

SENATOR ERDMAN: What's this program cost? [LB552]

DEBRA ANDERSON: It costs about $40,000 a school. Now this is how we look at this. Most schools have about 500 kids in them. What we're seeing on average is a 5 percent penetration rate or utilization rate so far, so you can estimate that about 25 kids out of a school of 500 are going to need our services in a given year. So with that, 50 kids is a caseload. So what it costs us to go into a school would be about $40,000. Now the other thing to know about that is what we're paying, when you look at payer of last resort, high deductibles, copays, transportation, childcare costs, some of the barriers that prevent families from getting to treatment and we pay for those, on average it's $800 a kid. And then our program, my staffing, our overhead, everything that we have in the program itself is another $800 a kid. So it's basically $1,600 a child. We expect that our providers are going to bill for that child's Medicaid or other insurance that they have. What I don't know is how much we're leveraging and that's something we still need to figure out. So the $1,600 per child will cover our costs but it's not including what that provider is billing on, on top of that. Ninety-three percent of our kids have either Medicaid or private insurance. So over half, about 53 percent, have Medicaid and the remaining have some form of private insurance. We make every effort to match a child with a provider that carries the same, you know, that is paneled on the insurance that that child has. [LB552]

SENATOR ERDMAN: How many children do you say you work with? [LB552]

DEBRA ANDERSON: Twelve hundred. [LB552]

SENATOR ERDMAN: Twelve hundred in 90 school districts. [LB552]

DEBRA ANDERSON: Ninety schools... [LB552]

SENATOR ERDMAN: Ninety schools. [LB552]

DEBRA ANDERSON: We're in four school districts. [LB552]

SENATOR ERDMAN: And we have 245 districts. So $2.5 million may not even touch it. [LB552]

DEBRA ANDERSON: You're correct. [LB552]

SENATOR ERDMAN: Do you know anything about the funding, the other quarter, the one-fourth of it that's going to come from a local charity? [LB552]

DEBRA ANDERSON: You know one thing I know for sure about our partnership with Sherwood Foundation and the Bill and Ruth Scott, we're totally privately funded through the Bill and Ruth Scott Foundation and Sherwood Foundation. I know that we have really strong public-private partnerships, not just for the Connections program, but Child Advocacy Centers in Nebraska as a whole get really strong private support. So I believe that we will continue to get private support for the program. The other area that I think...I'm talking a little bit off the top of my head here, but I just have started getting some requests from ESUs in more rural areas wanting to replicate the program. And you know, the ESU in Omaha is a bit different than the ESUs when you get into rural Nebraska. When you get into rural Nebraska, ESUs do way more in terms of addressing behavioral health needs than they do in the urban areas. And I think there's an opportunity to partner with the ESUs and maybe with Department of Education. [LB552]

SENATOR ERDMAN: Because at that rate, at $2.5 million at $1,600 a student, that would be 50-100 students. You're already doing 1,200. [LB552]

DEBRA ANDERSON: My budget is over what...is over $2.5 million. [LB552]

SENATOR ERDMAN: Okay. [LB552]

SENATOR RIEPE: Other questions? Senator Linehan. [LB552]

SENATOR LINEHAN: Thank you, Chairman Riepe. Are you a medical doctor? [LB552]

DEBRA ANDERSON: I am not. [LB552]

SENATOR LINEHAN: I'm a little...who overwatch...where's the medical professionals? This is very serious. I mean... [LB552]

DEBRA ANDERSON: Yeah. [LB552]

SENATOR LINEHAN: And then and you go into the families and I would assume if you have a child with problems there's a parent with problems. So who is...who is overseeing the medical? Who's the medical person here? [LB552]

DEBRA ANDERSON: Well, one of the things that is very common in mental health treatment that's different than in medical treatment is that it almost turns the system on its head, that there

is this...there's a tendency for people to think that if someone has a problem, I'm going to go to the highest trained, most qualified person, which in this case would be a psychiatrist, right? [LB552]

SENATOR LINEHAN: Uh-huh. [LB552]

DEBRA ANDERSON: And then the psychiatrist is going to do a psychiatric evaluation. And then they're going to recommend them seeing a psychologist, and they're going to do a psychological evaluation. And then they're going to recommend them for therapy at that point. It's actually the other way around. What typically happens is you do an assessment first and master's level... [LB552]

SENATOR LINEHAN: Who does an assessment? [LB552]

DEBRA ANDERSON: Master's level social workers. So master's level social workers and counselors are trained in how to do screenings and assessments. They do those first and then, based on what they learn from that, they would make the recommendation that this is outside my scope and this child really needs either a psychological or a psychiatric evaluation. So it happens really at the lowest level possible with that screening and assessment. We don't always know what we're dealing with. Just as an example, many of the kids that we're working with have symptoms of trauma. And trauma symptoms, if you've grown up in a violent neighborhood and you've been exposed to maybe some maltreatment of your own and you've seen violence in your neighborhood and maybe your parents are divorced, and these are some of the ACE factors, it would not be unusual for that child to have behaviors that looked really similar to ADHD. So ADHD symptoms and trauma symptoms can look very similar. And so that might be a case where we say, you know what, we think this child needs an evaluation by a school psychologist in order for us to figure out is this really ADHD or is this something else. So we go through a process to help ascertain that and we don't automatically assume that the first line is with a physician. If a child does need a psychiatric evaluation or a psychological evaluation, we have contacts that we work with and then we can help. It's one of the most expensive services we pay for but we can do that as well. [LB552]

SENATOR LINEHAN: Okay, so of these 1,500 kids you're working with on behavioral health, how many of them have seen at least a PA, a physician assistant, that works with a psychiatrist? [LB552]

DEBRA ANDERSON: We expect that every one of them will have a primary care physician but we would not automatically assume that they're going to need to see a psychiatric medical professional just because they've been referred to us. [LB552]

SENATOR LINEHAN: Maybe I didn't ask... [LB552]

DEBRA ANDERSON: So that decision is typically made by the provider, by the mental health provider. So if we've matched a child with somebody from Lutheran Family Services or Heartland Family Service, they have consulting psychiatrists they work with and they would then make the determination if they need to bring that person in. [LB552]

SENATOR LINEHAN: So what percentage of them see a licensed...either a physician assistant or a psychiatrist? [LB552]

DEBRA ANDERSON: I don't know that, the answer to that. [LB552]

SENATOR LINEHAN: So if they don't see that person, who are they working with? [LB552]

DEBRA ANDERSON: They're working with their licensed mental health practitioner. [LB552]

SENATOR LINEHAN: So what...okay, I...maybe I just...I'm not asking the questions right, but... [LB552]

DEBRA ANDERSON: No, I think you are. I think that what you're coming from is... [LB552]

SENATOR LINEHAN: I mean if you get a kid in school and you're going to say that he's got a behavioral health problem,... [LB552]

DEBRA ANDERSON: Uh-huh. [LB552]

SENATOR LINEHAN: ...that's going to follow that kid around for the rest of their life. So who's making that decision? I think that that concerns me greatly. [LB552]

DEBRA ANDERSON: Right. So what would happen is what the school does is they would identify that a child has certain behaviors. So maybe the child is very, very withdrawn. I'll tell you, the three most common reasons we get referrals are anger management problems in the classroom; family conflict, so there's something going on in the family, usually it's a divorce, separation, or something like that and it's caused some anxiety and some problems for the child; and the third reason is self-esteem. Those are the three primary reasons schools are making referrals to us. The other thing that to me is very interesting about that is if you look at the districts that we're in, the ages are different. They're coalescing around a different age, but that

the reasons remain the same. So in Millard Public Schools the number one age that we get are 12- and 13-year-old girls. And if you go to OPS, it's 8- and 9-year-olds. And if you go to Papillion, it's 6-year-olds. But the reason for the referral is the same: anger management; family conflict. So these are kids who are acting out in the classroom. What I hear teachers saying is they're throwing chairs, they're bullying other children, and they need some help. So that's the purpose of doing the evidence-based screenings and assessments that we do and they would point to whether a child needed more intensive services. [LB552]

SENATOR LINEHAN: So are these people...who licensed these people? [LB552]

DEBRA ANDERSON: The state. [LB552]

SENATOR LINEHAN: So you work with the Department of Health and Human Services? [LB552]

DEBRA ANDERSON: Well, the state of...when you go to graduate school for social work or counseling and you graduate with a master's degree, you have to get so many supervised hours and then you take an exam and you pay your money to the state and it's like getting... [LB552]

SENATOR LINEHAN: Okay. It's Friday night. I'm taking too much time. I got it. Okay. [LB552]

DEBRA ANDERSON: So the state licenses them. [LB552]

SENATOR RIEPE: Senator Erdman. [LB552]

SENATOR ERDMAN: Thank you, Senator Riepe. So these children come to you for a year or so and then you assume that they're fine. [LB552]

DEBRA ANDERSON: We follow them throughout the time that they're with us. Now we've only been in existence for two years so we're still... [LB552]

SENATOR ERDMAN: Okay. [LB552]

DEBRA ANDERSON: ...tracking. Typically they stay with us around six months and... [LB552]

SENATOR ERDMAN: Do they come back? Do you have kids, children (inaudible)? [LB552]

DEBRA ANDERSON: We have kids that have come back. Yeah, we've had kids where the case has been closed and then they come back, and that's one of the beauties of our program is that they can. We don't have limitations on that, up to grade 8. Now the other thing we'll do is that if a child is in grade 8 and we get a referral...some of the schools have learned this--I'm going to refer my 8th graders in May--because they know we're not going to just close it. We're going to serve those children. [LB552]

SENATOR ERDMAN: So you have a child who is in an abusive place or in a violent deal,... [LB552]

DEBRA ANDERSON: Uh-huh. [LB552]

SENATOR ERDMAN: ...and you treat that child. Unless you get them out of that environment, you're not helping them a whole lot, right? [LB552]

DEBRA ANDERSON: Well, if it's to the point where there's violence in the home and it requires a child protective service referral and it goes that direction, Connections would not be involved. [LB552]

SENATOR ERDMAN: But if it's not (inaudible). [LB552]

DEBRA ANDERSON: So we're looking at that...Kristin calls it that squishy area in between. [LB552]

SENATOR ERDMAN: Yeah. [LB552]

DEBRA ANDERSON: It's not to the level where they need a child protective service involvement or a juvenile justice involvement. It's before. We're trying to prevent that from happening by intervening early. [LB552]

SENATOR ERDMAN: Yeah, because if you don't do anything about the home environment, you're just treating the symptom. [LB552]

DEBRA ANDERSON: Right, which is why our... [LB552]

SENATOR ERDMAN: You have to treat the cause. [LB552]

DEBRA ANDERSON: That's why our program is designed to try to help the whole family and even the evidence-based models we use, every one of them has a family component to them. We have had amazingly strong parent engagement. And I don't mean that like it's a big surprise, but it was somewhat of a surprise to us. Families are looking for help and they don't know where to go. [LB552]

SENATOR RIEPE: Sounds similar to child abuse where the front line is oftentimes the teacher... [LB552]

DEBRA ANDERSON: Yes, which is why... [LB552]

SENATOR RIEPE: ...because they seem them every day and so they know a little bit more... [LB552]

DEBRA ANDERSON: Yes. [LB552]

SENATOR RIEPE: ...of...over maybe the year how they're...some changed behavior and that something is going on. [LB552]

DEBRA ANDERSON: That's exactly why we're doing it with schools and we work with some medical clinics as well for the same reason, because nurses also see them. [LB552]

SENATOR RIEPE: I think the education budget could accommodate this money, (laughter) little property tax. Senator Howard, with that I would go to you. [LB552]

SENATOR HOWARD: Thank you. And I apologize because I'm going to have to leave to get back to Omaha. And this may be a more appropriate question for our regions or...I always say Patti, Ms. Jurjevich from the regions. But I think maybe what would be helpful is if you or Patti could talk about the types of licensed professionals we have in terms of therapy, so LMHPs, LIMHPs, community health workers, whoever that looks like, and then who does that initial screening and who's allowed to do that initial screening. [LB552]

DEBRA ANDERSON: Right. [LB552]

SENATOR HOWARD: Because I think that is a really legitimate concern. Does it look like an unlicensed professional who's doing this screening... [LB552]

DEBRA ANDERSON: Right. [LB552]

SENATOR HOWARD: ...and putting this diagnosis onto a child and sending them to a program? I mean we talk about licensure a lot but you want to make sure that the type of professional who's doing that initial screening... [LB552]

DEBRA ANDERSON: Absolutely. [LB552]

SENATOR HOWARD: ...is appropriate. [LB552]

DEBRA ANDERSON: Yes. [LB552]

SENATOR HOWARD: And so I think that's a very legitimate concern. But I also want to make sure that we understand the levels of licensure that we're working within for these services. [LB552]

DEBRA ANDERSON: Right. Okay. Would you like me to answer that or... [LB552]

SENATOR HOWARD: Either/or, I would say. [LB552]

DEBRA ANDERSON: So what typically will happen in the first referral is we will ask the school to identify symptoms. Schools don't want to get into the business of diagnosing, and they shouldn't, and so...and they don't have the qualifications to do that. So we need to know from them just a list of what that child's symptoms are. And they have...we go...we have a form that they use. It's an evidence-based screening tool that we use with them that can be completed by a nonlicensed professional. So you don't have to have a license...you don't have to be a licensed clinician to do that. Once that happens we will make contact with the family and we will make contact with that referral source to go through that, because we also want to hear from the family's perspective. One of the tools we use is called the Strengths and Difficulties Questionnaire. It's a pretty common screening tool. It's used by a lot of clinics. It's used by a lot of schools across the country to look at child symptoms. And the reason we selected the Strengths and Difficulties Questionnaire is because the research shows that building on a child's strengths is more predictive of success than just dealing with deficits. So we're wanting to identify that child's strengths as early as we can in the process, and doing that with families and schools is a beginning to help them think more positively maybe than they have about that child for a while. So the SDQ, Strengths and Difficulties Questionnaire, can be administered by any of us. Once that happens and we are able to make a match between that child's symptoms and our trained mental health providers that are in our pool, then it's that mental health provider who's a

licensed...they're either a licensed mental health provider by the state of Nebraska or a licensed independent mental health provider. The difference is: if you're independent, you can work without anybody overseeing your work, basically; and if you're not independent, you need somebody to oversee your work. [LB552]

SENATOR HOWARD: And who's the "somebody"? [LB552]

DEBRA ANDERSON: The "somebody" is typically a psychiatrist or a psychologist, a board-certified psychologist. [LB552]

SENATOR HOWARD: And if you're independent where do you usually work? [LB552]

DEBRA ANDERSON: Most of them are in private practice. [LB552]

SENATOR HOWARD: Okay. [LB552]

DEBRA ANDERSON: But you could be licensed independent and work in an agency as well. [LB552]

SENATOR HOWARD: Right. [LB552]

DEBRA ANDERSON: So you could work either way. That's really personal preference. Am I saying that...? So that's typically how it happens. [LB552]

PATTI JURJEVICH: Uh-huh. Yeah. [LB552]

DEBRA ANDERSON: So that's typically how it happens and they will use their own assessment tools. They also you an additional one that we require because we're wanting to measure symptom change over time, so we ask them to use another tool as well. And then we also use the Protective Factor Survey because we want to be able to compare our kids to kids that are in the child welfare system and they use the Protective Factor Survey as well, and that looks at family functioning over time. We want to see that there's an improvement in that over time. But in terms of doing more serious assessments, not just the screening which any one of us can do but this assessment level, that's up to that licensed mental health provider. And our state allows, at those two different levels, an LMHP, licensed mental health provider, or a licensed independent, allows them to do those kinds of assessments. They're the ones that will determine whether or not a

child or family or any one of us would need a psychological evaluation or a psychiatric evaluation, and it goes up from there. [LB552]

SENATOR LINEHAN: And then again you don't know how many that turns out to be. [LB552]

DEBRA ANDERSON: It's not many of ours, no, because our program is real...I don't know the percentage but our program is designed not to work with kids that are so...needing such intensive services that they would require that level of service. [LB552]

SENATOR LINEHAN: Okay. [LB552]

DEBRA ANDERSON: Which is closer to 80 percent of them. [LB552]

SENATOR LINEHAN: Oh, I'm sorry, I'm out of order. I'm sorry. [LB552]

SENATOR RIEPE: No, you're not, it's fine. That's why we have hearings. [LB552]

SENATOR LINEHAN: (Laugh) With the rules. [LB552]

SENATOR RIEPE: Are there any other questions? Hearing none, thank you very much. [LB552]

DEBRA ANDERSON: Thank you. [LB552]

SENATOR RIEPE: Other proponents, please. Just give us your name, sir, and spell it. [LB552]

ERIC NELSON: Good afternoon. Eric Nelson, E-r-i-c N-e-l-s-o-n, and I am actually a principal at Fontenelle Elementary in Omaha. We have 93 percent free and reduced lunch. And I think, instead of reading this, maybe you guys can just ask me some questions. [LB552]

SENATOR RIEPE: All right. That would be great. [LB552]

ERIC NELSON: Because I can answer a lot of the ones that you were talking about. [LB552]

SENATOR RIEPE: Thank you for your patience and staying. And obviously, as every school principal, you have challenges. [LB552]

ERIC NELSON: Yes, we do. [LB552]

SENATOR RIEPE: Are there questions from the committee? What percentage of your children do you think have some mental health issues, or is that a fair label? [LB552]

ERIC NELSON: You know, going back, I really believe it's the trauma piece. I wouldn't say they have mental health issues. And to kind of go off what you asked earlier, with the Connections program, we don't label them at all. And the great thing about the Connections program is they come into the school and when they come into the school they don't have to leave to go to an appointment. They don't have to find transportation. We had a situation where a little girl, 4th grader, who saw her older brother get...he committed suicide, and so she had a younger brother so the two of them, I mean they were all of a sudden distraught, throwing things in the classroom, stealing, do all sorts of things that you wouldn't want to see happening. They were going to go to Immanuel to get some help, but their dad got arrested and so when he got arrested, the grandmother was the only one there and so she couldn't transport them. So the best thing we could do was actually get them into the Connections program. And it doesn't last for a year. It doesn't last. It truly lasts as long as it needs to be for those kids. We've seen a couple instances where they, after a few months, they'll come back and get some extra help, but when they can work in the school and actually utilize real-time strategies, it makes a world of difference than going to a therapist outside and then having to come back. It's just keeping it in the safe place that they're in. It has been phenomenal for the kids. [LB552]

SENATOR RIEPE: Please, Senator Linehan. [LB552]

SENATOR LINEHAN: Thank you very much for that. So my, as you can tell, I'm very anxious about this, but my anxiousness is not because you're trying to help your kids, which I appreciate very much. And you have a child who gets killed and it's on the radio the next morning, counselors will be available to talk to all the students, that's all appropriate and smart. My concern here, and I think you're addressing it, is we're calling this mental health issues, which is a medical term. [LB552]

ERIC NELSON: Uh-huh. [LB552]

SENATOR LINEHAN: And if you stick that on a kid, that's a big, big deal. That's why I'm like... [LB552]

ERIC NELSON: And I agree. I mean you don't want to stigmatize anybody with that. The great thing about...you know, Deb brought up parent engagement. You know, it's kind of funny

because things happen that we don't really anticipate. But the parent engagement is huge right now because it's not the school calling. It's the therapist or whoever is working with the family. And so the parents are more apt to call, pick up the phone and answer it. And so we have seen a family atmosphere working. You know, they don't just work with the kids; they work with the whole family. And of the kids that we've serviced at Fontenelle, not one of them has been put into special ed. Not one of them has been labeled anything. They've gotten the help they've needed and then they're back in class, I guess for lack of better terms, because, like Deb said, it's not the...it's not the 5 percent who we're actually servicing, because they're already seeing somebody usually or on a behavioral program or something else. And so we've never used those terms of mental health. We've used just, you know, you throw a chair in class, you need help because that's not normal. [LB552]

SENATOR LINEHAN: Thank you very much. [LB552]

SENATOR RIEPE: How many students do you have and how many are from fatherless homes? [LB552]

ERIC NELSON: That's an interesting question. We have 600 kids at Fontenelle. We had more last year but we lost 6th grade, so we're pretty excited about that. [LB552]

SENATOR LINEHAN: But what if they weren't right? [LB552]

ERIC NELSON: (Laugh) [LB552]

SENATOR RIEPE: Or is that an issue for (inaudible)? [LB552]

ERIC NELSON: Well, it is because there was a study actually done, I don't remember who did the study, but a couple years back that we had the most single moms per capita in the city of Omaha right around Fontenelle, because we have...it's a very neighborhood school. And I started thinking that can't be right, but that's pretty much all I talk to are moms, single moms with multiple children and going through. You know the ACEs study, the 10-point survey, a lot of the kids, they have three, four, five things on that list that they're dealing with and, you know, you can't...you don't...you can't really study or be in class and be present if you're still dealing with all that stuff that you bring to school. It's very difficult. [LB552]

SENATOR RIEPE: Senator Crawford, please. [LB552]

SENATOR CRAWFORD: Thank you, Chairman Riepe. And thank you so much for being here and sharing your experience. Can you tell us some difference that you've seen in the classroom or in learning outcomes since you've had this program in your school? [LB552]

ERIC NELSON: Yeah. One of the greatest things is we have partnered with Project Harmony and I brought, to explain the program, we brought them in to talk to the staff. And so the staff is more aware of what's on, you know, because you have those staff members who...they didn't grow up in the area. They don't know what's going on. It's very difficult for them to put...to step in their shoes of the kids. And so...what was your question? [LB552]

SENATOR CRAWFORD: About a difference in the classroom or difference in learning outcomes. [LB552]

ERIC NELSON: Thank you. [LB552]

SENATOR CRAWFORD: Thank you. [LB552]

ERIC NELSON: We...you see a big difference because the kids, you know, they're excited to go see someone and then, when they get back, instead of suspending the kid for throwing a chair they're back in the classroom, which is huge, you know? I'm not saying that throwing a chair is okay. [LB552]

SENATOR CRAWFORD: Right. [LB552]

ERIC NELSON: But having them in the classroom is by far the best thing that they...and the teachers are definitely on board and they understand that. It gets scary at times, but when they see...the teachers can see the difference almost immediately when the kids come back from a session or whatnot in the school. [LB552]

SENATOR RIEPE: Okay. Senator Erdman. [LB552]

SENATOR ERDMAN: Thank you, Senator Riepe. Just out of curiosity, there's several schools in that Omaha school system that are not doing well. Is yours one of those or do you know where your ranking is? [LB552]

ERIC NELSON: Are you talking about the "needs improvement"? We are on "needs improvement," yes. But I could go into that because it's not fair, but... [LB552]

SENATOR ERDMAN: I was just curious. [LB552]

ERIC NELSON: ...we'll leave that for the Education Committee. [LB552]

SENATOR ERDMAN: Yeah. There's a lot of schools there. [LB552]

ERIC NELSON: Huh? [LB552]

SENATOR ERDMAN: A lot of schools in that district. [LB552]

ERIC NELSON: There are. And there's a lot of schools that have 93 percent free and reduced lunch and kids that have multiple trauma issues that come to them. And I'm proud to be in OPS and I'm proud that we service the kids we do because they're amazing kids and they're kids. And we're doing the best we can. A hundred percent on a test is never going to validate anybody and... [LB552]

SENATOR RIEPE: Would you be more successful if you had strictly one grade, 5th grade, that's it? [LB552]

ERIC NELSON: No. [LB552]

SENATOR RIEPE: I thought maybe it was the mix of kids that caused problems too. [LB552]

ERIC NELSON: Oh, no. [LB552]

SENATOR RIEPE: Like big kids bullying the little kids or... [LB552]

ERIC NELSON: No. [LB552]

SENATOR RIEPE: Okay. [LB552]

ERIC NELSON: Sixth graders are just...you know, their hormones are going crazy. (Laughter) [LB552]

SENATOR LINEHAN: (Inaudible.) [LB552]

SENATOR RIEPE: That ends when they get about 40 but...Senator Linehan. [LB552]

SENATOR ERDMAN: It takes that long? [LB552]

SENATOR LINEHAN: So you...you do have...thank you, Chairman. There's school psychologists or you're not budgeted for psychologists? You are short in OPS. They don't have very many psychologists, right, is that...? [LB552]

ERIC NELSON: I have one two days a week. [LB552]

SENATOR LINEHAN: There's not one in every school, because there was talk about that but then they didn't fund it, right? [LB552]

ERIC NELSON: Right. [LB552]

SENATOR LINEHAN: Okay. Thank you very much. [LB552]

SENATOR RIEPE: Do you use telemedicine? [LB552]

ERIC NELSON: What? [LB552]

SENATOR RIEPE: Do you use telemedicine at your school? [LB552]

ERIC NELSON: Telemedicine? [LB552]

SENATOR RIEPE: Telehealth, telemedicine? [LB552]

ERIC NELSON: No. [LB552]

SENATOR RIEPE: There are some schools I know through the south Omaha clinic, what is it, OneWorld, that works with one of the inner city schools that we visited and... [LB552]

ERIC NELSON: Yeah, there's... [LB552]

SENATOR RIEPE: ...they were doing mental health counseling and, you know, felt very good about it and it was an efficient way of on-site delivery in the school. [LB552]

ERIC NELSON: The school I was at before Fontenelle was Kellom. It's on 24th and Hamilton. And we were able to get the school-based health center there and we had an LMHP on staff that...at the time Alegent, now CHI, had staffed every day, full time, and that was phenomenal. [LB552]

SENATOR RIEPE: Are there days when you feel like Arnold Schwartzenegger in Kindergarten Cop? [LB552]

ERIC NELSON: (Laugh) No, actually, not anymore. [LB552]

SENATOR RIEPE: Well, we'll get you whistle. Maybe you can. Senator Linehan. [LB552]

SENATOR LINEHAN: This is not really in education either but does Health and Human Services, if you get 95 percent of your kids on free and reduced lunch, then they're all eligible, probably every...I don't know about every kid but I'm guessing most kids in your school are eligible for CHIP? [LB552]

ERIC NELSON: Uh-huh. [LB552]

SENATOR LINEHAN: So does Health and Human Services help you make sure they all get signed up, or is that just somebody else does that or how does that...because Senator Chambers tells me all the time they don't have healthcare. And then we had a little scramble yesterday that I said, well, they should be because they're eligible for CHIP. [LB552]

ERIC NELSON: I don't know. We don't...OPS is so big that I'm sure someone in the.... [LB552]

SENATOR RIEPE: I know this much. Children's had a clinic at Creighton, 75 percent Medicaid. We had an office there with an FTE, full-time person, who helped sign parents up for CHIP, so... [LB552]

SENATOR LINEHAN: Okay. Well, that's... [LB552]

SENATOR RIEPE: ...it was to our advantage as a pediatric organization, it was more to our advantage than it was to the state's. [LB552]

SENATOR LINEHAN: Well, Children's signs them up as they walk in the door of the hospital. [LB552]

SENATOR RIEPE: Well, we were Children's. [LB552]

SENATOR LINEHAN: Oh, yeah, that's right, you were. Okay, yes. [LB552]

ERIC NELSON: Well, now it's one of the things that the school-based health centers really helped with because a lot of the families and kids at Kellom would go straight to the Creighton ER because they didn't have a family physician. They didn't have any sort of access to anything, so they just went to the ER and that got very expensive. [LB552]

SENATOR RIEPE: Are there additional questions? I think the building locks at 8:00. I just (inaudible). Thank you, sir, and thank you for your patience. We appreciate that. More proponents. [LB552]

PATTI JURJEVICH: (Exhibit 2) Good evening. [LB552]

SENATOR RIEPE: Good evening. If you'd state your name and spell it, please. [LB552]

PATTI JURJEVICH: I sure will, Senator Riepe,... [LB552]

SENATOR RIEPE: Thank you. [LB552]

PATTI JURJEVICH: ...members of the committee. My name is Patti Jurjevich, P-a-t-t-i J-u-r-j-e-v-i-c-h. I'm the administrator of Region 6 Behavioral Health Care, one of the six behavioral health, regional behavioral health authorities in the state. I'm here representing the Nebraska Association of Regional Administrators, and I appear before you today in support of LB552. So this bill recognizes the importance of addressing behavioral health issues in the public school systems. Getting our children and their families the help they need as early as possible has proven to be an effective way of preventing more serious problems from developing later in life. Effectively addressing the needs of children who have been exposed to adverse childhood experiences, as provided in this bill and the Children's Connections program, are instrumental in helping to prevent involvement with systems, such as juvenile justice and child welfare. The report of the Mental and Behavioral Health Task Force issued by LR413 identified, as one of its recommendations, the need for additional early intervention strategies and offered the Connections program as an effective option available for expansion across the state. LB552 moves this recommendation forward and provides the framework and funding to initiate these intervention efforts. The Connections program, provided by Project Harmony, is a valuable resource in our community. The Connections model promotes strong, collaborative partnerships with schools and service providers that ensure an efficient use of available capacity in the

treatment community. The Connections program is an excellent resource for trauma-focused care and program dollars have been dedicated for training clinicians in evidence-based therapy practices, as well as providing training for school personnel on the impact of trauma on children and their school success. The program efforts are clearly focused on connecting youth to appropriate services provided by quality, well-trained, and experienced clinicians and on overcoming barriers that may hinder participation in treatment. The Connections model also includes coordination staff that facilitate the referral process and support the youth and family through the treatment experience. An important consideration in the development of Children's Connections programs is the allowance for flexible funding. The ability to train...to fund training for clinicians and school personnel, to support reimbursement mechanisms that recruit and retain the most qualified clinicians and ensure timely access, and to have dollars available to identify and remove barriers to treatment will allow for better outcomes and create a program that is responsive to the needs of youth and their families. LB552 calls for local match of at least one-fourth of the total cost of the initiative. Although we understand the importance of local investment and the positive impact of public-private partnerships, this may be challenging for regions and local communities due to constraints on local funding and lack of access to private funding, such as foundations or other charities. Nebraska is embarking on a statewide children's System of Care initiative that is designed to improve the lives of children who struggle with mental health challenges and their families. The Children's Connections program will be an important component of Nebraska's children's System of Care initiative by providing evidence-based resources to address mental health challenges. LB552 provides the funding and infrastructure to expand the development of needed early intervention services and supports for our youth and families across the state. I urge your support of LB552. Given the success of the Connections program in Region 6, this is a wise investment in the behavioral health system to address the needs of children throughout Nebraska. The regions look forward to the opportunity to strengthen our support of and partnership with schools and expand our capacity to better serve youth in our communities. So I thank you for your ongoing commitment to our behavioral health system and will certainly try to answer any questions that you might have for me. [LB552]

SENATOR RIEPE: Thank you very much. [LB552]

PATTI JURJEVICH: Uh-huh. [LB552]

SENATOR RIEPE: Thank you for your patience. And are there questions from the committee? Senator Linehan. [LB552]

SENATOR LINEHAN: Thank you, Chairman. I'll try to be really quick. When you say--and I probably should know this and I'm going to look very foolish--when you say Nebraska is embarking on a statewide children's System of Care initiative, who's doing that? [LB552]

PATTI JURJEVICH: Well, within the Health and Human Services, the Division of Behavioral Health applied for a federal grant through SAMHSA and they were awarded a grant. It's a four-year grant. I think it's $3 million per year and those dollars are being...have been allocated across the regions in the state to develop new services and develop better collaboration with other systems, like child welfare and probation, other...and the education system so that we can come together and hopefully bring up additional services to better serve our youth and their families. So the federal dollars is kind of the jump-start money to begin this process. [LB552]

SENATOR LINEHAN: But this is the Department of Health and Human Services. They're running it. [LB552]

PATTI JURJEVICH: That grant is through the Department of Health and Human Services. [LB552]

SENATOR LINEHAN: Okay. [LB552]

PATTI JURJEVICH: Correct. [LB552]

SENATOR LINEHAN: I can ask them about that. [LB552]

SENATOR RIEPE: Okay. Thank you. Are there additional questions from the committee? Seeing none, we appreciate your patience... [LB552]

PATTI JURJEVICH: Thank you very much. [LB552]

SENATOR RIEPE: ...and thank you for being here. Are there other proponents? Any opponents? Any testifying in a neutral capacity? [LB552]

SENATOR WILLIAMS: Come on, Joe. [LB552]

SENATOR CRAWFORD: Come on, Joe. (Laugh) [LB552]

SENATOR WILLIAMS: Joe. [LB552]

JOE KOHOUT: No, no, no. (Laughter) [LB552]

SENATOR RIEPE: Tyler, do we have any letters? Senator, you can come up. Tyler, do we have any letters? [LB552]

TYLER MAHOOD: (Exhibits 3, 4, 5, 6, 7, 8, 9, 10, and 11) Yes. The following letters are in support: Peg Harriott of the Children and Family Coalition of Nebraska; Sarah Hanify of the Nebraska Association of...for the National Association of Social Workers, Nebraska Chapter; John Skretta of the Norris School District; Mary Bahney of the School Social Work Association of Nebraska; Kaitlin Reece of Voices for Children in Nebraska; Jason Hayes of the Nebraska State Education Association; Jessica Walters on behalf of herself; John Cavanaugh and Pat Connell of the Nebraska Child Health and Education Alliance; and Mary Jo Pankoke of the Nebraska Children and Families Foundation. [LB552]

SENATOR RIEPE: Thank you, Tyler. Senator Walz, before we ask you to close, if I may ask, we apologize. We normally would have had your bill up first. We had some testifiers from the last bill that had to catch air flights. That's why you ended up at this hour of the day and not earlier. [LB552]

SENATOR WALZ: That's fine. [LB552]

SENATOR RIEPE: Okay. Well, I just wanted to say that. [LB552]

SENATOR WALZ: That's good. I'm just glad that we're here and that we're able to testify. [LB552]

SENATOR RIEPE: Well, and you're, please, (inaudible) close. [LB552]

SENATOR WALZ: All right. One of the things that I just want to address is the word "squishy" and that they're trying to catch those kids, you know, before it's too bad. And you know I think sometimes in our minds we might think, well, you know, it's not really an emergency yet so we don't need to find those funds. The key word is prevention. The key word is not waiting until it's an emergency and not waiting till those kids have to go into foster care, not waiting till those kids have to go to juvenile detention or whatever it is. The key word is prevention. So again, I want to thank you for the opportunity to present this important legislation to you today. Every child's situation is unique and I don't think that any of us can imagine some of the hardships that children and families face. We need to make sure we are providing support to children that need our help and give them the best chance to succeed and live prosperous lives. We all know that this is not an overnight fix, but it is important that we have this conversation and start moving in the right direction. I'm happy to work with anyone who wants to strengthen this bill to provide

the essential services our children in our state need. I urge you to advance LB552. Thank you. [LB552]

SENATOR RIEPE: Thank you very much. And with that, that concludes the HHS public... [LB552]

SENATOR LINEHAN: Uh-oh. [LB552]

SENATOR RIEPE: What? What? Oh, I'm sorry. [LB552]

SENATOR ERDMAN: It's all right. [LB552]

SENATOR RIEPE: Senator Erdman, please. [LB552]

SENATOR ERDMAN: Thank you, Senator Riepe. So do you have an answer, who pays the 25 percent? [LB552]

SENATOR WALZ: Local match can be a school district, a private donor, some sort of local group. Was that the question? [LB552]

SENATOR ERDMAN: Uh-huh. [LB552]

SENATOR WALZ: Okay. And they...you said local match. It's designed to try to keep the costs down. But again, we're willing to discuss any other ideas that you might come up with. [LB552]

SENATOR ERDMAN: Thank you. [LB552]

SENATOR WALZ: You're welcome. [LB552]

SENATOR RIEPE: I'll look up and down the line this time. Okay. [LB552]

SENATOR ERDMAN: Sorry. [LB552]

SENATOR RIEPE: No. No, don't be sorry. That's perfectly...I just apologize for missing it. This concludes the HHS public hearing on LB552. Thank you again. [LB552]