Health and Human Services Committee
June 27, 2017

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The Committee on Health and Human Services met at 9:00 a.m. on Tuesday, June 27, 2017, in Room 1510 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public hearing on briefings on rate methodology for dual eligibility and Heritage Health. Senators present: Merv Riepe, Chairperson; Steve Erdman, Vice Chairperson; Sue Crawford; Sara Howard; and Lou Ann Linehan. Senators absent: Mark Kolterman and Matt Williams.

SENATOR RIEPE: Thank you, everyone, for being here today. This is the Health and Human Services Committee and this is a briefing on the rate methodology for dual eligibilities. First, I would like to say there is only invited testimony for this briefing. However, if a member of the public would like to testify about this issue, they will be able to testify at the 1:00 p.m. hearing. I would like to ask all of the staff people...I would say before that is the reason lights are dim is because of the cameras and so we're unable to brighten it up. We're not trying to be clandestine here. I'd like to ask the committee members if they would for self-introductions and then I will introduce the pages. I'm going to ask staff to do it as well so, Senator Howard, would you start.

SENATOR HOWARD: Thank you. I'm Senator Sara Howard. I represent District 9 in midtown Omaha.

SENATOR ERDMAN: Steve Erdman, District 47, ten counties in the Nebraska Panhandle.

KRISTEN STIFFLER: Kristen Stiffler, legal counsel.

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

TYLER MAHOOD: Tyler Mahood, committee clerk.

SENATOR RIEPE: And before we go to the pages, I would like to introduce Senator John McCollister and Senator Rob Clements; and I appreciate them both being here. They're here in the audience. Also our pages that are here and helping us today back in the shadows there is

Brenda Gallardo. Thank you, Brenda, and also Alexi Richmond so we appreciate that. My name is Merv Riepe. I'm from the Omaha-Millard district and I serve as Chairman of this committee. Our hearing today is your public part of the legislative process. The committee members may come and go during the briefing. It's not an indication of lack of interest. It's just a matter of the process and other activities that might be going on. To better facilitate today's proceeding, I ask you to please turn off or silence any of your cell phones that you may have. I'd also like to make a few remarks before we begin this briefing. I have asked interim director Rocky Thompson to present on the new rate methodology that will take effect on July 1 of 2017. It's my understanding that Nebraska was one of six states that paid reimbursement for dual eligibilities at the Medicare rate. With the new methodology, the reimbursement rate will move to the lesser of for reimbursement. It was a tough year for the budget and Medicaid was one of the divisions affected by the line item vetoes. I have asked interim director Thompson to present on the new methodology and what are the greatest impacts for members and providers. I look forward to a stimulating discussion. And again, I thank the members of the committee for taking the time to be here on this briefing. This is our interim recess period, and so they've made a special effort and I am very much appreciative of that extra effort that they have exhibited. So with that, Mr. Thompson, Director Thompson, I turn the show over to you.

ROCKY THOMPSON: (Exhibit 1) Good morning, Chairman Riepe and members of the Health and Human Services Committee. My name is Thomas "Rocky" Thompson, T-h-o-m-a-s R-o-c-k-y T-h-o-m-p-s-o-n, and I am interim director of the Division of Medicaid and Long-Term Care in the Department of Health and Human Services. Thank you so much for inviting me here today to discuss this issue and my division's plan to manage our budget within the appropriations given without impacting essential services to the most vulnerable individuals in our state. On our first slide today's discussion--we have an outline for today's presentation--first, I'll provide a brief background on Medicaid nationally and in Nebraska just so you know its impact on our providers, on our residents, and on our economy. And I'll discuss the budget passed last month. Then I will move to ways we will manage within our budget and touch upon the meetings I've had with different provider organizations over the last month since the finalized budget was signed. Briefly, I'd like to discuss Medicaid nationally and the impact it has here in Nebraska. As you know, Medicaid is a state-federal partnership with federal oversight through the Centers for Medicare and Medicaid Services or CMS where my predecessor has left to go assist the rest of

the nation with its Medicaid programs. Medicaid is the single largest insurer and provides significant financing to hospitals, community health centers, physicians, nursing homes, and jobs in the healthcare sector. The Medicaid program finances over 16 percent of all personal health spending in the United States, and Medicaid is also the primary source of long-term care coverage. Now in Nebraska, we have a population nearing 2 million individuals. We provide coverage for 12.6 (percent) of all Nebraskans, around 230,000 people; and also we pay for a significant number of births in the state, 37 percent of all births are paid for by Medicaid in Nebraska. Now Medicaid is an entitlement program. If an individual qualifies for our services, they are entitled to receive them under federal law. So if enrollment and utilization both increase, then the costs of the program increase. That is why the Medicaid budget does not have specific line items for provider types. Dependent upon actual utilization, costs incurred might be (inaudible) other provider types. However, costs have become more predictable in our budget due to the implementation of our new managed care program, Heritage Health. With most of our population covered and services included, we are able to develop a better forecast for our budget. Based upon our current forecast, we will be extremely close to utilizing our entire $833 million. Now that's just General Funds. That does not account for the federal portion. If something changes like enrollment increases beyond our current projections, then we will likely use up our entire appropriation. So that is why it is important that we continue to manage our budget and monitor if there's any kind...any spike in enrollment, for example. Under the budget passed and signed by the Governor last month, there was a reduction in the Medicaid budget that requires Medicaid, like other agencies in the state, to make some tough decisions. Because of the nature of the Medicaid budget, we are able to manage our budget in such a way to minimalize any adverse impact on our residents covered by our program. While across-the-board rate cuts were originally proposed to achieve these savings, based upon feedback of provider organizations and all of you on line item veto day, we were listening, it was determined that this was not the best way forward. Nebraska Medicaid looked for alternatives to across-the-board rate cuts and found that by making a change in payment methodology for Medicare/Medicaid crossover claims we could achieve the necessary savings to ensure that we can work within our appropriation while keeping current rates to providers stable. This change will make reimbursement of claims for Medicare/Medicaid crossovers so payment will not exceed the lesser of the Medicare or Medicaid allowable amount. Currently, we pay at the Medicare rate. Nebraska is one of only six states that pays a full amount allowed for Medicaid inpatient, outpatient, and physician services.

Capping payments at the Medicaid rate, as most states do, is projected to achieve $11.3 million in General Fund savings annually. We also feel this is a better policy than across-the-board reimbursement reductions. This is also the market standard. We are currently working to implement this payment methodology change, including making necessary regulatory, state plan, and contractual changes. Additionally, I have been meeting with numerous provider organizations over the last month to discuss this change and to make sure that they understand its impact on their specific provider groups. Thank you for your time today. I'll be happy to answer any questions that you might have.

SENATOR RIEPE: Thank you. Are there questions from the committee? Before we go on, Senator Erdman, let me introduce Senator Linehan, who is...

ROCKY THOMPSON: Good morning.

SENATOR LINEHAN: In the wrong room.

SENATOR RIEPE: I understand that. We all start down that way. But we appreciate you being here very much and also with us today in the audience is Senator Steve Halloran from the Hastings area so thank you for being here as well. Now, Senator Erdman, question.

SENATOR ERDMAN: Thank you. Thank you, Chairman Riepe. Thank you for coming this morning. So this process of changing over to the new form of payment, how long is it going to take before this transition is completed?

ROCKY THOMPSON: This will be in effect July 1.

SENATOR ERDMAN: Of...

ROCKY THOMPSON: Of this week, Saturday.

SENATOR ERDMAN: Okay. Thank you.

SENATOR RIEPE: Senator Howard.

SENATOR HOWARD: Sure. And this is sort of a broader, well, actually I want to step back. You said 37 percent of all births are covered by Medicaid.

ROCKY THOMPSON: Correct, in Nebraska.

SENATOR HOWARD: And I remember my first year four years ago Vivianne Chaumont told me that 52 percent of births were covered by Medicaid. Why has that number declined?

ROCKY THOMPSON: I'll have to check and see the reasons. It might be a better economy than when she was here and then, of course, the economy is not doing as well right now so we might see a spike in (inaudible).

SENATOR HOWARD: And when we're talking about Medicaid, we're talking about Medicaid and CHIP collectively?

ROCKY THOMPSON: Medicaid and CHIP.

SENATOR HOWARD: Okay. How many dual eligibles do we have currently in the system?

ROCKY THOMPSON: I'd have to check. The last number I saw...I'll have to get back to you on the exact number for you.

SENATOR HOWARD: I mean, I sort of...I'm trying to get a feel for how many individuals will be impacted by some of these provider rate changes.

ROCKY THOMPSON: It's less than 50,000. I want to say 40,000; but I'll have to get you the exact number.

SENATOR HOWARD: We have 40,000...

ROCKY THOMPSON: Medicare/Medicaid dual eligible.

SENATOR HOWARD: Dual eligibles.

ROCKY THOMPSON: Um-hum.

SENATOR HOWARD: Okay. Okay. I'll (inaudible).

ROCKY THOMPSON: And I'll give you the exact number.

SENATOR HOWARD: That would be great, thank you.

SENATOR RIEPE: A question I might have is that by making the adjustment on the dual eligibles so pay the lesser of, is that a dollar-for-dollar offset to what the veto included or (inaudible)?

ROCKY THOMPSON: The Governor's line item veto was $11.8 million so there's a difference of about a half a million dollars.

SENATOR RIEPE: Okay. I'm looking to see if there are other questions here from the committee as well. What's the implications on this from a critical access hospital?

ROCKY THOMPSON: Critical access hospitals won't be affected by this methodology. They're reimbursed through their cost reports so they're reimbursed differently than other hospitals.

SENATOR RIEPE: Okay. Okay. Senator Linehan.

SENATOR LINEHAN: You said there were six other states...only six other states that pay as we used to.

ROCKY THOMPSON: Correct.

SENATOR LINEHAN: Do you know...can you tell me what those six states are?

ROCKY THOMPSON: Arkansas, Iowa, Mississippi, Vermont, and Wyoming.

SENATOR LINEHAN: I'm sorry, I'm not writing that fast.

ROCKY THOMPSON: Okay. Arkansas, Iowa, Mississippi, Vermont, and Wyoming.

SENATOR HOWARD: Are those all managed care states?

ROCKY THOMPSON: No, ma'am. Wyoming is, for example, not a managed care state.

SENATOR HOWARD: Well, we know that Iowa is.

ROCKY THOMPSON: Iowa is. Arkansas is not a managed care state also. And then Vermont, I know they've been looking at reforming their Medicaid program to a single-payer system. I'm not sure where they are with that.

SENATOR HOWARD: Yeah.

SENATOR RIEPE: Senator Crawford.

SENATOR CRAWFORD: Thank you, Chairman, and thank you for being here to discuss this change. When we're thinking about major players who are impacted by this change so you've talked a bit about how it doesn't impact critical access hospitals, I would guess one of the major players that will be impacted would be our folks who are providing more long-term care because that might be a big batch of the dual eligibles in pretty sparsely populated areas. Could you talk a bit about any analysis that has been done or projections on how it will impact the viability of long-term care facilities, especially in more sparsely populated rural areas?

ROCKY THOMPSON: Yes, Senator. Actually this change has been already implemented for nursing facilities I think about eight years ago.

SENATOR CRAWFORD: Okay.

ROCKY THOMPSON: So there will be little to no impact on nursing facilities. The biggest player that will be hit by this are hospitals, but not our critical access hospitals.

SENATOR CRAWFORD: But not the critical access hospitals.

ROCKY THOMPSON: Correct.

SENATOR CRAWFORD: Okay. And what does it look like in terms of outpatient services?

ROCKY THOMPSON: I have a list right here about if it's...let's see. What I'm looking at right here about half of it will be the hospitals and about a fourth will be outpatient. But I can give you exact breakdown.

SENATOR CRAWFORD: And then what...

ROCKY THOMPSON: This is by the provider type that I have this breakdown right now.

SENATOR CRAWFORD: And then about what is the other one-fourth then?

ROCKY THOMPSON: There's outpatient, inpatient in the hospitals.

SENATOR CRAWFORD: Okay. Thank you.

SENATOR RIEPE: Senator Howard.

SENATOR HOWARD: So you have to do a state plan amendment for this change?

ROCKY THOMPSON: Correct.

SENATOR HOWARD: Can you tell me how that process is going, how long you anticipate that process to take? And tell me a little bit about your comfort level with making this change before the state plan amendment is submitted or approved.

ROCKY THOMPSON: First of all, I'm very comfortable with submitting the state plan amendment before it is approved, making this change before the state plan amendment is approved. If it was a rate cut, CMS has been increasing scrutiny on any rate cuts that states are making since there was a regulation that was issued by the federal government back in 2015 ensuring that access to services are provided.

SENATOR HOWARD: Is that the maintenance of effort?

ROCKY THOMPSON: It's not maintenance of effort. It's the access rule.

SENATOR HOWARD: Okay.

ROCKY THOMPSON: So they make sure that we had to submit an access plan to CMS. They have to ensure...we have to ensure that there's access to critical services for our Medicaid population if any rate change is made. And that has led to CMS waiting up to a year before states can make any kind of rate reductions.

SENATOR HOWARD: Okay.

ROCKY THOMPSON: With this change already implemented in 44 other states, I think it will be a pretty simple state plan amendment. As you know, a state plan amendment can be retroactive to the first day of the quarter that it is submitted. For any kind of rate change or rate methodology change, we have to submit a public notice posted to our Web site letting individuals know what the federal fiscal impact will be of that prior to the first day of implementation. That's already been post...that was posted to our Web site last week. We have to provide a tribal notice. Tribal notice is going out today. We have to wait a month after tribal notice is sent to send the state plan amendment. But the state plan amendment will be effective July 1, and I'm confident that it will be approved by the federal government.

SENATOR HOWARD: When was it submitted?

ROCKY THOMPSON: With the state plan amendment, we have to wait a month to submit the state plan amendment.

SENATOR HOWARD: After notice is given?

ROCKY THOMPSON: After tribal notice.

SENATOR HOWARD: Okay.

ROCKY THOMPSON: That's...but it's retroactive to the first day of the quarter in which it is submitted.

SENATOR HOWARD: When did you decide to start working on a state plan amendment? I'm trying to get a feel for how long it takes you to work on a state plan amendment.

ROCKY THOMPSON: It was the day of the veto override so it was mid May.

SENATOR HOWARD: Okay. And you anticipate how long will it take for it to be approved?

ROCKY THOMPSON: I don't anticipate it's going to take the full 90 days to be approved. I think this will...the sense is it's been done in other states. I think this will be a pretty simple...I would say maybe 45 days.

SENATOR HOWARD: And when did you update the Heritage Health contracts to reflect this change?

ROCKY THOMPSON: They signed the amendments last week.

SENATOR HOWARD: Okay. And when did you start talking to them about making this change?

ROCKY THOMPSON: We started talking to them in May.

SENATOR HOWARD: Okay, great. Thank you.

SENATOR RIEPE: Director Thompson, in your discussions with those that were, I think you described those that were affected that was over the rates, did they simply acknowledge that they had had the meeting or did they acknowledge some acceptance of that as being it is what it is or how did those conversations typically go?

ROCKY THOMPSON: Most provider organizations provided acceptance that that's the way it is. We have continued discussions with the Hospital Association to work through concerns. They did send a letter to me saying that they would urge us to monitor this change to see what actual savings is achieved to make sure that we don't actually go over the $11.3 million that we were talking about.

SENATOR RIEPE: Okay. Senator Linehan.

SENATOR LINEHAN: Thank you, Mr. Chairman. I think I understand this, but I just want to clarify. So if we...if the state reimburses the Medicaid rate, the federal government picks up a percentage of that, matches a percentage, right?

ROCKY THOMPSON: The way that Medicaid is financed, we pay for services and approximately the federal government pays for half of that, a little over half.

SENATOR LINEHAN: Okay. So if we pay the...which we have been doing, the Medicare rate, does the federal government still just pay half the Medicaid rate?

ROCKY THOMPSON: They pay the...we would continue to be reimbursed the same way that we reimburse for (inaudible).

SENATOR LINEHAN: Fifty cent...50 percent.

ROCKY THOMPSON: A little over 50 percent.

SENATOR LINEHAN: Okay.

SENATOR RIEPE: A question I have is on the methodology, how does that impact behavioral health especially out in the rural communities?

ROCKY THOMPSON: There will be some behavioral health impact. It's mostly higher level professionals for those. It's limited from what the impact would have been if there was a 3 percent rate reduction. So it's...I wouldn't say it's a significant impact. There is a behavioral health impact, but not the impact seen, for example, in hospitals.

SENATOR RIEPE: Senator Howard. Let's go back. Okay.

SENATOR HOWARD: Do you want to stick with behavioral health?

SENATOR LINEHAN: Yeah.

SENATOR RIEPE: Okay, Senator Linehan, why don't you go ahead?

SENATOR LINEHAN: I'm sorry. You need to clarify that a little bit. So I understand behavioral health sometimes includes hospitals, right?

ROCKY THOMPSON: Correct.

SENATOR LINEHAN: So they would be now reimbursed at Medicaid rate even, which they would have been anyway if they weren't on Medicare.

ROCKY THOMPSON: Correct.

SENATOR LINEHAN: So there's no change there.

ROCKY THOMPSON: Well, it's a change because we pay to the Medicare rate today.

SENATOR LINEHAN: Okay. So for behavioral health for someone who is a dual eligible, but behavioral health for somebody who is not a dual eligible there won't be a change?

ROCKY THOMPSON: Correct.

SENATOR LINEHAN: Okay. So it would be...okay. All right, that's helpful. Then I have another question, but if you want to stay on one subject.

SENATOR HOWARD: Oh, this one is pretty simple. Right now we're paying the Medicare deductible for our dual eligibles. Are we still going to do that after July 1?

ROCKY THOMPSON: We will, we will.

SENATOR HOWARD: Okay. And there will be no change in that.

ROCKY THOMPSON: It would be to Medicaid allowable.

SENATOR HOWARD: How...so what's the difference between what we have now and what's Medicaid allowable?

ROCKY THOMPSON: I would have to check exactly what that difference is.

SENATOR HOWARD: Okay, thank you.

SENATOR RIEPE: Senator Linehan.

SENATOR LINEHAN: So do you...and this is something I expect you'll have to get, but I would just be interested, if 12.6 percent of the population in Nebraska is eligible and using Medicaid services, how does that look nationally? Is that like a national average or? And if you don't know that, it's just something I would like.

ROCKY THOMPSON: That is Nebraska specific. As you know, some states have expanded their Medicaid program to include childless adults. So they have a higher percentage of their populations on Medicaid. And it also depends upon the poverty level in the state because some states might have higher levels of poverty as they might be more dependent upon Medicaid as a health insurance program.

SENATOR LINEHAN: Okay. So is there a chart somewhere that you can?

ROCKY THOMPSON: Sure. We can provide that for you.

SENATOR LINEHAN: Okay, thank you.

SENATOR RIEPE: Do you have a plan B, Director, if you don't accomplish your $11.3 million savings? What do you have to do then?

ROCKY THOMPSON: We're looking at our different options. I wouldn't say anything is off the table, but we will make sure to keep all of you informed before any change is made as we continue to monitor our budget and our forecast.

SENATOR RIEPE: Of the people that you talked to, do you feel that there's been groups that just haven't been represented or...and I guess the question always gets to be, too, is sometimes, you know, one can hear, but understanding and acceptance are kind of two different things. I don't know whether they may have, in your meetings, understood that this is what it is. I don't know whether they accepted that. Do you have a sense on it?

ROCKY THOMPSON: I've tried to reach out to all kinds of different provider organizations. When my predecessor left, I asked him before he left to come up with a list of people that I should talk to and I've been trying to go through that list. Of course, I tried to meet with anybody that asked and I'll be glad to meet with anybody else that feels that they might be impact of this so we can discuss that.

SENATOR RIEPE: My guess is, too, is the new rate methodology combined with a new delivery system of managed care just compounds the whole issue as well. It's a lot of change going on all at one time.

ROCKY THOMPSON: There's never an easy time to make changes in payment.

SENATOR RIEPE: Or a lot of other things, policies (inaudible).

ROCKY THOMPSON: And, of course, at the federal level there's those changes going on so see what comes out of that.

SENATOR RIEPE: Okay. Are there other questions from the committee? I know we will get a chance at the hearing, this is a briefing, so there is an opportunity for input. But there will be an opportunity at the 1:00 hearing this afternoon, and I assume that we will be hearing from some individuals that have concerns and thoughts. Senator Crawford.

SENATOR CRAWFORD: Thank you. Just to help us get an understanding of the scope of this and impact it would have, you noted that this is an alternative to an across-the-board 3 percent cut. And then, from what I understood, from the total number in managed care and about 40,000 are these dual eligibles so it looks like a fifth or so of the population. So can you give us an estimate of the actual percent of cut in reimbursement for those who are impacted?

ROCKY THOMPSON: I have...

SENATOR CRAWFORD: It must be over 3 percent then if we're concentrating as opposed to spreading it out.

ROCKY THOMPSON: I have to check the exact percentage. What I have right here is a percentage of savings that will be seen by each provider...from each provider type. And again, hospitals are the ones that are going to be hit.

SENATOR CRAWFORD: Can you provide that? That gives us at least a sense of where the cuts are happening.

ROCKY THOMPSON: Right and I can do that and compare it to what a 3 percent rate reduction would be.

SENATOR CRAWFORD: But you said you have it in front of you.

ROCKY THOMPSON: Yeah, I have that in front of me. I can provide that for you.

SENATOR CRAWFORD: Can you tell us that, just like the percent cut for those major categories?

ROCKY THOMPSON: Well, it doesn't have the percent cut for the total reimbursement.

SENATOR CRAWFORD: Okay.

ROCKY THOMPSON: It has a savings that (inaudible).

SENATOR CRAWFORD: Well, that would be good. That at least gives us an idea.

ROCKY THOMPSON: Um-hum, because with general federal funds you have 23, about $23 million. So hospitals are about $10 million of that.

SENATOR CRAWFORD: Okay.

ROCKY THOMPSON: From that you have professional claims, $5.3 million. You have rental and retail supplier, $1.9 million. Let's see, you have ambulance, $1.2 million. Federally qualified health centers, $62,000. Indian health hospital clinic, $30,000; nurse practitioner, $510,000; occupational therapy health services, $156,000; optometrists, $388,000. So I can send you the exact list. There's more on here, but the large number, the hospital and the professional claims.

SENATOR CRAWFORD: So this is the total savings.

ROCKY THOMPSON: Yep.

SENATOR CRAWFORD: It includes the $11 million state but then also the federal.

ROCKY THOMPSON: It would be...this is what the providers are actually going to feel.

SENATOR CRAWFORD: So this is how much less each of those types of providers are going to be getting because we are changing our methodology which also changes the federal reimbursement.

ROCKY THOMPSON: Correct.

SENATOR CRAWFORD: That's helpful to see those impacts. Thank you.

ROCKY THOMPSON: And we can provide you this full list.

SENATOR CRAWFORD: Thank you.

SENATOR RIEPE: Okay. Are there other...Senator.

SENATOR HOWARD: Since we are making requests, when I asked how many of these individuals, how many dual eligibles we had, if you were able to share even a little bit of demographic information. I mean, obviously we know that they're 65-plus and that they're elderly. And so we're really impacting...

ROCKY THOMPSON: Mostly elderly.

SENATOR HOWARD: Right. But sort of where are they concentrated? What are their needs? Are they in long-term care facilities? What does that look like? Even a little bit of demographic information so that we know who this is impacting would be really helpful.

ROCKY THOMPSON: Yes, ma'am.

SENATOR HOWARD: Thank you.

SENATOR RIEPE: Is there a chance that you might have some of that information at our 1:00?

ROCKY THOMPSON: I think we can provide some of that information, yes, sir.

SENATOR RIEPE: What you can, anything, any information. People have come from distances and we need to accommodate them and get them engaged to the extent that we can.

ROCKY THOMPSON: We understand.

SENATOR RIEPE: And again, in full and open disclosure, trying to make sure that everyone understands that there isn't a backdoor agenda, and the piece at 10:00, we're here to have a hearing, here to have a briefing, and here to get to some of the issues, if you will. Are there other comments or questions from the committee as such? Hearing none, we appreciate you coming here. We appreciate everyone coming here. We will...our second briefing will be at 10:00. We will honor that time as opposed to starting early because some people will be coming in anticipation at 10:00 and not starting at an earlier time. So we thank all of you for that. And with that, this briefing is concluded.

ROCKY THOMPSON: And thank you, members.

BREAK

SENATOR RIEPE: We are going to go ahead and get started with this 10:00 briefing. We appreciate all of you being here. This briefing is the first of what will be a number of established briefings and hearings to provide formal and ongoing oversight of the implementation of Heritage Health and its delivery of healthcare services to Nebraskans eligible for Medicaid outside of long-term care. Before I go on with that, I want to ask all of the committee members, so that all of you become familiar with them...and I want to express my deep appreciation for

their being here for this hearing. It's critically important and they have given up of their time, and I do appreciate that very much. So Senator Howard, would you introduce yourself?

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

SENATOR ERDMAN: Steve Erdman, District 47. I represent 10 counties in the Nebraska Panhandle.

KRISTEN STIFFLER: Kristen Stiffler, legal counsel.

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

SENATOR LINEHAN: Good morning. Senator Lou Ann Linehan. I am everything in Douglas County west of 180th Street.

TYLER MAHOOD: Tyler Mahood, committee clerk.

SENATOR RIEPE: And we have two pages with us today that are of great help. The first one is Brenda Gallardo...close? Thank you. She is an economics major at the University. And Alexi Richmond. And so thank you so very much for working today; we appreciate that. I am Merv Riepe. My district is 12, and that is the Omaha, Millard, and Ralston areas. And I serve as Chairman of the Health and Human Services Committee. Our hearing today is a public part of the legislative process, and the committee members may come and go due to some other issues that are going on, as well. There seems to be something all of the time, whether we're in session or in "recess." I will please ask you, a repeat from the earlier meeting, that if you have cell phones, if you would please silence them. Also in our audience on this 10:00 hearing, I look around; I see Senator Clements and I see Senator Bostelman and I see Senator Halloran. Is there anyone that's not here? Okay; thank you very much. Healthcare delivery is a very personal, emotional life experience. In providing healthcare services to some 230,000 of Nebraska's most vulnerable, I am reminded of the words of John Kennedy in his "going to the moon" speech,

when he said: We do it not because it's easy, but because it's hard. And healthcare is hard, Medicaid is hard, and all of the business is not an easy business. We must address the cost of healthcare, public and private, and we must begin now. For too long we have adopted a philosophy of "I would gladly pay you Tuesday for a hamburger today," from Wimpy of "Popeye" fame. And the cost of healthcare has grown more rapidly than inflation and most other goods and services. The state of Nebraska has experienced the same unsustainable healthcare costs with state health programs such as Medicaid. This Health and Human Services Committee has statutory jurisdiction for oversight of Medicaid and, with that, the implementation of Heritage Health. We will be responsible to our fiduciary duties, our accountability to each of those receiving and providing services, as well as the taxpayers of Nebraska. In concert with our federal Medicare and Medicaid partners, it's over a $2 million...$2 billion annual impact, and we must be vigilant in our oversight. The department introduced Medicaid integrated managed care as a partial answer for best spending the scarce dollars, and they started on January 1, 2017, and must manage risk reimbursement models away from fee for service, to value based. We cannot tolerate low standards but the department is not, and never will be, perfect in its service. That said, we must take a long view, remembering Heritage Health has been operational for just six months. We must remain calm. I am reminded of Senator Campbell, who was my predecessor in this particular chairmanship role, and I think at her desk and in a couple...in her office she had a sign that says: Stay calm; carry on. And I think that that is my peace, in terms of where we're at in introducing a new program, a program with such personal impact and such financial implications. With that, I welcome Interim Director Rocky Thompson back to present for our quarterly briefing on the implementation of Heritage Health. And that said, this is a briefing; we will be having a hearing where others will be afforded the opportunity to testify at 1:00 in this same room. So with that, I would like to turn it over now to Director Thompson, and please introduce yourself, if you would, spell your name for the record and we will proceed.

ROCKY THOMPSON: (Exhibit 1) Thank you, Chairman Riepe and members of the Health and Human Services Committee. My name is Thomas "Rocky" Thompson, T-h-o-m-a-s R-o-c-k-y T-h-o-m-p-s-o-n, interim director for the Division of Medicaid and Long-Term Care in the Department of Health and Human Services. Thank you for inviting me today for this quarterly meeting on implementation of the Heritage Health managed care program. I am joined here today by members of my staff, including deputy director of delivery systems, Heather

Leschinsky, and Carmen Bachle, administrator for plan management. Also here today are the CEOs of our three Heritage Health plans: Nebraska Total Care, United Healthcare, and WellCare of Nebraska, who can answer any plan-specific questions that you may have. Today I would like to give you a little background on managed care and Heritage Health, explain why these changes were made, and the benefits that we hope to achieve in this delivery system. Then I'll discuss the oversight of these plans. Then I will touch upon the public transparency for the program and the involvement we have had from stakeholders. Then I'll review our most current metrics for this program through May of 2017 and go over success stories that we are hearing from our members and how this has improved their lives. First of all, as has been shared before, it is important to remember that managed care is not new to Nebraska. It has been the prime delivery model for some time, including for behavioral health. There are many budgetary benefits for managed care, including greater budget predictability. Additionally, managed care organizations, or MCOs, have more flexibility than traditional Medicaid, including augmenting staffing, using newer information technology systems, the ability to provide value-added services, and the ability to provide greater coordination of care. Now Heritage Health covers...has to cover the same services as our Legacy, Medicaid program. Additionally, there are some other benefits that each plan offers outside of the...this benefit package, our value-added benefits. Then there are also some services that are not part of Heritage Health but are still covered by Medicaid, and those are dental services, nonemergency medical transportation, and long-term services and supports. Those are carved out, even though the members that receive those services do receive some of their services through managed care. As of this month, Heritage Health has a membership of almost 228,000 Nebraska residents and, again, this is the vast majority of Nebraska Medicaid members. As you can see from this chart, each plan has about the same number of members. And then there are about 2,000 members that are not enrolled in Heritage Health. And these are individuals that might have to have a share of cost obligation, or these are individuals that might receive medical...emergency medical services for aliens--things like that. Just so you understand the magnitude of this project, this program, the plans in the state since last year have had to work with 38,000 providers in Nebraska. And then the plans also have providers outside of the state. And each contract is over 1,800 pages. While there have been issues with the implementation that we will discuss later in this presentation, compared to other states, this implementation has been relatively smooth. And in fact, I met with a provider last week who also takes patients from other states. This provider said he compared to other states; there were little, if no, issues for that

provider. Now we understand that there are still issues that are emerging, there are still issues that we are and the plans are resolving, and that some provider groups do have issues that are continuing that we are working to address. Now Medicaid is serious about providing proper oversight of our Heritage Health plans. I said that each contract is over 1,800 pages, but each contract also has 850 different requirements. There are also 53 separate, regular, and other reporting requirements in the contracts, more than in many of the other states our plans do business in. If contract expectations are not being met by any one of our plans, the division has the ability to require corrective action plans and impose sanctions. Late last month, due to ongoing payment issues being faced by our providers and other concerns, we requested a corrective action plan from Nebraska Total Care. We are due to receive that corrective action plan from Nebraska Total Care at the end of this week. In the meantime, Nebraska Total Care has posted a list of, on their Web site, of known issues and their estimated time for resolution. When we have received the corrective action plan, we will determine whether sanctions will be required. Nebraska Medicaid logs and tracks every single issue that is brought to its attention. Now again, we...I emphasize "to its attention." If we're not aware of an issue, we might not be able to track that issue and hold the plans accountable to resolve on that issue. When we receive an issue, that list is shared with the plans, who have 24 hours to respond. Additionally, I go over this list with each plan's CEOs at biweekly meetings. We would urge our stakeholders that, if you are aware of any issues and can provide specific information for the state and our plans to respond to, please send it to our Heritage Health e-mail address for our staff to track; that's DHHS.HeritageHealth@Nebraska.gov. And this is important for us; it is important for us to keep track and hold our plans accountable. Now this next slide goes over the statistics for the issues that are active or closed by each plan, as of last week. As you see, there are 94 active issues with Nebraska Total Care and the resolved issues for Nebraska Total Care was 217. For UHC there were 60 active issues and 181 that have been resolved. For WellCare, 67 active issues and 223 that had been resolved. We do not close an issue until payment has been made to a provider, although a solution might already be identified. Currently Nebraska Total Care estimates that it has a little over $2 million worth of claims that are waiting to pay out to close these issues. WellCare has a little over $4 million and United has a little over $200,000. Some of these claims might be duplicates; some of these claims might be the actual charges billed by the provider and not the charges that are actually allowable to be paid by Medicaid, which might be lower. I think that WellCare estimates that many of these payments will be made at the end of this week.

Nebraska Total Care has their tracking sheet on their Web site, and United HealthCare is close to making payments. As I said, many issues have been resolved at this point; however, there have been continuing issues for our behavioral health and home health providers. For our behavioral health providers, there were initial issues with getting proper fee schedules to our plans. Additionally, there have been growing pains as the providers have moved from one plan for managed care, which was Magellan, to three healthcare plans. We continue to work with our behavioral health providers through regular behavioral health integration meetings, meetings with the Nebraska Association of Behavioral Health Organizations, and we have a weekly call to go over payment issues. One issue that has been a concern for the past several months from our behavioral health providers has been tracking prior authorization requirements between the plans. We issued a health plan advisory last week to relax this requirement until we finish our mental health parity reviews of the plans. Additionally for home health, Nebraska has had a more generous home health benefit than other states, and our plans have had challenges in providing proper reimbursement for this benefit. The plans have worked to develop a more exhaustive list of home health benefits for which Nebraska Medicaid is primarily responsible for and is working through their systems to ensure those claims are paid. As I mentioned on the slide before, last week we issued a health plan advisory to relax authorization requirements for behavioral health. This slide goes over other recent health plan advisories and the dates that are...they were issued. Now this is our main communication, formal communications of the plans other than contractual amendments for them to make change in their program administration. When we hear about systemic or an issue that requires resolution across the plans, we issue a health plan advisory. Now Nebraska Medicaid is committed to operating Heritage Health in a transparent manner and seeking stakeholder feedback in multiple venues. Additionally, by the end of this week, each plan is to have a dashboard in place, going over statistics in this chart. Now this adds to the statistics that are already available on our Heritage Health Web site, and those go through May of 2017. And those go through claims, call issues, and some other statistics. Now to receive stakeholder feedback during the implementation of Heritage Health and beyond, Nebraska Medicaid has set up several stakeholder committees to receive feedback on ways to improve the program and including an Administrative Simplification Committee, focused on behavioral...and a committee focused on behavioral health integration. And then there is also Quality Management Committee. Additionally, as I said before, there is a weekly call with members of behavioral health simplification committee to discuss issues of concern, including service

definitions, authorization processes, and other provider issues. And of course, we have these quarterly meetings with your committee to discuss and receive feedback on the administration of the program. Focusing on administrative simplification, we are trying to streamline the processes between plans for the benefit of our providers. Process improvements that have been implemented include: common authorization form for certain behavioral health services; common authorization time frames for behavioral health residential services; common authorization time frame for MST; common authorization time frames for extended rehabilitation for brain and spinal cord specialized services in a nursing facility; and the requirement for our plans to have DME products under $750, per the Medicaid fee schedules, not subject to prior authorizations. Now I'd like to go over some of the recent statistics we have about claims. This chart right here goes over the medical claims paid through May compared to the number received by the plans. While the amounts of that are...were actually paid are not shown on these charts, I would like to point out that through June of...June 22, physicians have been paid approximately $75 million, FQHCs $5 million, hospitals $144 million, behavioral health providers $28 million, and home health providers $6.6 million by our plans. This next chart goes over the number of pharmacy claims received to the number paid by each plan through May. Again, the claim amount is not shown in the chart, but the plans have paid approximately $102 million for pharmacy through last week. Timely payment is important to us, and this next chart goes over the percentage of claims paid by each plan within 15 days. The contractual requirement is that the plans are required to process and pay, or deny, a minimum of 90 percent of all clean claims for medical services within 15 business days of the MCO receiving the claim. Within 60 days, they have to process and pay, or deny, 99 percent of all clean claims. They have to fully adjudicate all other claims within six months of the date of receipt. And, as you can see, all the plans through May have been meeting that requirement. There were some issues with Nebraska Total Care in March and April, but they are all meeting that requirement now. This next chart goes over the percentage of pharmacy claims paid by each plan within 15 days. As you know, the way that pharmacy claims are paid is different than with medical claims. They're paid when the pharmaceuticals are received, and so the contractual requirement is different. The contractual requirement is that plans are required to process and pay, or deny, a minimum of 90 percent of all clean claims for medical...for pharmacy claims within 7 calendar days of receipt and 99 percent within 14 calendar days. Now I would like to go over some success stories from our plans, explain some of the actual benefits members are receiving

through Heritage Health. And one of the reasons we moved to this delivery system is for the better coordination of care in this integrated delivery model. From United HealthCare we have the story of a member who struggled with chronic homelessness, alcoholism, poor physical health, and mobility issues. This member reported owing money to the Housing Authority and his debt has been a barrier to accessing supported housing. This past winter the member was hospitalized for frostbite acquired while sleeping in a car on cold nights. The condition worsened, due to a lack of appropriate posthospital care and followup. Transportation has been an ongoing barrier to getting needed medical treatment. The member was hospitalized again earlier this year after frostbite turned to gangrene. Out of necessity, the member's toes were amputated. The care manager from UHC worked with a community health worker from an FQHC to get the member's needs met. They arranged Home Health to provide wound care for the member's foot. The care manager assisted in arranging transportation for all medical appointments through Intelliride and referred the member to the UHC housing navigator and tribal liaison to assist with the housing needs and potentially reconnecting this member with his tribe. The care manager and the community health worker followed up on all medical appointments, assisted with transportation with those...and being at the medical appointments. The community health worker was the first to notice the foot was not doing well and arranged to get the member to the ER when the foot had received...had gangrene. The care manager worked with a hospital discharge planner to transition the member to a stable living arrangement. This member was accepted at a nursing facility in Omaha. The care manager and a community health worker have worked together to ensure the entire care team continues to be informed to meet the member's complicated ongoing needs and plan for a healthier future. From Nebraska Total Care we have the story of a member, a 13-year-old member, who is nonverbal, uses a wheelchair, and communicates with NOVA Chat. Once enrolled with NTC, her mother immediately sought access to the health plan's value-added services that included YMCA and Weight Watchers memberships, in order to help the member get healthier and lose weight. Having access to these value-added services for the past five months has resulted in her losing 15 pounds. The member explained that swimming allows her to walk freely in the water, which has allowed her to move on to crutches outside the pool. She is increasing her distance, using crutches, and her endurance is also growing. She also shared that her daughter enjoys socialization of the weekly Weight Watchers support group, and the sharing of food ideas on Facebook has been fun. The mother reported the combination of Weight Watchers and the YMCA has truly made a difference in her

daughter's life. Then we have a story from WellCare about a 50-year-old male with unmanaged schizophrenia, who was isolating excessively due to unmanaged, yet recognized, mental health symptoms. He had no support other than his disability income and housing assistance from the Omaha Housing Authority. When the care manager first called, the member was agitated and did not want to speak with the care manager. The member then called back and apologized, saying he had not left his apartment in a few days at that time of our call and was paranoid. It was a subsequent challenge for the care manager to persuade the member to let him in. Since their first face-to-face meeting, the care manager has helped the member become more and more receptive to case management and, as a result, the member is now seeing a psychiatrist and receiving medications, has regular appointments with a PCP, has completed ACCESSNebraska applications for additional support, is also receiving personal assistance in accessing his SNAP benefits, is receiving follow-up calls from care management, which help remind him to go to the appointments. And he is to call his care manager to follow up after his appointments. And he is also receiving and regularly participating in physical rehabilitation for a shoulder injury. So those are some of the stories of the benefits that Heritage Health has provided members. And again, I am aware of continued issues with the implementation and payment issues that certain providers of ours are facing; and we are committed to resolving those issues. Thank you very much. I'm happy to answer any questions you may have.

SENATOR RIEPE: Thank you, Director Thompson. Are there questions that someone wants to start us off with? Senator Crawford has one.

SENATOR CRAWFORD: Thank you, Chairman. And thank you for this update; I appreciate that. And the...I'm just going to start with the...some of the claims data that's here. It's my understanding--so this is on page 8 and 9--so it's my understanding that these...this...these reports would be on what we...what you explained at our last hearing as clean claims.

ROCKY THOMPSON: That is correct.

SENATOR CRAWFORD: Clean claims. And so it's the clean claims that must be paid in 15 days. I think I heard you say that if something is not a clean claim, there are six months to clear that up. Is that correct? Is that what you said?

ROCKY THOMPSON: They have six months to pay claims.

SENATOR CRAWFORD: Okay. And I think at our last hearing we talked about whether you could provide us information on the number of unclean claims, and so that the percent of clean claims of all claims, so we have a feel for the claims that are not getting reflected, I guess, by this information.

ROCKY THOMPSON: I have that information right here.

SENATOR CRAWFORD: Great.

ROCKY THOMPSON: I believe it was sent over, but I'm not positive.

SENATOR CRAWFORD: I figured I'd see it this morning when we were trying to comb through.

ROCKY THOMPSON: Okay. Through April we had...okay, so in April we had 293,538 claims that were submitted for pharmacy.

SENATOR CRAWFORD: Um-hum.

ROCKY THOMPSON: Of those, about 6,000 were rejected and the acceptance was 97.89 percent. In April, for physical and behavioral health encounters, 375,531 claims were submitted. Of those, 42,437 were rejected, an acceptance rate of 88.7 percent.

SENATOR CRAWFORD: So are these numbers, the 293,000 claims, when you talk about 6,000 being rejected, so are you saying 6,000 are the nonclean claims? Or my understanding is the unclean claims are ones that are sort of...there's something unresolved about them.

ROCKY THOMPSON: Right.

SENATOR CRAWFORD: So if it's rejected, it would kind of be out of that category at this point. Is that...so an unclean claim is one there's still something messy about it.

ROCKY THOMPSON: Well, it could be a duplicate claim.

SENATOR CRAWFORD: Right.

ROCKY THOMPSON: And it could not have the right information on there, it couldn't be tied to a patient. There are several issues why a claim is not clean.

SENATOR CRAWFORD: Okay. And so we talk about 97 percent. Are you talking about 97 percent of these unclean claims or you're talking about 97 percent of all claims?

ROCKY THOMPSON: All submitted claims.

SENATOR CRAWFORD: All submitted claims, so...

ROCKY THOMPSON: Um-hum.

SENATOR CRAWFORD: Still kind of digging into what I suspect many of the problematic situations are these ones that aren't clean. I'm guessing.

ROCKY THOMPSON: Right. Or there might be an edit that's put on that we're not aware of...

SENATOR CRAWFORD: Right.

ROCKY THOMPSON: ...by the plan, and I know there was an issue with WellCare. A couple months ago there was an edit that put on that was having them reject claims that should have been clean. And so that was removed and took care of several issues.

SENATOR CRAWFORD: Good. I think really helping us track these, the percent that are clean claims, is an important oversight data piece that I think it's important for us to see regularly at

these quarterly meetings. So here's all claims. So these are clean claims we're seeing, but something with all claims and the percent clean and how that's...then hopefully improving, like a higher percent are clean as all these other issues get resolved. I would really like to make sure we're tracking that as an important measure of the functionality of the system, as well.

ROCKY THOMPSON: I appreciate that feedback, and we will make sure to include that in the next briefing as a chart.

SENATOR CRAWFORD: Thank you.

SENATOR RIEPE: Senator Howard, go ahead.

SENATOR HOWARD: Thank you, Senator Riepe. Okay. I want to talk a little bit about the corrective action plan and sort of the process behind it, what triggers a corrective action plan. So what was going on that triggered the CAP? And then what happens after the CAP? So walk me through the whole process.

ROCKY THOMPSON: There are several issues that can lead to a CAP. With Nebraska Total Care, there were continuing issues that we were aware of about the claims payment and the timeliness of actually fixing the issues involved with the claims payment.

SENATOR HOWARD: What kind of issues?

ROCKY THOMPSON: For example, with home health...

SENATOR HOWARD: Um-hum.

ROCKY THOMPSON: ...there were issues with the payment of home health claims that we were receiving, time lines that were unacceptable to us and Nebraska Medicaid for resolving those issues and for these providers, some of the providers that had not been paid since January 1. We wanted to make sure that this was resolved in a timely manner.

SENATOR HOWARD: Have they been paid now?

ROCKY THOMPSON: Some claims have been paid; some are still in process. And again, we're going to receive the actual corrective action plan on Friday so we can see whether that meets our expectation or not. If it does not, then we have the ability to impose sanctions on the plan. And the dollar amount is per instance.

SENATOR HOWARD: What are other issues that would lead to a CAP?

ROCKY THOMPSON: Anything that, if a plan was not meeting its contractual obligations. Again, there is 850 different contractual obligations; it depends on how serious the issues are. If we...we take our...the issues with claims payments seriously.

SENATOR HOWARD: So I have the one-pager from Nebraska Total Care, and they mention the claims payment. But what were the other issues that led to the CAP? Surely it's not just this one claims payment issue in home health.

ROCKY THOMPSON: There were...for example, there was an issue with having PI staff in Nebraska versus using the national resources for that. It was in their contractual requirement to have them in Nebraska.

SENATOR HOWARD: What else?

ROCKY THOMPSON: There were issues with participation in a work group that we have about encounters.

SENATOR HOWARD: They weren't coming to the work group? Or...

ROCKY THOMPSON: There wasn't participation from NTC, and some were canceled.

SENATOR HOWARD: And they were contractually obligated to participate?

ROCKY THOMPSON: Correct. Yes, ma'am.

SENATOR HOWARD: Okay. And so we'll get this CAP on Friday. And how long do they have to improve?

ROCKY THOMPSON: Oh, that's them telling us how they are going to come in compliance with their contract. And at that point, we determine whether that's acceptable or not acceptable. And then we determine sanctions, if any, will be imposed.

SENATOR HOWARD: So say it's a disastrous situation and they don't improve, we charge them with sanctions, and then what happens? Do they leave? Do we ask them to end the contract? What does that look like?

ROCKY THOMPSON: I don't see that happening. There is always the ability to terminate contracts, but (inaudible) terminated the contract at this point.

SENATOR HOWARD: See, in Nebraska, when we privatized child welfare, we actually did have somebody terminate a contract very unexpectedly. And so I guess I'm trying to get a feel for what this time line looks like for the CAP and sort of how prepared you are if it doesn't work out, and what that looks like.

ROCKY THOMPSON: One of the reasons why there is a freedom-of-choice provision in our waiver for managed care is so we have multiple managed care plans. So if in the...if a plan leaves unexpectedly, the members have a choice to join another plan so their care would continue.

SENATOR HOWARD: And we're not seeing the same issues with the other managed care plans that we were seeing with Nebraska Total Care. The other managed care plans aren't close to getting a CAP either.

ROCKY THOMPSON: At this point I don't anticipate having the other plans under a CAP.

SENATOR HOWARD: Great. All right. I have other questions, but you guys can go.

SENATOR RIEPE: I know my own experience in the healthcare arena is that corrective action plans are a pretty common management tool in terms of trying to focus on a particular problem and resolve it. I think it's important that, or at least as I view it, the perception isn't that a corrective action plan is, you know, one step away from being sent to Siberia. It's a management tool; I think it's a documented management tool. Now it seems to me that that's an appropriate way to go to get transparency, get good communication, so everyone is dealing off written, as opposed to verbal, conversations. That said, I also think that when I look at this--and I know managed care nationally over the years has had some challenges by providers as well--I like to think of it, a little bit of this, as being population management, which I'm a fan of because you are given 33, 33 and 34 percent by various providers. And the descriptions that you pointed out, I think, talk about going beyond and above the call of healthcare, as I view it, to helping someone get contacts, get arrangements, gets appointments and all of those things. So I think that's an important piece, too. I wanted to go a little bit into the...I think one of the greatest challenges, and I would invite you to agree or disagree, has been moving from the Magellan behavioral and integrating the behavioral into the three managed care organizations.

ROCKY THOMPSON: I agree with you on that, and that's why we started planning with the behavioral health community so far in advance of the implementation. And again, it has been bumpy; a lot of those issues are being resolved or have been resolved already. But we continue to work with them and focus special attention upon the behavioral health providers.

SENATOR RIEPE: And my understanding is that prior to Magellan's exit, and I'm not picking on them, but there were issues there as well in terms of preauthorizations. And so, unfortunately, it seems to be an inherent problem with behavioral health--tougher for getting authorizations and getting payment and--than it is in physical health.

ROCKY THOMPSON: Behavioral health is a service that has faced challenges in the past. And, you know, we continue to move into greater integration in our insurance model, and we hope to better equip our providers to deal with how healthcare is delivered.

SENATOR RIEPE: You talked a lot of things, which I was impressed of, when you talked about some commonality of both authorizations and--you have about three or four of those--and I sense

that it's a spirit of cooperation and not simply looking at proprietary programs that each of the three might have. But it sounds like that you've been able to pull those...do you have those to repeat again? What are some of the areas that they've...I think one was authorization?

ROCKY THOMPSON: I certainly can discuss some of the movement that we've had with administrative simplifications.

SENATOR RIEPE: I see they're on page 7, if I looked at it.

ROCKY THOMPSON: Correct (inaudible). I can just read them off again.

SENATOR RIEPE: Okay.

ROCKY THOMPSON: Common authorization forms for certain behavioral health services, common authorization time frames for behavioral health residential services, common authorization time frame for MST, common authorization time frames for extended rehabilitation for brain/spinal cord specialized services in a nursing facility.

SENATOR RIEPE: Okay.

ROCKY THOMPSON: ...and requiring DME products under $750 per the Medicaid fee schedule not to be subject to a prior authorization. And again, our Administrative Simplification Committee continues to work and look for ways that our health plans can work together on providing commonalities between the plans. There's a project that they had to undertake every quarter, and I think the next project that they're talking about is common over-the-counter medications for the plans.

SENATOR RIEPE: Okay. Would you walk us through the divisions, how the division addresses concerns, particularly with home health and paying before Medicare rejects the claim?

ROCKY THOMPSON: Certainly. This is an issue that we really became aware of April--late April, early May--and what the plans were doing is that they were requiring a Medicare denial before Medicaid would pay for certain home health services.

SENATOR RIEPE: All three of them?

ROCKY THOMPSON: All three of them. And for certain codes, certain home health codes, Medicare will never pay for those services and so Medicaid should be billed primary. And so we had a health plan advisory issued last month with certain codes that they have to pay Medicaid primary. And that wasn't enough to solve the issue, so we've looked for other codes. The plans have looked at sister states to see what other codes shouldn't be primary Medicaid, that might actually have a Medicare code, and so they are augmenting their systems to make sure that those claims are paid.

SENATOR RIEPE: So what you've done is identify the ones that we know are not going to be paid by Medicare and you just skip that step of having to run down there, try to get that approved, knowing it's going to get rejected, which again, then, takes I don't know how many days, but it's all...it's all aging of accounts, if you will.

ROCKY THOMPSON: That is correct. And many of our providers, they can't wait that long to receive payment. And some of their home health providers, they hadn't been receiving payments since January 1. And we want to make sure that payments are made.

SENATOR RIEPE: Okay. Would you also...what's the makeup of the members in the managed care organizations? I noticed...you know, one of my...there were 33, 33 and 34. How many of those were selected and how many of those did you have to assign? And then, if you would, if I can give you a dual question here, is how many of those are made up of dual eligibility--I assume that's small children--and also dual diagnoses?

ROCKY THOMPSON: We have...we try to promote member choice of choosing the plans in the fall for open enrollment. This fall we will do a campaign to make sure that individuals actually proactively choose a plan, and in their health. Of course, some members will not; most of our

members did not this past fall, even though we had a higher selection by the members than we normally see in other markets. The majority of the members that did choose chose UHC, and then the other plans...some chose their plans because of value-added benefits. Additionally, if...the members that did not choose a plan, they had to be assigned a plan. We have an algorithm to look at claims history, family members that are members of plans, things like that, to assign them to a certain plan of what plans that their PCP is assigned to, things like that.

SENATOR RIEPE: Um-hum.

ROCKY THOMPSON: For the membership mix of each plans, a majority of children are actually in WellCare. They're made up of children more so than the other plans. NTC has a large number of dual eligibles and so does United.

SENATOR HOWARD: Hmm.

SENATOR RIEPE: Do you have a question?

SENATOR CRAWFORD: Sure, yes.

SENATOR RIEPE: Go ahead; I'll take it.

SENATOR CRAWFORD: All right; thank you, Chairman.

SENATOR RIEPE: Give me a break.

SENATOR CRAWFORD: Sure, yes. So we've talked...

SENATOR RIEPE: Senator Crawford.

SENATOR CRAWFORD: Thank you. And we've talked...you've talked a bit about the possibility of sanctions for the plans if they're not paying their claims and the standards to which you're holding the plans. I wonder if you could talk about what relief or what provision there is

for helping to take care of issues for providers who are in the situations where they have not been paid, and this is a hardship for them in their business. So what do...what can we do or what do the contracts require in terms of relief or compensation back to providers who have had their payments delayed?

ROCKY THOMPSON: Thank you very much for the question. The plans have, for certain providers, offered lines of credit or payment advances to certain providers that have had payment issues. I can get you the exact number. I know we were requesting that, actually earlier today, from each of the plans to see what, what kind of money advances have been paid out to certain providers. You know, certain providers, for different reasons, wouldn't be willing to take those; and we understand that.

SENATOR CRAWFORD: What do you mean by that--certain providers would not be willing to take them--because there is some kind of...go ahead; explain what you mean by that.

ROCKY THOMPSON: Well, some providers have never taken out a line of credit before.

SENATOR CRAWFORD: Okay.

ROCKY THOMPSON: Some of the providers...there's pride issues, too.

SENATOR CRAWFORD: Sure. Is that a contractual obligation, or is that just a strategy that some of the plans are undertaking on their own?

ROCKY THOMPSON: I'll have to check and see what exactly is in our contract regarding this. It's common when there is payment issues, I've seen, in other states.

SENATOR CRAWFORD: It's common to have it as a contractual obligation?

ROCKY THOMPSON: Well, not...I don't know if it's a contractual obligation, but I can check and see if it is. But it's common for these types of strategies to be utilized.

SENATOR CRAWFORD: That would...I would appreciate that, in terms of if it...what our contractual obligation is, that's a first step. And then a second is just the extent to which this is being offered, what that looks like, in terms of how the plans are trying to address that real concern of providers. You know, I think that's another reason why there is so much extra stress on the behavioral health providers, because they're often much smaller, so there's much less margin for that waiting. And so some information about how...what those efforts look like by the plans is important. I just...another question I have is...I guess we have an algorithm to sort of allocate where the patients go. In the future year, if we have some plans that aren't performing as well, will we put fewer patients in those plans?

SENATOR HOWARD: Hmm.

ROCKY THOMPSON: We urge the plans to...we urge our members to select the plan that's best for them. In future years, we will be working on the algorithm to change it if it's better for, let's say, dual eligibles, then...

SENATOR CRAWFORD: Okay.

ROCKY THOMPSON: ...that will be a factor in determining which plan the member will be assigned to.

SENATOR CRAWFORD: Okay; thank you.

SENATOR RIEPE: I think one of the inherent improvements from Medicaid...my memory is that members could change every month. So with...if you have a member that changes every month in Medicaid, you don't have any continuity of care. Now this is on a year-by-year and they can choose, and I think there are opportunities if they have a terrible experience on either side, both the managed care organization or the provider or the patient, they could reconcile that. But I think that is a major improvement of...go ahead.

ROCKY THOMPSON: Just to say something about that. The...once assigned to a plan, a member will have...does have 90 days to choose a new plan. And if there is some sort of event,

like their primary care physician leaves that plan's network, they have the ability to select a new plan.

SENATOR RIEPE: Okay; very good. Did...I saw a hand down there. Senator Howard, go ahead.

SENATOR HOWARD: Thank you. I'm curious about the issues log. So this is the e-mail in-box that you have for issues. Are you keeping sort of an analytic stream of how many we're getting per day and how many are collecting per month?

ROCKY THOMPSON: We have that information. I don't have it here, but we have that information.

SENATOR HOWARD: And sort of how many e-mails are in the box? All of them have been answered?

ROCKY THOMPSON: I don't know if all have been directly responded to. All of them are tracked and all of them are logged. And we...I would have to check and see if staff directly respond to it or we wait until payment is made.

SENATOR HOWARD: How many FTEs do you have devoted to the issues e-mail?

ROCKY THOMPSON: I would have to check and see how many people actually have access to the issues e-mail. I know our deputy director does, our plan administrator does, her staff. So there's one, two, three, four, five, six. And certain other members...do have members...certain other members of the staff have access to that e-mail address.

SENATOR HOWARD: And then it sounds like you have a biweekly meeting about these issues?

ROCKY THOMPSON: That's with each CEO.

SENATOR HOWARD: About...with each CEO. And you sort of farm out the issues to them? Or does a team work on these issues?

ROCKY THOMPSON: The biweekly meetings, the meeting with the staff is made up of me, our finance deputy director, our administrator for plan management, our deputy director for delivery systems. We have our administrator over health services, and then we have the CEO of each plan, and then we have certain staff that the CEO might bring to the meeting. We have a set agenda. The first agenda is to go over the issues, the open issues that are...keep on going on, and any issues that they feel are resolved and should be closed.

SENATOR HOWARD: And so they're not just about what's coming out of the e-mail.

ROCKY THOMPSON: It's not just about coming...e-mail is a good way to keep track of the issues, but issues that we receive, for example, from the Ombudsman's Office, from state senators, from other meetings that we might have are also tracked and responded to.

SENATOR HOWARD: And so you will share those analytics with us.

ROCKY THOMPSON: Yes, ma'am.

SENATOR HOWARD: Perfect. I want to learn a little bit more from you about some of the behavioral health issues, because that seems to be what I, what we hear the most about. And while Magellan was no dream to work with, tell me a little bit about the challenge with the fee schedules. So what was the challenge, and then what was the time line for the conclusion of that issue?

ROCKY THOMPSON: There were fee schedules that had, that were created by Magellan, that were not actually done by Nebraska Medicaid, that we didn't have track of for certain services. And we were not aware that the plans were not paying these services because they didn't have the fee schedule. So we got the fee schedule and we had the plans adjust their systems accordingly to pay these claims. And they are contractually obligated to cover those behavioral health services, even though they didn't have the fee schedules at the time of launch.

SENATOR HOWARD: When did they get the fee schedules?

ROCKY THOMPSON: I think we identified the issue in January, so it was January-February.

SENATOR HOWARD: And they retroactively paid the ones that they already...

ROCKY THOMPSON: Correct, or we're in the process of doing that. I'll have to check.

SENATOR HOWARD: And so I've heard a lot about challenges with credentialing as well. And so there was no transfer of credentials from Magellan to the new managed care companies. So what were the challenges with credentialing, and what was the time line for those?

ROCKY THOMPSON: Certain providers were not credentialing according to...the plans were having difficulty with that. I think WellCare was one of the main ones. And I'm trying to think of what the time line...I think most of those are resolved. I would have to...I think there might be one lingering issue out there that I'm aware of with (inaudible)...

SENATOR HOWARD: What was the challenge?

ROCKY THOMPSON: It was getting the accurate information and making sure that accurate information was reflected by the plan from the provider.

SENATOR HOWARD: So they weren't getting accurate information from the providers who were trying to be credentialed with them?

ROCKY THOMPSON: There was difficulty getting that, yes, ma'am.

SENATOR HOWARD: Okay. Am I going to hear something different at 1:00? Providers?

ROCKY THOMPSON: I don't know.

SENATOR HOWARD: Okay. And then you're relaxing the prior authorization requirements.

ROCKY THOMPSON: Um-hum.

SENATOR HOWARD: But how long do you plan to do that for?

ROCKY THOMPSON: Until the mental health parity review is done. As you know, there was a federal regulation that was issued a couple years ago regarding parity between mental health and physical health services. And so we are reviewing each plan to make sure that they are aligned with the requirements of that regulation. And we have regular meetings with the Department of Insurance to see if there...to see what kind of requirements for parity are needed.

SENATOR HOWARD: How long do you think that will take?

ROCKY THOMPSON: I don't have a time estimate for that, but it's continuing.

SENATOR HOWARD: And then once that change is made, how much lead time are you going to give the providers to know that the prior authorization relaxation won't be available anymore?

ROCKY THOMPSON: I would have to get back to you on when that change is made, if that change is made, because the parity requirements might say that certain, certain services are not subject to a prior authorization.

SENATOR HOWARD: Sure; okay. And then I had a question about the dashboard. You had talked a little bit about how these are some of the minimum statistics that you're asking for, and you'll start getting them on Friday, which is exciting. First off, are you...are they going to look a little bit like the ACCESS ones, where we get sort of a monthly update in our e-mail or through the mail? Will you be sharing those with us?

ROCKY THOMPSON: I think this will be publicly on their Web sites, and we can send you those links.

SENATOR HOWARD: And then when these are minimum statistics, is there...are there other statistics that you plan on bringing into the mix later?

ROCKY THOMPSON: We can always do that. And our other plans have other statistics that they would like to show also.

SENATOR HOWARD: And then will these be reported monthly to you?

ROCKY THOMPSON: The...I have to see what the contractual obligations are. I assume they're monthly; they might be weekly, but I'll have to check.

SENATOR HOWARD: That would be great; weekly would be great. And then, when we're looking at claims data, you mentioned physical health and you mentioned pharmacy.

ROCKY THOMPSON: Health claims and...

SENATOR HOWARD: Health claims overall.

ROCKY THOMPSON: Right.

SENATOR HOWARD: Is it possible, because we've had so many challenges with behavioral health, to look at those claims data separately?

ROCKY THOMPSON: Yes, ma'am, and I have requested that from the plans, so I can provide that to you.

SENATOR HOWARD: That's great. And then you mentioned Intelliride. Are we...are things going better with Intelliride?

ROCKY THOMPSON: We are...you know, Intelliride's contract ends in December, and we're looking at our different options. We're working with our plans about the possibility of having them carved into our Heritage Health plan so it's a single-delivery system.

SENATOR HOWARD: Okay.

ROCKY THOMPSON: And there it's advised to make sure that individuals get to their appointments on time and get the services that...because they are financially liable.

SENATOR HOWARD: And is there an appetite with our MCOs to take on that?

ROCKY THOMPSON: There is an...there is an appetite.

SENATOR HOWARD: Okay; all right. And then for your stakeholder committees, I was looking at the Quality Management Committee. And those aren't set for September and December. Is it just because it's too far out, because we want to make sure that especially in Quality Management we have firm dates set for those meetings?

ROCKY THOMPSON: I assume that's because they're far out.

SENATOR HOWARD: Because we have those for the Administrative Simplification Committee in November.

ROCKY THOMPSON: Um-hum.

SENATOR HOWARD: But we don't have them for September.

ROCKY THOMPSON: Had to see if our Quality Management Committee, the staff that actually work that committee, had their date...those dates yet.

SENATOR HOWARD: And are any of these meetings, meetings where senators can just come and sit in?

ROCKY THOMPSON: Sure; feel free to.

SENATOR HOWARD: Thank you. Thank you.

SENATOR RIEPE: Thank you. I want to go back a little bit on this corrective action plans. Were those new with the managed care organizations, or did you use those in old Medicaid, if you will? And do you ever use corrective action plans with long-term care facilities or other services under your accountability?

ROCKY THOMPSON: We do utilize corrective action plans for all of those things. For example, Senator Howard just mentioned Intelliride. Intelliride was under a corrective action plan and had some issues that they had to resolve. So we do utilize these as a tool for our contract management.

SENATOR RIEPE: So you've used them for some time.

ROCKY THOMPSON: Yes, sir.

SENATOR RIEPE: A little bit where I'm trying to sort out in my own head is on a scale of one to five, five being in the red light on the dashboard, if you will, where does a critical corrective action plan fit in there? Is that a three or a four? A five would be...

ROCKY THOMPSON: We issue them when our vendors are not meeting the contract standards.

SENATOR RIEPE: But they might have varying importance? So a corrective action plan may not always be...A might not be the same as C; is that correct?

ROCKY THOMPSON: That would be correct.

SENATOR RIEPE: Okay. So they don't have a scale on that. I get...you know, is it...was it common in the past to post those on the Web page?

ROCKY THOMPSON: I'm not aware of previously posting CAP letters on our Web site but, again, we are committed to transparency and administrating our program in a transparent manner. So that is why it was posted to the Web site.

SENATOR RIEPE: Was Nebraska Total Care the first one that you posted on the Web?

ROCKY THOMPSON: I'll have to check and see if we've posted other ones in the past. The first one I'm aware of, but I'll check and see if we've done that in the past.

SENATOR RIEPE: Okay. My other question would be is do the managed care organizations have an...are they forewarned that this is going to be on the Web page, or do they find it out at the same time as everyone else?

ROCKY THOMPSON: Nebraska Total Care was made aware of the corrective action plan at the start of the week. I don't think it was posted to the Web site until Thursday or Friday that week.

SENATOR RIEPE: Um-hum. It seems fair. You know, I think we're trying to do this all together. I don't, you know I don't like...I don't think we should have ambushes or surprises. It's too serious of a business. I'm not accusing you of doing that. I'm just Curious George in the sense of asking when that all sequentially happens. I think the other thing in your payment--correct if I'm wrong--your payment to the managed care organizations is based on an acuity grading on the patients that they each have. Is that correct?

ROCKY THOMPSON: When we're...we are setting our new rates for January 1, and that is a consideration in that rate-setting process.

SENATOR RIEPE: Okay. Okay. Overall, how do you feel it's going?

ROCKY THOMPSON: I think it's...there is still bumps that we are facing that need to be resolved, and I'm committed to resolving them. I think it's smoother for some providers than others, and we are aware of that.

SENATOR RIEPE: Okay. Senator Crawford.

SENATOR CRAWFORD: Thank you, Chairman Riepe. Thank you, Director. So we've talked quite a bit about some of the challenges and the possibility of sanctions. Is it my...is my understanding correct that no plan has been sanctioned yet?

ROCKY THOMPSON: That is correct.

SENATOR CRAWFORD: All right. So are there...so there may be sanctions for not meeting some target over a long period. Are there ways that we're incentivizing short-term improvements as well? Are there bonuses that a plan can get or are there short-term as well as long-term fiscal impacts to a plan?

ROCKY THOMPSON: Each plan is subject to a medical loss ratio, so that their profits are capped and their administrative profit is capped. So if a plan better manages its members and provides better care and quality care and make sure they receive their preventative care and stay out of the hospital, there is potential for greater savings. And also they're subject to a loss if they don't manage that care appropriately.

SENATOR CRAWFORD: So it's primarily the loss they would experience from inefficiencies, potentially, and sanctions.

ROCKY THOMPSON: The...and sanctions. And also they have the, if they have a good reputation on the street, they can get a greater member mix.

SENATOR RIEPE: What's your greatest concern right at this time?

ROCKY THOMPSON: I would say the continuing provider issues that we are hearing. You know, as I said in the last briefing, I've met with numerous provider associations over the last month since I took this role, and I'm listening to them and I'm aware that there are fiscal challenges that they are facing. I know some are...have numbers that are going around. I think one group has $27 million, but I'm asking for just some clarity from that group about what that $27 million is made from, what provider groups, if that is actual billed amount or the actual

Medicaid-allowable amount, because we just need some of the details so we can follow up with our plans and see what the issues are.

SENATOR RIEPE: Okay. We appreciate very much that you're being receptive to that, because each one of the 49 senators will have both Medicaid recipients and also providers in their districts that are important to their communities. And it's important to them, and it's important for them to be able to act on behalf of their constituents and be able to get the message back to their constituents in terms of where we're at, what we're working on, how we're going to get there, and what kind of a time line we can expect to get there, all the time knowing that this is not ever going to be a perfect system. But it can be an awfully good one.

ROCKY THOMPSON: I agree.

SENATOR RIEPE: We say in the office: don't let perfect get in the way of good. So are there other questions of the committee? Senator Crawford.

SENATOR CRAWFORD: Yes, thank you. So earlier in the conversation, you discussed the fact that there was sort of outstanding claims you talked about: Total Care about $2 million; one of the other plans, WellCare, $4 million; United about $200,000. It was my understanding you were talking about sort of kind of outstanding claims that are still to be resolved or still to be paid. And then, just now, you mentioned a figure of $27 million as a figure that we're concerned about still needing to be resolved. So I just wondered how to reconcile those two (inaudible) discussion.

ROCKY THOMPSON: The numbers I recited before, those were claims projects.

SENATOR CRAWFORD: Okay.

ROCKY THOMPSON: So those are ones that the plans are aware of and are waiting to pay off...pay out, depending upon when their systems are ready. That $27 million came from a stakeholder group that has organized. And they sent that number and I've asked the head of that stakeholder group to get me the details about that $27 million and see what that's actually made

up of, see what provider groups are associated with that, see if some Medicaid billed are the Medicaid allowable, and also to see if some of the claims might actually...might not actually be Heritage Health claims, and see if there might also be private insurance claims. For example, our United HealthCare, it is both in the private market and in the public market. And so some providers might have responded about United claims that are private pay.

SENATOR CRAWFORD: Okay. So just so we understand the first set of numbers, the $2 million, the $4 million, and the $200,000, those are claims that have been validated, but they just have not been paid yet. Is that correct? That's outstanding obligation that has not been paid.

ROCKY THOMPSON: They're in the process of being paid. So once they have the systems ready, they will pay those claims.

SENATOR CRAWFORD: And what do you mean by when they have the systems ready?

ROCKY THOMPSON: When they have the system changes that are necessary to pay those claims. They've had to adjust their IT systems.

SENATOR CRAWFORD: The plans have (inaudible)...

ROCKY THOMPSON: The plans. Yes, ma'am.

SENATOR CRAWFORD: ...adjust their IT systems to pay.

ROCKY THOMPSON: To pay these outstanding claims. And so they are in the process. And so these will be paid, up to the Medicaid allowable.

SENATOR CRAWFORD: So would several of these be the claims then for which there weren't rates before? Is that...

ROCKY THOMPSON: I think most of those claims have been resolved.

SENATOR CRAWFORD: Okay.

ROCKY THOMPSON: These are other issues that have developed.

SENATOR CRAWFORD: Right. Can you give us an example of what those look like? So what's keeping...if the claim is approved, what's keeping the payment from being paid?

ROCKY THOMPSON: It might be a modifier on the code. It might be certain denials for certain services. There was an issue with a 599 CHIP about the actual identification of the unborn child and who those services are billed for, about the...with the proper name. So this is some edits have to be made so these claims are paid.

SENATOR CRAWFORD: Okay. But these are definitely claims that are valid and have been, I mean identified as valid claims.

ROCKY THOMPSON: Right. But these numbers are estimates and also these are not necessarily Medicaid-allowable charges; some of these also include the amount the provider has billed. And Medicaid will pay a lower amount than the actual amount that was billed in a lot of cases.

SENATOR CRAWFORD: That's true for the $2 million, $4 million...

ROCKY THOMPSON: Correct.

SENATOR CRAWFORD: ...for those numbers. There is still a possibility some of those are...still have to be approved.

ROCKY THOMPSON: Correct.

SENATOR CRAWFORD: Because my understanding before was you said they were approved and still have just IT issues. It's just...

ROCKY THOMPSON: Well, that's the estimate about when they have their IT systems ready, solving these issues about how much is actually going to be spent by the plans.

SENATOR CRAWFORD: So we have IT issues with all three plans to some extent, that are delaying these payments.

ROCKY THOMPSON: That is correct.

SENATOR CRAWFORD: And what is the corrective plan for those IT concerns specifically?

ROCKY THOMPSON: There...different issues have different time lines for resolution. Again, Nebraska Total Care is the only plan that we've issued a corrective action plan for...

SENATOR CRAWFORD: All right; yeah.

ROCKY THOMPSON: ...because of the time lines that they were giving for fixing the issues were unacceptable to us. And the other plans have time lines for resolution of their claims projects.

SENATOR CRAWFORD: Okay. So even though the amount is higher for one of the other plans, you're still satisfied with their strategy.

ROCKY THOMPSON: I believe one of the dates they had for paying a lot of those claims would be June 30, so I am satisfied with that.

SENATOR CRAWFORD: Okay. And so where we're looking, you're talking about their contractual obligation to pay most within 15 days and then the other claims that are problematic within six months. Would these claims that are in these categories be then the examples of ones that would need to be ensured that they're paid within six months?

ROCKY THOMPSON: Yes, ma'am.

SENATOR CRAWFORD: Okay. And if not...

ROCKY THOMPSON: Oh, there's always ways, if there are issues that we are aware of, that we can remove timely filing requirements for the claims.

SENATOR CRAWFORD: Okay. But those IT concerns in these categories...or I guess, are they different than some of these other simplifications that you've talked about and corrections that you've talked about?

ROCKY THOMPSON: Some of those issues might be involved...

SENATOR CRAWFORD: Okay.

ROCKY THOMPSON: ...but it depends on the claim. Again, a lot of the claims, a lot of the issues that we're seeing right now, there are different issues. It's not a systemic issue in a lot of cases.

SENATOR CRAWFORD: Okay, okay. Just sort of just what's stacked up in these plans.

ROCKY THOMPSON: Correct. And then, once we solve one issue, there might be another issue that emerges.

SENATOR CRAWFORD: Okay, okay. So includes some of these things like prior approval and the fact there wasn't a fee schedule; that's part of what's going on in these backed-up claims.

ROCKY THOMPSON: I would think so; yes, ma'am.

SENATOR CRAWFORD: Okay. But some other things. But overall, the expectation is that all of those, even ones that were having complications, get paid within six months.

ROCKY THOMPSON: That's right.

SENATOR CRAWFORD: And anything that's considered a clean claim gets paid within 15...a high percentage has to get paid within 15 days.

ROCKY THOMPSON: 90 percent in 15 days.

SENATOR CRAWFORD: And so, just to make sure I understand this, again is there any standard of accountability in terms of maintaining a certain level of clean claims? Is that something that we would hold them accountable to?

ROCKY THOMPSON: I would have to check and see if that's in the contractual requirements.

SENATOR CRAWFORD: Okay, okay. I know that is something that they don't entirely control, but still trying to facilitate and make sure it's easy to make a clean claim is something we're hoping that they're doing as well. So all right. Thank you; I appreciate that.

SENATOR RIEPE: Senator Howard.

SENATOR HOWARD: Thank you, Senator Riepe. So I've been sort of digging in the archive and I apologize because this relates to the dual eligibles issue that we discussed earlier. But I was looking at Senator Dubas who was here a minute ago. And I thought she had passed a bill several years ago that said that prior to the submission of a state clean amendment Medicaid and Long-Term Care had to submit a report to the Governor and a support to the Medicaid Reform Council before December 1 or as of December 1. So did we get that report and I just missed it?

ROCKY THOMPSON: We submit that biennial report that's associated with the Medicaid Reform Council every December 1. In addition, we have submitted that report to the Legislature as a supplement going over this specific issue.

SENATOR HOWARD: So I guess...so it's just...the statute is just related to the implementation of a state plan, not the submission?

ROCKY THOMPSON: It...I think it says the implementation of a state plan amendment, a waiver, or a regulatory change.

SENATOR HOWARD: And so...and the December 1 time line is there so that if there are issues with that state plan amendment or waiver implementation that the Legislature can address them?

ROCKY THOMPSON: I thought the December 1 time line or the date was so it would be aligned with Medicaid annual report, but I might be mistaken about that.

SENATOR HOWARD: Sure. I'm just...I'm only remembering it from a few years ago. But my understanding was that we wanted to make sure there was legislative oversight before there were broad changes to our Medicaid state plan so that we could exercise that oversight and help provide guidance to you.

ROCKY THOMPSON: We submit that report biennially as required by the Legislature.

SENATOR HOWARD: On December 1.

ROCKY THOMPSON: On or before December 1 I think the statute actually says, yes, ma'am.

SENATOR HOWARD: And can you remind me of a time when we submitted a state plan amendment without urging from the Legislature?

ROCKY THOMPSON: Well, we do it all the time.

SENATOR HOWARD: Right. You do your October and you usually do it twice a year?

ROCKY THOMPSON: For state plan amendments?

SENATOR HOWARD: Um-hum.

ROCKY THOMPSON: State plan amendments we submit all the time. I think we might have eight this year so far.

SENATOR HOWARD: And you just do them ongoing or are they updates to former state plan amendments?

ROCKY THOMPSON: It depends upon the issue or the...or what we're doing to...some of the state plan amendment changes that we've made were light language changes. Some of the state plan amendments that are done is due to federal interpretation and the need for that. And again, some state plan amendments we receive legislative authority to do. And I know that we just had one state plan amendment, peer support state plan amendment, that was just approved. And I know...I think you had that bill that was pulled after.

SENATOR HOWARD: That was Senator Riepe's bill.

ROCKY THOMPSON: Ah, Senator Riepe. Oh.

SENATOR HOWARD: He should get all the credit for that.

ROCKY THOMPSON: But that was just approved and as of...and we are covering that service starting on Saturday.

SENATOR HOWARD: And how long does it take for you to prepare and submit a state plan amendment?

ROCKY THOMPSON: It depends on the complexity of the state plan amendment. Some it takes us a couple months to prepare. Some of them that are just a simple language change might be quicker. Again, we have those federal requirements to seek approval from our Native American tribes. And so we have to submit a notice to them at least a month before submission. And if they have any questions, it is delayed for another month or so.

SENATOR HOWARD: And all of the state plan amendments and waiver changes that you make are included in that December 1 report?

ROCKY THOMPSON: I believe that they were included in that December 1 report.

SENATOR HOWARD: And so we should anticipate them this December then.

ROCKY THOMPSON: I'll have to check and see what the...because it's a biennial report so I will have to check and see what the time line on that report is.

SENATOR HOWARD: Great. Thank you.

SENATOR RIEPE: Thank you. Are there additional questions from the committee? Seeing none, thank you very much for your presentation. And that concludes this briefing session. I would invite you to return at 1:00 when we go from a briefing format into the hearing. And so you will hear much more about Heritage Health at 1:00 in this same room. Again, thank you all for being here and thank you to the committee members for your dedication (inaudible).

ROCKY THOMPSON: Thank you all.

SENATOR RIEPE: Thank you.

BREAK

SENATOR RIEPE: Take two. This is the Health and Human Services Committee and we have a hearing today that's on Heritage Health, and we thank you for attending today's hearing. This hearing follows the 10:00 briefing this morning and the briefing and hearings are the first of what will be a number of established briefings and hearings to provide formal and ongoing oversight of the implementation of Heritage Health and its delivery of healthcare services to Nebraskans eligible for Medicaid outside of long-term care. I also want to thank all of the senators who have made a special effort to be here for this. It's extremely important and they're extremely engaged and, quite frankly, Health and Human Services is one of the committees that has a high level of

expectations for its committee members. And so we appreciate all of their dedication and service. I would like to, as we start, and then I'll come back with some introductory remarks, but I'd like to have you know who serves on this committee so I would like to start with the senator to my extreme right.

SENATOR ERDMAN: Okay. Steve Erdman, District 47, ten counties in the Nebraska Panhandle.

KRISTEN STIFFLER: Kristen Stiffler, legal counsel.

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

SENATOR LINEHAN: Hi. Lou Ann Linehan, District 39, which is Elkhorn, Waterloo, and Valley.

TYLER MAHOOD: Tyler Mahood, committee clerk.

SENATOR RIEPE: And our page for this afternoon is Alexi Richmond. We appreciate very much having her here. I'm Merv Riepe. I serve Legislative District 12, which is Omaha, Millard, and Ralston, and I happen to serve as Chair of this committee. Our hearing today is for your public and the public's opportunity to participate in the legislative process. Some committee members may come and go. If they do, they have other things that they have to attend to, and don't take it personally as to your testimony. To better facilitate today's proceeding, I ask that you please silence your cell phones so that we don't have that disruption, and that you move to the reserve chairs when you are ready to testify. And we have some eager testifiers that are already in position up here and that's great. We'll ask you, if you're a testifier, to sign in and to hand your orange sign-in sheet to the committee clerk, Tyler, as you come up to testify. When you come on to the mike, we will ask you to spell your name, state your name, and that is for the purposes of the record. We'll ask you to be concise as we may have a number of people who intend to testify. I would at this time ask, by a show of hands, how many of you do intend to testify? Okay. Okay, thank you very much. I think that permits us to go to a...we'll go to a five-minute time. That will

be four minutes on the green. You'll get a yellow, and then there will be a red and we'll ask you to pull together your final thoughts on the red. And if it goes beyond that, we are not totally abrupt but I may come back and ask you to pull it together. I'll try to be very polite in doing that. This is not a traditional hearing that would occur during session on a bill that was introduced. There is no requirement to have this hearing, but obviously it's critically important to all of us and all of the senators that serve here in the Unicameral because this is such a pressing and big, major issue and one that we spend a lot of money on. That being said, the hearing is to provide feedback to Medicaid leadership for the implementation of the Heritage Health and for committee members to engage with the public, their constituents, regarding the implementation. We as the Health and Human Services Committee take pride in our statutory oversight over the department and appreciate all who are here today and who are watching on NET. We anticipate and appreciate personal stories on how members and providers have interacted with Heritage Health; however, I will make the judgment if the information presented could cause HIPAA or legal concerns. I may ask you to postpone your testimony and schedule a separate meeting either with us as the committee or with the Department of...or Division of Medicaid and Long-Term Care, or we may ask you...I may ask you to redirect your testimony if it's going into some violation of those particular issues. That's for your protection and for ours. I'd like to point out this is not a grievance session. This hearing is to provide constructive criticism of Heritage Health, if there is such a thing as constructive criticism, but that's what we're here to do, and to allow the committee members to provide information and oversight over the department and provide recommendations on how we might improve Heritage Health, always being reminded that we are at the six-month point of introducing Heritage Health. I would remind people, too, that the executive branch--we are the legislative branch--but the executive branch of government is responsible for the day-to-day management of the Heritage Health. With that, I would like to restate my opening remarks from this morning for those who may not have been here or would just love to hear them again. (Laughter) You don't have to raise your hand on that. Healthcare delivery is very personal and emotional lifetime experience in providing healthcare services to some 230,000 Nebraskans of Nebraska's most vulnerable. I'm reminded of the words of President John Kennedy in his "going to the moon" speech said: We do not do it because it is easy but because it is hard. And providing healthcare services to the most vulnerable is a very challenging ordeal but something that we do with a very serious heart. We also must address the cost of healthcare services, public and private, and we must begin now. For too long we have

adopted the philosophy of Wimpy from "Popeye" fame who said, "I would gladly pay you Tuesday for a hamburger today," which meant we kicked the can down the road. The time has come, our "Tuesday" has come. The cost of healthcare has grown more rapidly than inflation and most other goods and services. The state of Nebraska has experienced the same unsustainable healthcare cost with state health programs such as Medicaid. The Health and Human Services Committee has statutory jurisdiction for oversight of Medicaid and, with that, the implementation of Heritage Health. We will be responsible to our fiduciary duties, our accountability to those receiving and providing services, as well as the taxpayers of the good state of Nebraska, in concert with our federal Medicare and Medicaid partners, and in that total expenditure is over $2 billion annually. We must be vigilant in our oversight and protective of all those that we are here to protect. The department introduced Medicaid integrated managed care as a partial answer for best spending our scarce dollars on January 1 of 2017, and must manage risk reimbursement models away from fee for service to value-based services. We cannot tolerate low standards, but the department is not and never will be perfect in its service. That said, we must take a long view, remembering, as I said, Heritage Health has been in operation for just six months. "We must," and I quote on this, is Kathy Campbell, a former Chairman of HHS, always said, "stay calm and move on." That was her theme.We must be deliberate in our oversight and committed to work for good outcomes as we go forward. With that, I welcome all of you who have come today to testify; and we're going to start off with Interim Director Rocky Thompson, who's back with us from this morning to present a recap of our 10:00 briefing on the implementation of Heritage Health. So, Director Thompson, I turn the program over to you to start, and then we will move forward.

ROCKY THOMPSON: Thank you and good afternoon, Chairman Riepe and members of the Health and Human Services Committee. My name is Thomas "Rocky" Thompson, T-h-o-m-a-s R-o-c-k-y T-h-o-m-p-s-o-n, and I am the interim director of the Division of Medicaid and Long-Term Care in the Department of Health and Human Services. I'd like to take this opportunity to summarize the presentation I gave at our 10:00 briefing and also to provide some follow-up to some of the questions the committee raised. As you know, we are in our sixth month of implementation of the Heritage Health Medicaid managed care program. As of this month, Heritage Health has a membership of almost 228,000 Nebraska residents. This is the vast majority of Nebraska Medicaid members and most of their services are also delivered through

these plans. While compared to other states, the implementation of this managed care program has been relatively smooth. We acknowledge that certain providers have faced challenges, and we are working to resolve those challenges with our plans. Many of the lingering issues have been resolved but some do remain, especially for behavioral health and home health providers. Nebraska Medicaid is serious about resolving these issues and holding our plans accountable for the terms of their contracts. I would like to briefly touch upon and provide some clarifications and additional information to the committee based upon your earlier questions. First of all, I know there was a question about clean claims, and a clean claim is contractually defined as a claim received by an MCO for adjudication that requires no further information, adjustment, or alteration by the provider of the services or by a third party in order to be processed or paid by the MCO. It does not include a claim from a provider who's under investigation for fraud or abuse or a claim under review for medical necessity. The MCOs report this data that MLTC monitors on a daily basis. Should the contract management team see the percentage of accepted claims start to drop, it will be addressed with the MCO. Even though the performance standard of 15 days applies only to clean claims, the MCOs are not able to try to game the system and this standard by simply rejecting more claims inappropriately, without notice, action, or consequences from Nebraska Medicaid. As for performance incentives in the contracts, the plans do hold back 1.5 percent of their total payments and have to earn this back by meeting the performance targets across five metrics in year one. Year one metrics are focused on operational performance. Further metrics will be determined with input from the quality management committee. And I know Senator Howard had a question about why the quality management committee dates have not been set later this month. And the medical director of Nebraska Medicaid is working with the clinician members to find out what times are best for them, what times and dates are best for them so they can participate. As for advance payments, the contracts do not require the MCOs to make advance payments to providers. Some advance payments are provided by the plans, depending upon the severity, and they have been offered to some behavioral health providers as a good faith effort to recognize the administrative challenges for these providers in this transition effort. The contract does provide that interest can be paid for claims outstanding over 60 days. Also for clarification about the issues log, the issues log includes issues raised in e-mails but also in phone calls, walk-in visitors, members of the Legislature. Any issues that are raised today that we are not already aware of we will keep track through the issues log. And the MCOs have 24 hours to respond to the contract management

teams about the issues raised. But this is also the same list that I use in our biweeklies, so it's not like they only have to address them every two weeks. They have to address them within 24 hours. And I know there was an issue raised about credentialing and at the beginning, January 1, there was an issue with WellCare actually loading the credentialing information into their system, which I believe is resolved. So thank you again for this opportunity to speak before you and I look forward to hearing from the members of the public this afternoon.

SENATOR RIEPE: Thank you very much. Are there any questions of Director Thompson? We had our opportunity with you at 10:00, didn't we?

ROCKY THOMPSON: Oh, well,...

SENATOR RIEPE: Okay. Thank you very much.

ROCKY THOMPSON: ...I'm always available. Thank you.

SENATOR RIEPE: I assume, will you be staying?

ROCKY THOMPSON: I will be staying the entire time.

SENATOR RIEPE: Okay. We now invite those wishing to testify, sort of a...we're going to function on a first come, first served basis I guess. If you would be kind enough to state your name and spell it for the record, please.

JESSICA THOENE: My name is Jessica Thoene, J-e-s-s-i-c-a T-h-o-e-n-e.

SENATOR RIEPE: Okay.

JESSICA THOENE: Okay?

SENATOR RIEPE: You're free to go.

JESSICA THOENE: (Exhibit 1) All right. Like I just said, my name is Jessica Thoene. I'm a speech language pathologist and owner of Alpha Rehabilitation in Kearney. I'm also a member of the Nebraska Speech Language Hearing Association. Today I'm testifying on behalf of the newly formed Heritage Health stakeholders group, which includes a number of healthcare associations and organizations. The list of the members are in your handout that we've provided. I, like many providers in our state, participated in meetings and trainings with the new Heritage Health plans to prepare for the January 1, 2017, implementation of the program. We provided input on how to have smooth authorization payment processes, explain services to our...from our respective practice areas and on the covered under managed care. We conveyed the need for an effective communication system between Nebraska Department of Health and Human Services, the managed care providers. After the new year began, we submitted required documentation for authorizations and claims and waited to be paid for the services we had provided to the constituents. Time passed and payment did not arrive. While we waited to be paid, some of us began receiving denials for services that were authorized under the Medicaid managed care program. For example, individuals are being denied preventative products, such as medications that are effective in stabilizing mental illness. There is a lack of understanding by the managed care plans about coverage for dual-eligible clients. The managed care plans ask providers to bill Medicare for services that are only covered under Medicaid. Behavioral health providers experience many challenges with credentialing process and delays in receiving contracts. Many providers in different practice areas will tell you that managed care plans don't follow the state's Medicaid fee schedule. Some pay less than what the fee schedule requires, which makes it difficult for providers to cover their costs. Providers have become very frustrated with the managed care plan's apparent systematic problems. We have contacted our healthcare associations and organizations and asked them to help advocate for efficient authorization processes and timely reimbursement. Leaders from our organizations communicated with each other and gathered information about widespread issues and hardships caused by the Heritage Health program. We decided to form a stakeholders group to develop a vision, a strategy for an enhanced Heritage Health program. Your handout outlines some of the top-line challenges that providers are experiencing with the Heritage Health program, our group's vision for an enhanced program, and some recommendations that we have. I'll share a few specific examples so everyone in the room has a broad understanding of the types of challenges we are facing. We asked our provider members to share with us the amount of 2017 unpaid claims the last 60 days.

They have reported unpaid claims of nearly $27.2 million. Some providers haven't submitted their data and we believe the number of unpaid claims is actually higher. This includes behavioral health, mental health, home health, nursing home, assisted living, physicians, and hospitals. We are aware that providers...we are aware of providers that have had to reduce the number of clients they serve or reduce the level of services until they are paid. One provider has had to take out a line of credit to make payroll. Three others have filed for bankruptcy. Providers have had to add part-time administrative positions or reassign staff to follow up on managed care claims and authorizations. This is an unnecessary burden on healthcare providers and it takes away resources needed for patient care and services. Providers can't take the risk of delivering services without guarantee of timely, accurate reimbursement. And some have decided not to be involved with the Heritage Health program. We recommend strengthening the language in the Prompt Payment Care Act to address payment of services for Medicare beneficiaries. We certainly are interested in working with the committee to help develop needed legislation to ensure that there are more stringent accountability measures and help place timely payment to the providers. Citizens of outstate Nebraska are having difficulties finding providers in their local communities. It overloads the few providers that are serving Medicare beneficiaries. It's our goals...our group's goal to ensure that the network of providers around the state remains and we are able to serve the constituents' needs. The length of time it takes for managed care plans to modify their system so claims are paid correctly places financial burdens. We've experienced delay with the contractors when they adjust the Medicaid fee schedule. We have been informed that we need to anticipate these delays as the new CPT codes will go into effect with the new fee schedule. Our stakeholders group has requested a meeting with the Department of Health and Human Services, Courtney Phillips, Interim Director Rocky Thompson, members of the committee, and leaders for managed care organizations to discuss the corrective action plans, authorizations, and denials. Subsequent meetings will follow, focus on these issues and inconsistent information and lack of understanding of the services by the managed care organizations. We look forward to the meetings and working together to structure a managed care program for Nebraska's Medicaid beneficiaries that will allow them to receive the highest quality, cost-effective healthcare services that supports their needs. I will be glad to answer any questions that you have and would encourage any of the other providers and healthcare organization representatives in the room to share their perspective and their experiences with the Heritage Health program.

SENATOR RIEPE: You did an excellent job of taking three pages (inaudible) down into a five-minute piece.

JESSICA THOENE: (Laugh) Yes.

SENATOR RIEPE: We appreciate that.

JESSICA THOENE: Thank you.

SENATOR RIEPE: Maybe if we get some questions you'll have an opportunity to expand a little bit further if there are areas that you want to. So I'll turn to the committee and then I may have a couple here on my own.

JESSICA THOENE: Okay.

SENATOR RIEPE: We'll afford you an opportunity to share some more. Are there committee member questions or comments or...? Senator Linehan.

SENATOR LINEHAN: Thank you, Mr. Chairman. Thank you for being here today. Of the $27.2 million in unpaid, is that from the first of the year or the last 30 days or...?

JESSICA THOENE: When we submitted that data, I believe it was like three or four weeks ago, so I think it was from the first of the year up until that point.

SENATOR LINEHAN: And there was some conversation this morning whether this is the rate or the reimbursement amount.

JESSICA THOENE: Yeah, and I can't...I didn't gather the data so not specific to that but the information that I provided from my specific clinic was the Medicaid allowable amount, not the total amount that we could have billed.

SENATOR LINEHAN: And is any of this...is...I think the director tried to kind of break it down today or, I don't remember. I shouldn't...do you have a breakdown of $27 (million), like who? Is there one group that's really not working?

JESSICA THOENE: There...are you talking about the MCOs like...?

SENATOR LINEHAN: The providers. Of the $27 million that the providers...

JESSICA THOENE: Uh-huh.

SENATOR LINEHAN: ...are not getting paid, is it hospitals?

JESSICA THOENE: I know there's...I know there's a large percentage of hospitals and home health. We do have a breakdown of that information. Our CEO of our organization has the information broken down.

SENATOR LINEHAN: Okay, thank you very much.

JESSICA THOENE: Uh-huh.

SENATOR RIEPE: Do you feel that some of that $27.2 million that's in that number, was that, say if it's from the hospitals, I mean that gets built over into commercial rates? I'm not saying that's right...

JESSICA THOENE: Uh-huh.

SENATOR RIEPE: ...but, you know.

JESSICA THOENE: I think even if you would take 40 percent of that, even if you would say that that was billable, we only get paid 40 percent by Medicaid. That's still a significant amount of money of unpaid claims. And we know that that number is a lot higher because these are just

people that are active in these associations reporting, not providers across the state necessarily, just active members of these local associations.

SENATOR RIEPE: Did some part of that exist prior to Heritage Health in the old traditional Medicaid program? I mean we've never been known for overpaying.

JESSICA THOENE: I would...yeah, no, I would say (laughter) I'm going to speak from my business practice. I would say we always had some that weren't clean claims or that we were working on, but it wasn't 100 percent across the board. You know we...it's a huge issue.

SENATOR RIEPE: I know this morning, I think at our 10:00, we heard that I think the payment...or one of the documents talked about payment within 15 days. Is that your (inaudible)?

JESSICA THOENE: I can tell you in my practice that's not happening...

SENATOR RIEPE: Okay. I think maybe that's...

JESSICA THOENE: ...across the board with all MCOs.

SENATOR RIEPE: ...fairly new.

JESSICA THOENE: Yeah.

SENATOR RIEPE: Have you seen any marked improvement or any improvement at all?

JESSICA THOENE: I think now that we've opened discussions with Health and Human Services and letting them know, we're starting to finally make a little bit of progress, but it's still a constant struggle with administrative staff following up that the fee schedules aren't being paid correctly and having to go back and look, why is this one underpaid by $5, why is this one not paid. And knowing that they are clean claims is the most frustrating part. When we talk about clean claims, you're going to hear from providers, and I can speak to this, that those claims, a lot

of those claims are clean. They might say you have a box checked and that's why it's not going through, and we can pull up the form and that box is not checked, and that makes it not clean. So there's a lot of issues, I think, with what is perceived as a clean claim.

SENATOR RIEPE: Do you...you've talked and kind of like as the whole group so that are you saying that all three of the managed care organizations are addressing or challenged by some of the start-up things that are going on right now?

JESSICA THOENE: Yes.

SENATOR RIEPE: So it's not...

JESSICA THOENE: Not one.

SENATOR RIEPE: ...it's not one is a star...

JESSICA THOENE: No.

SENATOR RIEPE: ...and the rest of them are rascals.

JESSICA THOENE: No, (laugh) not at all.

SENATOR RIEPE: Okay. Are there other questions? Senator Crawford, please.

SENATOR CRAWFORD: Thank you, Chairman Riepe. And thank you for being here to share your experiences. I'm concerned about the clean claim issue just because if the incentives are paying 90-plus percent of clean claims, then it creates an incentive, I think, to call the claim unclean.

JESSICA THOENE: Uh-huh.

SENATOR CRAWFORD: And I'm afraid I'm hearing some confirmation of that from you.

JESSICA THOENE: Uh-huh.

SENATOR CRAWFORD: Could you tell me what you, in your experience, what percent of claims you think are being deemed unclean or not in that category that has to be paid in 15 days?

JESSICA THOENE: Since we've had so many problems from the start of the year,...

SENATOR CRAWFORD: That's all right.

JESSICA THOENE: ...yeah, it's a large percentage I would say, you know, because we're...our office staff is calling almost on every single claim that we put through to see what is wrong with it, why is this not a clean claim. And so the issues have switched too. If one time it's because it wasn't authorized. Well, we have confirmation; we have an authorization number. The next time it was because there was a check mark in this box. Well, that box wasn't checked. So it's a variety of issues with a variety of claims that isn't specific and you never know what you're going to get.

SENATOR CRAWFORD: Thank you.

SENATOR RIEPE: You talked about...I think there were three that you'd talked about filed bankruptcy.

JESSICA THOENE: Uh-huh.

SENATOR RIEPE: And I assume that probably didn't come to fruition in six months. There was some...

JESSICA THOENE: Uh-huh.

SENATOR RIEPE: ...prior to this. My question would be is, have any of the managed care organizations, until these issues would get resolved, given you an advance payment?

JESSICA THOENE: Well, not in my practice because we're not in that position, but sitting in the stakeholders meeting I can tell you there's a lot of people in there that are in financial crisis because of this implementation. I don't know the situation on the exact bankruptcy to be honest with you, but I think moving forward it's critical because people aren't getting paid and we can't deliver our services for not having payment. And so I, yeah, I think it's a crisis situation from the stakeholders meeting.

SENATOR RIEPE: Are you aware of any getting advanced payments (inaudible)...

JESSICA THOENE: I'm not.

SENATOR RIEPE: ...hard spots?

JESSICA THOENE: That came...we actually had a discussion about that before I came up here to testify. And our biggest concern with that is accepting a payment or an advance or even, you know, recommending that people in our association do that is we're having a hard enough time, track what they're paying because they're not paying consistently and inconsistently. By taking advance payment, we have no idea what that's going to look like and how to break it down and how to assign it to a claim when the claims aren't running through, which we feel that can make huge headache and huge administrative burdens.

SENATOR RIEPE: Okay. Senator Crawford.

SENATOR CRAWFORD: Thank you. One other question: You're talking about a desire to meet with the department so there are more groups and administrative simplification groups.

JESSICA THOENE: Uh-huh.

SENATOR CRAWFORD: Have you been a part of those conversations?

JESSICA THOENE: I have been and I'm on the administrative...

SENATOR CRAWFORD: Okay.

JESSICA THOENE: ...simplification committee.

SENATOR CRAWFORD: Okay. And can you remark on how those are working?

JESSICA THOENE: Yeah. I mean it's kind of like everything. You know, we talk, we talk, we talk, but we have to see the implementation of that. And so before Heritage Health was even, you know, implemented, we talked about the authorization processes and how it needs to be consistent for administrative burdens, for, you know, everything across the board, and it just hasn't been implemented. So I think the talk is there, but we have to start seeing some implementation from that.

SENATOR RIEPE: Senator Erdman.

SENATOR ERDMAN: Thank you, Senator Riepe. In your information you gave us, on the front side you talk about the challenges and then on the second page you talk about the vision and strategy. And then you go on to talk about the recommendations to the department. So are any of those visions and strategies more important to you than others? As we move forward and try to solve this problem,...

JESSICA THOENE: Uh-huh.

SENATOR ERDMAN: ...I see your recommendation was all payments be made by June 30, 2017, which is like two days from now.

JESSICA THOENE: Yeah. Yeah.

SENATOR ERDMAN: So I don't know if that one can be accomplished.

JESSICA THOENE: No. No, that can't.

SENATOR ERDMAN: But are there any of those others that we should be paying particular attention to?

JESSICA THOENE: Well, I guess the first thing is, in the stakeholders meeting we, as providers, have to get paid. And maybe that's not June 30 but it has to come soon, because otherwise people cannot afford to practice and we have to turn away clients, and clients that we're currently serving, we have to turn them out the doors because we can't operate a business that way. So I think first and foremost we have to receive payment for services that have already been rendered. Moving forward I think it's critical on authorizations that it's consistent and it's consistent across the board. So payment and authorizations I would say would probably be the top two.

SENATOR ERDMAN: Okay.

SENATOR RIEPE: Do you think that that 15-day payment window is fair and reasonable?

JESSICA THOENE: I would. I mean most, I would say with my practice, we say 30 days. You know, we expect payment in 30 days. If we could do it in 15, that would be a miracle. (Laugh) That would be excellent.

SENATOR RIEPE: Okay.

JESSICA THOENE: And I'm speaking for my practice, so other billing and agencies might have a different opinion on that, but I'm speaking from my practice.

SENATOR RIEPE: Okay. Overall, do you see light at the end of the tunnel?

JESSICA THOENE: That's why I'm here today. I want to see light at the end of that tunnel. (Laugh)

SENATOR RIEPE: Okay. Fair enough.

JESSICA THOENE: Uh-huh.

SENATOR RIEPE: If there are no further questions, thank you so very much.

JESSICA THOENE: Yes.

SENATOR RIEPE: We appreciate you taking the time to come here today.

JESSICA THOENE: Thank you.

SENATOR RIEPE: Okay. Our next testifier. If you'd be kind enough to state your name and spell it for us.

SCOTT JANSEN: Scott Jansen, S-c-o-t-t J-a-n-s-e-n. I'm the practice administrator at Complete Children's Health. We're a pediatrics practice here in Lincoln. I want to address an issue that is a cost issue as opposed to a reimbursement issue. One of the provisions of the Heritage Health plan when it came out was to help practices in offsetting the cost of translator services. We have a significant number of non-English speaking patients that we provide care to and each of the MCOs was supposed to provide a system for translator services. And my understanding is those costs are provided for in the costs of the contract. However, the parameters around how those services are acquired by offices make it difficult, if not almost impossible, to get a translator when it's necessary. My practice spends in...just slightly in excess of $100,000 a year on translator services. About 70 percent of that cost goes to Medicaid beneficiaries. At a recent Lancaster County Medical Society meeting, I suggested that perhaps the MCOs consider allowing us, as practices who use local, live interpreters, to pass our cost back to them, record that cost, pass it back to them, and they simply provide us reimbursement at whatever their contracted rate is with whatever language organization they've chosen to contract with. LanguageLinc, for example, is I think one of the big ones that the MCOs use. My recommendation has not been replied to nor has it been acted upon. I know a number of the MCOs offer telephone services as an avenue; however, that's not an effective means for a primary care office that depends in large measure on we have forms that need to be completed, we have a number of forms we review with our patient's information that's on site that we review with our patient, and it becomes extremely inefficient if we can't use a live on-site interpreter. So as we evaluate the performance of the MCOs, a lot of the focus has been spent on how quickly

they're paying claims and how timely they're doing that. But certainly there's a number of practices, medical practices, I think behavioral health practices, probably home health organizations that deal with non-English speaking patients that have...that carry a huge burden that is supposed to be at least partially reimbursed. And it appears that that is just not happening in an efficient manner. So if a suggestion could be made, if there would be some means of putting some additional teeth into that requirement that those dollars be funneled back to the providers, that would be much appreciated. If not, perhaps the state shouldn't have to spend the dollars.

SENATOR RIEPE: Okay.

SCOTT JANSEN: So thank you very much for your time.

SENATOR RIEPE: Thank you very much. One of the questions I have,...

SCOTT JANSEN: Yes, sir.

SENATOR RIEPE: ...is your pediatric group...what's your percentage of Medicaid patients?

SCOTT JANSEN: Twenty-five percent of our patients are Medicaid patients. That represents about 14 percent of our revenue currently. []

SENATOR RIEPE: Okay. Senator Linehan.

SENATOR LINEHAN: What languages are you dealing with?

SCOTT JANSEN: Primarily Spanish, although we have a pretty significant Arabic population as well.

SENATOR LINEHAN: When you want translators so you want...I assume you mean translators that are versed in medical terminology?

SCOTT JANSEN: Certainly that is helpful. A live, in-person translator is certainly best. And an understanding of medical terminology is certainly helpful. Now we realize that in...even in an ideal situation we'd like to have that but any ability to enhance communication is better than nothing.

SENATOR LINEHAN: Okay. Thank you very much.

SENATOR RIEPE: Is your pediatric group part of a system, like Bryan Health or CHI?

SCOTT JANSEN: We are not, no. We're an independent practice.

SENATOR RIEPE: You're a freestanding independent.

SCOTT JANSEN: Yes.

SENATOR RIEPE: Are you then a not-for-profit or are you a for-profit?

SCOTT JANSEN: No, we are a for-profit.

SENATOR RIEPE: You are. Okay. Senator Crawford.

SENATOR CRAWFORD: Thank you, Chairman Riepe. I just want to make sure I understand your concern is that the translation that's provided is phone translation and that doesn't fit the practice.

SCOTT JANSEN: It's not effective for us. When we use telephone translators, it significantly increases the length of the interaction that we have to have with the patient.

SENATOR CRAWFORD: Okay. This is also helpful to understand.

SCOTT JANSEN: Right.

SENATOR CRAWFORD: Okay. Okay.

SCOTT JANSEN: And so it really diminishes our efficiency. So we have chosen to continue to use live interpreters and have offered...you know, I don't know exactly what the MCOs pay for their services. I assume there is some contracted rate. We've offered to accept that contracted rate at whatever it is to help offset those costs...

SENATOR CRAWFORD: Okay.

SCOTT JANSEN: ...and have yet to receive...and that seems to make sense to me, but have yet to receive any positive...actually, any response at all, but any positive response to that.

SENATOR CRAWFORD: Thank you.

SENATOR RIEPE: Okay.

SCOTT JANSEN: Thank you very much.

SENATOR RIEPE: It's good information. Are there any other questions? Seeing none, thank you very much. Thanks for sharing that. And next witness, please. If you would just state your name and...

CORRIE EDWARDS: Absolutely. Corrie Edwards, C-o-r-r-i-e E-d-w-a-r-d-s.

SENATOR RIEPE: And you're welcome to go forward.

CORRIE EDWARDS: (Exhibit 2) Senator Riepe and members of the Health and Human Services Committee, I am here today representing Mid-Plains Center for Behavioral Health Services--I am the president and CEO of that organization--as well as NABHO, the Nebraska Association of Behavioral Health Organizations who represents about 29,000 Nebraskans each year that we serve. I would like to address not only the systemic issues but also the day-to-day issues with the implementation of Heritage Health's three managed care organizations. To say

that there have been challenges with this implementation would be an exaggerated understatement. In a time when government and Legislature are determined to reduce regulations and their barriers, my organization has experienced nothing but barriers as we struggle to manage the numerous inconsistencies between the MCOs. We did not receive a payment for two of the three...from two of the three MCOs for the first 60 days of this contract. By the end of February, we were one of the places that had maxed out our line of credit and we were unclear as to how we would make payroll. It was at that time that I put all of my CEO duties on hold. I resigned from several state advisory committees so I could spend the majority of my days and nights analyzing hundreds of pages of claims, procedure and denial codes, and memorizing allowable payment amounts. I began to realize that there was no rhyme or reason as to how each one of these MCOs operated. Sometimes we receive direct deposits for payments while other times we receive checks in the mail. When we receive checks in the mail, there is no explanation of benefits so that my staff then spend time trying to determine what has been paid, unpaid, or partially paid. Ultimately, this results in my staff spending hours on the phone, mostly on hold trying to get answers. Over the last six months I have added additional support staff who do nothing all day but track claims, payments, denials, and units authorized. One of the MCOs disseminates payments weekly; the other two disseminate payments almost daily. This is important to consider when an organization is expecting and is desperately waiting for cash to come in so that we can pay our staff. To provide perspective, my organization bills out over $180,000 a month in Medicaid claims. When we finally started receiving payments, payments were inaccurate, they were unpaid, or underpaid. The MCOs often cited lack of payment due to a duplicate claim submission; however, in my analysis, the initial claim was never paid. Primarily, this confusion impacts my most expensive program which is multisystemic therapy, MST. This is an evidence-based crisis program. I have talked to this committee before about this program. To date, the issues referenced above have not fully been resolved. Within the last 30 days, and coincidentally corresponding with today's hearing, I have been notified that two of the MCOs have implemented an adjustment project to reimburse us for the under- and unpaid amounts. I have received various dates as to when to expect payment. One MCO has changed the payment deadline date twice. As of today, we have not been fully compensated for all of the services we have provided. The number of units authorized varies between the three MCOs. For instance, one MCO--and this is prior to the authorization, the relaxed authorization that the director talked about earlier today--one MCO was authorizing 18 units for service while another authorizes 12.

Some authorizations have a time limit for use. For instance, there may be 30 units authorized, but the provider has to use them within a certain number of days; and if unused, they will expire. This becomes a tracking nightmare for my administrative staff. For families waiting for services like MST, they can wait sometimes as long as two weeks before an authorization appears. In the case of a denied claim, the time frame for payment starts over again. Oftentimes we wait another 30 days to receive payment. For the families that we serve, they are still in crisis and still in need of services. If the service is denied and we appeal the denial, we have had several families wait over three weeks for a decision for the appeal. I know of no other service arena where there is this kind of lack of accountability. There is an element of injustice that goes with watching as taxpayer dollars are spent to pay MCO staff. All the while we are providing services, taxpayer dollars have been allocated to pay for these services, yet we find ourselves begging for every nickel that we receive. I continue to have the unbelievably difficult task of trying to figure out how to pay my staff. It will take months, maybe much longer, to recover from this devastating financial damage; but we know we are one of the lucky ones as our doors are still open where other organizations have been forced to close. At the end of the day, this ill-equipped system has failed. It has failed service providers, but more importantly it has failed the children and families who truly need and depend on us to be there. And I am more than happy to answer any questions that you have.

SENATOR RIEPE: Okay. Thank you very much. Would you...I know you talked about units in there and I think, am I correct, and tell me if I'm not, a unit is like 15 minutes of billable (inaudible).

CORRIE EDWARDS: It depends on the service. It depends on the service. For MST, for example, it's billed off of a 15-minute increment and each increment makes up a unit.

SENATOR RIEPE: Okay.

CORRIE EDWARDS: Uh-huh.

SENATOR RIEPE: Okay. Are there questions from the committee? Senator Linehan, please.

SENATOR LINEHAN: Thank you for being here. It's very helpful. If this is...what percentage of your patients are Medicaid?

CORRIE EDWARDS: Probably right now, because we do a lot of children's medication management, we...probably 40 percent, maybe even as high as 50.

SENATOR LINEHAN: And what percentage of your patients are children?

CORRIE EDWARDS: Between...most of our programs are child focused. I would say 60 percent are children.

SENATOR LINEHAN: Okay. All right. Thank you very much.

CORRIE EDWARDS: Uh-huh. I can also talk about credentialing. I've got, you can almost ask me anything. I come well prepared today with my notebook.

SENATOR CRAWFORD: Okay. I'll take that hint.

SENATOR RIEPE: All right. Senator Crawford, please.

SENATOR CRAWFORD: Would you please just talk about your experience in credentialing and any changes in that experience.

CORRIE EDWARDS: Sure. Credentialing we...I started out with one HR director. They are no longer with me because they just (laugh)...I mean honestly it was too much. To go from one MCO to three has been very, very time consuming. And so the credentialing process is pretty cumbersome because you have to start with Maximus, which is the Medicaid, Department of Medicaid site. Then from there you go to each one of the MCO's credentialing sites. United takes about one hour to complete per staff person you want credentialed. That has been our experience. We've timed it. WellCare we have struggled to get responses from their staff if we have questions about credentialing. We to this day have got questions out with WellCare that we have not ever gotten responses back on. And so, you know, we can get response from Maximus pretty quickly

but that's...and that's good, but then when you have to wait for three more. And keep in mind it's not just these three. We then have to credential a therapist, let's say, with TRICARE, with Blue Cross. I mean it's not just these three. In the beginning, this was much more painful than it is now. Now we just...I think that the Chairman had asked a question earlier about whether we just suck it up and do it, or if something is changed. The answer is we just suck it up and do it. Nothing...I mean nothing has changed as far as credentialing except for you won't get paid if you're not credentialed. (Laugh)

SENATOR CRAWFORD: But you just said something about it was not as painful now (inaudible).

CORRIE EDWARDS: Well, because we now know what we're in for.

SENATOR CRAWFORD: Hmm.

CORRIE EDWARDS: I mean in the beginning, when you go from one MCO, and things kind of click right along, to three and my HR guy leaves in March, he's like, yeah, I'm not getting paid enough to do this, and he leaves, it's because...I mean this is hours and hours of time spent credentialing with three MCOs, making sure then, and I believe that the woman prior to me illustrated this, that a box is checked. Well, we now...this is how far we have gotten with this. We now screen shot the stuff before we hit the submit button because what she said we have experienced. A box was checked. No, it wasn't checked. Oh, yes, it was checked. Here's the screen shot. And that's very sad.

SENATOR CRAWFORD: Yeah.

SENATOR RIEPE: In your credentialing you said that 40 percent of your care was Medicaid, so do you have a different credentialing process for each of the three managed care organizations or is that uniform? And do you have credentialing that's different for your other...

CORRIE EDWARDS: Uh-huh.

SENATOR RIEPE: ...providers of other requirement in Blue Cross Blue Shield, regular United?

CORRIE EDWARDS: United asks the most amount of questions and it's most time consuming with United. That being said, and again I think that this all boils down to, in one of the presentations I made, it boils down to the IT issue, which I could talk about all day but we're not going to, and the web portals and the differences between these three companies and what's on the portal, what's not on the portal. And United asks for a lot of information and that's great, but when we timed this out with a pretty savvy HR person and all information is accurate according to Maximus, that's where this gets really time consuming. Because in our world, why wouldn't the MCOs just take the information that we've already given to Maximus? Let them go find. I mean, you know, we've got this therapist, we've already been through this with Maximus. Or come up with one way to register someone and then--it's an interesting idea--then share the information.

SENATOR RIEPE: Is the credentialing the same for United HealthCare regular and United HealthCare Medicaid?

CORRIE EDWARDS: I believe it is.

SENATOR RIEPE: That credentialing is the same.

CORRIE EDWARDS: I believe it is.

SENATOR RIEPE: Okay.

CORRIE EDWARDS: Uh-huh. I could also talk about translators. (Laugh)

SENATOR RIEPE: I assume that would be an echo of what we heard, right?

CORRIE EDWARDS: Actually, no.

SENATOR RIEPE: Tell us then.

CORRIE EDWARDS: Now interestingly enough, in the beginning we thought that translation services were not going to be covered with the MCOs. We then learn that it is covered with the MCOs. So we actively bill out, but here's the catch, and I don't know if the gentleman is still behind me or not. The catch is how you code it. You've got to code it with a translator code and if you do, and I can answer, since he asked, I'll answer this. It's $12. It's $12 an hour is what we get back. That's not, of course, what we pay out or that's not what we bill out but that is what we get reimbursed.

SENATOR RIEPE: Do you also...go ahead, Senator Erdman.

SENATOR ERDMAN: Thank you, Senator Riepe. How far behind are you right now?

CORRIE EDWARDS: Well, I am pleased to say that right now, as of the end of May so it's not right now, we are just $100,000 out. I will tell you the end of February it was a very different story. I will also say, Chairman, we were one of the places that got a cash advance.

SENATOR RIEPE: Okay.

CORRIE EDWARDS: And that was from Total Care, for anybody keeping track. We got $22,500 from Total Care. And we were able to track the...I understand what the woman before me had talked about, too, as far as the tracking nightmare to figure out when, you know, the little clicker stops clicking as to when Total Care...when the money is paid back. That was cumbersome but we just, again, sucked it up and did it because we were...I mean we were broke at the end of February. And we are an organization that we're the mental health center in the Grand Island area. We've done work out west. We've done work up north. I mean and for us, when you don't have that money coming in and you're expecting it at least within 30 days, we're expecting it within 15, then Magellan, you know, Magellan is done. They stopped payment probably middle of January for the stuff that we had billed out. And so then we've got another month and basically a month and a half of Probation still paying us and private insurance still paying us. And, thank goodness--and I will just say this--United, of the three, United was the only one that we were getting money from for the first 60 days. And they are also the only one that uses an algorithm to determine the "pre-auth" and "re-auth" issue as far as units. They don't

have a set number. Well, if they do it's a super secret number. But it's an algorithm then that they use for that. And so the only reason we could even make it through for that 30 days of not getting paid after Magellan stopped was because United was paying, but most of my MST kids are signed up with WellCare. It's just the luck of the draw. And to this...as of right now, WellCare and Total Care have not, through the use of their technology and their software configuration, have not been able to figure out how to fully reimburse us for MST services, which is my single most expensive service. I've testified in front of you when we looked at that state plan amendment for MST a couple years ago.

SENATOR RIEPE: Do you think that that is, in part, because United has been in the market?

CORRIE EDWARDS: Yes. Yes.

SENATOR RIEPE: ...and the other two...

CORRIE EDWARDS: We talk about this almost daily, uh-huh.

SENATOR RIEPE: ...are trying to catch up or figure it out?

CORRIE EDWARDS: Uh-huh.

SENATOR RIEPE: And is it something...sounds like something unique to Nebraska.

CORRIE EDWARDS: I believe, but I also...well, and we are, MST in Nebraska is unique because we are one of the very few states that, first of all, ever paid for it with Medicaid using any type of payment fee schedule. Because prior to the state plan amendment that I advocated for in 2015, we were using individual and family therapy codes. Now since the state plan amendment, we have got what we call H codes, and the H2033 code is for MST services. And the fee schedule was not given to the MCOs until mid-February, so prior to that they did not have a fee schedule for MST services. The other problem that went along with that is their software, two out of three software was not configured. Now I have heard for six months about software configuration. I am not an IT person. I don't really know what that means, but I would think that

maybe, I don't know, somebody with a Ph.D. or a master's degree in IT stuff could make some magic happen and just start pumping out, because right now when we bill out $160, we get paid $38, or if we bill out $320, we get paid $38 because it's not recognizing those units and it's just paying for one unit.

SENATOR RIEPE: A Ph.D. or a high school senior.

CORRIE EDWARDS: Maybe. Maybe. Maybe they'd like one of my staff's kids could go over and figure out the software configuration issue.

SENATOR RIEPE: Yes. I love that. Yes.

CORRIE EDWARDS: Uh-huh. But I mean at this point, and I think that the reason that we're...we are okay and we are more stable is the sheer lack of persistence, because it's hard to take when you go home at the end of the day and think that you're getting ready to put 70 to 100 people out of work and you're getting ready to shut down the community mental health center because two MCOs can't get it together to pay you what they owe you.

SENATOR RIEPE: You said "lack of persistence" or "persistence"? []

CORRIE EDWARDS: No. (Laugh) My persistence...

SENATOR RIEPE: (Inaudible).

CORRIE EDWARDS: ...and the fact that we...I mean at this day, at this point, we have ongoing weekly, me and the CEO or the COO of whichever company we're dealing with, we have ongoing weekly meetings where I, two days before the meeting, I'll go home and spread out hundreds of pages all over my bed where I just look at all that has not been paid, that's been underpaid, why have they denied this. And then sometimes we really...they really don't know why they've denied it. I would agree with what the first woman said. Sometimes they'll pay it at 100 bucks. Sometimes they'll pay it at 90 bucks. And when we ask them to explain this, there really is no...other than WellCare the other day finally did catch an LI, a licensed independent

mental health rate, which was different than just a licensed mental health rate. They caught that but prior to that nobody can really say why these are denied, you know. And again, most of this impacts MST, which is a crisis service. Who can wait three weeks for a reauthorization if the family is in crisis and needs for the service to continue? And we can't wait three weeks. But here's the catch. We also aren't going to stop serving that family because that's just wrong. And so we'll take it, we'll risk it, but that's sad and for me it's very scary because these are pretty well-trained therapists who, you know, they make decent money for therapists. And this is who this is really impacting as far as their clientele. And we did appreciate the "re-auth," the relaxation of the authorizations. However, when I e-mailed Medicaid right after I got the bulletin and asked specifically did this include then MST "auths" and "re-auths," the answer was no. So it's great and it will help me a little bit, but it won't help me with the most expensive service I have.

SENATOR RIEPE: Senator Linehan.

SENATOR LINEHAN: This is all very helpful. Are you a standalone? Are you part of the regional groups, or how do you fit in with...

CORRIE EDWARDS: We contract with...

SENATOR LINEHAN: ...the overall system?

CORRIE EDWARDS: We are part of the Region 3 Behavioral Health network, and when I say "part of," we receive funding from them. We are also...we do a significant amount of Probation work, whether it's with kids or adults. And we've got, believe it or not, quite a few self-pay clients and then we've got private insurance clients and then Medicare and Medicaid. But the dual doesn't impact us like it would maybe the people who have been up here before talking about Medicaid and Medicare. We don't have very many of those to...

SENATOR LINEHAN: So are you profit, nonprofit?

CORRIE EDWARDS: Nonprofit.

SENATOR RIEPE: Do you experience where that, from past experience, if you didn't get a bill in by such and such a date, it was null and void in a sense? Is that part of your managed care experience? Or is it too new in the game to know that too?

CORRIE EDWARDS: We have not...I mean here's what I can say. We have not reconciled with any of the three for every dime that is owed to us starting January 1. I mean and basically what I'm saying is we may still...we still have stuff out in January that was either unclean going in, we scrubbed it, we sent it back, maybe they denied it for another reason. We...and I started my weekly phone calls with these shops, the MCOs, probably the third week in February as a desperate attempt to get money. And as with everything else, the squeaky wheel gets the grease, I was the squeaky wheel. I mean I just...I could not leave this and let this go because I just didn't have the luxury. And what I meant in one of my last statements was very true. It angers people, consumers, staff, when we know for a fact that the MCOs aren't going without paying their staff, but I have to take a cash advance, which honestly I didn't want to. I had to. My credit was maxed out. And when we had absolutely no money left to participate in this experiment that is using three MCOs instead of one, I'm all for choice but going from one to three has been a huge issue. We just were not prepared for the number of staff it would take to track down three different organizations and the people to talk to, you know, to beg for our money. We were not prepared for...I was not prepared for this.

SENATOR RIEPE: These are non-revenue-producing staff.

CORRIE EDWARDS: These are. (Laugh)

SENATOR RIEPE: (Inaudible) back room.

CORRIE EDWARDS: Actually, I saw that quite often. Yes, these are non-revenue-producing staff.

SENATOR RIEPE: Essential but not...

CORRIE EDWARDS: Yes. Well, and even more essential than they were with Magellan. Magellan, you know, once they got it together, they clicked along, you know, okay. We could manage that. But I mean this alone has caused me to add three more people to doing nothing but this, and this has really cost me quite a few staff. Staff are burned out and they're very, very tired.

SENATOR RIEPE: You used the phraseology I think there--correct me where I'm wrong--is that when Magellan got its act together. And I'm assuming that you're an optimist, because you sound like a firm believer, a persistent optimist that these three managed care organizations are trying hard enough that they can get it together?

CORRIE EDWARDS: I believe that they are. I think that, you know, what I was perplexed by though, and this is again super secret information maybe, is I was surprised when the CAP came out for Total...and I think I'll just stop there. I was surprised when the CAP came out for Total.

SENATOR RIEPE: In the sense that it wasn't that much different than maybe some of the other plans too?

CORRIE EDWARDS: Right.

SENATOR RIEPE: Okay.

CORRIE EDWARDS: Right.

SENATOR RIEPE: Okay. The other one that I read in (inaudible) preparing for this hearing was that there was a challenge with billing expertise...

CORRIE EDWARDS: Uh-huh.

SENATOR RIEPE: ...of trying to get new organizations in five months of trying to get them...

CORRIE EDWARDS: Uh-huh.

SENATOR RIEPE: I liken it to an airplane. It's one thing to fly it at 30,000 feet. It's another one to get it up there.

CORRIE EDWARDS: Uh-huh.

SENATOR RIEPE: And it's harder...it's harder to...it takes a different kind of organization...

CORRIE EDWARDS: It does.

SENATOR RIEPE: ...to get it up to the 30,000 than it does to maintain it at 30,000.

CORRIE EDWARDS: I will tell you that we right now, I would say that we are as competent as any real go-getting doctor's office. You know, billing for us used to pretty...and I remember even the old ValueOptions days. I mean I remember those days. And billing used to be you bill it out, you get it back. I mean, you know, you'd bill it out, yeah, we got money coming in, we can get it back. And this has really...and the staff that we have lost, not been fired but that have quit because they are overwhelmed with the magnitude of this, when we are rehiring right now we are looking for people with accounting experience, some level of accounting background so that we can track this down more aggressively. Now with that comes the other problem of, how do you pay for somebody like that, especially when you're not getting paid? And that's where we are literally right now. We've got a couple ads running and I just am crossing my fingers because I am optimistic that this is all going to work out. But you know again, to give one a CAP...and I'm not saying that they didn't deserve the CAP, but I think that a lot of us were just very surprised by that because it's like, well, if you're going to give one a CAP you might as well have a friend and WellCare can join the mix.

SENATOR RIEPE: When you talk about accountants, do you include bookkeepers or is that old terminology?

CORRIE EDWARDS: I, right now we are looking for either a low-level, fresh out of CPA accounting person, or a really...

SENATOR RIEPE: A CPA?

CORRIE EDWARDS: Well, I mean I need somebody with an accounting background for all of this, I really do, and...or a really, really high-level bookkeeper.

SENATOR RIEPE: With a lot of perseverance.

CORRIE EDWARDS: A lot of perseverance.

SENATOR RIEPE: Okay.

CORRIE EDWARDS: Because I need to eventually--and I know that they'll be super sad to hear this, my colleagues of the three MCOs behind me--I eventually am going to need to go back to do what my board hired me to do but because this has been such a debacle, I mean this is literally all we have done for six months and, again, we're just tired. But I can tell you almost anything you'd ever want to about fee schedules. So there you go.

SENATOR RIEPE: Okay. Senator Erdman.

SENATOR ERDMAN: Senator Riepe, thank you. I was listening this morning when the comments were made about 1,800 pages, the contracts (inaudible) pages long...

CORRIE EDWARDS: Uh-huh.

SENATOR ERDMAN: ...has 850 requirements,...

CORRIE EDWARDS: Uh-huh.

SENATOR ERDMAN: ...53 reporting requirements. It reminds me of another healthcare bill that we once heard of, Obamacare. So it sounds to me like what we have to do here is pass this so we can find out what's in it. It is very disturbing what you have shared with us about the drain on you economically. This is not acceptable. And we're moving down this road very quickly, getting

to become past six months going to be...soon will be at a year. And we're losing people and we're losing services, and that's not what we intended to do. We have to make some quick decisions and get this thing fixed because you're down to $100,000 they owe you now?

CORRIE EDWARDS: Uh-huh. And now that's a good...

SENATOR ERDMAN: That's an improvement?

CORRIE EDWARDS: Oh, are you kidding? At the end of February we were down, oh jeez, $300,000-plus...

SENATOR ERDMAN: That's unacceptable.

CORRIE EDWARDS: ...I mean when you think about me billing out $180,000 a month and I'm down two months. And I really, really thank you, Senator, for saying that.

SENATOR ERDMAN: I would assume some of these requirements in that 1,800-page document came down from the feds, I would assume some of that. So we've got to figure out where it is, where reality is, and apply some common sense here and move forward with accomplishing what we're supposed to accomplish.

CORRIE EDWARDS: Well, and I did not...

SENATOR ERDMAN: And paperwork is not one of those things.

CORRIE EDWARDS: Right. I appreciate that. You know, I did not know until the interim director had mentioned it that interest, we could...interest could be paid on claims, unpaid claims after 60 days. Okay. I'll be going back and figuring up a bill. I mean I didn't know that.

SENATOR ERDMAN: So how much good is that going to do if they don't pay it?

CORRIE EDWARDS: Nothing, but at least it will give me some kind of satisfaction in knowing that at least we tried, in my perseverance; at least we gave it a shot.

SENATOR RIEPE: Have you missed a payday for your staff?

CORRIE EDWARDS: Two things, two things have happened and I'll just say this because I really kind of thought really hard about how much I wanted to divulge to you all about really where we are here. My CEO, not my CEO, that would be me, my CFO gave his notice. He gave me a 60-day notice last week, he cannot do this anymore. He just can't. So that...hence, the accounting background that I was referring to. We, the end of February, there was a time when I wrote a personal check out of my bank account to cover a staff's salary. And I just hoped that my house payment wasn't going to overlap. That's where we are. And we are a very stable, financially stable organization, but...

SENATOR RIEPE: Historically.

CORRIE EDWARDS: Historically. Sixty days, I mean thank God again, thank God for United and Probation. But you know, you also have to remember Medicaid and Probation pay together for MST; so you know, we would get Probation stuff but we were still then lacking on the Medicaid side. And you know, I've got an annual budget of $5 million, you know, 70...any given day 70 to 90 staff housed everywhere from Lincoln on out into the west and upwards in the north. I've been in your neck of the woods. And so we're not a fly-by-night. We are the community mental health center and this amount of damage...you know, when I first thought optimistically, because they kept saying the software configuration issue is going to be fixed, give us 30 days, okay, I've heard the phrase "give us 30 days" since the end of February. And so it's kind of like when a staff person says to me, I got this, but they really don't have it. That's kind of how I feel right now. We will get...the adjustment project will happen. I mean it's now on the Web site so I guess, you know, it's going to happen because it's right out there in front of everybody because now everybody is watching, but I mean this has been going on way too long. And I mean it's shutting people down. It is. We know that it's shutting people down. And you know, out in your area and out west, I worked out west for ten years, we can't afford to lose any providers up in the Panhandle and out west. We can hardly afford to lose any providers in the

Grand Island area. But you know, it's just had it not been for just this level of intensity of every single day, you know, from about 5:00 a.m. and to about 2:00 a.m., this is all I'm living and breathing is claims and how to get paid for them; is there a reason why? I mean why is it, why is it unclean? You've got to tell me why you're denying this. Don't tell me it's a duplicate. So I had a funny conversation--I'll share this with you--with one of the vice presidents of the managed care company. He said to me the other day on a conference call, well, you keep submitting this claim over and over again. And I said, yes. And he says, why? You know, you're just submitting it over and over again. And I said, because you all haven't paid for the first time I submitted it. Dead silence. And I think he was surprised that we knew that. But that's how sophisticated our tracking has gotten to be to keep up with their lack of payments. And it was true that, you know, we continue to resubmit hoping that today is the day, today is the day we're going to get paid. And he was irritated because the claim had come through like 12 times. I tell my staff, clean it, scrub it, get it right back out the door. I want it turned around in 24 hours. You keep submitting this claim; why do you keep submit...because you never paid it. I'm not crazy. I don't want to spend money on a claim clearinghouse processing these claims just for the heck of it. That's not what I'm doing all night. If you paid it, you wouldn't see it again.

SENATOR RIEPE: Uh-huh. Okay. Thank you so much. We probably need to (inaudible).

CORRIE EDWARDS: I know.

SENATOR RIEPE: We do appreciate very much your coming...

CORRIE EDWARDS: Thank you, Senator. It's always a pleasure.

SENATOR RIEPE: ...and your good work and your perseverance.

CORRIE EDWARDS: (Laugh) You said that last time I was here.

SENATOR RIEPE: Obviously, it stuck. Thank you for being with us. If you'd state your name, spell it, and then just proceed with your presentation.

MICHAEL FEAGLER: (Exhibit 3) My name is Michael Feagler, M-i-c-h-a-e-l F-e-a-g-l-e-r. I am the vice president of finance with the Nebraska Hospital Association. I appreciate the opportunity today to come and talk to you about the Heritage Health program. Several pieces of what I had in my letter you've had the opportunity to hear already and so I won't go into a lot of detail other than to, you know, one of the pieces that we talked about was the timely payment of the claims. You've been presented some numbers. Part of those numbers was generated through the Hospital Association and our membership. A survey of our members at the end of May, first part of June we had about 30 hospitals respond and it showed that there was over 10,000 claims with a value of about $24 million that were over 60 days passed. And just for your information, the $24 million is the billed charge number. So it isn't want the Medicare payment amount. That was the billed charges on those claims.

SENATOR RIEPE: Okay.

MICHAEL FEAGLER: Other issues that we're getting from our hospital organizations is that the providers have...they've identified issues with being paid correctly, which you obviously have heard already, too, from other providers. They're not getting paid according to the Medicaid fee schedule. And then there has been challenges with our hospitals. A lot of our hospitals employ their physicians and they have to credential those physicians as well. And that credentialing process, you know, just being able to provide Medicaid services and get paid for Medicaid services, you have to be credentialed. And they had significant difficulties, though I haven't heard of any specific examples recently of that. It was more so in the first quarter of the year when we first came on board, so. The one thing, though, I do want to say is that the Department of Health and Human Services I think has done a good job in trying to help providers in the state get through these problems. They have been working with the Hospital Association, so we appreciate their efforts to get this done, but obviously there's still a lot of issues out there that have not been fixed yet. With all that too, though, we have a lot of concerns. You know, we've had some discussions today about the dual-eligible program as well with the Medicare/Medicaid, and these MCOs are the exact same group of people that are going to administer that program when it's implemented July 1. This change in the reimbursement methodology for these beneficiaries, according to the department, it's going to impact the state by $23.6 million, and that's total funds. That's just not the General Funds. That's with the Medicare with the federal

match. But the concern for us isn't...it goes beyond the numbers, the dollars. The concern we have is that we've been meeting with the department to discuss how it's going to be implemented and their comment that was made to us was that the MCOs provide this service in other states so they can figure out how to implement it here in Nebraska for us. As you can understand, we have some concerns about that considering all the other issues that we're still trying to get corrected. And now we're throwing a methodology change on top of this with the MCOs. The MCOs, they're already making it difficult to get the claims processed timely and accurately, and we just think that throwing this right now on top of it is going to cause even more claim delays and inaccurate payments. There's a...you know, this is a significant methodology change that affects the reimbursement of all the Medicaid providers in the state. It was stated earlier today that it had no impact on CAH hospitals, but it does. CAH hospitals, as you know, are cost reimbursed for Medicare, but that cost is reduced by the amount of the deductibles and coinsurance that is due by the beneficiaries. So if they...if that claim has to roll over to Medicaid and Medicaid doesn't pay it, the CAH hospital isn't going to be able to collect that money from the beneficiary. So it is going to reduce their reimbursement that they would have gotten before. If...there is the possibility, depending on how the state processes that claim, they could claim it as bad debt with the Medicare program, but they only get 65 cents on the dollar for that. So even in that route there's still an impact on CAH hospitals with the dual-eligible issue. You know, our biggest thing is right now we would like to see them slow the process down to make sure that: one, it's properly implemented; that there's allowance for feedback from the stakeholders in the state; and ensure that there's critical access to like behavioral health, which is really impacted a lot by the dual-eligible issue, that they're not adversely impacted. You've heard how badly the impact was with the previous speaker on what's happening right now. This, even though she says dual eligibility is not a big issue for her, it will be on other providers of behavioral health services. So our hope would be that we could get things right on the front end and not have to go through this in six months talking about how badly the dual eligible program has impacted our providers. Just to finalize things, we just...we would expect to and we hope that the department, as they implement that program, would monitor the impact of those dollars and how it's impacting the providers. If they see substantial savings over what's anticipated, we would like to see that come back to our providers because, sure enough, if it doesn't generate the savings expected, we're going to take additional adjustments down the road because obviously we have $11.3 million to make up in the budget. So...

SENATOR RIEPE: Okay.

MICHAEL FEAGLER: ...thank you very much and I will answer any questions.

SENATOR RIEPE: A quick question that I have. I'm quickly trying to read through your letter here and I didn't see anything in there on the critical access hospitals. My guess is that the percentage of Medicare/Medicaid dual eligibility percentagewise is greater in critical access rural Nebraska hospitals than it would be in big Omaha or big Lincoln.

MICHAEL FEAGLER: It can. I don't know the exact numbers. We haven't had an opportunity to pull that information together. You know, the dollar number is probably smaller in a critical access hospital, but every critical access hospital is going to be impacted in some fashion. One of our member hospitals did do an analysis and they expected it to impact them about $130,000.

SENATOR RIEPE: Okay.

MICHAEL FEAGLER: That's a hospital here in the eastern part of the state, so.

SENATOR RIEPE: Just...and the critical access hospital--correct me if I'm wrong--I think they're reimbursed for Medicare at 101 percent.

MICHAEL FEAGLER: Right. So it's the 101 percent, less the deductibles and coinsurance, is the dollar amount that they actually receive from the Medicare program.

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

MICHAEL FEAGLER: Thank you.

SENATOR RIEPE: Our next testifier, please. If you'd just give us your name, spell it, and then proceed forward, please.

KATIE McLEESE STEPHENSON: (Exhibit 4) Sure. Good afternoon. My name is Katie McLeese Stephenson, long name, spelled K-a-t-i-e M-c-L-e-e-s-e S-t-e-p-h-e-n-s-o-n. I serve as the executive director of the Child Guidance Center in Lincoln, Nebraska. We were founded in 1949. We have a team of nearly a hundred staff and an annual operating budget of $5.6 million for the next fiscal year. We're accredited by the Joint Commission and we have extensive experience in working with children and families who have experienced trauma. We utilize a variety of evidence-based practices to achieve positive outcomes. We're based here in Lincoln and provide outpatient therapy at our clinic and administrative offices at 25th and O. We also have therapists in 13 public schools and other services within the school settings as well as an extended day treatment program for youth that are 5-12, typically about four hours a day, five days a week, and a therapeutic group home for 12 adolescent males from across the state that have sexually harmed others; 40 percent of those youth are from the Third Congressional District. And these young men have also been traumatized themselves. We provide mental health and case management services at the Lancaster County Juvenile Detention Center. Last year we served over 2,000 families. Because we serve children and women, we have a large population of clients whose primary insurance is Medicaid. Last fiscal year, that included 46 percent of our budget; 18 percent of our budget was through Probation and Child Welfare; and 17 percent of our budget through Region V Behavioral Health. The Medicaid rates that we currently receive reimburse us only for about 65 percent of the cost of providing the service. We rely on other sources of revenue and extensive fund-raising to meet the cost of care. The negative impacts of the implementation of Heritage Health as of January 1 are being seen at our agency and across the state. We all expected there to be some issues with a large system change. I did not imagine that the issues would be so deep and last for so long, given that we are at the seven-month mark next week. I worked for DHHS for nearly 20 years. Following that I worked for a large nonprofit agency that was one of the lead agencies for the failed child welfare reform efforts. I've been involved in developing systems, hiring hundreds of staff, and implementing complex systems under short and demanding time lines. In 35 years in this field, I have not been a part of a system change that has been executed so poorly as Heritage Health's implementation. Since January 1, we as providers of Medicaid services have been left holding the bag. This includes the following difficulties: execution of contracts with the managed care organizations, poorly designed and time consuming authorization systems, woefully inadequate billing systems that along with the authorization issues is leading to a large accounts receivable balance which is more than

agencies can shoulder. These issues are all further complicated by having three MCOs that each have their own systems, expectations, and procedures. And even when they have agreed to do something the same, they don't typically stick with that. The number of providers who are willing to accept Medicaid is decreasing in Lincoln. The reasons that I hear from providers include the rates, the cumbersome requirements, and the extensive lag time between when the service is offered and what the MCOs are paying. With the decreasing number of providers, we at our agency are seeing an increase in our waiting list for services. For outpatient services the end of December, we had 20 on our waiting list. At the end of May we had 54, with a high of 62 clients. By the time a family has decided to call us for therapy, having to wait is very difficult. As of yesterday, our agency is owed $231,238. When you subtract the adjusted amount and then the amount that is within 15 days, that amount is $193,895. That splits out to $76,568 with Total Care; $89,003 with United; and $28,324 with WellCare. Some of these dates, as others have mentioned, move...some of these bills date back to February. Our billing staff estimate that we are at 95 percent of clean claims and we typically bill $206,000 a month for our Medicaid services and 86 percent of those are for individuals 19 age or less. There is many other things that I can say here about this process, but I would like to say that with one of the companies, I as the executive director alone, have spent over a hundred hours problem solving since January with one particular company. And that also includes the director of finance, the billing supervisor, and various program staff. And that is just typically about the authorization and billing processes. As Corrie mentioned, I've had to give up other duties in order to do so. There's additional information here, but one of the things that I'd like you to note is even when something is fixed, for example, we were not being paid for the per diem for a group home. And that's $169.89 per day per young man at that group home. They didn't understand that you got a per diem rate and you also got a rate for individual family group therapy. So once they fixed that, one of the companies fixed it, then we started to get 25 percent of that instead of the $169.89. As of last week's payments, we were still getting 25 percent of that amount of $169.89. That alone with Nebraska Total Care accounts for $38,000 in what we're owed. So there's additional information here that you can read at your leisure, but I also included our accounts receivable for you, the last page. That will give you a breakout by company, by time frame of what we're owed, and the totals for that. I'd be happy to respond to any questions you might have.

SENATOR RIEPE: Okay, thank you very much. Are there questions from the committee? Senator Linehan.

SENATOR LINEHAN: Thank you, Chairman. So I want to ask this the right way. Thank you very much for being here. So of all the billing, are you getting a percentage that does get paid? Like what's the percentage that gets paid?

KATIE McLEESE STEPHENSON: Well, you can see on the very last page, since we started we...if you take the billed amount which is over $1 million at the very bottom there and you take out the adjusted amount which is $100,000, we've been paid of that total amount, $717,000. What we're owed there is the $231,000. So we've been paid about 70 percent, 80 percent. But when you're operating a nonprofit where your margins are very, very thin and you have payroll to meet and you're only getting paid at 65 percent of what it costs you to do this service, not receiving that large amount of money is very problematic.

SENATOR LINEHAN: Okay. Thank you.

SENATOR RIEPE: In the last 30 days, have you seen improvement?

KATIE McLEESE STEPHENSON: We have seen some improvement.

SENATOR RIEPE: Some.

KATIE McLEESE STEPHENSON: I would say we've seen some improvement...as Corrie mentioned earlier, it's sort of luck of the draw where, you know, the children were assigned to or where their families chose. And we had most of our children in our two highest levels of care which is our group home and our extended day treatment with Nebraska Total Care. We, as a result either of that or in addition to that, were having the most difficulty with payments from Nebraska Total Care. We had lesser clients with United and with WellCare, but they were billing at a higher proportion of care. So Nebraska Total Care has been the company that has caused us particularly the greatest difficulty. We have seen some improvements. I mentioned the $190,000-

some. You know, that's down a little bit from what we've been owed previously. But we're still owed a lot of money.

SENATOR RIEPE: Okay. Thank you. Any other questions? Oh, Senator Linehan.

SENATOR LINEHAN: Just because I'm trying...are you part of the regional...

KATIE McLEESE STEPHENSON: We are a regional provider for Region V and we receive 17 percent of our revenue from Region V.

SENATOR LINEHAN: Thank you.

KATIE McLEESE STEPHENSON: About 18 percent from Probation and from DHHS through child welfare.

SENATOR RIEPE: Senator Erdman.

SENATOR ERDMAN: Thank you, Senator Riepe. Can you explain why your charges to WellCare are such significantly less than the other two?

KATIE McLEESE STEPHENSON: Because we have fewer WellCare clients.

SENATOR ERDMAN: They just haven't chosen WellCare?

KATIE McLEESE STEPHENSON: You know, it's sort of depended. I believe 60 percent or 70 percent were auto assigned. And so it just is who we were serving at the time and were they or did they end up being a WellCare client. So it's not that we're serving or not serving any of the MCO's clients. It's just how many happen to be with WellCare, but it's significantly less than the other companies.

SENATOR ERDMAN: Okay. It appears the outstanding balance percentagewise is about the same on all three.

KATIE McLEESE STEPHENSON: Um-hum.

SENATOR ERDMAN: Thank you.

SENATOR RIEPE: Senator Linehan.

SENATOR LINEHAN: How much of this, that unpaid, do you think has to do with them...it seems that from the git-go they were missing some of...I forget exactly how it was explained. Magellan had closed. It didn't get transferred over, so there were claims getting denied because they didn't have the codes and then they had to correct the IT. How much of this do you think was due to that issue?

KATIE McLEESE STEPHENSON: I'm not certain about that. I do know for us a big issue is that the companies didn't seem to understand that for our extended day service and for our therapeutic group home that we received both a per diem rate and individual family and group therapy.

SENATOR LINEHAN: Okay. Thank you.

KATIE McLEESE STEPHENSON: So I think that accounted for a lot the...

SENATOR LINEHAN: So one...what does that mean in dollars then? One child per day, what does that mean?

KATIE McLEESE STEPHENSON: For the group home it's about $170 a day.

SENATOR LINEHAN: So that's both of them added together.

KATIE McLEESE STEPHENSON: No, that's just the per diem. And then on top of that there's individual therapy, family therapy, and group therapy. And that, the group therapy happens frequently, the individual is a couple times a week, and family therapy is usually once a week. And then it differentiates if it's a provisionally licensed therapist providing it or a licensed

therapist or a licensed independent practitioner or if it's a psychologist who is providing a supervision.

SENATOR LINEHAN: So considering all of those things, one juvenile in this program, do you have an amount that you think it costs a year when they're getting all these services or an amount you think it costs a week or a day? What I'm trying to do...

KATIE McLEESE STEPHENSON: Right.

SENATOR LINEHAN: ...is get some handle on how much...

KATIE McLEESE STEPHENSON: Yeah. Well, I think if it's $170 a day and you add...you know, some of the services are weekly or a couple times a week, I would say, you know, perhaps $300 a day. I know just with Total Care, if they solve this issue of paying us at 25 percent, they owe us $38,000 just for the group home for that service.

SENATOR LINEHAN: And then on top of those services would there be pharmacy charges?

KATIE McLEESE STEPHENSON: We do not provide those services.

SENATOR LINEHAN: Okay.

KATIE McLEESE STEPHENSON: We have a consulting psychiatrist who does medication checks at our facility, and we also have advanced practice registered nurse that provides medication checks and prescribes.

SENATOR LINEHAN: So any medication would be over the $300 per day.

KATIE McLEESE STEPHENSON: Um-hum.

SENATOR LINEHAN: Okay. Thank you very much.

SENATOR RIEPE: Seeing no other questions, we do very much appreciate the facts.

SENATOR CRAWFORD: Very helpful.

SENATOR RIEPE: It is helpful and insightful.

KATIE McLEESE STEPHENSON: Thank you.

SENATOR RIEPE: So thank you very much for being here. We appreciate it. Thank you. Next testifier.

TOPHER HANSEN: (Exhibit 5) Good afternoon. My name is Topher Hansen, T-o-p-h-e-r H-a-n-s-e-n. First, thanks for doing this. This is important. We wish we didn't have to be here. This is a problem that shouldn't be here, but thanks for digging in and helping us work it out. So I want to start by just saying yes, yes, yes, yes, yes to everything that has been said thus far. We're all...I don't know if you've noticed but there are lots of nodding heads in the crowd because we're all experiencing the same thing. The other thing I want to point out that I think is important to understand, the big picture context of this, which is what Katie just talked about which is these are people who are our, all of ours, most vulnerable citizens of our state. The state of Nebraska, and to some extent the counties, have responsibility for caring for indigent people who really are in trouble and need help. And the nonprofits are stepping up to this plate and have been for decades and decades. And we know from the state of Nebraska doing the research on this that the rates that we're being paid are way under what it costs to do services, especially since electronic health records and all the other electronic costs are in play. I'm spending about $30,000 more this year than last year just on electronic security so I don't get hacked by the Russians because we got hacked a year ago by the Russians in a cryptovirus. So it's stuff like that, that if you're going to be in this real world of providing high-level, quality services you have to get in at the high level and do what is the right thing to do. But our rates, which I call couch change funding, are inadequate for what we're trying to get done. So we have no margin. We have no capitalization in our businesses. And so as such, there is not much play here. Bear in mind that Magellan was our administrative services organization then stepped into, three years ago, an at-risk contract. Magellan is a much smaller organization than at least Total Care and

United HealthCare. I don't know quite how it compares to WellCare. But these all are very large corporations who do it elsewhere and have capacity and could fix these things if they chose to fix it. It is not rocket science. It is something they do in many, many other venues, they just have to get some focus on it. So as a result, what you'll hear is the providers are providing clean claims, overwhelmingly clean claims and then getting these same kinds of treatment back of partial payments and this, that, and the other thing. And it's one thing to get $20 when you're supposed to get $100. But then you've got to go back and you've got to record that in your system and then you got to figure it, you know, back and forth. So I'm not going to go in to other things other people said. What I can tell you right now is we submitted all our contracts last fall. I still don't have WellCare's back saying they signed it and it's...I signed it, but I don't have theirs back. So I'm still waiting for their fully executed contract from our submission last fall which we, by the way, had to send in again because they couldn't find it. The authorizations you've heard about, you know, they won't pay us for people who get retro eligibility. They can't take a bill that's a retro bill. So why do you even have retro eligibility if you're not going to pay a bill that was legitimately done in that time frame? Just silly things like that. So the one thing I do want to point out to you is one that caused harm. So what I learned in this process is when members get an authorization for request that...we do the authorization for request then the member will get a letter saying that was denied. That's disconcerting to people who are already fragile and feel like they are hanging on to their last thread. So there are two different programs. One is called a psychiatric residential rehabilitation facility and so that's where you live at night and you learn how to do things, cook and just sort of daily living kind of things in a residential setting, but then during the day you have to go away from that setting and get care someplace else. People often go to day rehabilitation settings so we happen to have both. And so we have been denied a number of times saying that's duplicative, we're not paying that by at least a couple of different organizations...of the MCOs. And in fact, this practice has been going on in Nebraska for a long time. But we're...adamant denial is, no, this is duplicative, you can't do that, and so they won't pay. So we have one person who got on a utilization review, got denied the day rehabilitation. You can't go do that because you're already in day rehab. And so they took it away. We continued to serve the person and have appealed that. But then in the review of the psychiatric residential program, then they said, no, you...we don't think you should be able to do that. Well, why is that? Why are you denying this? Well, because they've baselined. Well, what's baselined? Well, they've (inaudible) a maximum medical improvement or something equivalent to that, but the word was

"baselined." And then they said so who's the guardian for this person, because they were deemed unable to make their own independent decisions so they were appointed a guardian? And they said who's the guardian? We told them. And they said, well, can't they go live with the guardian instead of get this care? And we said, no, they're not done improving. We are teaching him how to live independently. And you've now denied them on both levels of service and pushed them out the door. And in the meantime the person is getting these letters saying all their services are getting cut off. This has caused great harm to that individual. This kind of practice has to stop. The first rule here is the Hippocratic Oath--at least do no harm. And what we see from all this is not only are members getting harmed in some of these processes, but the thin-margined providers who are stepping to the plate on this are also being thrown into the mill on it and coming really close to disaster. We, too...I haven't had a line of credit in our business since 1989. And we now have a line of credit just to cash flow what's going on because that's what we're talking about is cash flow. Magellan paid within five days, Senator Riepe, to answer your question, within five days. You submit the bill, you get the payment back; submit the bill, get the payment back. That happened overwhelmingly with clean claims and so on. So everybody got in the rhythm of that and that happened pretty fast. Now we are six months out. So I have provided you in here not only an accounts receivable--and these are actual amounts, not an inflated bill rate; this is an actual amount--and we have been up to almost $400,000 in this. But then these other pages are what...are retractions. So they've paid $17.42 for the service in error and then they retract and retract and retract and retract and retract. We've got 11 pages of retractions that we've had to enter in our system and then get paid again at an inadequate rate and get a retraction again. So it happens over and over in these kinds of ways. So the kind of ineptitude that we're seeing from very sophisticated organizations is remarkable. It's astonishing. It's suspicious (laugh) to me at some...I know this is going on in Iowa. I know it's going on elsewhere. And why are all three companies not able to grab on to this? What is that about? And regardless of what it's about, we appreciate that the department has put their foot down with one organization and said get a corrective action plan going. That's a step in the right direction. We need that level of accountability. I think providers overall want this to work. We want to serve the people that need the help, and we want to work with the MCOs to try and innovate and help provide the best service possible. And ultimately if you do that, you lower cost down the road. But when you do these kinds of things, what you do is you devastate the system and create greater effort and more cost because people aren't going to get better sooner for longer. So we really want that to happen

and want the accountability pushed at the state level to say here's the contract, here's your performance, step it up and get focused on this and get the job done.

SENATOR RIEPE: Okay. Thank you. Is some of what you're saying is an absence of common sense?

TOPHER HANSEN: It's an absence of focus maybe.

SENATOR RIEPE: Okay.

TOPHER HANSEN: Really an organization the size of at least...well, of all of these, I can do it. I'm a $12 million organization. These guys just dwarf me. And we can get it done, so why can't they get it done?

SENATOR RIEPE: Where I was going is one of our state senators is often saying that common sense is a flower that doesn't grow in everyone's garden.

TOPHER HANSEN: That's true.

SENATOR RIEPE: Senator Erdman over here is busily working away. Are there questions? Senator Linehan.

SENATOR LINEHAN: Thank you, Chairman Riepe. Thank you for being here.

TOPHER HANSEN: Sure.

SENATOR LINEHAN: I think you said, I wrote it down here, I know this is going on in Iowa. What did you mean by this? What's going on in Iowa?

TOPHER HANSEN: The same payment problems and people owed lots and lots of money and at least one similar...one of the organizations is common to both Iowa and Nebraska.

SENATOR LINEHAN: Okay, so are there other states that you heard from, too, other peers in other states?

TOPHER HANSEN: I haven't surveyed so I couldn't tell you.

SENATOR LINEHAN: You say 27 percent of your revenue is from Medicaid, so are you part of the Regional health...?

TOPHER HANSEN: Yes, we're...

SENATOR LINEHAN: So they give...

TOPHER HANSEN: We're in provider networks in Region II, V, and VI, and then also Medicaid and we do other business as well.

SENATOR LINEHAN: Some of yours is private pay I assume.

TOPHER HANSEN: We have very little private pay; 65-75 percent of the people who come in our door are homeless at admission and 75 percent make less than $5,000 a year. And everybody is in poverty.

SENATOR LINEHAN: Okay, so where does your revenue come from then?

TOPHER HANSEN: We get Regional money from the different Regions that we do business with, Medicaid money, Lancaster County gives us money to do what we do because we help homeless and indigent people extensively. We do business with HUD and VA. So we have several different lines.

SENATOR LINEHAN: Are a number of your clients veterans?

TOPHER HANSEN: Yes.

SENATOR LINEHAN: Do you have a percentage?

TOPHER HANSEN: We operate about 41 beds that are veteran only.

SENATOR LINEHAN: Is that Omaha or here?

TOPHER HANSEN: That's here.

SENATOR LINEHAN: Thank you very much.

TOPHER HANSEN: Um-hum.

SENATOR RIEPE: Okay, any other questions? Seeing none, thank you so much for being here today.

TOPHER HANSEN: Thank you. Yep.

SENATOR RIEPE: Thanks. If you would be kind enough to state your name and spell it and then proceed forward.

CONNIE BARNES: Thank you very much. My name is Connie Barnes, C-o-n-n-i-e B-a-r-n-e-s. I am from northeast Nebraska and am the CEO of Behavioral Health Specialists, Inc., and we provide extensive services throughout the northeast area. With that, I'm going to follow suit with everybody else and literally just tell you, yes, yes, yes, yes, yes, because everything that I've heard others report is exactly what is our experience as well. With that, a couple of notations just to help you understand our line of business is that 30 percent of our income comes from our Medicaid work, 40 percent of our income comes from a combination of three different contracts that we have with Region IV, Region III, Region I, and occasionally Region V calls on us to serve clients in one of our short-term residential drug treatment programs as well. In addition to that, we are a child welfare foster care provider and have business through Probation. And so the combination of those that I just named is about 40 percent of our income and about 30 percent of our income then comes through our self-pay clients and their insurance companies that are non-

Medicaid, non-Medicare, so just to give you that as a flavor. So one of the things that I would identify for you that's very costly is the amount of time that it takes to acquire an auth and we're talking 20-45 minutes. Auths should be able to be secured in ten minutes or less. I did offer last week at the Heritage Health behavioral health meeting, I offered personally to help the companies train their staff on how to obtain...you know, to vet an appropriate auth and that it actually can and has been done in ten minutes or less. And again, that's an example that Magellan had helped finesse while they were here in Nebraska. As a side note, I am in my final days of the past president seat as a NABHO board member, although I've been elected to a different role on the board which will occur with the new month coming. And when Magellan was in operation, I was one of three NABHO members that served on the Nebraska Magellan board of directors. And with that, Magellan really heard our voices, really listened to our voices, incorporated, responded appropriately. You know, it's not that we didn't have some heated conversations. We certainly did. But things operated so smoothly, absolutely so smoothly. I have worked in the behavioral health field in Nebraska for more than 35 years and our situation has never been as dire as it is now. And at the moment we have $181,000 of unpaid claims. And the largest amount of that is with Nebraska Total Care. And then it's an equal amount with United HealthCare and WellCare; each of those are around $36,000 each. As of the end of May, our profit on our finance statement shows $100,000 profit. However, we're sitting without $181,000 of payment of which is far more than...you know, that dates back quite a ways. In April we were at $300,000 unpaid claims more than 90 days out. So we have had to take what I want to call unfortunate steps which is we cut our funding of continuing education for our providers. We are not...we have it as a tentative that perhaps we could do a 1 percent raise, but we can't proceed nor act on that until we know we're going to even be able to be able to do that. And with that, also, we implemented other cuts throughout our organization on items that, you know, absolutely...involve building repair, that sort of thing. We happen to have four different building sites. All of that's very...you know, we don't want to have to go too long without attending to those items. And so I really just want to be a voice of...I would really love to see this all work out beautifully, but it needs to work out beautifully quickly.

SENATOR RIEPE: Okay. Are there questions from the committee? Seeing none, thank you very much. We appreciate you being here.

CONNIE BARNES: Thank you.

SENATOR RIEPE: Let me ask this. How many more testifiers do we have? I see three. Okay, we were talking about taking a break but if we have three I think we'll go on and just go through that. So you're close. You want to go? If you'd be kind enough to state your name and spell it and then proceed.

NICOLE KAUK BURSOVSKY: My name is Nicole Kauk, N-i-c-o-l-e K-a-u-k; my married name is Bursovsky, B-u-r-s-o-v-s-k-y.

SENATOR RIEPE: Thank you. Go ahead.

NICOLE KAUK BURSOVSKY: (Exhibit 6) I represent the Nebraska Counseling Association, NCA, as their public policy and legislation chair as well as the Nebraska Association of Behavioral Health Organizations, or NABHO, and finally myself as a private citizen who works with the new Heritage Health system providing outpatient behavioral health services in the state of Nebraska. I am a private contractor with Adultspan Counseling located in Lincoln, Nebraska. I am fully licensed as both a mental health practitioner and a professional counselor. I hold a master's degree from Doane College and I've been running my own businesses for nearly three years. I provide counseling to individuals with Medicaid in my office, in the community, and to a nursing home in Crete, Nebraska. Prior to the transition January 1, I was providing care for six to eight or more Medicaid patients per week in my practice, in addition to patients with other insurance plans and private pay. Two major problems, authorizations and payment, have forced me to reduce this number. We were promised no prior authorizations for outpatient behavioral health services prior to January 2017 and as late as November 2016. As a Medicaid provider, I am already required to complete a written review of my treatment plans every 30 days, a requirement no other insurance company has, and then to review these in a face-to-face supervision once per month, a total of around two to three hours of unpaid work. The addition of a three-page prior authorization sheet has added administrative burden and exponential unpaid hours to my week, including tracking, completing, and managing the denials. All this work must be done by hand, as on-line processing has never been fully functional on the provider Web sites. There is also no consistency between authorizations for how many sessions are given, and there's

no feedback on why that decision is made. We simply receive a fax back with the number we are allowed, with no idea if this is the last session that will be authorized or if more are possible. This is a difficult problem as it is vital in therapy to discharge patients in a healthy termination session, as many people have already experienced abandonment in their lives. If more sessions were denied, I would either have to terminate without a final session, which is bordering on an ethical violation, or I would have to have an unpaid session. Additionally, the number they are authorizing makes no sense in some cases. I recently submitted an authorization on June 2 and received it back on the 8th for six sessions between June 1 to July 1. There are not even six weeks in that time frame, and further, due to the timing of sessions I would only have two sessions prior to the 1st of July anyhow. If I needed more sessions, I would have needed to take one of the two sessions I had to complete and submit another authorization. I also cannot and will not see patients without a current authorization, and recently I've had problems with having to cancel sessions due to authorizations taking nearly two weeks to be returned. So now not only are authorizations affecting myself and my business choices, but also my patients and their access to care. In total, due to the amount of unpaid work that has been added, I have already reduced my Medicaid caseload to four to six patients per week. I simply cannot keep up with the required amount of work for each patient at current reimbursement rates. It is not financially feasible or responsible. And finally, the biggest issue in my practice and across the state has been payment. MCOs have cited a myriad of problems, mostly IT issues, and fixes have taken months. The problems and excuses are endless. I am still waiting on reprocessing for sessions I submitted as far back as February. Currently, personally, I am owed for 21 sessions from between February 28 through May 10. When problems are not fixed for months, these are months that we as providers are not getting paid. My paychecks have been cut in half since January. We know that facilities have been closing, borrowing money to stay afloat, and providers are limiting their Medicaid caseloads due to the problems of Heritage Health. I myself am considering leaving Medicaid altogether because of the challenges the past six months. This is a statewide crisis that must be addressed. And quite frankly, the thought of the next step of their plan, value-based contracting, terrifies me based on the fiasco this has been. Thank you.

SENATOR RIEPE: Thank you. A question that I had, in your document it says the addition of a three-page prior authorization sheet has been added...has added an administrative burden. So

when I read that, I read that that was a state requirement of the MCOs and not something that the three MCOs implemented. They did that at the direction of the DHHS. Is that your assumption?

NICOLE KAUK BURSOVSKY: I'm not clear on where that directive came from. I only understand that we were promised as late as November 2016 in town hall meetings held by the MCOs that there would not be prior authorization required for outpatient mental health.

SENATOR RIEPE: I think part of our committee interest or responsibility is to sort between what are requirements from DHHS that are maybe, whether it's fair to say excessive or encumber the delivery of services, or is it delivery at the three different managed care organizations. So there's sort of two sides to this and we have to try to sort through and figure out which is which and what is what. Are there other questions? Senator Linehan.

SENATOR LINEHAN: Thank you, Mr. Chairman. Just...so you work with private insurance companies too.

NICOLE KAUK BURSOVSKY: Yes.

SENATOR LINEHAN: So is it...like is it night and day or you have issues with them.

NICOLE KAUK BURSOVSKY: Yes.

SENATOR LINEHAN: It's night and day.

NICOLE KAUK BURSOVSKY: It's night and day.

SENATOR LINEHAN: Okay. Thank you.

SENATOR RIEPE: Okay. Other questions? Seeing none, thank you very much. Thank you for being here.

NICOLE KAUK BURSOVSKY: Thank you.

SENATOR RIEPE: Thank you for being patient over the last two hours. Senator, I won't tell you the drill. You know the drill.

ANNETTE DUBAS: (Exhibit 7) You'll hold me to a higher standard, as you should probably. Good afternoon, Senators. My name is Annette Dubas, A-n-n-e-t-t-e D-u-b-a-s, and I am the executive director for the Nebraska Association of Behavioral Health Organizations, or NABHO because that's a mouthful. We represent a very diverse group of behavioral health providers, consumer organizations, and regional behavioral health authorities all across our state. And, Senator Riepe, we really appreciate you holding this hearing and the pledge to hold quarterly meetings. I think this is the best way for us to get things out in the open and open that communication up and really be able to problem solve. And from the very beginning when the RFPs were put out, NABHO was at the table. We wanted Heritage Health to work. We need Heritage Health to work not only for our providers but for...especially for the people they serve. So we were committed. You know, we wanted to be there. We wanted to offer our expertise to help make it work. And that commitment is still there today, so through these hearings hopefully we will get there. We knew there'd be problems as well and we told our members, you know, to be prepared, and as you heard today, they were. They took out lines of credit. They did a lot of things to be prepared for those initial bumps, but we did not anticipate still being where we're at today. One of the things that I'd like to touch on that has been touched on a little bit is the advisory committees that were put in place. And there's three of them. There is the Administrative Simplification Committee, the Behavioral Health Integration Advisory Committee, and the Quality Management. And we believe that those were good steps. Providers are represented on those committees. They were intended to help smooth this transition. I think maybe we might have had some different expectations for those committees than what, I don't know, DHHS had or how they turned out, especially in the area of the administrative simplification because, again, from day one our members knew what it was like to deal with one managed care company. They knew the paperwork. They knew things that were expected. So they were like, okay, we're going to be dealing with three companies now. This is going to add a lot more administrative requirements on our part. What can we do to help facilitate creating more of a streamlined process with authorizations, with a lot of the other things? And unfortunately, I just don't think we got there like we had hoped we would. And you've heard those examples today, especially with the authorizations. We met with the MCOs. What can you, the three of

you, do to sit down together and create this uniform...more uniform or more consistent process? And as I visited with some of my counterparts in other states, I know that can be done. It's just maybe needing to do more of a push. So I'm hoping as these committees move forward that we can get more of a focus. The agendas have been set. We meet for a limited amount of time. I participate on the Behavioral Health Integration Advisory Committee and, again, I don't want them to think we don't appreciate it because we do. But it was only the last two meetings where we said we don't really have a chance as providers to bring our concerns forward. The MCOs are there talking about the things they're doing, but we really haven't had a chance as providers to bring up our side. You're meeting with the MCOs on a very regular basis. We understand that. But we think the provider voice probably hasn't been as representative...as represented as it could or should be. We've had our meetings with Medicaid, with the Division of Medicaid. We've appreciated that but I think there are ways to improve these advisory committees to be more effective. I think the Administrative Simplification Committee has met six times since a year ago, I believe is when they first started meeting. And by the way, at the bottom of my testimony is the link to the Heritage Health page. If you haven't checked that out yet, that has a wealth...probably more information than you'd ever want to know about Heritage Health, all of the presentations, all the FAQ...everything is on there, as well as the minutes and the agendas for all three of these committees. So you can actually go back and read the minutes if you don't have anything else to do and see the types of things that have been discussed. So I think there is a lot of opportunities still there to maybe improve those processes. As been pointed out, my members are businesspeople too. And they know what it means to cut corners and to be efficient and do the things you have to do to keep their doors open. But I think it's been pointed out today that the financial challenges that have been presented to them over these last six months are making it very, very difficult for them to keep moving forward and serving the people that they serve. So we again stand ready to work with the Legislature, to work with the division, to work with DHHS as well as the MCOs to make this a program that works, especially for the people we're trying to serve. So I'd be happy to answer any questions you may have.

SENATOR RIEPE: Thank you for being here. Are there questions? Senator Linehan.

SENATOR LINEHAN: Just one quick one. Thank you, Mr. Chairman. You said some states do it well. So can you give us examples.

ANNETTE DUBAS: I don't have any specific examples. I certainly can get those. Again, I know that there are states that have looked at how can we create a more unified or streamlined process or whatever. I just got some information from Illinois and Indiana this last week, I haven't been able to read it, dealing with credentialing and creating a more effective credentialing system. So I'm anxious to read through what they've put in place to see if there's something that we can...

SENATOR LINEHAN: I would appreciate, I think all of us would, if you have examples of where states, anything with behavioral health where other states are...have found the magic to make it work, I would appreciate you sharing that with us.

ANNETTE DUBAS: You bet, you bet. And in fact, I'll be in September be meeting...as a state association we belong to the National Council of Behavioral Health and we'll be having an executive directors retreat. And we do a lot of sharing of that kind of information at that retreat. So I'll be happy and I'll try to get as much as I can ahead of time for you as well. And I also included with my packet of information, I surveyed my members first part of May about give me your top five issues, what are your top five priorities that need to be addressed now? And that's kind of the compilation of what those consistent, across-the-board problems were as well as what were some of the more specific to each of the MCOs' problems. And the answers to those particular issues are also listed on the Heritage Health resource page.

SENATOR RIEPE: Okay. Additional questions, concerns, thoughts? Senator Crawford.

SENATOR CRAWFORD: Thanks Chair, and thank you for being here and thank you for the survey. That's very helpful as well. I know that you were involved in conversations through the lead-up to the contracts and I assume that this question about the administrative simplification and, you know, as much as possible single form for credentialing and for reimbursement was a part of those conversations from the very beginning. Do you think that that obligation was put in the contracts? And so is there a contractual obligation that they're not meeting, because this has been an emphasis from the very beginning?

ANNETTE DUBAS: I'm not...I hate to speak to the contract because even after trying to read through the 180 pages...

SENATOR CRAWFORD: Right, I figured you had been (inaudible)...

ANNETTE DUBAS: It's not something that I'm really competent. As far as I can think, there's nothing really specifically outlined in the contracts but the conversations were definitely held. And I will tell you that they were always kind of met with, in my estimation, a lukewarm response. I mean, each of them are their own separate companies and they have their own practices, some of which are very proprietary. And so asking them to come together and...there was...I think there was kind of a, yeah, yeah, yeah, we will work on that. But I'm not quite sure that the real full commitment to making that come to be was really there. And I think maybe that's some push from Medicaid and maybe even from the Legislature to say this is something that should be done and needs to be done if we're going to make this program work.

SENATOR CRAWFORD: So just to dig down on one example, credentialing. So if I understand from several of the people who have spoken, you have to get it approved through Maximus first.

ANNETTE DUBAS: Maximus is the provider enrollment. So all of our providers have to go through Maximus to be enrolled. Credentialing is kind of another step or another process and that's through other...and again, I'm not totally up to speed on that. So I mean they kind of complement each other but they are not the exact same thing. And so the credentialing can be a pretty complicated process. And, you know, if you have multiple locations you're not only credentialing providers but those locations. And I think there's just some complexity to it that with better communication on both sides probably can be worked through.

SENATOR CRAWFORD: So there is something different. It's not as simple as saying as long as you got through Maximus there should not be any additional...?

ANNETTE DUBAS: To my understanding, no. I don't know if it could be something as simple as that, but to my understanding, no.

SENATOR CRAWFORD: Right, right. Thank you.

SENATOR RIEPE: Okay, are there other questions? Senator, thank you very much for being with us today...

ANNETTE DUBAS: Thank you, again for the opportunity.

SENATOR RIEPE: ...and for your patience in waiting.

ANNETTE DUBAS: You bet.

SENATOR RIEPE: I believe that we have at least one more testifier over here. If you would be kind enough to state your name and spell it.

JANET SEELHOFF: Sure. My name is Janet Seelhoff, J-a-n-e-t S-e-e-l-h-o-f-f. I'm the executive director for the Nebraska Home Care Association and the Nebraska Speech Language Hearing Association. And I'm also the person who helped organize the newly formed Heritage Health stakeholder group. I reached out to a number of healthcare organizations once my members started contacting me with issues, and we quickly learned of all the issues that you've heard about today. And I'm the person who collected the claims data and I know that was a question earlier. So I just wanted to briefly give you the numbers that were given to me and as mentioned earlier we do believe these numbers are higher. And you've certainly heard from some individual providers today that would not be part of this $27 million. So what was presented to me was the Nebraska Hospital Association, $24 million and I know the CFO mentioned that number earlier; home health agencies, out of about 70 in our state, about 27 reported back to me and they had about $2 million of unpaid claims past 60 days. And then I also heard from two audiologists and one speech language pathology practice and that was about $56,500. The Nebraska Medical Association reported to me numbers from six physicians and that was $250,000. So I'm sure those numbers are significantly higher than that. And then LeadingAge gave me a figure of $500,000. So those are the numbers that were reported and we did try to reach out to lots of different healthcare groups. We may have missed some, so I just want to say to everybody behind me, if you're not part of our group and you'd like to be, please do let me now. And I just wanted to, again, extend the invitation to all of you to be part of these meetings that we'd like to schedule regularly because I can't emphasize enough how important that communication and transparency

is going to be moving forward. I know just with home health in particular, CMS has recently issued what's called a Medicaid face-to-face requirement that requires a physician to review plan of care so many days and sign off on that and that's been directed to the managed care plans. And, you know, we've been told that it will be a very simple process. But we already have concerns about the differences and what they may review after the claims are submitted. So things like that are just good examples of where we really need to be proactive and not wait until a new rule takes effect and then have to go back and address, again, authorization issues and claims and things like that but really work together closely and make sure that everything can move as seamlessly as possible. So everything else that my members have been dealing with are things that Jessica highlighted earlier, so I won't take up any more of your time except to...be glad to answer any questions you might have.

SENATOR RIEPE: Okay. Thank you very much. Are there any questions? Seeing none, we appreciate very much your being here.

JANET SEELHOFF: Thank you.

SENATOR RIEPE: Are there others that would like to testify? Please, if you'd come forward. If you'd be kind enough to state your name and spell it and then just proceed.

STEPHANIE WIESE: My name is Stephanie Wiese and it is S-t-e-p-h-a-n-i-e W-i-e-s-e. And I'm up here. I wasn't planning on talking, but I'm the billing payroll manager for Elite Professionals Home Care Company. And I just wanted to tell you since you've had behavioral health and hospitals and therapies, from home healthcare perspective, right now we are...what is owed to us from Nebraska Total Care since January 1 is over $200,000. What is owed to us from United HealthCare Medicaid is $72,000, and WellCare is probably in the range of $15,000 to $20,000 dating back from January 1. We are also dealing with the issue of denial because they say that we need to get a Medicare denial first. We've never had to do that in the past. Medicare is specific in that they want us...the clients we service are quads, paraplegics, people who are long-term care. They're never going to get better. Things aren't going to change and we have to...so we're always going to constantly have to take care of them. That is not something usually covered by Medicare. Home health aides only Medicare will not cover. Pill fills by the skilled

nurse every week, not covered by Medicare. So we as an agency know when we need to go to Medicare and do services provided under Medicare for that short amount of time because Medicare is more of a rehab, get them better, get them discharged. And so most of our claims that are being denied is because they want a Medicare denial. And to get a Medicare denial, that's like a two-month process. So it's been a back and forth of what codes do we need to do, all this. It's just been a big headache. And since I'm the one who oversees all of it for our company, it has been. I mean, I have had to give up other duties, just like the other people have said, to take care of it. My stack of claims that are denied by Nebraska Total Care is literally that big. I have a picture if you'd like to see it. So I just thought I'd come up and if you...and authorization, by the way, for all three companies is all three different. One has us authorize by day, one has us authorize by visit, and the other one has us authorize by so many visits per week. So you have to remember who wants what. So I just thought I'd come up; and if you had any questions, I'd be more than happy to answer.

SENATOR RIEPE: Are there questions? I think the department has sent out new codes on the home health care. Has that been beneficial? I mean I think (inaudible)...

STEPHANIE WIESE: No, I'm still getting denials. In fact, I got letters today from WellCare for denial because they want me to do Medicare first.

SENATOR RIEPE: Okay. Okay, and on the dual eligibilities, I think they're saying if it's determined that Medicare is always going to deny and put Medicaid as primary, that it's my understanding the managed care organizations are flying right to that as opposed to a sort of delay tactic of sending them to Medicare.

STEPHANIE WIESE: Right.

SENATOR RIEPE: Are you saying that's not your experience?

STEPHANIE WIESE: No, we've always...our clients, like I said, are bowel care, skilled nurse, things that are going to be continuing are pill fills, sorry. And then home health aides are never covered by Medicare if it's only home health aides. And a lot of these people only need home

health aides. So it's...if they see these Medicare HMOs...Medicaid HMOs are seeing that they have Medicare they will deny it right away.

SENATOR RIEPE: Okay.

STEPHANIE WIESE: United HealthCare is in the same boat. They've been with...under the managed Medicaid program forever now they are starting to say, too, they've been saying since January 1 that we need Medicare denial. And we have not had that issue before.

SENATOR RIEPE: Okay. Are there other questions? Hearing none, we thank you very much.

STEPHANIE WIESE: Thank you.

SENATOR RIEPE: Are there any other testifiers? Okay, we do have some letters for the record. Tyler, could you share those with us?

TYLER MAHOOD: (Exhibits 8-10) Yes, I have a letter from Project Harmony signed by Gene Klein; a letter from Health Center Association of Nebraska signed by Amy Behnke; and a folder from Angie Bellinghausen of the Addiction and Behavioral Health Services, Incorporated.

SENATOR RIEPE: Okay. Thank you. I did want a comment to be on the record, too, that shortly after the closure of ABH mental health there in Omaha we had a discussion with...or I did with the owner. And I had invited her to testify and I gave her information that said 10:00 and they were unable to stay for the 1:00. And I apologize to her for that. I think there's maybe some handouts coming with that information. But she did have an interest in testifying and I thought she had some very good points to make and some challenges that they had had at their ABH center there in Omaha. I also would like to say that I had scratched out some notes about what I try to pull together for summary. And I found that senators' comments here correlated with mine and they were, to some of the issues seem to be authorizations, contracts, claims billing, credentialing, communication, and I added a sixth one which was managed care organization payment relationship to cash flow. That seemed to be the biggest issues that I gained out of the hearing. I also wanted to say that as a Health and Human Services Committee, we will be

meeting each quarter as a committee to provide oversight to Heritage Health. That is our fiduciary duty and we will fulfill that duty. And so we would invite you, if we need to, to hear from you again. I frame that in that way. Hopefully all these problems will be solved and this room will be totally empty. But we're probably not going to count on that right away. Unless there are other comments, this hearing is concluded and thank you very much for being here. And thanks to all the committee members for your time. I know it's been a great commitment.