Health and Human Services Committee
September 22, 2017

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The Committee on Health and Human Services met at 10:00 a.m. on Friday, September 22, 2017, in Room 1510 of the State Capitol, Lincoln, Nebraska, for the purpose of a public briefing followed by a public hearing on Heritage Health. Senators present: Merv Riepe, Chairperson; Sue Crawford; Sara Howard; Mark Kolterman; Lou Ann Linehan; and Matt Williams. Senators absent: Steve Erdman, Vice Chairperson.

SENATOR RIEPE: Today's agenda is a briefing and it's available at the entrance, if you will. The first thing I'm going to do, I'm going to ask our members of the committee, which I very much appreciate their being here today, and we are going to have one modification on the agenda as we start out and that will be is we're just going to flip flop. We're going to have the managed care organizations present first. That was a request. And then we'll have Interim Director Thompson come forward. And today what...we'll go through this. We're having a hearing at 1:00 and this is the briefing side, so that we'll create some questions hopefully that we get on. I happen to be Merv Riepe. I'm Chairman of the Health and Human Services Committee. And I would like to start with the young guy down here on my far right and have him introduce himself.

SENATOR KOLTERMAN: (Laugh) I'm Senator Mark Kolterman from Seward. I represent District 24.

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

KRISTEN STIFFLER: Kristen Stiffler, legal counsel.

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

SENATOR WILLIAMS: Matt Williams, Legislative District 36: Dawson, Custer, and the northern part of Buffalo Counties.

TYLER MAHOOD: Tyler Mahood, committee clerk.

SENATOR RIEPE: And our clerk for today is...do I see a page? Oh, hi. That is Kaylee Hartman. Thank you, Kaylee, for being here, very important and we'll use her. If not, are you going to be here with us for the hearing too this afternoon?

KAYLEE HARTMAN: Yes.

SENATOR RIEPE: Okay. Very good. Thank you. We want to start off this morning with we're going to do the invited guests, as we start out here, and that is going to be Kathy Mallatt. We're taking these in alphabetical order of the managed care organizations. Kathy is the president and chief executive office of the UnitedHealthcare Community Plan. And so with that, I am going to turn that over to Kathy.

KATHY MALLATT: (Exhibit 1) Good morning, Chairman Riepe and members of the committee. I am Kathy Mallatt, K-a-t-h-y M-a-l-l-a-t-t, chief executive officer of UnitedHealthcare Community Plan and a Nebraska native. Thank you for the opportunity to address you today. Let me briefly explain the organization I represent. UnitedHealthcare Community Plan serves Medicaid members and nationally involved in Medicaid programs in 26 states serving over 6 million members. UnitedHealthcare Community Plan is one of the business segments of UnitedHealthcare. The other business segments include employer and individual, Medicare and retirees, and military and veterans. All of these business segments serve Nebraskans today. UnitedHealthcare has been operational in Nebraska since 1984 and has served Nebraska Medicaid clients since 1996, first, in three counties. We've served the state for 21 years in Medicaid and this happens with careful, thoughtful planning and delivering on commitments to providers, individuals, community organizations, and our state. Today UnitedHealthcare business segments employ 500 individuals across the state of Nebraska. This number has grown substantially since August of '16 when that number was 308 employees. UHC's annual financial investment in Nebraska in 2016 was $70 million and we expect to exceed that number this year. In terms of social responsibility, our Nebraska team alone supported 27...(recorder malfunction)...this procedure now has a chance of maintaining vision. Another closed challenge included improving access to durable medical equipment in rural areas. What we learned is that in the rural areas, pharmacies traditionally provided DME and supplies but they weren't contracted with the health plan for those services. They were contracted as pharmacies. Our

efforts included focused recruitment of the pharmacies, utilizing some really great data from MLTC and targeted contracting efforts to add the pharmacies to our network. On slide 6 we have listed four challenges that we are still "solutioning." One that I would like to highlight includes researching and seeking process improvements related to prior authorization process for custom wheelchairs. We are in active engagement with the provider to understand and address concerns and seek collaborative solutions. We met with them on Wednesday with our political teams. Two requests from the provider on Wednesday included, one, a direct contact to one of their team to address UHC questions regarding authorizations. The provider's second request on Wednesday was for our clinical team to re-review six cases. We fulfilled both requests yesterday afternoon. We believe we are moving forward in good faith to work out a solution. Slide 8 includes our global projects which are posted on our Web site. Now shifting to describing a few accomplishments, we believe that discipline is the bridge between goals and accomplishments. Many of the accomplishments I will touch upon are goals that we set in 2016 before we implemented the contract. And with dedicated, disciplined work of the team, the goals have become reality this year. The numbers tell the story on the next slides, two slides, 10 and 11. Later today you will hear about Steven's (phonetic) story. We've been focusing on social determinants of health and housing supports and that's one of my favorites. At UnitedHealthcare, we have an initiative to help people live healthier lives by connecting them to safe, affordable housing with referrals to support services to improve their health. Our housing navigator and care managers have assisted 107 individuals through August of this year. In addition to the work with care managers, the housing navigator works with local youth, homeless prevention programs, participating in street outreach, or meeting with community resources to assist members. At UnitedHealthcare, we believe housing can be a powerful tool for change. It can improve one's chances of employment and provide the necessary community support for those suffering from isolation. It provides and helps individuals access the healthcare that they need. On slide 12 we highlight some other accomplishments: strengthening our provider network for the expansion, including adding providers in border states--we recognize many of the individuals we serve receive services from border states as well; a successful audit from the state's external quality review organization that was held last week; establishing member and provider call centers in Nebraska; and receiving a certificate of appreciation from two key community partners. Slide 13 highlights some other key accomplishments, including a provider expo that was held on September 14 and attended by 135 providers. Slide 14 highlights the

implementation of whole person care that integrates physical health, behavioral health, and pharmacy services as well as social needs with internal and external resources in order to meet the needs of our members and their families. Slide 15 describes the accomplishments relative to our quality management program, including successfully completing a national quality for...National Committee for Quality Assurance reaccreditation in July, maintaining our status of commendable with NCQA. Slides 17 and 18 describe our member survey. We measure customer satisfaction through a tool called Consumer Assessment of Healthcare Providers and Systems, known as the CAHPS survey. It's a mouthful. We like to say CAHPS survey. Members completing the 2017 adult, child, and CHIP surveys rated our customer service as an eight, nine, or ten in 86 percent or greater of the surveys. There's nothing more powerful than the voice of the customer. I believe we have the leaders, the people, the skills, the experiences, and the resources to take our Nebraska Medicaid program to a consistently higher level of performance if we concentrate fully on the basic elements that contribute to strong, consistent execution; listening closely and cultivating deep relationships with each other; staying focused on what do our customers want; working together, communicating and collaborating fully, honestly, and deeply; taking ownership and accountability for the work that we do; and to do the job with high attention to the details; to get wet and to constantly follow through and follow up, getting everything right to the best that we can every time consistently. Thank you, Chairman Riepe and other members of the committee.

SENATOR RIEPE: Thank you. Does that conclude your presentation?

KATHY MALLATT: Yes, sir. Yes, it does.

SENATOR RIEPE: Okay. With that, I will...I have a couple of questions, but I want to open it up to the committee first. Senator Crawford.

SENATOR CRAWFORD: Thank you, Senator Riepe. One of the issues that has been raised to some committee members is being able to understand if or when a provider is getting an interest payment and knowing, if they're getting a payment, if it's an overpayment or an interest payment. Could you comment on the process for United or if you're...how you're identifying interest payments?

KATHY MALLATT: I'm not a subject matter expert on this but what I would tell you is that the system has the capability of knowing when an interest payment is required and then they attach that to the payment.

SENATOR CRAWFORD: Do you know if it is identified or marked in any way?

KATHY MALLATT: On a provider remittance advice?

SENATOR CRAWFORD: Uh-huh.

KATHY MALLATT: I would believe that that would be broken out separately but I am not 100 percent certain.

SENATOR RIEPE: Senator Howard.

SENATOR HOWARD: Thank you, Chairman Riepe. Thank you for visiting with us today. One of the things that I've heard about United, and United actually I hear more positive feedback than negative, but one of the challenges I've heard is about sort of a different credentialing procedure than some of the other managed care organizations through United. Has there been any conversations between the managed care companies to streamline credentialing or somehow make it a little bit easier for providers so we can all be on the same page?

KATHY MALLATT: So, Senator Howard, I think that there are some internal processes that all three of us have that might be different, but at the beginning of Heritage Health, we worked pretty closely to provide in public forums and on the Heritage Health Web site the credentialing process for each of the managed care organizations. And there's kind of a front-end process that the provider can use one time, and once they go through that process then their data is there and they don't have to repeat that information.

SENATOR HOWARD: Okay.

KATHY MALLATT: And I think it's CAQA. I'm sure somebody back there knows those abbreviations. But I think that all of that information is on the Heritage Health Web site, in the health plans presentations from the very beginning, and we repeated that message across the state when we all went out to do individual meetings and group meetings. Do I think that there's probably an opportunity to take that a little further and see if there are more things that over time we can simplify? Yes. We've already done some work on it and I think that that's probably one of the areas somewhere down the road perhaps the Admin Simplification Committee might be considering.

SENATOR HOWARD: Okay. The other thing I wanted to ask about was I've not heard any complaints about your processing of 599 claims. Can you tell us some of what you're doing that's working in that regard?

KATHY MALLATT: Early in the process, we met with one of the federally qualified health centers who identified to us that what we were asking for them to do with those claims didn't work, and it did not work because when individuals come in to receive services in the health center they have a name and they have a name in the medical records. And so for us to ask them to bill without that name in the name of the baby, so "Baby Smith," didn't work. And our senior...well, actually, our chief financial officer meeting with them came back and said this doesn't work. And you know, and it all made sense when you heard their story, right? You know, you have to have a name in your medical records. And so we made those changes. I would say on behalf of others they've made those changes too. I think sometimes it takes a little bit of time to get caught up and to get those. But that change was made.

SENATOR HOWARD: And then for UnitedHealthcare, all the 599 claims are now up to date and they're all paid?

KATHY MALLATT: We...yeah. You know, I...to the best of my knowledge, yes.

SENATOR HOWARD: Okay.

KATHY MALLATT: There are things that pop up here and there in the normal course of business or something else pops up as maybe an edit or something that's impacting claims, and then we'll go back and take a look and is this broad, is this a global issue or is this just a one off, and...

SENATOR HOWARD: Sure.

KATHY MALLATT: ...and then fix it.

SENATOR HOWARD: Great. Thank you.

KATHY MALLATT: You're welcome.

SENATOR RIEPE: Senator Williams.

SENATOR WILLIAMS: Thank you, Chairman Riepe. And thank you, Ms. Mallatt, for being here today. You mentioned the number of employees that you have in the state. Would you let us know where they are living, where they're actually working, and what your plans are for expanding that further.

KATHY MALLATT: There are individuals located, Senator, across the state. I would say the vast majority are in Omaha and Lincoln. But because we are a virtual organization in some sense and we're serving many different business units, including a segment of UnitedHealth Group called Optum, there are folks who live in very rural areas working from home. I don't have with me exactly where they all live. I'd be happy to provide that to you if that's something you'd like. And I think that growing that staff is dependent upon growing the business, right? I mean that comes along with growing the organizations.

SENATOR WILLIAMS: Right. This next question is not meant to be a criticism of your organization but just a general statement. In my legislative district, I have five critical access hospitals. And I've had the opportunity this summer to visit with most of the CEOs in that and they are under financial pressure to run the most efficient business unit that they can, which

means not having extra employees. And what I'm consistently hearing is the time spent on the billing, collection, this whole end is...the amount of time spent is larger today than it was before we went this direction. And because of that, there's a frustration level there with these people. In fact, in some cases the concept of...it just gets to the point on some things it's not worth the time so we just forget it and let it go. I'd like to just hear your response generally to that comment.

KATHY MALLATT: With those five critical access hospitals, my first response would be I'd love to go out and visit with them with you and to understand what their concerns are. We have a provider services operation in Nebraska and if they are having concerns we would want to know and figure out how can we address it. When any kinds of questions or concerns come in, they go through a provider relations process and we work to resolve them. So I'd love to come out and go to those facilities with you and spend some time understanding what areas do they have concerns with.

SENATOR WILLIAMS: I appreciate your willingness to do that. Thank you.

KATHY MALLATT: You're welcome.

SENATOR RIEPE: Senator Crawford.

SENATOR CRAWFORD: Thank you. One of the issues that we have heard also is the provider consultants, provider relation contacts, that there are contacts with those entities and then it really often takes the engagement of a CEO at a meeting to kind of push some of those issues that have been going through that provider relation system. Do you have a way that you're tracking resolution of those issues through that direct provider consultant that you can talk about, how you try to make sure that those issues are getting resolved?

KATHY MALLATT: Sure. We have our internal tools, but all of the issues that come in to Medicaid and Long-Term Care are put into, for lack of better words, an issues log. And each of those are reviewed as our program managers come into the health plan every two weeks and they go through those items, including calling providers, both with us and independently who are on the list, to say, is this closed? We will report that an item is closed and Lacie Pika, our program

manager, will call with our COO and ask, do you believe that this is closed to the provider? So that is...that's being tracked and, as I understand, Lacie makes those calls even without us as well on her own as a course of normal business.

SENATOR CRAWFORD: And through that process, when there are issues that are identified, how do issues that get identified there, for example, let's say inappropriate denials, how do those issues then get elevated to something that might show up here as an open issue that's tracked and addressed by the organization?

KATHY MALLATT: So all of the issues are on the issues log. And when we determine that something is what we call global--so it's not just a one off, it's not just a couple of providers, it's a larger...it's touching a larger group of providers--then we post that on the Web site.

SENATOR CRAWFORD: Thank you.

SENATOR RIEPE: Senator Howard.

SENATOR HOWARD: Thank you. And sort of piggybacking off of that, and you talked a lot about the survey that you're doing for consumers. Are you doing any type of surveying of your providers?

KATHY MALLATT: Yes, we do an annual provider survey.

SENATOR HOWARD: And when does that happen?

KATHY MALLATT: That, I believe, started...that would have...our last results would have been survey that was conducted I believe towards the end of last year. It's an annual survey. It's required.

SENATOR HOWARD: And so what were those results?

KATHY MALLATT: Off the top of my head, I don't remember the specific results. I'm sorry. What I can tell you, though, is that we take those results. We have a cross-functional group, a committee, across the organization so it could be someone from claims, from provider services, provider relations, contracting, health plan, and different disciplines and look at those results and say, okay, if this area isn't where we want it to be, what are we going to do to improve it. And then we put together a plan and we work that plan throughout the year.

SENATOR HOWARD: Uh-huh.

KATHY MALLATT: And then at the next survey we look to say, did we have a measurable improvement here? Did it stay flat? Did it get worse? And what can we do then to address it? So it's a continuous process. It gets senior leadership attention and it also goes through the quality committee process. So it is eventually reported as it goes through the committees to the quality committee.

SENATOR HOWARD: And so you'll be starting that again at the end of this year?

KATHY MALLATT: I think it's towards the end of the year, yeah. I'm sorry. I...

SENATOR HOWARD: That's okay.

KATHY MALLATT: Yeah.

SENATOR HOWARD: And if you do figure it out, would you mind sort of following back up...

KATHY MALLATT: Absolutely.

SENATOR HOWARD: ...with me or the rest of the committee? Thank you.

SENATOR RIEPE: Senator Kolterman.

SENATOR KOLTERMAN: Thank you, Senator Riepe. Could you explain to me, UnitedHealthcare is a pretty big provider in the state of Nebraska, not just with Medicaid. Do you segregate Heritage Health from the rest of the aspect of your business in Nebraska or do you treat it all as one book or business?

KATHY MALLATT: It's a separate business (inaudible). So the individuals who work in UnitedHealthcare Community Plan all focus on Medicaid.

SENATOR KOLTERMAN: So you're...one of the concerns that I've had all along with the way we're handling the Medicaid through Heritage Health is the networks. Traditionally, you've not had a strong work in western Nebraska or across the state. How has that improved through the Medicaid process and through the Heritage Health process?

KATHY MALLATT: We have a complete network for Medicaid across the state for physical health, behavioral health. And we meet all of the access standards, pharmacies, physicians, hospitals, federally qualified health centers. And it's a process. So as Heritage Health became a reality, then our UnitedHealth network's contractors were out across the state building that network.

SENATOR KOLTERMAN: Broadening the network.

KATHY MALLATT: Absolutely.

SENATOR KOLTERMAN: And how much is that continued? How much of that do you continue to do?

KATHY MALLATT: We continue to do that and, as a matter of fact, we report monthly on providers at our monthly (inaudible) meeting that have been added to the network. It's a...

SENATOR KOLTERMAN: So as you grow your network across the state, does that...and this is where I guess I'm asking about the total book that you have.

KATHY MALLATT: Uh-huh.

SENATOR KOLTERMAN: Does that also help the state employees that are with UnitedHealthcare in Boone County, as an example?

KATHY MALLATT: I understand. Yes. So our goal is always to contract for all products.

SENATOR KOLTERMAN: Okay.

KATHY MALLATT: Sometimes a provider doesn't want to do that and...but I would say generally all of our contracts are all products. So when I say that, their employer, the provider contracts include employer, Medicare, Medicaid, and military and veterans if applicable.

SENATOR KOLTERMAN: So Medicaid has a set fee that you pay a doctor.

KATHY MALLATT: That's correct.

SENATOR KOLTERMAN: Is that a better fee if you're private pay or in a group health plan?

KATHY MALLATT: We utilize the state's Medicaid fee schedule.

SENATOR KOLTERMAN: For...across the board for everything?

KATHY MALLATT: For the most part, yes.

SENATOR KOLTERMAN: Okay. Thank you.

SENATOR RIEPE: Thank you. I'd like to remind those in attendance that in the past Arbor did the rural and we had a rural-urban divide. We've gone to now an integration of behavioral and pharmaceutical into the plans and the plans are all statewide, so that there's a number of changes in the variables that are out there. As a former healthcare administrator, I always viewed these things as we have two different...we have clients and we have customers. I always refer to the

providers as our clients and the people that we served, in this case in the healthcare end of it was patients and I think we called the members as customers. So we have those two factors that we are committed to caring for. I think that that's an important piece. And we also have to have management or measurement tools to be able to be able to score this so that we have some feeling if we're making progress. The other thing I would say is we need to be careful too. I know that we talked about your CAPs and, well, we also have, Heritage Health, the department's CAPs which are...those are not so good and yours are intended to be good, we would hope. Have you seen progress since our first quarterly meeting to this one that was in June now? Can you share with us a little bit things that you think that have gotten better or if you think they've deteriorated? I think that's part of this Oversight Committee to understand. Thank you.

KATHY MALLATT: So areas that I think have gotten better would be around, for the most part, communication. I think it has opened up lines of communication where maybe an organization might not reach out before and now they have taken...they've made that outreach. So I think it's opened up some lines of communication.

SENATOR RIEPE: Relationship management building kind of?

KATHY MALLATT: Sure, absolutely.

SENATOR RIEPE: Okay.

KATHY MALLATT: And problem solving or putting out ideas that have you thought about could we make something like this work. And so it's opened up some of those discussions as well.

SENATOR RIEPE: Now the commercial side of UnitedHealthcare, another total product line difference,you're statewide on that or are you? Are you now?

KATHY MALLATT: Yes, employer...the employer is statewide.

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

SENATOR CRAWFORD: Thank you. So what I understand from the contract is when there's a clean claim and it's not paid within 60 days, there's interest that's charged on that if it takes longer than 60 days. So when there's a claim that comes in, that's denied and then it turns out, upon review, it was denied inappropriately, how does that...how are providers compensated for delay in time for inappropriate denials? Are they...do the...does that...are there any mechanisms by which they would be compensated for a delay that's caused by inappropriate denial?

KATHY MALLATT: I'm not sure.

SENATOR CRAWFORD: It's not something that your system has in place as some mechanism to provide compensation when there's an inappropriate denial?

KATHY MALLATT: I would have to go back and ask that question. I would hate to answer the question and answer it inappropriately or incorrectly, but I would be glad to get that information for you.

SENATOR CRAWFORD: Okay. Thank you. Thank you. I think that one of the concerns about time is if claims are inappropriately denied, still creates that time line that the provider has to deal with and...but it's a little different situation than the interest situation where there's compensation.

SENATOR RIEPE: Okay. Seeing no other questions, thank you...

KATHY MALLATT: Thank you.

SENATOR RIEPE: ...very much, Ms. Mallett. We appreciate you being here today and for sharing with us.

KATHY MALLATT: Thank you.

SENATOR RIEPE: Our second presenter is from WellCare of Nebraska and that is Ms. Rubel. Welcome. If you'd be kind enough to just state your name and spell it so we have it for the record. We appreciate you being here.

LAURALIE RUBEL: (Exhibit 2) Certainly. Good morning, Senators. My name is Lauralie Rubel. That's L-a-u-r-a-l-i-e R-u-b-e-l. I am the plan president and CEO for WellCare of Nebraska. I am also the wife of a disabled Navy veteran, an amputee, and the mother of a teenager with a serious behavioral health diagnosis. So my passion around what we do is very personal. Today I'd like to talk to you a little bit about some of the challenges we've had in the early part of the implementation and corresponding solutions that we identified. I'd also like to spend just a few minutes on some of the innovations that we've developed as a result of learning more about the needs of Nebraskans with Medicaid. And I'm going to share just a couple of really brief care management examples where we've been able to improve a member's life significantly. So with that, I'd like to begin. If you'll go to slide...it's actually slide 4, we articulated some of the key challenge...I'm sorry. Did you have a question?

KAYLEE HARTMAN: I'm handing out (inaudible).

LAURALIE RUBEL: Okay.

SENATOR CRAWFORD: Okay.

SENATOR WILLIAMS: We don't have them yet.

LAURALIE RUBEL: Oh! (Laugh) My apologies. I'll wait for you to...

SENATOR CRAWFORD: Okay.

LAURALIE RUBEL: ...receive them and digest for a moment.

SENATOR RIEPE: We'll speed read it.

LAURALIE RUBEL: Okay. (Laugh) My apologies. Beyond the agenda slide you'll see the next one articulates challenges, but I'd like to move to the following slide which speaks to some of the corresponding solutions to those challenges. My colleague from UnitedHealthcare already addressed some of the common issues that we all experience, such as the 599 CHIP eligibility category. We've had some opportunities for better understanding of historical behavioral health reimbursement by the prior behavior health MCO. We...also provider contract affiliations and corresponding credentialing have been an opportunity to develop process improvements and specific health system solutions. I'll be glad to provide more detail around that as you're interested. I wanted to say a word about clean claims for just a moment. I know that's one of the questions that the committee has. And with your permission, I'd like to send you the citation from the Federal Register that governs. You may be very well familiar with it already. I don't mean to presume. But it has a clear definition from the federal government of a clean claim. And that is what we apply to configuration in our systems. Part of the determination of a clean claim are things like verifying the member is eligible for Medicaid, verifying that some of the services provided are actually Medicaid benefits. And so these things, as we work through some of these issues, you may have heard the term "front-end rejections" rather than "claims denials." Our primary opportunity there was to do a better job of informing providers the distinction, what is a front-end edit versus a denial code, because the reason for them are very different. So again, I'll be glad to provide more detail during the questions and answers, as you like. Resulting from some of the challenges that we've encountered are some coming changes. I'll speak briefly to physical therapy prior authorization associated with disabled children. We are relaxing both the authorization criteria and the limits on the number of visits associated with each authorization. We recognize that there are members among our population that it makes sense to relax some of that criteria. So I'm eager to share that with you and it will be implemented on October 1. I'll speak briefly to our corrective action plan. As you know, it is on the Heritage Health Web site and is public information. We received notification on August 16 and we responded on September 14 with a comprehensive response to each of the findings and how we plan to address them. We've set up weekly calls with the MLTC to review progress on our action plan, upon it's approval by MLTC, and I feel very confident that the work steps we have in place will remediate some of the concerns that were surfaced. I know we kind of laughed a minute ago about the difference between CAPs and a cap. (Laugh) I truly believe that a corrective action plan gives us the opportunity to up our...to improve, to find those areas where we can be of better service and a

better partner to the state of Nebraska. So I'm not sure I'd say thank you for the CAP (laugh) but I find it to be a very valuable tool in helping us improve our program. Some of the other efforts underway to remediate issues have been ongoing since...for several months. We're doing a lot of direct outreach and interaction with our providers. We have joint operating committee meetings, both telephonic with providers across the state and in person with the larger health systems, FQHCs, and providers who we want to stay, you know, very close to. They've had challenges and issues. We do a number of what we call executive summaries to summarize the outcomes of reprocessing projects. I do want to, if you would indulge me, speak to the question about interest payment. We, again, it ties a little bit to the clean claim definition, but if the claim was truly processed in error by WellCare then interest is automatically applied, and I mean it's automated in the system. And our remittance advice clearly delineates the difference between the interest and any overpayment. So I'd be glad to talk more about it if you'd like. But as I listened to questions you had for my colleague, I thought I'd go ahead and speak to some of them. Additionally, beyond joint operating committees and individual provider group meetings, we have a provider advisory committee. We have a clinical advisory committee. These consist of external providers from across the state. We recently gave a presentation to MLTC in great detail about when those meetings are, who participates on them, what the recent topics were that we covered, and we encourage broader provider participation. We need that guidance and input. Related to member services, we have to date had 260 member education events across the state with varying member groups and advocacy organizations. And I'd like to segue to talk about our...a couple of innovations we have around members. Again, I would like to speak to the provider satisfaction survey question. Ours will be fielded for 2017 in December, in early December, so we do not have results to share with you yet but we'll be glad to publish them once they're available. All right. A couple of things, and we'll go to the WellCare highlights. Around some of our innovations I would like to share with you some specifics about WellCare and the way we approach care management and the obligation to be so much more than just a payer of claims. The state hired us to take care of Medicaid members in the state, and so we do that through a number of channels. One is our Welcome Rooms. If you would go to the next slide, please, we have four Welcome Rooms across the state, in Scottsbluff, Kearney, Norfolk, south Omaha, and then our headquarters is based in Omaha...well, our headquarters is based here in Lincoln but our main operations are in Omaha. We employ roughly 70 Nebraskans across the state. Some work from home. Many work from these Welcome Rooms. And we have services in

the Welcome Rooms that are both member-facing services as well as community. Anyone can walk into one of our Welcome Rooms and receive information about local social service agencies, assistance with coordination of transportation, or perhaps housing or food insecurity. So we're there to help the community, not just our members. If you'll go to slide...it's called Roles and Responsibilities, our office...our Welcome Rooms are staffed with office coordinators who are trained on our computer service protocols. They actually are field-based customer service personnel. Any member can walk in, or provider, and get assistance with a claim issue. We provide care management services in the Welcome Rooms and these associates have been trained very specifically to support our membership. I'll let you read through the rest of the Welcome Room information. I did want to spend just a few minutes on a couple of care management examples, if you go to...yes. Thank you. Similar to my colleague, we have had some incredible and moving opportunities to support people who would not otherwise have gotten the kind of support WellCare was able to provide. I'll reference a 62-year-old female with dementia, memory issues, depression, diabetes, and no housing. She was homeless. When she did find someplace to stay, it was somebody's couch. And we found her through claims data. She was visiting the emergency room quite a bit for some of her medications. By assigning a care manager who is now coordinating everything on her behalf, the care managers also helped her find housing, helped her obtain support with nutritional needs. It's so much broader than just making appointments with a primary care provider. Another example, we have a nine-year-old Iraqi boy in Omaha. He has cerebral palsy and he needed a specific walker, very expensive walker, that was the only thing that would meet his needs. We have certainly coordinated the approval and provision of the walker. However, it's too wide to go through the doorways in his home. So we're working on home modification or--and we've given the family the choice to--if they'd like us to help find other living accommodations, either through the League of Human Dignity or other service organizations. Those are just two. I have a list of many if you'd like more. Before I conclude I would like to just give you a high-level preview of our Baby's First program. It is a hallmark innovation that we're going to be leveraging both technology and data to better serve our moms and newborns. The program is designed both for members and nonmembers to educate moms about baby's needs in the first 15 months. It's a text-based program that the member or nonmember opts into. There are specific goals. If we could move to slide 16 I believe. Again. I don't want to read slides to you. Nobody likes that. If you go to the one titled "Goals." Yes. We want to increase a number of health outcomes for the babies and the

moms enrolled in this program. You can see them there. They're all quality-based metrics and health improvements. We also want to decrease things like infant mortality, food insecurities, vaccine preventable diseases. If moms were getting their children to get their vaccinations, we have some opportunities there. And the last...the next to the last slide, yes, it articulates what benefits are available to all Nebraskans and then specifies the additional benefits for members enrolled with WellCare. And that concludes my presentation.

SENATOR RIEPE: Thank you very much.

LAURALIE RUBEL: Thank you.

SENATOR RIEPE: Questions from members of the committee? I see a hand. Senator Howard.

SENATOR HOWARD: Thank you, Senator Riepe. Thank you. It's nice to see you again, Lauralie.

LAURALIE RUBEL: Nice to see you.

SENATOR HOWARD: So I've sort have been tracking our managed care transition. I have this huge binder, right? And I was hoping you could walk me through what happened with the addiction and behavioral health services group. I know through the e-mail chain that you had stepped in and they did eventually close their doors in June. And so I suppose it's two questions. One is, have you rectified that situation? Have you paid out what was owed in that instance for addiction and behavioral health services? And then, because they were providing such a unique service, especially in Sarpy County...

LAURALIE RUBEL: Uh-huh.

SENATOR HOWARD: ...to their juvenile court, which obviously impacts our child welfare system as well,...

LAURALIE RUBEL: Certainly.

SENATOR HOWARD: ...have you made any strides to fill in the gap that they left with their closure?

LAURALIE RUBEL: Certainly. Yes, we have rectified the claims issues that were presented to us that were resulting from processing errors. There were a number of claims issues affecting that provider that were not errors on WellCare's part, so. But the reprocessing has been completed and payment has been made. We'd be glad to provide you, if you'd like to sit down with the executive summary that outlines the specifics of that project and go over with it in detail with you so you can see how many claims were reprocessed, how many claims. And all of this has been provided to Ms. (inaudible) Hansen (phonetic).

SENATOR HOWARD: Yeah, I mean, you know, looking at the e-mails, it looks something along the lines that it started with provide ID numbers for the state, but then the other MCOs didn't have that same issue. It was only WellCare. And then they were told to resubmit. They resubmitted, nothing occurred. And I'm sure there must be...all of these situations have subsequently been rectified by WellCare?

LAURALIE RUBEL: Yes. One of the complexities, without going too far into the weeds, is the requirement that our claims data matches what's on the state Medicaid provider roster and so when I say "match," the NPI, there are specific elements that have to match directly with the roster. WellCare applied very stringent matching rules at the initial outset of the program, which we subsequently relaxed. That, by relaxing those, that remediated several of the problems that ABH was having as well as other providers. (Laugh) So that's a big root cause of that problem that has been fixed.

SENATOR HOWARD: And then how have we done filling in the hole, the provider gap there?

LAURALIE RUBEL: I am not aware that we have a gap. I can certainly provide you with a county-specific mapping of the alternative providers that are covering those services, but I'm not aware of any network deficiency as a result.

SENATOR HOWARD: And so my concern is more this length of time in terms of providers getting paid and the submissions and that sort of thing. And just yesterday we got an e-mail, the whole committee got an e-mail from Bryan Independence Center.

LAURALIE RUBEL: Uh-huh.

SENATOR HOWARD: And it looks like they've been reaching out to WellCare several times and as of yesterday they haven't heard back. And my concern is that I don't want to see another provider close. I don't want to see another provider not get paid or leave these gaps and then not be able to meet our access requirement. And so can you tell me a little bit about what's going on with the Bryan Independence Center?

LAURALIE RUBEL: I'm afraid I'm not familiar with the particulars, but I'll be glad to gather them and report back to the committee.

SENATOR HOWARD: Sure.

LAURALIE RUBEL: We meet with Bryan on a regular basis and so it may be something that's a known issue to my team, but I'm not prepared to address it right now.

SENATOR HOWARD: And so when you have an overpayment to a provider,...

LAURALIE RUBEL: Uh-huh.

SENATOR HOWARD: ...how is that managed?

LAURALIE RUBEL: If an overpayment occurs as the result of a coordination of benefits, we give the provider the opportunity to either refund us, which is really not anybody's preference--we prefer clean accounts receivable management--to offset the overpayment against future claims. So if there was an overpayment of $100, the provider can certainly send us the $100, but it's easier and cleaner if it's offset against future claims.

SENATOR HOWARD: Can you give me an example of why an overpayment would occur?

LAURALIE RUBEL: Sure. Coordination of benefits, when I say that primarily I'm speaking to members who have Medicare as their primary coverage and Medicaid as secondary, Medicaid being the payer of last resort. In certain instances, we have erroneously paid as primary when we shouldn't have for...and there are a number of reasons, both operational and manual error, where our responsibility was only as the secondary payer.

SENATOR HOWARD: Okay. And then...and so your preference is that they keep the overpayment and apply it to later billing or your preference is that they refund it?

LAURALIE RUBEL: Again, we can do it either way. I mean some providers would rather get the money off their books and just send it to us so there's not any impact on future claims payment. But it's entirely the provider's discretion.

SENATOR HOWARD: And then just...you mentioned the interest payments.

LAURALIE RUBEL: Uh-huh.

SENATOR HOWARD: How does that work? So WellCare is in arrears to a specific provider for appropriate claims and that builds up for a period of time, and then by...contractually you're obligated to give them an interest payment on top of the payment?

LAURALIE RUBEL: Uh-huh.

SENATOR HOWARD: Okay.

LAURALIE RUBEL: If it was...a couple of key caveats to this conversation. The clean claim definition drives a whole lot of whether or not interest is due to the provider. And we can spend more time on that or not. But that seems to be part of the sticky wicket around this question. Our system is configured to automatically pay interest to any clean claim that ages past the required timeliness. We do a couple of things. If a provider has a large claim project, we would prefer to

work with them on reprocessing back to the original date of submission because if they resubmit the claim the interest clock resets. This is why submitting duplicate claims is not a good idea, because if you've sent the same claim five times the clock starts with the most recent date of submission. Is that...is that clear?

SENATOR HOWARD: Yeah.

LAURALIE RUBEL: So that's one aspect of it. But it's an automated process.

SENATOR HOWARD: Uh-huh.

LAURALIE RUBEL: That interest is automatically calculated and applied and it's clearly distinguished on the remittance advice from the allowable payment.

SENATOR HOWARD: All right. And my last question, I promise.

SENATOR RIEPE: Okay. Sure.

SENATOR HOWARD: What's the recourse for a provider if maybe they feel as though their payments were in arrears for too long or their interest payments weren't appropriate? Do they have the ability to potentially sue WellCare? Is there some type of liability there?

LAURALIE RUBEL: Well, there's certainly tiered opportunities for dispute and appeal and a state fair hearing. There are levels of review that would give both parties the opportunity to present their perspective on the matter. So we do make every effort to resolve things at the dispute level, but certainly if a provider feels that our decision is not accurate, they have other means to pursue.

SENATOR HOWARD: Has WellCare ever been sued in other states in this matter?

LAURALIE RUBEL: Around interest payments?

SENATOR HOWARD: Or payments as a whole.

LAURALIE RUBEL: Well, I would imagine that we have. I can provide you more detail.

SENATOR HOWARD: All right.

LAURALIE RUBEL: We have not in Nebraska.

SENATOR HOWARD: Uh-huh.

LAURALIE RUBEL: To my knowledge, we have been able to successfully address any litigation.

SENATOR HOWARD: Okay. Thank you.

LAURALIE RUBEL: You're welcome.

SENATOR HOWARD: I promise, I'm done.

LAURALIE RUBEL: No, that's fine. Bring it on.

SENATOR RIEPE: And I'd also like to add, for full disclosure, on the day and the Omaha ABH closed, I spoke with the owner and their problems were not limited strictly to, certainly, to Medicaid through Heritage Health. There was a carryover from past Medicaid and there was also a significant issue with commercial payers that all of a sudden stopped authorization and threw them into a financial situation, so. I also wanted to talk a little bit. I appreciated your story about the young person that was in the walker and how you were looking at home modifications. I think it plays to managed care in the 1970s was a "Mother, may I," yes or no, and that was simply how it worked. As I see through Heritage Health, the managed care organizations are more to my liking, which is population-based management...

LAURALIE RUBEL: Yes, sir.

SENATOR RIEPE: ...of trying to go in and go into the homes, understand what the needs are. And many of those are driven beyond simply medical needs, and how to then try to help them find resolution on that. So it's, as Dr. Lazarus says, it's not your father's managed care organization and so we might come up with a better nomenclature on it, if you will.

LAURALIE RUBEL: In that instance, sir, if I could share...

SENATOR RIEPE: Sure.

LAURALIE RUBEL: ...that the child is eligible for the developmental disability waiver and, therefore, does not have the home modification benefit associated with that waiver program. But because it's the right thing to do, WellCare is continuing to pursue it as a service to the member.

SENATOR RIEPE: And that's commendable. Are there other questions from the committee? Senator Williams.

SENATOR WILLIAMS: Thank you, Chairman Riepe. And thank you for being here today. And I appreciate the things that you are doing and special stories that you are telling. The concerns that I am hearing from providers are more the day-to-day kind of things, not the special thing: the inconsistency of claims being handled when a provider is sending in a claim and they've done the same one before and this one now gets handled differently. My question specifically goes to your training of employees because I continue to hear from my providers that when they do call in and talk to someone they are not getting the same answer from...they're getting a different answer from different people. Let me put it that way. So how do we address that issue in a way that builds that consistency long term?

LAURALIE RUBEL: Thank you for the question, sir. Our training is near and dear to my heart. We're only as good as the information that we provide through our associates. And so call monitoring and follow-up training is a fundamental part/process in our operations organization. We do regular knowledge assessments with our call center agents as well as our field agents. But I agree that there have been instances where providers have gotten mixed messages depending on who they speak to. We in every instance follow back. Each call is recorded and so we follow

back up with the agent who took the call and use that as an education opportunity or a performance management opportunity, as the situation presents itself. Additionally, there's a continuing management of frequently asked questions or frequently...frequent errors, if you will, that are used to develop new training modules and platforms for across-the-board deployment. I agree that it's been an issue, not only for our call center agents but our field base associates. We can do a better job of training all of our team.

SENATOR WILLIAMS: Thank you.

LAURALIE RUBEL: Thank you.

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

SENATOR CRAWFORD: Thank you. And thank you for being here today. So I just wanted to follow up and make sure I understand how the interest and overpayment worked just a little bit...

LAURALIE RUBEL: Sure.

SENATOR CRAWFORD: ...from your perspective. So you had mentioned if it's a clean claim, and then if it is denied but then it turns out it was denied inappropriately, then if they work with you on that claim to make sure they're working back to the original claim date as opposed to just...as opposed to submitting a new claim, then it's still...it would be possible that you would earn interest for a delay in payment that's caused by an inappropriate denial. Is that true?

LAURALIE RUBEL: It is, but with the caveat that inappropriate denial can be a loaded definition.

SENATOR CRAWFORD: Okay.

LAURALIE RUBEL: If the provider failed to get authorization, if the...if it was an appropriate denial...and maybe that's what we need to drill into a little bit is some examples of inappropriate denial and how that was remedied and interest was applied. Do you...I don't know if you have

any specifics from your constituency around examples of that, that I could research for you. Or would you just like a general response?

SENATOR CRAWFORD: I'm just concerned about delay in payments and if denial...some concerns about the kind...about denials that were received or inconsistencies in denials. And so if payments keep getting delayed by denials, if the provider has recourse...

LAURALIE RUBEL: Uh-huh.

SENATOR CRAWFORD: ...in terms of interest payments...

LAURALIE RUBEL: Certainly.

SENATOR CRAWFORD: ...if the delay is not, oh, it's just sitting there and hasn't been paid but the delay is being caused by denials that may be inconsistent or turn out afterwards to be inappropriate.

LAURALIE RUBEL: Then interest would be automatically applied through the reprocessing.

SENATOR CRAWFORD: Okay. So, and what about an example like the 599 example where you recognize there was a systematic problem? So would there be interest applied to those claims that were delayed?

LAURALIE RUBEL: I don't know if they were or not. The issue with 599 CHIP is that the eligibility data we receive from the state--and this is just the nature of that category of aid--cannot be reconciled through an automatic process. You can't match the eligibility record to a claim. And so the opportunity to address that requires manual intervention for now. We are working on a more crisp and automated solution. But the manual piece is rife with the opportunity for error.

SENATOR CRAWFORD: Uh-huh.

LAURALIE RUBEL: So in those instances, yes, interest would be...would apply.

SENATOR CRAWFORD: Apply? Okay. And one more question...

LAURALIE RUBEL: Sure.

SENATOR CRAWFORD: ...in terms of your portal and interface. Does your portal allow a provider to see a negative balance from overpayments?

LAURALIE RUBEL: Yes, through their...through our electronic funds transfer processing system, they can track negative payments.

SENATOR CRAWFORD: All right. Thank you.

LAURALIE RUBEL: Yeah.

SENATOR RIEPE: Okay. Senator Kolterman.

SENATOR KOLTERMAN: Thank you, Senator Riepe. Can you tell me a little bit about the presence of WellCare in Nebraska prior to Heritage Health?

LAURALIE RUBEL: We had a footprint with our prescription drug program or Part D prescription drug card. I'm not sure how long it had been here but we had a few hundred Nebraskans on that program.

SENATOR KOLTERMAN: What about commercial insurance?

LAURALIE RUBEL: No. We don't offer commercial. We specialize only in government programs.

SENATOR KOLTERMAN: Okay. Okay. Do you feel like you were ready to go January 1 when the clock started ticking?

LAURALIE RUBEL: Certainly, but I think we learned a lot of important lessons along the way. I'm grateful for the partnership that the provider community has shown us. If...the provider network is the backbone of the program, and if we're not taking care of our providers that's where we go off the rails. And so we've had many opportunities to improve things through healthy conversations with large providers who we needed to improve things for.

SENATOR KOLTERMAN: And has your provider network improved since January?

LAURALIE RUBEL: Yes, sir.

SENATOR KOLTERMAN: Are you continually adding new providers?

LAURALIE RUBEL: Yes, sir, month over month. And we also have a strong footprint in the border states, including Colorado, South Dakota, Iowa, Missouri, Kansas. We have providers in...for all of the routine patterns of care that Nebraskans in border counties have been used to.

SENATOR KOLTERMAN: Throughout the whole state or is it...

LAURALIE RUBEL: Yes.

SENATOR KOLTERMAN: ...primarily in eastern Nebraska?

LAURALIE RUBEL: No, it's in western Nebraska as well.

SENATOR KOLTERMAN: Okay. Thank you.

LAURALIE RUBEL: You're welcome. Thank you, sir.

SENATOR RIEPE: Okay. Thank you very much. I'm not seeing any more. Thank you very much. And we understand that you lost your father last week. Our condolences to you.

LAURALIE RUBEL: Thank you, sir.

SENATOR RIEPE: Thank you. God bless.

LAURALIE RUBEL: I appreciate that.

SENATOR RIEPE: Thank you.

LAURALIE RUBEL: Thank you, Senators.

SENATOR RIEPE: Our next presenter is Mr. Ryan Sadler, who's with the Nebraska Total Care. Mr. Sadler, if you would...if you'd be kind enough to state your name and spell it and proceed forward. Thank you.

RYAN SADLER: (Exhibit 3) Hello. Good morning. Thank you for the opportunity to provide this update today. My name is Ryan Sadler and I'm the CEO of Nebraska Total Care. It's R-y-a-n S-a-d-l-e-r. First, I want to mention that I appreciate the opportunity to be here and to do business in the state. It is not lost on me that we work at the pleasure of DHHS and the Governor, this committee and the Unicameral, and I appreciate the opportunity. But also, I understand the responsibility. I'm pleased that many of you were able to join us in our Omaha office last month, visiting our office, getting to know our people and our processes, and hearing some about the great work that we're doing. So for those of you who were unable to attend, I personally want to invite you to join us and visit us at any time, happy to show you what we have going on in Omaha and in our Lincoln office. This next slide is titled "Remember the Member," and we start off all of our meetings with this. I think many of you have seen something like this, but it is important both on our team in Omaha but all of our staff that we're focused on what we're doing for the members that we serve. And this particular story is great because it's the perfect marriage of how we have integrated care with both behavioral health and physical health services. And so what we have in this case was a member who had...assigned a behavioral health case manager and as their clinical needs evolved over the last several months, the behavioral health clinical manager realized that the patient was becoming a little bit more and more disconnected. And so that behavioral health case manager engaged our member connections team. And these are our team on our physical health side that go out into the homes, that go out into the community, knock on doors and ask them sort of what's going on. Immediately upon that visit the

connections representative realized that this patient was very disoriented, not clear exactly what was going on in their surroundings and in their home environment. And at that time, that care manager then linked in our physical health case management team to say, hey, we've got to get this person in to see their PCP; there's something going on here. And so our case manager team set that appointment up. They called the PCP's office, gave them the clinical background and observation notes as well as a detailed conversation with the nursing staff in that office. Afterwards, the PCP called us back to say thank you and that individual was then admitted into an assisted-living facility because they couldn't, quite frankly, take care of their own needs on their own. The impact is untold but I think the story speaks very well for the care model and how we're looking at this from a holistic approach. So Nebraska Total Care is local, and it's not a story about job creation. It's about Nebraska job creation. Today we employ 158 employees and we manage the care for the most fragile members in our communities across the state. We're proud about being local and, really, it's the wholesome values of Nebraska that are driving our model of Nebraskans serving Nebraskans. Our team is committed to impacting the quality of care for our members while being the best stewards of taxpayer dollars that we can. As a learning organization, we are improving our processes each day, and the focus is living up to our mission of providing the highest quality of care for our members. And while we manage care for the sickest Medicaid patients in the state, we welcome this opportunity because together we can make the biggest difference in these members' lives. So while we've been around for eight or nine months now, making the biggest difference in our members' lives is our goal. It's our commitment to the taxpayers and, most importantly, to the people that we serve. So on this slide you see that our commitment to members and providers alike require us to adapt and change as we learn more about the people we serve. And as a learning organization, we are committed to improving our processes for providers and ensuring that our members get the highest quality of care, treated with the utmost dignity and respect. We continue to meet frequently with DHHS, providers, members of this committee, and all key stakeholders to give updates on what's going on with our provider community and our members, as well as to meet or exceed all contractual requirements. As you can see on this slide, significant improvements have been made since going live on January 1 and we remain well-positioned to continue making Heritage Health a success. As previously mentioned, Nebraska Total Care manages the healthcare needs of the sickest of the sick. As a result, it is no surprise that Nebraska Total Care has paid more in claims and claims dollars to providers than the other...than all of the MCOs. As of last week, Nebraska

Total Care has paid nearly $230 million to providers on roughly 2.3 million claims. We receive between 35,000 and 50,000 claims a week and our average weekly payments range from $5 (million) to $6.5 million a week. To date, it is important to note that Nebraska Total Care has paid approximately $25 million to provide...behavioral health providers in Nebraska. These next two slides speak to clean claims and I think it is important and helpful to clarify a couple points about what is and what is not a clean claim. So clean claims are those that are billed correctly per DHHS and CMS billing requirements. And as we'll show you on the next slide, more than 99 percent of claims that are coming in the door for June, July, and August have been considered clean claims. The most common example of an unclean claim would be a paper claim that has handwriting on it, because that is not allowed by CMS, or where certain fields that are required are omitted for one reason or another. So this slide, while busy with data, shows the percentage of clean claims received by month and also shown on this slide is that nearly all of our claims are being adjudicated. This means either paid or denied within 15 days of receipt. So what this slide really shows, however, is that Nebraska Total Care has learned more about billers in Nebraska each and every week, and providers have also learned more about how to bill in our systems as well. So I think it's important to note that more than 99 percent of all claims coming in the door are clean and being paid or denied, and that at this point, more often than not, providers are billing correctly. This is my final slide and I think it's of interest and relevant to the committee as it shows the highest cost drugs for our members. And what I think is so fascinating and so important for us to focus on and not lose sight of is at the very top of this list are ADHD medications and behavioral health medications. Maybe more telling is that towards the bottom of the list are opioids. This signals to us that as we focus in on this data and work to solve the underlying root cause of some of these issues that we can make the biggest difference for our members. So I want to thank you again, Mr. Chairman, members of the committee. I appreciate the opportunity and the great privilege and responsibility to be here and to do business in this state. Thank you very much. I'm happy to answer any questions and I'll be here all day.

SENATOR RIEPE: Thank you. Senator Williams.

SENATOR WILLIAMS: Thank you, Chairman Riepe. And thank you, Ryan, for being here. You heard the questions that I asked the other people that were up here concerning training and the inconsistency. Your data would indicate that over this period of time you have found a way to

address some of those issues in a positive way. Would you like to talk about what you believe you have done that's been different than what other managed care organizations have done?

RYAN SADLER: Thank you, Senator. So I appreciate the opportunity to answer that question. I'll tell you, I can't speak for the other companies. I know we are all working diligently to make this program a success and continue making it a success. One thing that has worked for us at Nebraska Total Care is that we have a local call center where our claims team, our provider relations team, our executive team can literally walk down the hall and say let's talk about this call, let's talk about this example, let's figure out a way to move forward and how to make sure that this problem is corrected on a go-forward basis. So we use a lot of those interactive learnings every day. We provide that training to them on a frequent basis, and I'm talking about our call center reps in particular but that's true for our provider relations team and others. And so we're doing a lot of cross-functional training and the idea, particularly with respect to our call center, is that these individuals can act as a front line and get smarter and smarter and work more efficiently every day.

SENATOR WILLIAMS: When a provider has an issue and they need to call in, what's the normal time frame in which they can get ahold of someone, specifically get to that claim and get it resolved?

RYAN SADLER: So I think it will be dependent on a claim-by-claim basis. Certainly, in terms of phone calls that are coming in our call center, the average speed to answer, as they call it, ASA, is well south of 30 seconds. So they're getting answered. Having said that, certainly appreciate that the nuance of that claim requires discussion, probably research, that sort of thing. So it really is dependent on the particular issue at hand. Some can be resolved in a first-call resolution, that we call it, in real time. Others certainly we need to take back and do some more research.

SENATOR WILLIAMS: You heard my question earlier about concern that several of my providers have had about inconsistency in talking to those people. Have you run into that?

RYAN SADLER: I think that's a fair comment and it's something that we've been focused on addressing relative to additional training for the call center in particular. But, you know, look, we've been here for nine months and we're learning more and more every day and, you know, we're committed to continue learning and improving those processes.

SENATOR WILLIAMS: All three of the managed care organizations are placed in the position of having to add people over a fairly short period of time in a state that we have less than 3 percent unemployment. Where are you finding your people and are they qualified enough to do the job?

RYAN SADLER: Qualified, absolutely. Finding staff is a challenge I think that's not unique for any business across the country but also here in Nebraska. We had substantially full staff on January 1. We've added staff since as we've learned where certain bottlenecks are, where certain areas need a little bit more attention, particularly with our claims team, for example, and our provider relations team. So we've been successful in being able to post and find qualified candidates and putting them to work, and it's been successful.

SENATOR WILLIAMS: Thank you.

RYAN SADLER: Thank you.

SENATOR RIEPE: Thank you. Senator Kolterman had his hand up first so we'll go to him.

SENATOR KOLTERMAN: If you'd like to go first, that's fine.

SENATOR HOWARD: Oh, no, get after it. (Laughter)

SENATOR KOLTERMAN: Thanks, Senator Riepe. Ryan, talk a little bit about your provider growth model and how you're growing rural Nebraska as well as eastern Nebraska. And then can you tell me how's your loss ratio running?

RYAN SADLER: Right. So great questions. First of all, we have an extremely robust network. We generally apply the "any willing provider" mentality, so if folks want to do business with us then we will engage with them and contract with them. So, generally speaking, we have a extremely robust network and I would say that's certainly true in the west as well. We were out and I was out doing a provider town hall in Gering a week or two ago. The room was completely full, maybe 65-75 people there, providers. So, no shortage of people who are interested in doing business with us as well as our interest in doing business with them. Certainly if folks are interested in contracting in our network, we welcome them. We want them. And we're doing what we can to bring them in to our organization. Our loss ratio, commonly referred to as an MLR or HBR, is I would say higher than where we would like it to be but that is a function of the fact that we had the sickest of the sick population. So our acuity level in terms of medically need...medical need and the medical need of the patients that we serve is high and so, by extension, the medical loss ratio and the expenses that we pay are high. And that's okay because we expect the corresponding structure of reimbursement to be allocated to pay for those expensive services. And just by sort of example, we have more Katie Beckett members than the other MCOs. Again, neither here nor there, that's the way the membership fell. We have more long-term care, dual-eligible members than the others. But each of us have more or less of each different aid category than another and somebody has to be first, second, and third. And so while we all have an even split of membership, the types of members that we have varies dramatically from plan to plan.

SENATOR KOLTERMAN: Okay. Thank you, Ryan.

RYAN SADLER: You're welcome.

SENATOR RIEPE: Senator Howard.

SENATOR HOWARD: Thank you. So there are two provider issues that I've been hearing. One is the psychiatric residential treatment facility.

RYAN SADLER: Uh-huh.

SENATOR HOWARD: It's the per diem day rate that they're supposed to be paid and they haven't been paid this year and that's at Bryan.

RYAN SADLER: Bryan Independence?

SENATOR HOWARD: Uh-huh.

RYAN SADLER: Okay.

SENATOR HOWARD: And I don't know. They said overall you're paying correctly on most claims but for this specific level of care they haven't been paid yet for the year.

RYAN SADLER: Okay.

SENATOR HOWARD: Do you know anything about that?

RYAN SADLER: I do not. This is the first I'm hearing this so I will certainly follow up and get you a response.

SENATOR HOWARD: Thank you.

RYAN SADLER: I do know that we've been paying Bryan Independence, but...

SENATOR HOWARD: Right, (inaudible).

RYAN SADLER: ...relative to their PRTF, I'll validate that.

SENATOR HOWARD: The other one I wanted to ask about was about durable medical equipment. I know the billing has to be run through the skilled nursing facility.

RYAN SADLER: Right.

SENATOR HOWARD: And we have one person who they're seeing a lot of unpaid claims because of some confusion between the SNF and the DME and the...and GC all together.

RYAN SADLER: Right.

SENATOR HOWARD: Can you speak to that issue?

RYAN SADLER: Yes, I can. So there's an interesting nuance and rule, regulation relative to certain DME providers who are billing on behalf of a SNF, a skilled nursing facility. And you know really the best way to think about it is that they are acting as a third-party biller for the SNF. And so what I mean by that is that when that claim comes in the door, it, by all indications, it looks like and feels like and is treated like a skilled nursing facility claim. The reality is that it is being billed by a DME provider and so there's some certain nuances on the claim requirements for a skilled nursing facility claim versus a DME claim. So where we have seen challenges on that, we've looked at the claims, found out why they might be rejecting on the front end, and are working through them on a case-by-case basis to make sure they can get their claims in. So one group in particular we've been very successful in finding the solution root cause and working towards making sure and validating that those claims are now coming in the door. So we pay a tremendous number of dollars and claims relative to SNF, in skilled nursing facility claims, so I'm confident that as those claims come in that begin to look like SNF claims that we'll be able to adjudicate them.

SENATOR HOWARD: Thank you.

RYAN SADLER: You're welcome.

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

SENATOR CRAWFORD: Thank you, Senator Riepe. And thank you, Ryan, for being here. Could you speak a bit about how you notify or mark interest payments when they are a part of a payment to a provider? And you could also then speak to overpayments. So how would a

provider be able to see or know if there's an interest payment or an overpayment or a negative balance from an overpayment?

RYAN SADLER: Right. So thank you, Senator. And I will tell you the interest conversation flows multiple directions, but suffice it to say that when a claim project is put in, there's an automatic formula that looks for the date of service. And so if it is beyond the 60 days, the interest payment is automatically generated to pay, unless we are specifically telling them do not pay on this project. An example of that would be if there's a policy change. Maybe we're going to add a procedure code that we're now going to start covering, and by that I mean the Heritage Health program. We might choose to go back and pay claims older but we may choose not to pay the interest on that if they're prior to that policy change. So sort of as a good faith effort, we'll look to pay claims beyond the date instructed. But in so doing, we waive the interest. If it is a claim project where we have certainly done something in error, then the system is set up to automatically defer to the date of service. So when they get that EOB, they'll see the interest payment on it. What I can tell you is I have heard from providers that the EOB, explanation of payment or benefits, can be confusing so...in that regard to interest. So we have heard that. We are taking action on that. And we are redesigning our EOB to be more clear about interest and negative balances and those will be rolled out actually on November 20. So that is under construction and it is forthcoming. So hopefully that helps providers be able tick and tie where that interest going. And then specifically relative to overpayments, what they will see in a project that comes out, we'll say here's a notice letter, there's an overpayment, there's a recovery coming, there are 60 days. Would you like to send us a check or would you like us to turn on the negative balance to automatically offset in the claims process? And so to the extent that those are occurring, that's how they will be notified.

SENATOR CRAWFORD: Okay. Thank you.

RYAN SADLER: You're welcome.

SENATOR CRAWFORD: So could I...

SENATOR RIEPE: Senator Crawford.

SENATOR CRAWFORD: ...just follow an example? So you mentioned if there's a date that the claim comes in and that's what marks those 60 days, and if it's the case that you know you made a mistake, it still is the case that's getting tracked in those 60 days, so interest due if it takes time to resolve that problem.

RYAN SADLER: That's exactly right.

SENATOR CRAWFORD: So you mentioned, though, if it's the case that later you find you had denied something and it was more a systematic problem or a change in policy, can you just clarify an example of that or what that looks like, a time when you would not go back and apply interest?

RYAN SADLER: So, for example, there's a healthwide advisory 1704, and in that provider advisory, and I don't the date of it but let's call it March 1, the date of that advisory says for certain procedures you no longer need to require a Medicare EOB. So maybe we denied a claim in February without that Medicare EOB. We may unilaterally decide to go back and pay them back to January 1 just to keep it clean. And in so doing, we may not pay interest on the February claim. Even though we're not required to pay that claim in February, but if we do it on our own volition, we may not apply the interest, if that makes sense.

SENATOR CRAWFORD: Okay. Could you explain how that might apply in terms of the...we had 599 CHIP claims...

RYAN SADLER: Sure.

SENATOR CRAWFORD: ...that came to you? If there was a delay in those claims because of the confusion about how those claims operate, are you...how that falls into this scheme of whether or not that's something for which you would pay interest and why or why not?

RYAN SADLER: Yes, it is and we will.

SENATOR CRAWFORD: Okay. Thank you.

RYAN SADLER: You're welcome.

SENATOR RIEPE: Okay. Seeing no other questions, thank you very much. And given the fact that we do not serve lunch, we will want to get on to Mr. Thompson. So thank you, Mr. Sadler.

RYAN SADLER: Thank you.

SENATOR RIEPE: If you'd be kind enough to share your name and spell it, we appreciate it.

THOMAS "ROCKY" THOMPSON: (Exhibit 4) Of course. I'll wait for it to be passed out first, the presentation. Okay. 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 serve as the interim director of the Division of Medicaid and Long-Term Care in the Nebraska Department of Health and Human Services. Thank you again for this opportunity to give you an update on the ongoing progress of Nebraska's integrated managed care program, Heritage Health. I am joined here by my plan management staff, including two of the most hardworking individuals in state government: deputy director of Delivery Systems, Heather Leschinsky; and administrator of Plan Management, Carmen Bachle. This slide is a brief outline on our presentation today. I know we're under some time constraints so feel free to ask me any questions during the presentation and also at the end of the presentation. Here are some brief highlights from the first eight months of the Heritage Health program. While some of the previous months were bumpy for some of our providers, as I discussed back in June, we are moving towards ongoing operations and looking forward to working with our providers and our members on the exciting opportunities which will be allowed by providing integrated benefits to our state's over 230,000 Medicaid members. As was said by our previous panel, each plan is serving about a third of the Medicaid population and working with over 30,000 providers in Nebraska. Through July of 2017, over 4 million claims were processed, and more than $400 million were paid to providers by the end of June. And here is a breakdown per plan. As you can see, again, it's about one third for each plan. While each plan has about a third, the member mix and the acuity of the members of each plan vary. Over the past several months the question has often come up, why do we have three plans instead of one? There are two main reasons for this. First of all, federal law requires multiple plans for a benefit package like those provided by

Heritage Health. Simply, the federal government does not want a state to be left with only one plan if a plan leaves the market. Second, we feel it is important for a Medicaid member to have choice in the plan he or she enrolls his or her family in. Each of our plans, while providing the same basic Medicaid state plan benefits, has differences in their value-added services not typically covered by Medicaid and may have differences in their provider networks. We want to empower our members by selecting their own plan and in that way having them own their own health. While a large number of our Medicaid members were assigned to plans, we've had a higher self-selection plan than in other states with their implementations. Additionally, the Centers for Medicare and Medicaid Services requires through Managed Care Final Rule that states provide choice counseling for new enrollees and during open enrollment, when members have the opportunity to change enrollment, which is coming up and I will discuss later on in the presentation. In the previous slide I mentioned value-added benefits. This slide lists some. Now for a value-added service, a service must be medically appropriate and cost-effective. The expanded services may include healthcare services that are currently noncovered services by the Medicaid state plan or which are in excess of this amount, duration, and scope in the Medicaid state plan. Value-added services include those focused on reduction of nonemergent use of the emergency department through increased access to after-hours care, urgent care, same-day appointments, data sharing with physicians and hospitals, member education, or other interventions identified by the MCO. Improved birth outcomes through prenatal, postnatal, and pregnancy care, reduction of early elective deliveries and C-sections and other interventions are also examples of value-added services. Value-added services are not Medicaid funded and, as such, are not subject to appeal and fair hearing rights. A denial of these services will not be considered an action for purposes of grievances and appeals. Another benefit offered by our Heritage Health plans and touched upon by the previous testifiers is care management. For members with high needs, each plan offers additional outreach through this program. The plans have identified over 13,000 members in Nebraska who are now enrolled in care management through our three plans. This slide goes over some of the requirements for care management, pursuant to the Heritage Health contracts. Each plan is required to have a care management program focused on collaboration between the plan, the member, his or her family or guardian, providers, and other services coordinators serving the member. The plans must work with providers to ensure a patient-centered approach that addresses the member's medical and behavioral health need...care needs in tandem. And the plans must use a high...health-risk

screening tool on all members upon enrollment to identify members in need of care management, and this is an option for the members. The members aren't forced into care management. They can take advantage of this service to help them. As contract managers for our Heritage Health plans, Medicaid and Long-Term Care provides oversight to ensure care management is meaningful and beneficial to our Medicaid members. The plans report quarterly on their care management populations, their risk score and health risk assessment completion. Monthly meetings with each of our plans monitor that they understand and utilize available resources, including those offered by the Department of Health and Human Services, and we discuss specific difficult issues and cases. Now this next slide are two examples from our plans on successes so far through care management. The UnitedHealthcare member had a large number of ER visits per month and they worked with him on working on housing for that member. The Nebraska Total Care member no longer needs a liver transplant thanks to a dedicated care manager. It not only saved the state money but improved that member's quality of life. Now we start on some of the more concrete information that will tell us how the Heritage Health plans are doing. As discussed last time, the plans are required to produce over 50 different reports, some monthly, some quarterly, and some annually, which report on over 850 different measures. MLTC requires reports from plans regarding network adequacy and cultural competency; network and primary care provider access; network development and GeoAccess for various provider types. The following charts are also available on our public dashboard, available on the Heritage Health Web site. MLTC continues to evaluate and add to these reports and determines which ones are best to put on the public dashboard. For areas where the plans are not meeting the requirements that MLTC requires, we do require corrective action in different manners, including corrective action plans, as was discussed earlier by two of the plans. The plan management teams continue to work with the plans in areas where they're falling short so that by the end of the year the requirements are being met in full. And again, many of these are annualized measures so if there's a drop in one month it doesn't necessarily mean that that's a contract...they're not meeting the contract standard since it's an annual amount. You want to go back? Yes. Okay, well, I guess since...but if you have any questions about the charts, let me know and we can discuss those later. Again, if you have any specific questions about any of the charts, feel free to ask me at the end of the presentation. This goes...this slide goes over the issue log and known issues tracking. While most of the systemic issues are resolved that we were hearing from providers, certain providers are still facing difficulties. While we are finding and

dealing...what we are finding and dealing with now are individualized problems that require provider education or other customized methods of resolution. The health plans have different claims and different policies for determining medical necessity, they are all permissible. Providers adjust and new issues arise on different time lines. And it's still somewhat a transitional period as we move forward into ongoing operations. If a provider has an issue that a plan has not resolved, I highly encourage them to e-mail the Heritage Health mailbox so the state can work towards this resolution. For example, one provider came to me two weeks ago with a problem that had been going on for...ongoing for several months. If I had known earlier, we could have resolved the issue much quicker. We continue to track, add, and close issues raised by providers. We do not close an issue until a provider is satisfied with the resolution. I believe Ms. Mallatt mentioned about how my staff was on the line with a provider and we are on lines with providers throughout the week and asking if their problem has been resolved with the plans, and unless the provider is satisfied we do not close these issues, and that's even if the plan believes that an issue had been resolved. Each plan has been required by the state to add to its Web page a known issue log with the expected dates of resolution. Here are the links and it was also mentioned in the testimony of the previous individuals. Here are some examples of issues being worked on right now and issues that have been closed by each plan. The plan represents above did go into some of these issues and some of these were addressed by the committee members, including overpayment issues that some of our providers have been facing. We have continued to seek public input on the program through our three Heritage Health stakeholder groups, as I mentioned earlier today. We have our Administrative Simplification Committee. That is to ease the provider experience and eliminate unnecessary administrative burden for our providers. We have our Behavioral Health Integration Advisory Committee working with our behavior health provider community to make sure that we work towards integration of these services into our plans. And we have our Quality Management Committee, led by our medical director for MLTC who has been out on medical leave but is coming back at the end of this month. Additionally, there have been other avenues for feedback since our last meeting. Since the last meeting we have added an Administrative Simplification Subcommittee meeting for the plans to share the latest information on known issues being resolved and to hear from our provider community about new issues that they need to have addressed. And at these meetings we have state leadership and leadership from each of the three plans. The plans have also added provider outreach forums. There have been NTC town halls, WellCare has utilized their Welcome Rooms

for provider outreach, and UHC has done provider outreach expos. And additionally, members of this committee went to the three plans last month and got to know more about the experience and especially about how claims are processed. As discussed in the last meeting, one of the tools the state can use to ensure contract compliance are requiring corrective action plans, or CAPs. We have issued a CAP to Nebraska Total Care, which was lifted after extensive efforts to improve their payment system, particularly the claims paid for behavioral health providers. They have added additional staff since the CAP was issued and they work with consultants to see how best to streamline its system for behavioral health claims. We are continuing weekly calls with behavioral health and home health claims payment reports with NTC. And we participate in biweekly calls with MLTC with plan leadership. And again, this is in addition to our biweekly...my biweekly meetings with the plans, our quarterly briefings with each of the plans, and also our operations meetings with the plans. And again, while this CAP was lifted, if there are ongoing issues, we will issue future CAPs. We continue to evaluate our plans and our plan performance and to make sure they meet the requirements of their contract. In August we did issue a CAP to WellCare and we received their response last Friday and we are going through that response to see if it's sufficient. And we will work with them on the implementation of their CAP response. Now this is important because Heritage Health is not only a Medicaid program. We have the involvement of our entire department on this program. They were with us as we evaluated the...as we developed the RFP for Heritage Health and as we evaluated the RFP for Heritage Health, and we continue to work with our sister divisions on this continued implementation. We coordinate with Children and Family Services, Behavioral Health, and Developmental Disabilities. On services for foster care youth, we are working with them as the Division of Developmental Disabilities unbundles their services. We participate on panels with our sister agencies. Additionally, we are also working with the Office of Probation on ensuring access to behavioral health supports and other services, including MST. And I met with Probation last week and I also met with a provider who's considering providing MST and we are trying to make sure that this service is provided to our children that are in need of it. Now this goes over open enrollment. As I mentioned earlier, we have open enrollment coming up from November 1 to December 15, and this is a chance for members to be able to check...select a plan without for-cause reasons. If a member is happy with their current plan, they do not need to change it. They do have choice counseling, have that availability. And we have our enrollment broker, AHS, who is working with our members who provide that information about value-added

services, information about what providers are in each network for our members so they can make a meaningful choice of each plan. Now I'd like to briefly go over some member stories and this one is from NTC and this about a care coordinator who helped a 44-year-old woman obtain a GED. After sending the member a study guidebook, a Member Connections representative accompanied the member to the Northeast Community College to meet with a counselor and testing coordinator. The member obtained her GED and decided to sign up for continued education. Nebraska Total Care is also working with her on improving attendance at her doctor's appointments and helping her identify public transportation options to assist with getting around town. The next one is from WellCare and this is about a WellCare member with unmanaged schizophrenia who was isolated and the care manager helped the member see a psychiatrist and receive medications, and he's receiving follow-up calls from case management to help him to remind him to go to appointments. And the last story, I will briefly go over it but we also have a video. And again, these stories are added just to understand what impact these plans have, more than just the medical needs of these individuals but also their own quality of life. And this members was formerly homeless who began working with a housing navigator who helped him first move into a homeless shelter and then into low-income senior housing. The housing navigator helped him obtain behavioral health services through Heritage Health. Before Heritage Health, he was incurring an average of three ER visits a month. That dropped to zero in 2017. And here's a video from United.

(VIDEO PRESENTATION):

MAN: These are the woods basically where I camped out when I was homeless. I became homeless after I had lost my job and then I was working with temporary services but I wasn't getting enough work to support myself and pay my rent, and it's being in the city but it's still remote. I got evicted so I was homeless for about three years. (Inaudible) a dock behind a furniture company. They let me stay there but from like 9:00 at night until 9:00 in the morning. It was right by a library. I slept there a few times, under some bridges. I slept all around town. You can get by but it's not easy.

WOMAN: I work for UnitedHealthcare Community Plan of Nebraska and I'm a housing navigator. The role of the housing navigator is to work with members of our plan that are in

housing crisis. It could be shelter homeless (inaudible) homeless, eviction, doubled up on someone's couch. I work with them on connecting them to area resources. Hello, how are you?

MAN: All right.

WOMAN: I got a call from (inaudible) worker. They said (inaudible) under transient operations but I just got word that he's at the hospital, so I went direct to the hospital. He was there.

MAN: My health was kind of bad. My feet were bad. I (inaudible) frostbit (inaudible) on my hands. I have COPD and it's hard for me to (inaudible) when it's hot out.

WOMAN: He also has high blood pressure and some substance abuse issues. You still seeing the psychologist?

MAN: Yeah.

WOMAN: He was a frequent ER user. He utilized (inaudible) about 26 times to the local ERs in our community.

MAN: (Inaudible).

WOMAN: Yes.

MAN: I met Sara. She (inaudible) I was homeless and she works for the (inaudible) and she's helped me out with my housing and several other things.

WOMAN: So I talked to one of the area shelters and got him in there. (Inaudible) Social Security had given him four month's back pay which he used to help (inaudible) an apartment.

MAN: This (inaudible) basically be my living room, (inaudible), six months. It has everything that I need. It's spacious enough. I like having security doors to the outside so people can't get in.

It's been quite a while since I've had a place of my own. (Inaudible) this place here, I'm really working on trying to fix it up as best as I can.

WOMAN: Housing is a complex issue. (Inaudible) services are wraparound if it's a Medicaid service or a nonprofit in the community.

MAN: It's fairly stocked fairly well.

WOMAN: I was able to reach out to people I know and fill his cupboards with food and then all the furnishing are furnished through a community agency partner too.

MAN: (Inaudible) better off, absolutely, I'm a lot better off. At my age now I don't think I could (inaudible).

WOMAN: Just putting people in affordable housing, it lessens their use of the ER. In Steve's case, he went from using the ER 26 times till December to 0 since December. He's been able to access his primary care doctor through the use of going to a clinic. But it really sounds like you're doing really good and...

MAN: (Inaudible) never give up hope. (Inaudible) long time now and (inaudible). This is where I'm going to be.

THOMAS "ROCKY" THOMPSON: And I think that story helps show the meaning that this program has to our members and that's who we serve. So I'm willing to take any questions you might have. If you want to go to lunch, that's fine too. (Laughter)

SENATOR RIEPE: My only request would be is that if you could in the future, number the pages so that if we need to reference back to various graphs or whatever, that it's...

THOMAS "ROCKY" THOMPSON: Yeah. I was just thinking about that, so, yes.

SENATOR RIEPE: Sure.

THOMAS "ROCKY" THOMPSON: (Laughter) Great minds think alike.

SENATOR RIEPE: Senator Williams.

SENATOR WILLIAMS: Thank you, Chairman Riepe. And thank you, Director Thompson, for being here. And I'm trying to look at these charts rather quickly here and we heard earlier a discussion about the advantage of having clean claims and how much quicker the process works. And there is a slide in the middle that is "Clean Claims as a Percentage of Total Claims." And I'm trying to make sense of why the companies wouldn't have pretty much the same results and it does not appear that they do. Seems that some companies do better in that area than others. Can you explain that for me?

THOMAS "ROCKY" THOMPSON: Certainly, Senator Williams. We have...each one of the three plans have three different claims processing systems and each one of the plans requires minor differences in what it takes to have the claims enter their system. So, yes, we want to continue to work with our providers to make sure that the claims that are submitted are able to be adjudicated in the systems. And for those providers that we have identified that have had issues with submitting claims that will be adjudicated by each one of the systems, we have asked the plans to reach out to those providers and even go on site to work with those providers to ensure that they submit clean claims.

SENATOR WILLIAMS: Is it a provider problem or is it the problem of one of the three provider...three providers. Is it a user of it or is it the provider that's the problem?

THOMAS "ROCKY" THOMPSON: It's both.

SENATOR WILLIAMS: Both?

THOMAS "ROCKY" THOMPSON: It's both. The current providers have had issues submitting claims that would be considered clean by the systems, and the companies have had system edits that would cause them to reject claims that should have entered their systems. So there have been issues with both.

SENATOR WILLIAMS: And the next slide following that is "Pharmacy Claims Received and Paid by the Plan." And I...it would seem to be there should be some consistency between claims received and claims paid. And again, between the companies, the three different companies, there are significant differences of...it would seem to me--tell me if I'm wrong--that the claims received and the claims paid there should be...they should be reasonably close to being the same.

THOMAS "ROCKY" THOMPSON: Well, not all claims received by a plan will be paid. Some will be denied. Additionally, there are issues with pharmacies submitting claims that will be paid. So there might be duplicates in there also.

SENATOR WILLIAMS: So we're making the assumption that one of these providers has more of those kind of pharmacies that are submitting back claims than another?

THOMAS "ROCKY" THOMPSON: Well, there's also an issue that there's different acuity levels for each one of the three plans. So one plan might have more members that utilize a pharmacy service than the other plans.

SENATOR WILLIAMS: Okay. Thank you.

THOMAS "ROCKY" THOMPSON: Yeah, thank you, Senator.

SENATOR RIEPE: Are there other questions? Senator Kolterman.

SENATOR KOLTERMAN: Thank you, Senator Riepe. Rocky, my questions are primarily focused on the future. You walked into a can of worms when Calder left. I had some real concerns going...originally, when we were setting out on this journey to implement Heritage Health. I didn't think we were ready. Obviously, it's proved out to a little bit. I've been through a lot new companies come into the state where you have an experience. They don't have the networks. They don't have the claims processing necessarily in place. Two of the three are brand new in our state. How is your...well, first of all, how committed are we to the fact that Heritage Health is our future? And what kind of commitments do we have from these folks over the next

three to five years? Are we locked into this for three to five years, or is this a...can this be changed?

THOMAS "ROCKY" THOMPSON: We have a base contract with them for a period of five years and it can be up to seven years.

SENATOR KOLTERMAN: Okay. And then...and I think we're getting through some of the challenges that we faced early on. My next question would deal with continuity. Many of the people we're dealing with don't like to be bounced from company to company. So as we look at open enrollment, do you see that that's going to change? Do you anticipate a big movement from one company to another? And how do you equalize that if we're going to try and keep all three companies relatively the same as...do you put CAPs on each company if we get so many more? Are we going to bring another company in? How do you deal with all of that?

THOMAS "ROCKY" THOMPSON: Well, we do...thank you for the question, Senator. We do encourage our members to practically select their own plan. If they're happy with the plan they have now, they can stay with that plan. Now we might have a large number, most Medicaid programs, I think all managed care programs have members assigned to each plan and we try to assign them in such a way that it's about a third, a third, a third. Now the algorithm will be adjusted in the future to further identify those plans that have specialties and the care of certain populations, and that will also be looked at in the algorithm for the auto-assignment.

SENATOR KOLTERMAN: So how much auto-assignment do you do?

THOMAS "ROCKY" THOMPSON: We have about 30 percent that proactively selected plans this past year, so the rest of the...

SENATOR KOLTERMAN: So that's how you balance it out, through the auto-assignment.

THOMAS "ROCKY" THOMPSON: Correct. That's correct, Senator.

SENATOR KOLTERMAN: Okay. Are you happy with the growth of the networks?

THOMAS "ROCKY" THOMPSON: I am, Senator.

SENATOR KOLTERMAN: Okay. Thank you.

SENATOR RIEPE: Of those that are auto-assigned, they still have, as I understand it, 90 days to reselect on their own.

THOMAS "ROCKY" THOMPSON: That is correct. And also we have "for cause" reasons. For example, if their provider leaves the network, they can select a different plan.

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

SENATOR KOLTERMAN: Yeah, thank you, Senator Riepe. One last question: From a financial perspective, is this working? Are we saving money? Or are we just experimenting?

THOMAS "ROCKY" THOMPSON: For the July 1 capitation rates we had a 1 percent decrease in what was paid for the January 1 rates. So that savings was put in to the capitation rates that went into effect July 1 with the plans. So we are see...we did see that savings. And we also have further budget predictability through managed care that we're able to work with in our budget for this biennium.

SENATOR KOLTERMAN: What is our loss ratio?

THOMAS "ROCKY" THOMPSON: Our medical loss ratio is 85 percent, according to contracts.

SENATOR KOLTERMAN: Okay. Thank you.

THOMAS "ROCKY" THOMPSON: And also their profits are capped at 1 percent.

SENATOR KOLTERMAN: Thank you.

SENATOR RIEPE: Are there other questions? Senator Crawford.

SENATOR CRAWFORD: Thank you. And thank you for the presentation and for all the data. One quick question: As I'm looking through your graphs and charts, and I appreciate you tracking the clean claims as one of those issues, and share the concern that at least one of the providers seems to have more persistent issues on that front. So we have your issues log and your known issues tracking. And you have the issues submitted and then you have them resolved or closed. What happens to those cases that are...what about all the space between those bars of resolved and closed, those cases that are open? Like what's going on with them?

THOMAS "ROCKY" THOMPSON: We continue to, on our biweekly meetings, we have that list that we go over with the plans. We have our plan staff that go out to the plans once a week, go on site and call those providers and find out how they're doing on resolution. And we also have our plan staff and the staff of each plan work through these issues and we expect updates every week.

SENATOR CRAWFORD: Okay. So continue updates every week until it's resolved.

THOMAS "ROCKY" THOMPSON: Correct. Yes, ma'am.

SENATOR CRAWFORD: I see. So do you track how much interest is paid to the providers through all three systems. Do we have a sense of how much that is or how often there are interest payments added to payments that go out?

THOMAS "ROCKY" THOMPSON: That is not something that the state tracks and we have to request that information from the plans themselves.

SENATOR CRAWFORD: Okay. Have we sanctioned any of the providers? We've had correction plans, but have there been sanctions imposed on any providers...I mean the MCOs?

THOMAS "ROCKY" THOMPSON: For the NTC CAP that was issued back in May, there were sanctions but we waived their sanctions once they provided their Corrective Action Plan.

SENATOR CRAWFORD: Okay. Thank you. And could you speak to progress on the coordination of benefit agreement that was sent to CMS to address systemwide overpayments to providers?

THOMAS "ROCKY" THOMPSON: Yes, Senator. We are still waiting for CMS approval, their Medicare side, for the approval of those agreements, so that any overpayments to our nursing facilities will be solved once that is done.

SENATOR CRAWFORD: Thank you.

SENATOR RIEPE: Senator Howard.

SENATOR HOWARD: Senator Crawford, were you done?

SENATOR CRAWFORD: Go ahead.

SENATOR HOWARD: Just following up on coordination of benefits, that agreement, why don't we have one right now?

THOMAS "ROCKY" THOMPSON: Thank you, Senator. We do have those agreements but the agreements need to be changed because there was something left out on the original agreements that were submitted earlier this year.

SENATOR HOWARD: What was left out?

THOMAS "ROCKY" THOMPSON: I would have to get the exact language that was left out but it was the information about the Medicare eligibility of some of these individuals in nursing facilities.

SENATOR HOWARD: Okay. And so what's sort of the result of us not having that agreement?

THOMAS "ROCKY" THOMPSON: It has led to overpayments to certain facilities by the plans.

SENATOR HOWARD: Specific facilities? Like a specific type of facility?

THOMAS "ROCKY" THOMPSON: Nursing facilities.

SENATOR HOWARD: So nursing facilities are being overpaid because we don't have this agreement?

THOMAS "ROCKY" THOMPSON: Because we don't have this agreement that allows the plan to receive this information about the status of their membership.

SENATOR HOWARD: How long have we gone without this agreement?

THOMAS "ROCKY" THOMPSON: Well, again, Senator, there is the agreement that's in place but we have to change this agreement, and we were notified back in July or August and we've made the changes to the agreements and we have submitted those agreements to CMS for approval.

SENATOR HOWARD: When did we originally submit the agreement?

THOMAS "ROCKY" THOMPSON: It was probably January, February.

SENATOR HOWARD: And then we got it back in July?

THOMAS "ROCKY" THOMPSON: We had the agreement that was accepted by CMS and it wasn't that we just got it back. We were notified by the facilities that they received overpayment and we dug into the issues about why they were receiving overpayment and this was the issue.

SENATOR HOWARD: Was the COBA.

THOMAS "ROCKY" THOMPSON: That is correct, yes, Senator.

SENATOR HOWARD: Okay. And so what's our time line for getting that issue resolved?

THOMAS "ROCKY" THOMPSON: I hope that we will receive the finalized versions in a month.

SENATOR HOWARD: Okay. I had heard somewhere that Director Lynch had signed the agreements and that that was inappropriate, but that's not accurate?

THOMAS "ROCKY" THOMPSON: We did have to change the agreements to put my name on them, but that was not the issue with the overpayments.

SENATOR HOWARD: That was not the time line issue. Okay. And then I did want to ask, just because you introduced yourself as the interim director, what's the status of us finding a permanent director, or do you think that you'll be the permanent director?

THOMAS "ROCKY" THOMPSON: I know that the CEO and the Governor are actively recruiting for a permanent Medicaid director.

SENATOR HOWARD: And there's a position open?

THOMAS "ROCKY" THOMPSON: There is a position open.

SENATOR HOWARD: Great. Thank you.

SENATOR RIEPE: Senator Crawford.

SENATOR CRAWFORD: Thank you. Could you speak to patterns that you see in inappropriate or inaccurate denials and any work that you've been doing through the Simplification Committee, Subcommittee, or other efforts to work with the three MCOs to improve the consistency and clarity of what kinds of claims are denied?

THOMAS "ROCKY" THOMPSON: Yes, Senator. For example, we had issue with home health back in May that we went into and we determined that the plan...some of the plans didn't have enough codes in their system to figure out what would be paid Medicaid primary. So that was

one of the issues we issued the NTC CAP on. And so they worked with their partners in other states and got a more complete list of codes for their system to about 5,000 codes (inaudible) the CEO of Nebraska Total Care described. And from that point, the other plans also looked at that same list that NTC had. For example, WellCare looked at the list, compared it to the list they had, and utilized that to make sure that those claims would no longer be denied in their system.

SENATOR CRAWFORD: So I think, if I understand that, that's a situation where they were being required to get approval for Medicare service. Is that the situation that you're (inaudible)?

THOMAS "ROCKY" THOMPSON: Yeah, they were being required to receive a Medicare denial before payment.

SENATOR CRAWFORD: Before payment, right. And these MCOs would all have been in other states where they saw that pattern before. So I guess it's a little hard for me to understand why they wouldn't have understood, anticipated that challenge.

THOMAS "ROCKY" THOMPSON: There's a phrase that's often used in Medicaid that if you've seen one state's Medicaid program that's one state's Medicaid program.

SENATOR CRAWFORD: Yes.

THOMAS "ROCKY" THOMPSON: Each different state has different benefits that are provided to its members. The home health benefit is...in Nebraska is pretty rich and they hadn't seen this in many other states.

SENATOR RIEPE: The question was asked about the status of the new director, if you will. It's my understanding, you can confirm or deny, that there are eight states that are looking for a director of Medicaid program, similar to looking for an athletic director. (Laughter)

THOMAS "ROCKY" THOMPSON: Eight or nine right now. I was just told that Iowa found a Medicaid director. Missouri is without a Medicaid director, Indiana, Maryland. Georgia found

one. South Carolina doesn't have one. Illinois doesn't have a permanent one. Nevada does not have a permanent one. Oregon does not have a permanent one, and Nebraska.

SENATOR RIEPE: We won't ask you why those positions are open. We'll just... (Laughter)

THOMAS "ROCKY" THOMPSON: Different reasons, but it is fun and it's great working with (inaudible) members.

SENATOR RIEPE: Are there other questions?

SENATOR CRAWFORD: Quick.

SENATOR RIEPE: Sure.

SENATOR CRAWFORD: Just, well, a follow-up on the example we were just talking about. So you have found a systematic denial concern that's causing denials or delays, so does the...or issues that are shown in your tracking log. Does the department follow up to make sure that when there are those delays that interest is correctly applied to the payments in those cases? What kind of tracking or oversight do you do to ensure that where interest should be paid it is in these more complex cases where there may be denials?

THOMAS "ROCKY" THOMPSON: Thank you, Senator. We have not been specifically tracking interest for these claims. And we can. We can begin to do so, so we can paint a picture...a better picture for you for the next quarterly briefing.

SENATOR CRAWFORD: Right. I appreciate that. I think that's one of the concerns of providers, if they face those costs of delays,...

THOMAS "ROCKY" THOMPSON: Uh-huh.

SENATOR CRAWFORD: ...that there's compensation for...some kind of compensation for those costs in place.

THOMAS "ROCKY" THOMPSON: Right. And again, the interest is annualized at 12.5 percent.

SENATOR CRAWFORD: Thank you.

SENATOR RIEPE: 12.5 percent?

THOMAS "ROCKY" THOMPSON: 12.5 percent.

SENATOR RIEPE: Ooh! Are there additional questions? Hearing none, seeing none, thank you, Mr. Thompson. And thank you, committee members, for being here. And thank you all for being so attentive and for keeping our audience, if you will, at such a great level of interest.

THOMAS "ROCKY" THOMPSON: Thank you, Senator. Thank you.

SENATOR RIEPE: This concludes the Health and Human Services oversight briefing. And we will return to this meeting room for the hearing, the public hearing, at 1:00 p.m. So thank you.

BREAK

SENATOR RIEPE: (Recorder malfunction)...quorum in hand, and it's a little bit after the hour and I'd like to get started because we have some festivities that are going on right next door when they're going to dedicate the fountains and then there's more celebration later on this evening, too, here in town. So this is the second...the quarterly meeting of the Heritage Health Oversight Committee. We appreciate all of you being here. I'm going to start out with some introductions and we may have a couple more senators that will be joining us. But, as I said, we do have a quorum so we can and need to be moving forward. I happen to be Merv Riepe. I'm Chairman of the Health and Human Services Committee. And I would go to Senator Howard.

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

KRISTEN STIFFLER: Kristen Stiffler, legal counsel.

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

SENATOR WILLIAMS: Matt Williams, Legislative District 36: Dawson, Custer, and the north part of Buffalo Counties.

TYLER MAHOOD: Tyler Mahood, committee clerk.

SENATOR RIEPE: And I will go back to Senator...

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

SENATOR RIEPE: So I thank all of the committee members for freely giving up their time. This, as you know, is the actual recess but here we are. We're going to start this particular public hearing by asking Mr. Thompson to come forward, the acting director of the Division of Medicaid and Long-Term Care. He did testify this morning at a briefing, for those of you who weren't here, but this again is a public open. What we're going to do here is Mr. Thompson is going to testify, then we'll afford the opportunity for providers or members, consumers to testify. And then we're going to come back to Mr. Thompson again so that if there are some open-ended questions we can make as big a contribution to the information that we have at hand. So again, thank you very much.

THOMAS "ROCKY" THOMPSON: Thank you, Chairman Riepe and members of the Health and Human Services Committee. Again, 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 serve as the interim director of the Division of Medicaid and Long-Term Care in the Nebraska Department of Health and Human Services. You know, within my position and my staff, we're dedicated to making sure that our members are serve in the best way possible and our provider community experience the best experience with our new integrated managed care program known as Heritage Health. And I look forward to hearing from our stakeholders as we...I look forward to hearing from our stakeholders this afternoon. And I do afford them the opportunity to also speak to us at different stakeholder groups that we have, including our Administrative Simplification Subcommittee in which also the department can

hear their concerns. And also, if they have any other issues, I urge them to also e-mail the Heritage Health e-mail mailbox so we are aware of those and we can make sure that they are resolved by the plans. Thank you very much, Senator and members of the HHS Committee.

SENATOR RIEPE: Thank you. Are there questions? Senator Williams.

SENATOR WILLIAMS: Thank you, Chairman Riepe. Rocky, are you going to be around during the afternoon and be available at the end of the hearing so if we have a question or two for you, you'll still be here?

THOMAS "ROCKY" THOMPSON: Senator, I have the entire day blocked off.

SENATOR WILLIAMS: Thank you.

THOMAS "ROCKY" THOMPSON: Thank you, Senator.

SENATOR WILLIAMS: Just wanted to be sure.

SENATOR RIEPE: I'd also like to introduce Senator Linehan now. You can tell us...you can tell (her cell phone rings). (Laughter)

SENATOR LINEHAN: I'm trying to turn it off. (Laughter) Hi. I have a cold, so I'll not try to get too close to anyone. I'm Senator Linehan, District 39: Valley, Waterloo, and Elkhorn. Thank you.

SENATOR RIEPE: Thank you. Thank you for being here.

SENATOR LINEHAN: Thank you.

SENATOR RIEPE: Additional questions of Mr. Thompson?

THOMAS "ROCKY" THOMPSON: I look forward to this afternoon.

SENATOR RIEPE: Okay. Thank you very much. We are going to use the five-minute light system with our testifiers. That means, you know, you'll get the...about four minutes in and then you're going to get a blinking yellow, just like driving the highway. And then at the five minutes you're going to get a red and we'll try to be gentle but I may call and say, you know, your time is up, can you wrap this up, so that we can move on to get as many people who want to share their thoughts and testify with us that we possibly can. So I first would like to go to proponents or...no proponents? Oh, just open testimony. Well, whether you're for it or against it, you all come on up, okay? (Laughter) Yes, (inaudible) fashion, I might add.

STEPHANIE WIESE: (Exhibit 1) Senator Riepe and members of the Nebraska Legislature Health and Human Services Committee, my name is Stephanie Wiese, S-t-e-p-h-a-n-i-e W-i-e-s-e. I work for Elite Professionals Home Care in Lincoln and I'm testifying on behalf of the members of the Nebraska Home Care Association. Thank you for giving us your time today to go over the issues that we as home health agencies in Nebraska continue to experience with the Heritage Health program. At the time of the June 27 Heritage Health briefing, we reported to you that providers had reported $27 million in outstanding claims passed 60 days. About $2 million of those claims was from home health providers. Ten home health agencies have reported to the Nebraska Home Care Association this week that they still have outstanding claims of more than 60 days in the amount of nearly $370,000. We are still seeing some denials on claims due to needing Medicare authorization and only partial payments on claims with the reasoning that the benefit maximum has been reached and the remaining portion of the claim will not be paid. The Medicaid managed care plans are supposed to be paying interest on delayed claims but have not been doing this, stating that claims coming to them the first time are not clean claims and, thus, they don't have to pay interest on these claims. When speaking to other home health agencies, the majority of agencies have stated that the claims they submitted the first time were, in fact, clean claims and that there were no issues but errors on the Medicaid managed care plans for not following state guidelines; denying for Medicare primary; no prior authorization on the claim, even though it was on the claim; or other errors that were simply not on the claims that were submitted to begin with. The agency also has reported outstanding hospice...sorry. One agency has also reported outstanding hospice claims of more than 60 days of $8,513.50. The hospice claims are with UnitedHealthcare Community Plan. The services were preauthorized but UnitedHealthcare kept denying for "not covered per managed care contract." When the agency

has followed up with UnitedHealthcare staff to resolve this, there has been no response. The second issue has been authorizations for home health services. With clients needing a continuation of care, home care agencies cannot stop providing cares to the elderly and disabled persons while they wait on authorization. I know that my agency has received denials more frequently on clients that have been providing cares...that we have been providing cares to for years. We have had to do many peer-to-peer reviews with the medical director to convince him to approve some coverage on these clients so they can continue to remain in their home. The frustration is when you receive a denial two weeks after cares have started. We would recommend that the case managers for the managed care plans would be more proactive in meeting with the team of providers delivering care and services for clients so that they can better understand the patient's medical necessity and develop a plan for their long-term care needs. A third issue is authorizing retrospectively for babies after they are born and become Medicaid eligible. Two of the managed care plans have not done well with this. It has required constant resubmissions of authorization requests to get approval. My agency currently has two authorization requests that were submitted to Nebraska Total Care on 8/31 and 8/11 that haven't been approved. For WellCare of Nebraska, I have one outstanding authorization from 8/22. UnitedHealthcare has one outstanding authorization for 9/14, but that was approved today. A fourth issue is that one home health agency is still receiving denials from all three managed care plans for authorizations that should have carried over from the former contract until that authorization date expired after January 1, 2017. All three managed care plans are also asking for EOBs for Medicare, even if the client would not have been billed to Medicare. The agency was told to put one unit in for hourly nursing instead of the full number of hours worked, and then the authorization was denied. They have been rebilled but no payments have been received. A fifth issue is that one home health agency continues to experience issues with the managed care plans processing implantable pump claims. Most claims are past 60 days and interest for late payments has been received. A few home health agencies have reported that the managed care plans have overpaid them. The overpayments are much more than what is owed to the home health agencies. We reported to you at the June 27 Heritage Health briefing that providers have had to add part-time administrative positions, or reassign staff, to follow up with the managed care plans on authorizations and claim issues. This continues to be an unnecessary burden to healthcare providers and takes away critical resources needed for patient care and services. I spend an average of 30 hours per week following up on authorizations, claims, tracking, or other

issues related to the Heritage Health program. We have appreciated the follow-up and response from the leaders of the managed care plans as providers have reported issues to them. We would like to see all managed care plan staff consistently reviewing and approving authorizations and paying claims in a timely basis. We want to be able to work together with DHHS and the managed care plans to ensure that people with disabilities, the elderly, children, and all citizens receive the care and treatment that they need and deserve to receive high-quality, cost-effective healthcare services and supports that meet their needs. And one last thing. I'm a visual person so I have a...I see...when I see something, I understand it better. So I thought I'd bring to you, these are my denied claims or either denied or partial payment for WellCare. These are my denied or partial payments from UnitedHealthcare. And these are my denied or partial payments from Nebraska Total Care. So that kind of gives you an idea of what I deal with every week.

SENATOR RIEPE: You said everywhere. Are these for one week or these are within 60 days?

STEPHANIE WIESE: No, this is since the beginning of the year, but they're constantly either denied or partial payments. And then I'm trying to...I have a whole list of stuff that I send to them and try to keep it updated, but it literally takes me a week to get through everything to keep it updated that I send on to them and to Rocky Thompson and to Carmen Bachle to let them know.

SENATOR RIEPE: Now of those, have they all been adjudicated?

STEPHANIE WIESE: Have they all been what? I'm sorry.

SENATOR RIEPE: Adjudicated. I mean have they been either yes, no, denied? I mean some of those...

STEPHANIE WIESE: Yes.

SENATOR RIEPE: ...may have been denied.

STEPHANIE WIESE: They have been denied. Some of them have been denied and then, like I said, some of them are just partial payments where they only pay so much per line and then they say it's a max benefit for that day. But that's not the case for home health. Like if you have a home health aide go into the home four times a day, that's a set amount of payment for the day. There's only a set payment on nursing for people over the age of 21.

SENATOR RIEPE: Uh-huh. Are you getting notified within the acceptable parameters as to...for preauthorizations so that you aren't out there for two weeks giving care that's not going to get paid?

STEPHANIE WIESE: We usually...I try to submit my authorizations. If it's the 60-day recertification, at least a couple days in advance of that certification period starting. And then if it's somebody who's new, we can't submit a 485. If it's coming home from the hospital then I submit the hospital discharge paperwork, but sometimes you have to wait until you have your orders done to submit it and that's usually...I try to do it the same day or the next day.

SENATOR RIEPE: My guess is that there are certain things that whoever is approving or disapproving that you have to meet certain requirements and qualifications. That patient would have to be approved.

STEPHANIE WIESE: Correct.

SENATOR RIEPE: Do they share those with you, so that your staff could look and say, you know, the probability of getting approved doesn't look good on this? And then is there a way to accelerate that? I mean I don't think any of us want or expect any of the providers to be giving care...we need to minimize any retroactive denials.

STEPHANIE WIESE: Right. We usually have a pretty good idea. I mean we've been...I've been in this for 13 years. We know what should be covered and what shouldn't. We were having like a three-time-a-day...or a three-time-a-week bath was denied but we talked to the medical director and convinced him this guy has cerebral palsy and wasn't getting in the bath at all until we got into the home. So, I mean...

SENATOR RIEPE: I assume that you also provide care for commercial carriers.

STEPHANIE WIESE: Yes, we do.

SENATOR RIEPE: And how does this compare to commercial carriers?

STEPHANIE WIESE: We know...commercial carriers, if it's a child, they usually don't cover, but usually the children have Medicaid as a secondary insurance. So the commercial insurance usually says that it's custodial care, whereas you're home with the child while the parents are at work or overnight hours while the parents sleep. Short nursing visits, that's usually covered by insurance and we get authorization for it where we can.

SENATOR RIEPE: Are the commercials very responsive or is it pretty obvious that, particularly on a child, that this is going to have to go to Medicaid under a CHIP's program then?

STEPHANIE WIESE: Usually when we get the kids, they already have that set up as an insurance primary and a Medicaid secondary.

SENATOR RIEPE: Okay. Okay. Questions? Senator Howard, please.

SENATOR HOWARD: Thank you. Thank you for visiting with us today. What was it like before January 1?

STEPHANIE WIESE: We would submit into Telligen, and they are the ones that did the fee for service. And we would put our authorization in that day and we would get a response back that day of whether it was approved or denied. And payments up until about November of 2016 we were getting...we would submit claims one week and the next week it was paid.

SENATOR HOWARD: So it's a pretty stark difference.

STEPHANIE WIESE: Yes, a very big difference.

SENATOR HOWARD: Thank you.

STEPHANIE WIESE: Yep.

SENATOR RIEPE: Other...Senator Crawford.

SENATOR CRAWFORD: Thank you. And thank you for being here to share you experience. Can you give us a couple of examples of the partial payment cases?

STEPHANIE WIESE: So for...I have a client that, let's say, we see him four times a day under a home health aide visit. We do a.m. cares, noon cares, lunch, dinnertime cares, and bedtime cares. It's four visits a day at $55.54, so whatever that total amount is--I can't think of it (laugh) off my head--that's what the amount should be. And so like Nebraska Total Care, we have to submit one line payment for the full amount for that day. So let's say it's $222. They're paying me $200 and saying that $22 is over the limit for the day, and that's the benefit maximum. But that wouldn't be the case because we did four visits at the contracted rate of $55.54 a day (sic--visit), so.

SENATOR CRAWFORD: So that's in dispute, is that (inaudible)?

STEPHANIE WIESE: Yeah, and I send it all back to them and said that's not right and I know other agencies are working with it, too, that have those four-times-a-day or three-times-a-day visits that there is no benefit max on the home health aide.

SENATOR CRAWFORD: Did you submit that to the log on the department e-mail?

STEPHANIE WIESE: I do know I have a whole sheet that I've gone through every single claim that I've been denied on and written stuff on it and then I submitted it to Carmen and Rocky and to Mary (phonetic) with Nebraska Total Care.

SENATOR CRAWFORD: Okay. Have you had any resolution on any of your partial payment?

STEPHANIE WIESE: No.

SENATOR CRAWFORD: Okay. Thank you.

SENATOR RIEPE: Do you have a provider agreement with the managed care, each one of the managed care organizations?

STEPHANIE WIESE: Yes. I have a provider agreement with all of them. WellCare, Nebraska Total Care follow the Medicaid fee for service guidelines, and UnitedHealthcare has their own separate contract.

SENATOR RIEPE: So if there a section in there on reimbursement that stipulates that there's a max of $200 a day no matter what?

STEPHANIE WIESE: Not for home health aides.

SENATOR RIEPE: Not for home.

STEPHANIE WIESE: Only for if you have a client that's over 21 years of age or older, there is a nursing cap of $294 a day so that's usually about seven hours of high-tech nursing for a client. But other than that, that's the only cap.

SENATOR RIEPE: Okay. Okay. Other questions? Okay. Thank you very much.

STEPHANIE WIESE: Thank you very much.

SENATOR RIEPE: It's helpful for facts. That helps all of us. Next testifier, please. Could you just state your name, please, and your organization?

JANET SEELHOFF: (Exhibit 2) Good afternoon. My name is Janet Seelhoff, J-a-n-e-t S-e-e-l-h-o-f-f. I serve as executive director for the Nebraska Speach-Language-Hearing Association. Our members are audiologists and speech-language pathologists around the state, and I am representing them today in this hearing. Want to share some experiences that our members are continuing to have with the Heritage Health program. They, like home health providers, are

struggling to obtain some authorizations for services. Some are not receiving timely payment, and again there's some inconsistency across the managed care plans with just their procedures and trying to work through those items. We are pleased that the managed care organizations do reach out and are in contact with the providers, but we are continuing to see some systemic failures. Again, as Stephanie just mentioned, the administrative burden that's being placed on providers continues. And we just had our annual convention last week and we heard from some providers that they have had to scale back on the number of Medicaid clients they can serve. I'm aware of an audiologist in Columbus who is an owner of a very small practice that has had to stop services altogether. And that's certainly very concerning to know where our citizens are going to receive the care. And, Senator Kolterman, I know you mentioned this morning or asked some questions this morning about network and making sure we have enough providers, particularly in outstate Nebraska, and I think in the audiology and speech-language pathology world we don't have enough. We know there are Nebraskans that are driving to Omaha and Lincoln for services that a limited number of providers are able to give them. And if they have difficulty with transportation, that's a concern. So we would like to continue to work with the providers and really with the managed care plans and get more providers into that network. Just a few other things that I'll mention, this is an example of an actual client receiving speech-language services to help improve his quality of life. It's a young man. We'll call him patient D. He was born at 30 weeks premature, secondary to a placenta abruption suffered by his mom. He was deprived of oxygen when he was born and, as a result, he now has cerebral palsy. He was unable to learn how to feed properly as a baby and so a feeding tube was placed. His physician quickly identified his inability to meet normal developmental milestones and he was referred to the school system. However, feeding and swallowing therapy is not a service that can be performed in the schools, so he was referred to outpatient speech therapy through a private clinic for specialized services. Feeding and swallowing therapy was initiated. And after one year of therapy two times a week, the feeding tube was removed. Patient D continued to require services for communications as he was nonverbal and he did not have a way to communicate. He was unable to indicate pain or refusal. Self-abuse was present. He would bite his arm and hit his head to communicate frustration in not being able to communicate. The therapists identified positive indicators that he had the ability to develop skills for communication. This patient is currently receiving speech-language therapy, teaching him to use an iPad to be able to communicate his wants and needs with a speech-generated app that speaks for him. He's able to indicate pain by

using this device and, as a result, his self-abuse has reduced significantly. Patient D continues to show progress and benefit through his therapy. The clinic that provides the speech therapy services initially received authorization numbers, but unfortunately has been receiving denials now for the services. And if this patient is discontinued with services, it will really limit his ability to be able to communicate. So that is a concern that we have. On the audiology side of things, we had...we're pleased to report that we've been able to work with Nebraska Total Care to increase the authorization period for audiology services from 30 days to 60 days, and we greatly appreciate their work with us on that to make sure that patients have enough...that the audiologists have enough time for patient assessments, diagnosis, fittings, and follow-up visits. I listed out here a couple of issues that we are working with, with WellCare of Nebraska. The authorization period is 14 days for services. However, they are putting that as the date when the authorization request is received rather than the start date and so that is kind of decreasing the amount of time that's available for the audiologist to do the assessment and provide the care. So that's a concern we're trying to work through with them right now. Just in the last week, we've been informed that WellCare of Nebraska has denied some services for audiology. They told one provider that you're not in the network, even though they really are, and that they needed to be part of their EPIC buying group, and they are not. So we have alerted WellCare and are working with them on that. We were also informed that WellCare is now requiring preauthorization of all audio testing if the patient is 21 or older, and if preauthorization is not obtained then a claim denial is issued, and that's certainly an issue that should not be happening. And then the third issue brought to our attention is preauthorization paperwork with WellCare of Nebraska. They're asking for a diagnosis and that's very challenging. Audiologists can't provide an accurate diagnosis until they've done the testing on the patient. And there's no diagnosis code for suspected hearing loss so the payment can't be collected without the preauthorization. Preauthorization can't be done without diagnosis. And the audiologists can't diagnose without the test results. So it's kind of an ongoing cycle there. Again, we appreciate you having this update with us today and just ask for continued oversight and working together to make sure that everyone receives the services and that people are able to communicate and function independently.

SENATOR RIEPE: Okay. Thank you. Questions from the committee members? Senator Howard.

SENATOR HOWARD: Thank you, Senator Riepe. Thank you for visiting with us today.

JANET SEELHOFF: Sure.

SENATOR HOWARD: I want to make sure that I understand this fully. They're requiring a preauthorization for the test, for the testing for audiologists?

JANET SEELHOFF: For the service which you have to do a test to determine what the patient's needs are.

SENATOR HOWARD: Okay. And then from the testing then you would be able to ascertain a diagnosis...

JANET SEELHOFF: Correct.

SENATOR HOWARD: ...to be billed, but you can't have a diagnosis unless you provide the service and the test. Okay.

JANET SEELHOFF: Right. It all goes hand in hand.

SENATOR HOWARD: All right. I just wanted to make sure I understood that.

JANET SEELHOFF: Yes. Yes.

SENATOR HOWARD: Thank you.

JANET SEELHOFF: Sure.

SENATOR RIEPE: Okay. Seeing no other questions, thank you very much. May I see a show of hands of those who intend to testify just so we have (inaudible).Okay. Okay, thank you. We would invite the next testifier.

JODY FALTYS: I'll be really quick, I promise.

SENATOR RIEPE: That's okay. You take your time.

JODY FALTYS: (Exhibit 3) I want to thank everybody for coming here and giving testimony because the words that were being spoken this morning showed everything to be all hunky-dory, but I think you're starting to see that things are not going as well as you were led to believe this morning. So I am just John Q. Public. I'm a member of Total Care. That's who is my managed care organization. And I've been on Medicaid for, oh, since 1989 and I receive home health aide four times a day. And I have a nurse every other day (inaudible), so.

SENATOR RIEPE: Would you be kind enough to give us your name so we get it on the record?

JODY FALTYS: I am sorry, I did forget that. It's Jody Faltys, J-o-d-y F-a-l-t-y-s.

SENATOR RIEPE: Thank you.

JODY FALTYS: Okay.

SENATOR RIEPE: Now proceed.

JODY FALTYS: Yes. January 1, 2017, was heralded as a groundbreaking new start with the introduction of Heritage Health to Nebraska. Many promises were made, promises of being more user friendly, making preauthorizations and reimbursements faster, all while being fiscally responsible. The reality, unfortunately, hasn't been worth celebrating. From the very start, it took three separate phone calls before I was assigned the doctor of my choice, the doctor I've been with for over 15 years. The problems didn't start there as a preauthorization for new wheelchair batteries took over 35 days to approve, which is a great hardship as dying batteries is like having a broken leg that never heals. While those problems were annoying, the issues regarding the large amounts of reimbursements owed to providers is the most troubling. For many of us in the disabled community, we rely on Medicaid and the home and community-based services to live independently, to live in our own homes, go to work, and pay taxes. Since January 1, however,

home health agencies have been trying to provide cares without reimbursement. Because of this, the survival of these agencies is becoming doubtful as I know of no company who could go without income for close to ten months. Heritage Health wouldn't tolerate going without payment this long, so why are providers being expected to? Heritage Health was contracted to do a job and it's a job that they're failing at. The massive amounts of reimbursements not being made will have big repercussions as fewer providers will be accepting Medicaid, and those who do will either stop accepting new Medicaid clients or will let go of those already on Medicaid. A person such as myself will lose the independence I've fought for, those unalienable rights promised by the Declaration of Independence as the right to life, liberty, and the pursuit of happiness. Without home healthcare and all the other needs of mine that are being met by Medicaid, my overall health will be put in jeopardy and I could very likely end up in an institution. If Heritage Health continues to fail in living up to their promises, very hard decisions will have to be made as a disabled person, decisions I wouldn't wish on anyone, decisions that seem simple to others, like getting out of bed, going to the bathroom, and bathing. For me, though, they're struggles made easier by my home health agency and made harder by the irresponsibility of Heritage Health. I beg of you to hold Heritage Health accountable and demand that they do the job they were contracted to do. As we go forth with the long-term care redesign, Heritage Health's actions do not inspire confidence in me. Nebraska's Medicaid recipients came into this in good faith and Heritage Health has let us down. As each person tells their story today, I hope the Legislature listens very closely and addresses the failures of Heritage Health to fulfill the promises they made on January 1.

SENATOR RIEPE: Thank you very much.

JODY FALTYS: That's it.

SENATOR RIEPE: Are there questions? Seeing none, thank you very much.

JODY FALTYS: Thank you very much.

SENATOR RIEPE: Thanks for being here. Next testifier, please. If you'd be kind enough to give us your name and organization.

MELANIE STANDIFER: (Exhibit 4) Good afternoon. My name is Melanie Standifer, M-e-l-a-n-i-e S-t-a-n-d-i-f-e-r, and I'm the revenue manager for CenterPointe, a behavioral health provider here in Lincoln. I wanted to thank the committee for the opportunity to share our ongoing experiences regarding the Heritage Health plans. Since January, CenterPointe has submitted 9,305 unique claims to the three managed care plans, serving 430 Medicaid clients over 12 different levels of care. The level and variety of claim submissions warrants a very detailed level of knowledge and experience of Medicaid regulations and claims processing. As a former administrator in the Division of Medicaid and Long-Term Care, I was in a unique position to assist CenterPointe in navigating the Heritage Health transition. While I fully anticipated that behavioral health providers would experience challenges and payment delays, I was quite unprepared for the depth and breadth of the issues. I'm happy to report that there have been significant improvements with all three plans, however, there is still much work to do. As of today, we continue to experience ongoing payment delays, invalid denials, and overpayment issues with all three plans. While I can share countless stories of the problems we have encountered over the past nine months, I will limit my testimony today to our most recent experiences with each plan, as they are indicative of the overall experience. Nebraska Total Care has demonstrated a great deal of improvement in claims processing since January. I fully commend DHHS for enforcing the provisions of the contract and the corrective action plan. This provided NTC with the appropriate level of motivation to make the necessary system changes to pay clean claims correctly. However, over the past month we have begun to see...receive invalid denials or zero dollar payments for clean claims, particularly from our residential levels of care. Each denial or zero payment represents anywhere from $1,300 to $7,000 per claim. These claims represent the cost to feed, house, and render treatment to residential clients. Each denial or payment delay causes a significant hardship on our agency as we have incurred real costs in rendering these services. WellCare has presented the most significant challenge in receiving accurate and timely claims payments. For nearly eight months we did not receive payment on any of our residential services as WellCare repeatedly rejected our claim format. And I know this morning there was some discussion regarding rejections as opposed to denials. So after spending significant time and effort working with their staff and reconfiguring our billing system numerous times, we finally came to the understanding that the original configuration was correct. However, since WellCare rejected those claims rather than denying them, they requested us to resubmit them, and they refused to pay interest on those claims even though services were

rendered back in January. On August 15, we resubmitted these claims, totaling approximately $136,000. As of today, we have only received payment on $75,000 of these services. Despite our agency having been enrolled in electronic payments with WellCare, they issued a check for $46,000 of those services, which our agency has yet to receive. WellCare's policy requires 45 days to pass before they will even investigate a lost check. We can't even initiate that process until October 8. UnitedHealthcare has been the most consistent payer. However, they have experienced payment challenges as well. Since January, UHC has consistently struggled to pay claims for day rehabilitation. The incorrect payments are reimbursed at approximately 30 percent of the Medicaid allowable. In the process of making these corrections, UHC offsets the incorrect payments against new claims payments. In the pages that follow my testimony, you'll see that the most recent request we received from UHC, which was dated yesterday, represents 256 claims that they paid erroneously that we will have to manually process in order to make sure that our records are correct. As other providers have stated, these issues add a tremendous administrative burden to providers which are already nonprofit agencies, so we do appreciate the fact that you are continuing to hold these hearings and provide oversight to the Heritage Health plan.

SENATOR RIEPE: Thank you. Are there questions from the committee members? Senator Williams.

SENATOR WILLIAMS: Thank you, Chairman Riepe. And thank you for being here today. Can you explain a little more in depth the additional cost that you are incurring from a staffing standpoint of having to deal with this compared to where you were under the old system?

MELANIE STANDIFER: Well, for example, I was hired at CenterPointe as...originally as their compliance officer, but due to my in-depth knowledge of the Medicaid program they asked me to shift over to full-time working on the revenue side to try to help investigate and resolve these problems. So that's...

SENATOR WILLIAMS: So you, in essence, would be a new employee of CenterPointe...

MELANIE STANDIFER: Absolutely.

SENATOR WILLIAMS: ...for that job. You've seen these. Part of your testimony at least indicates that there's been improvement during this period of time. Do you believe they are on a path to getting this to an acceptable level?

MELANIE STANDIFER: I think that's...you know, I wanted to acknowledge the fact that there was improvement. I don't think that it's been at the pace or to the extent that providers and consumers need. You know, CenterPointe predominantly serves a population that's most vulnerable, a lot of homeless, and to jeopardize funding for an agency like ourselves that already runs on pretty tight margins. The amount of time that I spend just to get the claim payment for the same amount we would have received one year ago that now we've had to incur the additional costs of 30 hours of my 40-hour week just on getting the money we should have gotten because we submitted a clean claim, it's really inexcusable that we're in September and still experiencing this level of difficulty.

SENATOR WILLIAMS: Thank you.

SENATOR RIEPE: Senator Crawford.

SENATOR CRAWFORD: Thank you, Senator Riepe. And thank you for being here and sharing your experience. So can you explain what these attachments mean and what that means for your processing?

MELANIE STANDIFER: Thank you. I appreciate you asking that question. As I saw my time running out I thought, well, that's probably not going to make a whole lot of sense. So the following pages, each line represents an individual claim that UnitedHealthcare paid at an erroneous amount.

SENATOR CRAWFORD: Okay.

MELANIE STANDIFER: So even though we submitted the claim correctly, they paid at 30 percent what Medicaid allows. For most of these, they've subsequently paid the correct amounts and so we had a credit balance or overpayment sitting on these claims and so this is their process

of taking those claims back, which requires each claim to be manually reprocessed. Even though we've already received our payment, we have to, the way that they do it, requires a very manual...and you can see. This is just one remittance from yesterday which represents 256 claims. Most of these claims date back to February, between February and May. So we still have, unfortunately, even as recently as this week, United has continued to pay these claims incorrectly. So next week and the week after, I will receive similar take-backs as they attempt to correct those errors.

SENATOR CRAWFORD: This is money you're expected to pay back?

MELANIE STANDIFER: Yes. So this particular example is about $4,300 that they're taking back against claims that they're paying currently. So this was included with a $20,000 payment that really should have been about a $25,000 payment. So we have to take that money off of the claims that they erroneously paid and push them forward to new claims to be able to balance our books.

SENATOR CRAWFORD: Thank you.

SENATOR RIEPE: Senator Howard.

SENATOR HOWARD: Thank you, Senator Riepe. So I'm trying to understand this. So they made the mistake in overpaying you and then it's your responsibility to hire additional staff and manually enter and reprocess all of these claims?

MELANIE STANDIFER: Absolutely. We, at the onset, we contacted UnitedHealthcare and asked them to go to a manual claims processing on their side, because if one of us had to do manual work we felt that the burden should be on them as it was their errors, which they did. So for some time claims payments sort of smoothed out. They felt they had the issue corrected and went back to an automated claims processing, at which time we received another additional several hundred claims paid erroneously. So we are currently back to them processing claims manually, which I have to say for an organization the size of Optum is absolutely unbelievable that nine months later...and this is just one level of care. It's a pretty straightforward per diem

payment, should be easy to process for a company that size. But I know that other providers that render this same level of care have shared that they are having the same situation.

SENATOR HOWARD: And so this is for 1 level of care but you provide 12 different levels of care.

MELANIE STANDIFER: Yes. Well, 12 levels of care that Medicaid reimburses. We provide far more than that.

SENATOR HOWARD: Right. And I'm just sort of struggling with, from what we heard this morning, that everything is going very well and that we're...the claims, they're beautiful; we have these beautiful graphs.

MELANIE STANDIFER: Uh-huh.

SENATOR HOWARD: I'm sort of struggling to rectify that with what I'm hearing from you.

MELANIE STANDIFER: Yes, as I listened to this morning's testimony, I struggled to not talk back to my computer screen as I was preparing my testimony for this afternoon, particularly in regards to claims payments and the issues regarding particularly WellCare and their statements about how they pay interest. You know, the $136,000 that they asked us to resubmit were for claims incurred in January and February. So by August they should have certainly incurred interest.

SENATOR CRAWFORD: Uh-huh.

MELANIE STANDIFER: But because they asked us to resubmit, even though they rejected them erroneously, they re-aged the claims. And now, of those $136,000, there's still a $46,000 check floating around that they won't even investigate for another couple of weeks. So that's more time that really they should have incurred interest. But I'm sure, because they issued the check, they will not issue interest on those claims either.

SENATOR HOWARD: How do you appeal a rejection?

MELANIE STANDIFER: There's really not a process for appealing a rejection because, in their eyes, the claim really never came into their system.

SENATOR HOWARD: Uh-huh.

MELANIE STANDIFER: They're only acknowledging that they received a claim and that's where I kind of take issue with what was stated this morning. The claims, after nine months we finally came to the understanding, they were originally submitted correctly but their rejection was because their system was configured too narrowly. And so at that point we wanted to cut our losses and at least resubmit the claims and get payment on them, which as of this point we still have not.

SENATOR HOWARD: Is $136,000 the most you've been owed in arrears?

MELANIE STANDIFER: No. That was just for two different levels of residential care. We experienced a much more difficult problem. Before Nebraska Total Care was put on a corrective action plan, I think at one point our receivable with them was close to $250,000.

SENATOR HOWARD: Thank you.

SENATOR RIEPE: On this one report that you shared with us, is that $4,295, that was an overpayment on their part?

MELANIE STANDIFER: Yes, the total of all of those claims. So each dollar amount represents the erroneous payment that they made, so the total of those erroneous payments was $4,295.

SENATOR RIEPE: It would have been greater burden to you had they asked you to repay that then.

MELANIE STANDIFER: Well, they are essentially asking us to repay it because they're taking it against claims that they owe me now.

SENATOR RIEPE: Yes, that I understand.

MELANIE STANDIFER: But if they had either denied the claims entirely, it would have been a much less...much less burden than to have them pay them erroneously. They don't just pay the difference that they owe. They have to take the original payment back and then repay the full claim.

SENATOR RIEPE: My experience is that it gets rather complicated when you're putting an outstanding balance against...so you're taking it off of this bill and then by the time you get it figured out, it's hard to tell which is which. In the hospital business, we always, claim by claim, we repaid it. We were fresh on our next claim. I...that...

MELANIE STANDIFER: Absolutely, and that would have been our...

SENATOR RIEPE: ...(inaudible) talking about this morning.

MELANIE STANDIFER: ...our preference that we had the opportunity to just submit a bulk repayment, like you mention, but United didn't afford us that opportunity and so now this does certainly complicate our financials. And we've crossed over fiscal years and the list goes on.

SENATOR RIEPE: Well, to me, when you commingle these things, it really gets...

MELANIE STANDIFER: It is. It's very...

SENATOR RIEPE: ...difficult to track to find out...

MELANIE STANDIFER: Absolutely.

SENATOR RIEPE: ...how much you have left in your account or not in your account, where did it go to and everything else. Other questions? Okay, thank you. Thank you very much.

MELANIE STANDIFER: Thank you.

SENATOR RIEPE: Thank you for bringing facts. It's very helpful. Yes, sir, if you'd be kind enough to introduce yourself and your organization.

KENNY McMORRIS: (Exhibit 5) Yes, I am Kenny, K-e-n-n-y, McMorris, M-c-M-o-r-r-i-s. I am the CEO of Charles Drew Health Center in Omaha, Nebraska, and also representing the Health Center Association of Nebraska and the seven health centers that are truly the safety net provider for a lot of our families in Nebraska. Like all FQHCs in Nebraska, Charles Drew primary mission is to provide medical, dental, and behavioral health services to low-income, uninsured, and traditionally underserved individuals. In 2016 Nebraska health centers provided care to nearly 85,000 unduplicated patients, a 10 percent increase of the previous year. Ninety-eight percent of our patients fall below 200 percent of the poverty guidelines and seventy percent are from racial and ethnic minority populations. Our health centers are the safety net that provide care regardless of insurance status and half of our patients are uninsured, paying a nominal fee for using a sliding fee scale based on income and number of people in household. Twenty-nine percent of our patients receive health insurance through Medicaid. We are the safety net providers in the state. Because of the high rate of uninsured patients served by the health centers, consistent and accurate payments for private insurance and Medicaid managed care providers is critical to the financial stability of the health centers. We continue to experience issues with respect to payment consistency through Heritage Health. Some of our ongoing billing issues include not being paid the FQHC encounter rate for behavioral health services, claim denials for 599 CHIP claims for care provided to undocumented pregnant women, failure to pay the FQHC encounter rate for well visits, and denial of claim for well child visits. Many of these claims date back to January and our health centers have been required to resubmit hundreds of claims, both electronically and on paper, in an attempt to resolve the billing issues. As of July, the health centers have approximately $700,000 in outstanding claim issues. While some claims have been resolved, our health centers are undertaking a lengthy reconciliation process to verify that all claims have been paid correctly. Our bigger concern is that, to date, none of the health centers

have received interest payments, despite the fact that payment delays or denials are due to system errors, not claim errors, and many of those payments occurred outside the 60-day claim processing deadline. It is our understanding that interest must be paid when the claim is paid under the terms of the contract. However, we have not received clarification to when the 60-day processing time line begins. We are aware that the contract with the managed care companies, as well as provider manuals, define clean claims and claims processing time lines; however, the practical application of those definitions is not entirely clear. If it has taken eight months to process claims due to process fixes or system updates, it would seem that interest payments should apply. System breakdowns are not...their system breakdowns are not just impacting billing on our health center; they are impacting continuity of care. As an example, staff at People's Health Center in Lincoln spent two weeks attempting to obtain a prior authorization for a pediatric patient to see a podiatrist to have an infected toenail removed. The managed care company would not process the authorization request because the health center has not been listed as a primary care provider. The parents had attempted to update the PCP but, due the language barrier, no one could provide adequate assistance. The parents were never offered the opportunity to use an interpreter, were only able to make the change after the outreach staff at People's Health Center provided assistance. Once the change was made, staff was still unable to resolve the authorization request despite repeated attempts and hours on the phone. Finally, working outside of the managed care company, the staff at People's located a podiatrist to take the patient with a written prescription, knowing that there will be months of claim issues on the back end. In the meantime, a child with a known medical issue had care delayed because of system inadequacies. Finally, as Medicaid care moves to...as Medicaid dental care moves to managed care on October 1, we encourage the committee's diligent oversight of the implementation. We are already experiencing issues with inability to process test claims and unreliable communication from the new dental beneficiary manager. While we hope to see improvements prior to October 1, we have reservations about the impact on access to care and the readiness to serve patient needs. Our health center patients face numerous barriers with accessing healthcare. The managed care companies should not pose an additional one. While some bumps are anticipated with any transition ongoing...with any transition, but nine months after implementation should not be tolerated. We are committed to working with the department and the managed care companies and this committee to find positive solutions to improving access to care, smooth claim processing, and improving the overall quality and efficiency of the

Medicaid program. We encourage your continued oversight of both Heritage Health and the new dental beneficiary manager. I'll take any questions and thank you for your time.

SENATOR RIEPE: Your timing is impeccable. (Laughter)

KENNY McMORRIS: Ah, yes. Yes.

SENATOR RIEPE: Questions from the committee? Senator Crawford.

SENATOR CRAWFORD: Thank you, Chairman. And thank you for being here. Appreciate your service. So we know what an option may be if we were trying to go back and reconcile the interest payment issue, when you were asked to resubmit payments, are there ways to link or connect the resubmitted claim to the original claim? I mean is it possible to know how old the original claim is?

KENNY McMORRIS: Yeah. So depending on the nuances of what services were rendered, and as indicated before, for us, we're providing medical and behavioral health, so we're kind of getting a dual service piece, there are ways. I mean each health center has systems for both electronic and even processing paper claims. However, as was previously testified, the amount of resources and time that goes into that, and I think that all of our health centers have taken the approach that we're going to realign staff appropriately because this is a big part of what we do. A significant number of our patients are uninsured and Medicaid and how that is managed is a big payer for us. We operate on the margins. And so there are ways to go back and track and reconcile; however, the staff commitment, the resources, the capacity to do that effectively is the challenge for most of our health centers.

SENATOR CRAWFORD: But does...the managed care systems should be able to track that, do you think, or no?

KENNY McMORRIS: Yes.

SENATOR CRAWFORD: Yes.

KENNY McMORRIS: Yes, they should.

SENATOR CRAWFORD: Okay. Should be able to able to put the burden on them.

KENNY McMORRIS: Absolutely, that's right.

SENATOR CRAWFORD: Okay. Okay.

SENATOR RIEPE: You're obviously in the business. You have some commercial sites. How does this compare and can you compare United to United?

KENNY McMORRIS: Yeah. Yeah, so in our world most FQHCs do not have a high volume of commercial payers. Every one is uniquely different but, again, the space in which we operate is typically with Medicaid. That's our niche. That's the market in which we operate with. Again, every commercial payer is uniquely different and there are challenges with those commercial payers as well, but again, when you're looking at your largest payer being Medicaid, those challenges are far greater because it's a big part of your payer system resources to operate your business.

SENATOR RIEPE: Okay. Senator Howard.

SENATOR HOWARD: Thank you. Nice to see you again, Mr. McMorris.

KENNY McMORRIS: Thank you.

SENATOR HOWARD: I wanted to ask you about the interest payments, because what we were hearing from previous testifiers is that the request was that they resubmit. Is that the theme for the FQHCs as well?

KENNY McMORRIS: Well, we've been unclear, quite frankly, on what we should be doing with that. So again, if that's the case, then we will resubmit appropriately. And actually, I was shocked to kind of hear that this morning, so I learned a lot this morning about what probably should and

shouldn't be happening. Our world is...that's not what we're going on our side. But I would assume that that's the process that we should be going through.

SENATOR HOWARD: And then how are things going on the 599?

KENNY McMORRIS: Yeah. I would say that, as indicated before, one of our health centers is really plagued by dealing with that issue. And while I believe process...or believe progress has been made, I just don't believe that it's sufficient for what we're trying to accomplish here. And again, as I indicated before, it is important that we are receiving payment for the services that are rendered. I mean it creates such a burden on an FQHC and our model of care if we're not paid on time. Again, they've heard us and I can say that they've been responsive, but we do not believe it's just adequate for what we should be getting at this point, being nine months in.

SENATOR HOWARD: And then for...on the behavioral health side, not all of the FQHCs practice integrated health, behavioral and primary care, or all of them do?

KENNY McMORRIS: All of us do.

SENATOR HOWARD: With the warm hand-off, and so there were challenges in the billing for the warm hand-off for the second visit?

KENNY McMORRIS: Correct.

SENATOR HOWARD: And so can you help me understand how that might work on the billing side?

KENNY McMORRIS: Sure. Yeah. So to kind of talk a little bit about our warm hand-off and integrated model, most if not all FQHCs across the country and specifically in Nebraska, we work...we use therapists to work with our primary care providers. We know that a lot of the challenges that our families face on the medical side are directly correlated to challenges on the behavioral health side. And so we working collaborative with therapists at what we call a warm hand-off. So depending on that visit, that medical visit, if a therapist is available then that

primary care provider will work in conjunction with that particular therapist to render services that are appropriate for that patient. In some cases that dictates or triggers a payment that would be on the behavioral health realm. To that extent, there's been some inconsistencies in how the payments are being made to the FQHCs and how we are submitting those claims in relation to both the medical and the same day behavioral health visits. And so it's just taking us some time to kind of get through the processes. I would say that of the three, we are making significant progress with two of them. However, it's still again not to the liking of what we will want to see because it's a big part of our operation. A significant number of our patients do have behavioral health barriers and so it's important that we're getting paid appropriately.

SENATOR HOWARD: Thank you.

SENATOR RIEPE: Senator Crawford.

SENATOR CRAWFORD: Thank you, Senator Riepe. And thank you again. I just want to clarify, do I understand you correctly that you believe that you have not received any interest payments?

KENNY McMORRIS: Charles Drew specifically, yes.

SENATOR CRAWFORD: Okay.

KENNY McMORRIS: I can't say 100 percent for my colleagues, but I know that we've had challenges across (inaudible).

SENATOR CRAWFORD: Do you believe you've had clean claims submitted that have been delayed over 60 days?

KENNY McMORRIS: Yes.

SENATOR CRAWFORD: Thank you.

SENATOR RIEPE: Okay. Thank you very much. I would like to add that in our third quarter review, we will be talking about having oversight then for dental...

KENNY McMORRIS: Yes.

SENATOR RIEPE: ...as it comes into fruition.

KENNY McMORRIS: Okay.

SENATOR RIEPE: So we...our life is too simple right now. We want to add some more to it.

KENNY McMORRIS: And we would very much appreciate that and we'll spend time with you on that as well.

SENATOR CRAWFORD: Thank you.

SENATOR RIEPE: Thank you very much.

KENNY McMORRIS: Thank you.

SENATOR RIEPE: I've seen your picture before so it's nice to see you live.

KENNY McMORRIS: (Laugh) Nice to see you as well. Thank you.

SENATOR RIEPE: If you would be kind enough to state your name and your organization.

JON NOVAK: (Exhibit 6) Yes, sir. Senator Riepe and committee, thank you and...for taking the time today. This is a good opportunity for us to just kind of give an update as far as what's been happening with us. My name is Jon Novak, J-o-n N-o-v-a-k. I am the CEO of Total Respiratory and Rehab. We are a Nebraska corporation. We are a provider of durable medical equipment, primarily the wheelchairs is the primary business that we do work in. We have a, in Nebraska especially, we are, because we are also located and have locations in Iowa and Missouri and

work with their Medicaid MCO programs as well, we are working diligently in the state of Nebraska where it's a little bit different. Nebraska, for some reason, and it happened back in August of '13, made a mandate per CMS, for whatever reason, that the payment of wheelchairs does not go to the provider. Now this is different than it is in the state of Missouri and in the state of Iowa where we have business and we are familiar with the reimbursement. What is happening in the state of Nebraska is that there is a benefit, fortunately, for these residents in skilled nursing facilities, but the payment needs to go to and it needs to be billed to...from the skilled nursing facility and paid to the skilled nursing facility. This is very unique. It's very different and it has been an extreme challenge here in the state of Nebraska. So just to give you a little bit of an idea, we are very much committed to the industry of the wheelchairs and working with the skilled facilities. We've worked with people in facilities and out of facilities, and so when I'm talking today there's two, basically, I always kind of look at it as almost two different types of businesses, one that we are working with over 85 percent of the facilities in the state of Nebraska. Our arrangement with them when this came out, because it was a shock to them that they would have to possibly be trying to bill and work with and figure out codes and billing processes for wheelchairs was, hey, I know you don't want to be in my business, I don't want to be in your business. I went to them and said, here's what I'm going to do. We're going to try to basically try to keep this about as simple as possible. We're going to come to you. We're going to work with your residents. A therapist identifies a need in your facility and then what we're going to do is we're going to come in and do an assessment together and figure out what is the proper medical necessity, proper equipment for that patient. Medical necessity is then justified. There is a prior authorization. At that point in time the prior authorization prior to January 1 of 2017 was very simple. It was basically if there's medical need and coverage and there was criteria, then it was approved. Since then, the January 1, 2017, then the...we ended up starting to have...that's when my office basically...and we employ several people in Nebraska, both locations in Omaha and Lincoln, but we serve the entire state. We have members in every district that you all represent in facilities. Starting in January, my office basically got turned upside down. We started trying to get authorizations. We weren't able to get authorizations. Now...and I understand there's going to be problems. Everybody is trying to do as good of a job as they possibly can. The problem has come recently in the fact that now Total Care and WellCare are doing authorizations just like before. There's basically been no interruption, no difference in level of service as far as on the front end prior authorization process. However, what I have here is UnitedHealthcare prior

authorizations. They are using a criteria that is completely different than what Nebraska Medicaid has ever used. It is not even Medicare criteria. My gosh, my time is coming up. So we have...and so we don't even have the ability to use the Medicare criteria because the...when you have the Medicare, we're not sure what their criteria is. What's happening is people are getting denials on wheelchairs and then what's happening is it's causing my staff to get phone calls from therapists, nursing homes, administrators, caregivers, family members, and patients trying to figure out where their equipment is and what's going on. Meanwhile, we're trying to submit, appeal, and do all kinds of things. That is the biggest problem here as far as between us and UnitedHealthcare. If you look at the...and if you look at the advisory dated April 6 from Calder Lynch, it says right here that the client's condition must meet the coverage criteria outlined in the appropriate medical (sic--Medicaid) provider chapter in order for reimbursement to occur. To me, that means that the coverage criteria should be based on a Medicaid criteria. The UnitedHealthcare is stipulating that they have something from the NAC that is different from that. I have so much more to say but I don't know if I have time. But I also have many reimbursement issues. We haven't even been able to get most of these claims on file with the MCOs. Right now my current accounts receivable is $1,476,739.34 as of yesterday.

SENATOR RIEPE: You may get an opportunity here with some questions (inaudible) help you to continue to elaborate.

JON NOVAK: I would appreciate it because I've got a lot to go over, but I only had a few minutes. So I apologize for taking so much time.

SENATOR RIEPE: Well, let me say I understand that United is working with you and they're trying to work this thing through. Is that true or not true?

JON NOVAK: That is true and that, as you go down, I have a part that I was...just haven't gotten to. There is light at the end of the tunnel.

SENATOR RIEPE: Okay. And I think legal counsel is also working with you, on this committee, Kristen is?

JON NOVAK: Not as of yet. We did reach out to her the other day just to find out about this procedure and then we found out about her. And so we have not engaged yet.

SENATOR RIEPE: Okay. We can help there, too, from that standpoint. With that, I'll turn to the committee and see if they have questions that will afford you an opportunity. Here we go. Senator Howard is going to give you a go for.

SENATOR HOWARD: So I did ask the question about durable medical equipment through skilled nursing facilities to one of our morning testifiers. Were you her for that?

JON NOVAK: Yes, I was.

SENATOR HOWARD: What were your thoughts on their response?

JON NOVAK: As far as their response, they are working diligently with us. We have had many, many challenges to try to figure out basically how to get claims on file. And we have done a couple of test claims. We believe that we are on the road to recovery with that particular firm. But we have not received any payment. But what I can tell you is communication is going well with that particular MCO. They are giving, you know, the best good faith effort they can. I'm a business owner. I have employees. Everybody, you know, there's certain things that, you know, right now what I'm seeing is there's good communication, there's good open lines right now. They recognize that there's a problem. The fact of the matter is with that particular one we have not been paid for one chair that we put into a facility. However, we are hopeful, and I'm keeping my fingers crossed, that this is possibly going to happen. Now I will tell you with WellCare, we have been getting some payments through the facilities. It seems like they are also doing a very, very good job. Some of these facilities are getting payments on the chairs and then it is working out better. They are also, on the nonskilled facility side, I mean they just were able to figure out with many, many system errors, and this goes back to what Senator Crawford, on the interest side. I was so glad just to see some money show up, and then I actually did get a very large interest payment that I wasn't even expecting and it was due to system errors and they went back and did correct that. But to answer your question, Senator Howard, I mean it's...their answer was

correct. They are working on it and they've identified a couple different ways for us to get claims on file.

SENATOR HOWARD: Okay.

JON NOVAK: Before that, we were not even able. They were directing on the front end. So then as far as what we were concerned about was on the timely side, they were not even...we were concerned because if you can't even get them on file then timely issues can start because they don't even know that we actually sent the claim.

SENATOR HOWARD: They don't know when you sent the claim?

JON NOVAK: If it's getting rejected on the front end,...

SENATOR HOWARD: Uh-huh.

JON NOVAK: ...and so it was imperative that we figured out a method to get these in there, at least get them in there, to...so we didn't have timely issues. And they told us that they would work with us. They have been excellent, they really have.

SENATOR HOWARD: What were the reasons for the rejection on the front end?

JON NOVAK: Different areas to be filled out on the forms.

SENATOR HOWARD: Okay.

JON NOVAK: And, you know, we've worked with many and we reached out to many, many different facilities and asking them what do we fill in there, and most of them are saying that they didn't fill in those areas on their side...

SENATOR HOWARD: Okay.

JON NOVAK: ...because we are a contracted biller for the wheelchairs for those facilities. And so, you know, we were just trying to figure out the method of getting it submitted. And so we're calling and saying, well,...they were saying, well, the facilities have to have this. So then we're calling the facilities and we talked to many of them, very large facilities and very small facilities, and asking are you filling in these areas? If you have this information, just send it over and we'll fill it in so we can get our claims on file. They didn't fill it in.

SENATOR HOWARD: Okay. Thank you.

JON NOVAK: Uh-huh.

SENATOR RIEPE: Senator Kolterman.

SENATOR KOLTERMAN: Yeah, just a simple question. Thanks for coming today. The accounts receivable dollar amount that you quoted us, is that just the MCO stuff that you have out?

JON NOVAK: That is. And thank you for asking that question, Senator. That is. That is. That represents only the accounts receivable on the MCOs and that is going to be...but that is...and just to clarify, that is total. And so what I have is direct, so there's going to be some of that money that is direct to Total Respiratory and Rehab, but then the way that it is done in the state of Nebraska where they pay the facility, the facility, the agreement that we have is the facility doesn't pay us until they get paid. And that was an agreement that went back to August of '13 and I just didn't change it. I didn't anticipate this. And at the same time, if I were to go to a facility and ask them for, you know, money for a wheelchair that they haven't been paid on, they're going to be very reluctant to put that money out as well as far as cash flow. I will also tell you that on these items and the...on this $1.4 (million), I have had to pay for the equipment. The manufacturers, to keep shipping to us, expect to be paid. We have to stay in good standing with these people. I also wanted to let you know that our aging on most of this is over 120 days old. For those of you who have been in business and understand, banks don't like to loan money on aging that is over 90 days. Now most of this is over 120 days. Keep in mind we have been providing wheelchairs in the skilled nursing facilities for, you know, this is coming up on

October, for many months. We have not been paid on most of these. I would say 95 percent of these we have not.

SENATOR KOLTERMAN: Can I follow up?

SENATOR RIEPE: Yes, please.

SENATOR KOLTERMAN: So when you...it seems like a convoluted way of doing business where they pay the facility, and then the facility has to pay you. How long does the facility sit on the money once they get it?

JON NOVAK: Their terms are 30 days.

SENATOR KOLTERMAN: Well, that's still another 30 days. That hurts your aging.

JON NOVAK: Yeah. Right now my banker is pretty impressed with my aging report. It's...but, you know, the thing of it is that it all comes back to relationships. It all comes back to explaining to them what's going on and trying to, you know, communicate effectively, and that's what we're doing. But, you know, fortunately, we're a solid company. Fortunately, this is not all of our business but it is a very large part of our business. I mean this is something that we are committed to. We are continuing, just so you all know, to provide the wheelchairs. So there's the prior authorization. You get the prior authorization. We are providing the wheelchairs, even now, knowing in good faith that these MCOs are hopefully going to be continuing to work with us, which they are, and trying to figure out with their system how to pay us. But we are still not letting up service and providing people's mothers, brothers, family members with their chairs that they desperately need so they cannot be bedridden or have to be pushed around their facility and so they can be independent if they have that ability to.

SENATOR KOLTERMAN: Do you charge interest on your accounts receivable?

JON NOVAK: We do not. We do not. We never have. And you know, we are very much a relationship company that we try to just understand their needs and have them understand ours

and try to keep a very simple relationship that works out very well. Obviously, you have to have some contracts and some things involved, but I can tell you that we have very good relationships with all these facilities and we know them all very well and they are very concerned about what's going on. I have tried to not make them aware of our problems because they all have so many problems, and you know we all got our own problems. But when it comes down to it I do feel like we are making some headway, even on this UnitedHealthcare issue. I mean we have talked a couple of times on the issue as far as just trying to...because they are having to give us prior authorization within 14 days. Well, sometimes before, with UnitedHealthcare, they would come back on the last day and say you have to get this information, additional information, from the doctor or the therapist and get it back to us today. Oh my gosh, that sometimes is impossible. And so then, if not, then you have to send in a whole new appeal because it will be denied if you don't get back to them that day. So it's very difficult to sometimes work with them, but they have been trying to work with us a little bit at least on the ability or the communication side. Now they are still standing firm that they can use their own criteria.

SENATOR RIEPE: My question is this. I know you reached out to some state senators. My question is, did you...the logical first step to me is you go back to the managed care provider that's in question. If you get no satisfaction, then you go to DHHS. If you get no satisfaction from that point, you know, I would like to think that it comes to the Oversight Committee because otherwise with 30,000 providers, 232,000 recipients, you know, these things are like manure hitting a fan. You know, I mean it gets very difficult to solve problems when it's coming from all directions.

JON NOVAK: Yes. We worked diligently with all three of the MCOs and letting them aware and working with provider relations (inaudible) things like that.

SENATOR RIEPE: And they give you...they...not to your satisfaction.

JON NOVAK: We're working on it. Let's try it this way. We have a system. We have known issues we're going to be working on them. We are going to be doing this and that so hopefully your claims can start going through. And then it is, you know, as time moved on and this number

continued to move up, then the pressure continues, because you want to be patient. You know that you have a long-term relationship with these MCOs.

SENATOR RIEPE: But did you take it to a, if no resolve, to the managed care organization? It seems to me like it was started in a variety of directions and I don't know whether you even talked to DHHS.

JON NOVAK: We did. We worked with them multiple times through their provider reps, and then...

SENATOR RIEPE: To conclusion, that they said no or yes?

JON NOVAK: We've never received a no. Everything has been: we're working on it; we need to make changes; that we're having to change configurations; it's an IT issue, you know, different things. And so we never receive noes. It was...but it just kept on getting delaying and delaying. And so, you know, it's not that we ever received, no, we're not going to do this or we're not going to pay that. It never came down to that. And so it was, hey, just be patient. We've got so many other critical issues here we're trying to work with. We trying to get yours. And so we weren't getting noes so there was...you just try to be patient, understanding no different than one business to any business or one person to another person, understanding their situation, have them try to understand yours. So then approximately about six weeks ago we first...about six weeks ago now, we first reached out to DHHS and then did have a meeting with them and, you know, then we kind of explained it. That kind of got the ball rolling a little bit more. And then at the simplification meeting, Administrative Simplification meeting about two weeks ago, I stood up and basically kind of explained what was going on. At that point, Rocky Thompson was there and his team, and I think that people were somewhat surprised as to what was going on and concerned. And I will tell you his team has been all over this since, and so has the MCOs.

SENATOR RIEPE: Well, we're going to be bringing Mr. Thompson back up so he'll have a chance to clarify or whatever. Senator Linehan.

SENATOR LINEHAN: Thank you for being here today. I just want to make note that Mr. Novak is a constituent of mine and lives in my district, and I appreciate you being here today. And he did come see me about this and I appreciate that, too, because I welcome my constituents coming to me with problems. So thank you.

JON NOVAK: Thank you. So, yeah, that is the channel that we used. We were trying to be patient working with the MCOs. Understand we have a long-term relationship. We then went to DHHS about six weeks ago, and then at the simplification. And that's really when things have really gotten a lot of momentum as far as trying to work with them.

SENATOR RIEPE: Okay. Thank you. Are there other questions from the committee or comments? Now hearing none, thank you very much and we appreciate your time.

JON NOVAK: Thank you.

VICKY McHUGH: (Exhibit 7) Good afternoon. My name is Vicky McHugh, V-i-c-k-y M-c-H-u-g-h. I'm a physical therapist and the sole owner of a private practice in Omaha, and serve the surrounding community of about a 60-mile radius. I have...I want to share our perspective as a small private practice that is serving much of a large population of Medicaid recipients across the entire life span. I'd just give a little bit of information about our practice because I think it's really relevant. We serve physical therapy, occupational therapy, and speech therapy. We have an 8 FTE staff with an additional 1.5 FTE administrative support. We work with our clients exclusively in their natural environment, so we are breaking down the barriers of accessibility and going to these clients and serving them in their home and in their community rather than them coming to our clinical site. Our current Medicaid caseload is 51 of our current clients. That is 30 percent...36 percent of our entire caseload; 38 percent of our entire weekly visits are done for Nebraska Medicaid clients. We have, different than Mr. Novak I'm glad to say (laugh), but we have $80,000 in open claims to the MCOs right now. For my organization that goes across a three-month total. With an 8 FTE and a much smaller network, that has a substantial financial impact on our organization. And we are serving clients that can't get into facilities to be served, and so we really are breaking down those barriers to accessibility. But the financial situation and the accessibility that I'm trying to work through with the MCOs is becoming a larger barrier to

me as a provider wanting to serve this population than I think some of our clients are experiencing trying to access their services. I won't go through the details but I've just given a little bit of perspective about the three different MCOs with the aging...the open claims and what our average dates of aging are for those. One we get a claim in, we're getting paid on a fairly reasonable, timely basis. Our biggest issue actually comes to what we're getting paid and how the MCOs have manipulated new evaluation codes for our ancillary services under PT/OT and speech, as well as with our authorization process. We are struggling immensely with WellCare and their subsidiary--I don't know what the right word is--but WellCare and Evicore. We actually took about five weeks to understand the difference between which...and this is from them guiding us, in direct communication with the provider representatives, of how to get prior authorization. WellCare requires prior authority for all three services that we provide. Some of it goes through WellCare itself; some of it goes through Evicore. It took five weeks for us to be told and instructed which ones were which. And our administrative resources are spending approximately 20 hours a week out of my 60-hour allocation on authorization processes. This is getting an opportunity to even see these clients. We are not even talking about claims or filing or managing their cases. We're talking about getting a case open and getting authorization approved. It is very prohibitive. And at this juncture, with the reimbursement rates being approximately 75 percent less than what we would be getting from either Medicare or from a commercial insurer, it is...we are losing money on almost every single Medicaid visit we do across the board. It is a huge challenge for me because I think that...well, from a mission standpoint, this is a huge priority for my organization. I don't have anywhere near the durability to withstand an accounts receivable, as Mr. Novak has illustrated, because we are a small organization. I've been in practice for 11 years and we are committed to working with this population. I am working closely with the representatives at WellCare. Nebraska Total Care did a great change in July with making their authorization process an immediate 12, and the reauthorization process is very clean with them. We're getting about three- to five-day answers on our reauthorization processes from our outpatient authorizations. We are not seeing that happening with WellCare. I did hear the woman speak this morning that she has worked on approving that for PT and OT for increasing the number of visits that they're allowing on an authorization, but I'm still not hearing that they're doing anything to make that authorization approval process any better. Logistically, I think one of the questions one of the committee members asked back to the Nebraska Total Care CEO was what are you doing differently. There

are some substantial things that we're experiencing as a providing in the authorization process that Nebraska Total Care is doing differently, one of which is their platform. They have a very usable computer process that allows us to put...submit a prior authorization request and the supporting documentation for clinical support of medical necessity. WellCare does not offer anything in that way and we are stand...we are being transferred repeatedly and being told we're in the wrong department. It is not uncommon to spend an hour on a telephone call within the WellCare system to try to get authorization. I know I just got my little red light but I do want to say one thing. We have the administrative time that we're spending, when we are calling we're not getting good, clear communication back from Evicore and/or WellCare. People don't know who to direct us to. We're getting mixed answers. We're in this confusion of their confusion and it is prohibiting us to serve these clients. They are not giving us authorization that goes back to our evaluation date. We're getting denials that are coming back. Thirty-eight percent of our denials on prior authorization requests are coming back on a clerical or nonmedical issue. We are getting a huge denial that has nothing...or I said that backwards. We're only getting 38 percent of our authorizations approved; 60 (percent) are coming back as nonapproved and there are 10-12 percent are on a medical issue. The other 50 percent are coming back on a rejection issue or a clerically related issue that we don't have the right coding on, we're circling the coding and sending it back: Please note on the prior authorization request it's on there. But their system doesn't seem to be able to integrate the information that they're asking for us to provide to them to be able to do the authorizations that we need to be able to see their clients.

SENATOR RIEPE: Have your concerns with Evicore, have you met with and expressed that to WellCare?

VICKY McHUGH: Yes, sir.

SENATOR RIEPE: Okay.

VICKY McHUGH: At great length, if I may add.

SENATOR RIEPE: And did you get any satisfaction? Apparently not.

VICKY McHUGH: The really concerning part from my standpoint is I'm not sure. It's not a pathology they don't understand or aren't aware of. My concern is their apparent ability to address it. Everyone tells me that it's a problem when I talk to their system, whether it be within the WellCare, whether it be a provider relations person or a customer service relation person. We are...but they're working with WellCare...I mean with Evicore, and it's not being...doesn't appear to be a clear path to how they're going to resolve it.

SENATOR RIEPE: And if that's not, I'm curious whether they're working within the guidelines or requirements of DHHS. And if not, then that needs to be brought to the attention of DHHS and hopefully then sooner rather than later they come into compliance.

VICKY McHUGH: Their time frame on authorization replies to us is somewhere in the neighborhood of 10 to 14 days for us to do an evaluation, turn the paperwork in, and then provide. They have some sort of answer. Many times it's that they never received our request. About 25 percent of the time they report that they've never received our request. But because they don't have a very good intake process, we don't have any way, besides our fax confirmation that it went, for us to say, well, it was sent 15 days ago.

SENATOR RIEPE: So at the same time you might have a patient that's missing out on therapy...

VICKY McHUGH: Our clients...

SENATOR RIEPE: ...or you're providing the therapy on the come that you're going to get paid.

VICKY McHUGH: Correct. Right. And we found out that WellCare does not. Nebraska Total Care will give us authorization based on our dates that we're attempting to see them, not on the time frame of the clerical process. WellCare does not. They approve, like if I evaluate a client on September 1, my paperwork goes in on the 7, they approve it on the 10, the authorization starts on the 10. So I can't even in good faith know...have confidence in my medical assessment and our process to be able to say, let's just see them and we'll probably get authorization, because their authorization doesn't cover services until they approve it.

SENATOR RIEPE: Of course. Okay. Senator Williams.

SENATOR WILLIAMS: Thank you, Chairman Riepe. And thank you for being with us and sharing this information. If I'm remembering what you said correctly, you've been in the private physical therapy business for about 11 years.

VICKY McHUGH: Yes, sir.

SENATOR WILLIAMS: And your business model in your current operation is 37 to 38 percent Nebraska Medicaid people.

VICKY McHUGH: Yes.

SENATOR WILLIAMS: And that business model has been a successful business model for your physical therapy up until...

VICKY McHUGH: Up until recently.

SENATOR WILLIAMS: ...January.

VICKY McHUGH: Uh-huh.

SENATOR WILLIAMS: Okay.

VICKY McHUGH: It has. It is...

SENATOR WILLIAMS: So this change is making you rethink whether you can serve this group of patients.

VICKY McHUGH: It is making it cost-prohibitive to continue to be able to.

SENATOR WILLIAMS: What I'm hearing from private providers in my legislative district is the fact that they are now making a decision to get out of this part of the business because (inaudible).

VICKY McHUGH: There's no one that supports my business model (laugh), besides me. When my accountant looks at it, when my banker looks at it, when anyone looks at this it's a clear decision that should be made. Our speech services are reimbursed at anywhere...it's like (inaudible).

SENATOR WILLIAMS: Well, it's certainly part of our goal to be sure that the state provides the opportunity for a business model like this to work. Okay?

VICKY McHUGH: Well, thank you.

SENATOR WILLIAMS: You also talked about I think that there was a clear difference between the providers that you're dealing with at this point.

VICKY McHUGH: Yes, sir.

SENATOR WILLIAMS: I wanted to be sure that I understood that. So at least one of those providers seems to have turned the corner.

VICKY McHUGH: Their process has been renovated and it's substantially improved.

SENATOR WILLIAMS: And so it is possible,...

VICKY McHUGH: Yes.

SENATOR WILLIAMS: ...you believe.

VICKY McHUGH: Oh, I think so. Yes.

SENATOR WILLIAMS: If those organizations would devote the time and energy that you're devoting to filing or to making your part work, maybe it would work. Thank you. That was my only editorial comment of the day...so far.

VICKY McHUGH: I appreciate it though.

SENATOR RIEPE: Is there any way for you to take that successful model and constructively take it and say, this is the model I have with XYZ, (inaudible)?

VICKY McHUGH: It's not my model but, yeah. I mean that's...

SENATOR RIEPE: But it's a model that you say is working and that's what we're looking for is things that work.

VICKY McHUGH: Certainly. I would welcome an audience.

SENATOR RIEPE: Okay. Well, we'll leave that up to you. Good luck and...

VICKY McHUGH: Well,...

SENATOR RIEPE: Okay. Thank you very much. Thank you for being here. Thank you for sharing your story.

VICKY McHUGH: Thank you.

SENATOR RIEPE: Others? Please come forward.

TIM GOODLETT: Thank you all for your time.

SENATOR RIEPE: If you'd share your name and your organization...

TIM GOODLETT: Yes, sir.

SENATOR RIEPE: ...and (inaudible) begin.

TIM GOODLETT: My name is Tim Goodlett. I'm the president and COO of Total Respiratory and Rehab, and I wanted to clarify a couple of things. One, we were working with the MCOs since January up until August when a deadline was missed when they told us they would have certain things corrected. That's what prompted us to go to the state hearing with Rocky at that time. And, honestly, we didn't know what to do. You know, we didn't know what process to follow to try to get this corrected. We never had this happen. So we tried to work with all the MCOs up until that deadline was missed on August 1. So we then went to that hearing and after that, since we were at the...near the Capitol Building, we went and saw Senator Linehan because she is...Jon is in her district and...

SENATOR RIEPE: Sir, would you give us your name and spell it for the record?

TIM GOODLETT: Oh, yes, sir. T-i-m G-o-o-d-l-e-t-t.

SENATOR RIEPE: Thank you.

TIM GOODLETT: And we had been working with the Midwest Medical Area Equipment Suppliers Association, who has been in contact with, I believe, the state on several of these issues. The bulletins that we were looking at, the first one issued April 6, had stated that the MCOs are to follow the appropriate Medicaid supplier chapter and they are to pay according to the maximum allowable rate on the DME medical equipment supplies fee schedule whether the facility is in or out of network. Now since that time some of these payments have started coming through from some of the MCOs. Nebraska Total Care and WellCare recently are making significant improvements, is starting to do things correctly. Mind you, all this equipment for these facilities has prior authorizations. This is equipment that they have approved to be paid, but due to system issues they were not able to process the claims. Recently, we have also started receiving some payments from UnitedHealthcare. However, they're sporadic and they're not paying correctly, according to the health plan advisories that were issued, the first of which was April 6, the second...which was, I believe Calder Lynch, and the second of which was August 15, which was issued by Rocky. So they state the fee schedule amount that they're supposed to

follow. They state the appropriate supplier manual that they are supposed to look at for coverage criteria. And Total Care and WellCare have been following these health plan advisories. But the problem we are having right now and the biggest point of contention that we have with UnitedHealthcare is that I believe they don't think that this applies to them. So that...or they're having system issues with the payments. But on the coverage criteria, we have met with their senior leadership and it's...we have been told that they believe there is other...they have the ability to create other criteria. The problem with that is that, for one, it is much more stringent than Medicaid, it is much more stringent than Medicare. We are a huge Medicare provider. We provide multiple complex chairs that require prior authorization through Medicare. We submit them. They're approved all the time with similar documentation. We recently had a patient that was a quadriplegic. They overturned it yesterday, right prior to this hearing, and approved it after I had a meeting with all their medical directors and pointed everything out. But it was denied when I feel it should never have been denied. And this happens a lot. It takes a ton of our staff's time to fight this, the physical therapists, the doctors that have given the necessity documentation. It's because the bar has been set so high for the criteria that you...there's no way to possibly document everything that they would want to see. It has been set that high. Medicare is here, theirs is here. Medicaid's was lower, I'll admit. Medicaid's criteria was less than Medicare's, but even when documenting to Medicare standards, this equipment for patients with MS, quadriplegia, paraplegia, you name it, it is still getting denied and we're having to fight tooth and nail to get them what they need in order to get around, ambulate, prevent pressure sores, and it's just be a huge burden on our entire staff. So we need some guidance as to what rules they should be following so that we know the game, the doctors know the game, the therapists, because a lot of them are very irate about this and the fact that they feel they've given every reason for the necessity of this and it still continues to deny. So we just need some clarification on that as well as the sporadic and inconsistent payments, one of which for a facility was 14 percent of the Medicaid fee schedule just recently. So we need all this clarified, so.

SENATOR RIEPE: That said, and my understanding is that United is seeking clarification from the Department of Health and Human Services. That would be Mr. Thompson probably. Is that your understanding that they are? And is there any time line when they think they'll have resolved to more clarification? May or may not be to your satisfaction, but at least they'll have an answer.

TIM GOODLETT: They did tell us yesterday that they are seeking clarification. I have no idea on a time line or time frame.

SENATOR RIEPE: Okay.

TIM GOODLETT: But I am curious how does that affect past things when we were operating under what we thought was a health plan advisory that the other two MCOs are following but they are not. And the first of which, like I said, was issued in April of this year; the second of which that says the exact...pretty...well, I won't the exact same thing, pretty much the same thing regarding those two issues was issued again in August reiterating what was already said in April. So even...

SENATOR RIEPE: Well, once clarification is in place then it might say, and it should have been back then and you should have the potential at least of having some recourse to claim some of the money that you're owed.

TIM GOODLETT: Yes. Yes, sir. And please understand, if I would have known that we should have come to you guys initially to get this going or to Rocky first, we would have done that. But the first thing we did was try to work out these issues directly with the MCOs diligently. I can show you...

SENATOR RIEPE: That's (inaudible) that's good. That's the right place.

TIM GOODLETT: I can show you piles of notes from our billing department, phone calls, everything that we have done to try to get this resolved with them. And after it failed, because they gave us a dead...one of them, I won't say which, gave us a deadline of August 1. That's when we went on to the state. So I want you to understand that, that we've been diligently...

SENATOR RIEPE: And in fairness to you, there's the question of how much time do you stay at the MCO before you move to the Medicaid central division, Rocky.

TIM GOODLETT: Yes, sir.

SENATOR RIEPE: That's a judgment call and it's probably never the same. But, okay, other questions from the committee? Seeing none, thank you very much. Thank you.

TIM GOODLETT: Thank you all for your time. Appreciate it.

SENATOR RIEPE: Welcome. If you'll state name and organization.

MARY WALSH-STERUP: My name is Mary Walsh-Sterup. It's spelled M-a-r-y W-a-l-s-h-S-t-e-r-u-p, and I am here representing Central Nebraska Rehabilitation Services and we provide physical, occupational, and speech therapy to multiple locations across central Nebraska. We have an outpatient in Kearney, Grand Island, Hastings, Aurora, and four clinics here in Lincoln. And first of all, I'd like to just start off by saying a payment thing that started on the 1st of January, and I'm not sure if this is a Heritage Health thing or a state issue, but recently CMS changed the evaluation codes for PT/OT and speech to incorporate a more complex evaluation and to recognize the amount of time and the information they were getting out of the evaluations for those providers. Prior to January 1, we received $65.60 for the evaluation. It was a one-time evaluation. Since January 1, the evaluations were broken up into a low complexity, a moderate complexity, and a high complexity, and all of these receive a little different rate. The state of Nebraska with Heritage Health currently on all three complexities of an evaluation, which could last up to 60 minutes, we receive reimbursement of $20.50 when previously we received for the low complexity, which was the one evaluation, $65.60. This, when we're talking about our PT colleague here that was talking about making it cost-prohibitive for us to see these patients, it starts with the evaluation. The next issue I want to address is, interestingly, is also the authorization process. The good side is we have made leaps and bounds with all three MCOs. I can tell you that the people that work directly, locally here with the MCOs are great people. We have reached out to them. They are very willing to work with us. They have, I believe, attempted to work with us to make things happen. The problem that we are seeing is specifically with authorizations. We, too, acknowledge that Nebraska Total Care has changed their process and it has made a huge difference for the patients that we see. And I think that's probably the biggest thing that I want to echo today is it's not necessarily about me as a provider but it's about the patients that we see and their families. We are a fairly large provider and in our pediatric division alone we currently have 61 patients on WellCare. I could not go back through and find a claim

where we saw an authorization on WellCare and we received what we asked for. How this works is a physician sends a prescription to our clinic and says they want this child to be seen, or an adult, they want this person to be seen X number of times over this many weeks. We complete the evaluation. We request a treatment plan. I cannot find a treatment plan where they gave us the number of visits that we asked for. I'll give you some examples in real numbers. We have an infant with torticollis. The physician ordered therapy twice a week over an eight-week period of time. We requested eight visits to start with. We were given two visits in eight weeks. We had another, an anoxic brain damage syndrome child that we had orders to receive therapy two to three times a week over a six- to eight-week period of time. We requested 24 visits. We received eight visits over a two-month period of time. We had a complex pinning of an elbow for a subcondylar fracture. The prescription from the physician was for three times a week for four to six weeks. We received eight visits in four weeks. We don't feel like we can provide the care that is necessary for these patients with the limitations that they are giving us. They'll tell us in the authorization process that the patient needs to do it on their own at home and we can provide you with stacks of documentation that say 50 to 70 percent of the patients don't do it at home. And with these kids, is it fair to say that they should do it on their own at home? We can also provide you stacks and stacks and stacks of documentation that say outcomes are better with structured therapy completed in the manner as prescribed. And I have a lot more examples. And I apologize, I'm new to this so I didn't know that I was supposed to bring a little sheet but I'll bring one next time.

SENATOR RIEPE: It's okay. We have plenty of reading.

MARY WALSH-STERUP: Okay.

SENATOR RIEPE: I guess my question would be do you have physicians or providers that simply say tell me what your professional assessment is as to what--I'll pick a child--what this child needs? You, I think in your testimony you said like six times, but my sense is, as the professionals in the arena, you probably have a clearer idea as to what it's going to take for this child or this adult...

MARY WALSH-STERUP: Right. Right.

SENATOR RIEPE: ...than maybe the physician does.

MARY WALSH-STERUP: Right. And that's true. And so what we do in a situation like that is we look at the doctor's referral and a lot of times we understand it is a big picture and it's a cost picture. And sometimes with a Medicaid it's a, you know, getting them to therapy picture. So a lot of times we'll say, okay, the doctor said three times a week, but we think if you continue these and we think with where you're at you can get by with once or you can get by with twice, we try...

SENATOR RIEPE: Or need more.

MARY WALSH-STERUP: Yeah, or you need more. And then we go back to the doctor and request that. Correct. With Evicore, with WellCare, it doesn't matter what we say. They're going to cut it in half or less, doesn't matter.

SENATOR RIEPE: Hmm.

MARY WALSH-STERUP: There are...and let me clarify that. There are a couple instances where we were able to do a peer to peer, which is almost like doing this with WellCare, where we've had to set up a time, take outpatient care, take our therapists away from patient care and have them basically dialogue back and forth with somebody in another state trying to decide whether that person said that they can approve therapy. And we've had a couple times successes with that with a peer to peer, but the administrative burden on us to do a peer to peer to get four visits and two months later do another a peer to peer for the $20.50 we're getting, it...we can't continue to operate.

SENATOR RIEPE: Okay. Senator Linehan.

SENATOR LINEHAN: Just...thank you, Mr. Chairman. Just clarification: So you don't have this problem with the other two providers.

MARY WALSH-STERUP: No, we've made leaps and bounds with the other two providers, correct, yeah.

SENATOR LINEHAN: So you did have problems but they...

MARY WALSH-STERUP: We had some more problems initially. I think everything just was like upset the applecart in January, and so no one really knew what was going on. And so we've been able to figure it out and, to Total Care's credit, you know, they realized it was a problem and so they changed their system and they now have this bucket of authorizations you can draw from.

SENATOR LINEHAN: Okay. Thank you very much. Thanks for being here today.

MARY WALSH-STERUP: Uh-huh. Okay.

SENATOR RIEPE: Thank you. Thank you very much. Others? If you can testify, please come forward.

BRIAN BRUNKEN: I have been here before and I forgot my handout, too, so I apologize.

SENATOR RIEPE: That's okay. If you'd be kind enough to give us your name (inaudible).

BRIAN BRUNKEN: Sure. Brian Brunken, B-r-i-a-n B-r-u-n-k-e-n. I represent the Nebraska Physical Therapy Association. I am their reimbursement chairperson for this committee. I thank many of you for attending our legislative breakfast that we have every February and the time to speak today. I'm also a private practitioner. I own my own clinic. I have two clinics, one in Gretna and one in Omaha. I have not been affected as adversely as some of these previous speakers as far as the amount of monies that we're talking. However, I just want to bring up that last July I had a representative from Total Health Care come to my clinic, provide a contract. We completed it and assumed, erroneously, that everything was correctly filled out, had no conversations again until November, and then we just checked to see if everything was acceptable and found that we had filled out the wrong application. And I will not bore you with the retails but it was for a single provider and we have multiple providers at our clinics. Filled

that out in early November, got that back within two days, did not hear anything again. In January, we received a contract, had it sitting right by me. We did not have a Total Health Care patient until June of this year. Tried to get authorization. Found out we had no contract, no NPI number, anything was recognized in the system. It's very difficult to contact somebody and it wasn't until my office manager billing specialist spoke to our neighbor who provided a name to speak with somebody at Total Health Care specifically, and we have then had multiple phone calls and e-mails to try and get this contract situation taken care of. I took it upon myself last week to start calling two different people--I do not want to mention names--at that company and e-mail. And finally I still have not heard anything. And then two days ago I called a supervisor through their 800 number and it was...now we have a contract in place as of September 20. So I feel like July through September, that is just an inordinate amount of time even though I've just had two patients now that...so it does not affect me, like I said. But it's frustrating. We don't know whom to call, can't get ahold of anybody, nobody answers our phone calls or our e-mails. I do want to commend Rocky and his staff. He has met with me and Julie Peterson, the president of the Nebraska Physical Therapy Association. He and his staff were more than willing to listen to our concerns and we do have another meeting set up in December where we will go over the evaluation codes, as previous speakers have told you. And I have not been to the last quarterly meeting but, as you know, $65 was...approximately $65 was the reimbursement in 2016 and now we're $20. I primarily do see outpatient patients and I have had zero patients that fit the high complexity code in my clinic this year...or my clinics this year. And I've had four that have met the moderate. So low number, but if we were to take that across the board, the majority of what we see is low complexity, so we're talking the reduction from $65 to $20. I realize there's a budget shortfall. We're privy to this information. But we're the only state that's doing this until just recently that Colorado has now decided or will soon do striated payments as well. As far as WellCare goes, both clinics were audited in person, very nice woman by the name of Sara Meyer (phonetic). We were told that we needed AEDs in both clinics. I have come to find out after those visits that I do not need the AEDs. Three to four thousand dollars later, I now have two very nice shiny AEDs but did not need those. Could not get an answer on whether or not we needed those. Were told that all five of my providers were in network and everything was also accepted. And then we finally had a patient from them determine that only two of my providers were actually credentialed with WellCare. And it just so happened that one of those three that weren't was...she saw a patient in February. So didn't find that out till much later; consequently,

didn't get paid. Frustration as far as those things go. That is really about all I have. I have one more thing I want to present. We did a survey of all of our Nebraska Physical Therapy Association members. Got about a 29 percent response on the survey in...we had several questions, we had ten, but the one that I want to highlight is that as of April 26, 73 percent of the people that responded had no idea that the reimbursement rates, if we go back to the codes when we were talking about the $65 to $20 reduction, 73 percent of those respondents had no idea that it had been reduced by that much. And we're talking already four months into the year. That's all I have and I thank you for your time.

SENATOR RIEPE: Okay. Thank you. Other questions from the committee members? Seeing none, thank you very much.

BRIAN BRUNKEN: Thank you very much.

SENATOR RIEPE: Are there other individuals who are going to...come forward, please. If you'd be kind enough to state your name and spell it for us, please.

CONNIE BARNES: (Exhibit 8) You bet. Thank you, Senator and everyone here. My name is Connie Barnes. I'm the executive director...oh, you want me to spell my name. C-o-n-n-i-e B-a-r-n-e-s.

SENATOR RIEPE: Thank you.

CONNIE BARNES: I'm the executive director for Behavioral Health Specialists in Norfolk, Nebraska. We have operations based on Norfolk as well as in the Columbus community. At the last hearing, I testified but I probably looked tremendously different because I wore a wig. And I am a breast cancer survivor and so this is chemo hair, so. And I just need to say that to get that out of my head so I can focus on this. So our agency is currently owed $165,000 in total from the three MCOs. Thirty-five percent of that $165,000 is over 120 days old. With Nebraska Total Care, we currently have $83,000 in outstanding claims, $44,000 which is over 120 days. We have had very improved service from Nebraska Total Care. Not everything is fully worked out but we're working really hard with them to get there. With that, we have received overpayments

from them and so we're working with them to get that straightened out with them and we have two short-term residential addiction treatment programs that we operate. One is in Norfolk. One is in Columbus. The one in Norfolk is 16-bed. The one in Columbus is 25-bed. And it is...and so that service is called short-term residential. And by Nebraska Total Care, those claims are largely being paid but we've not received payments for our care out of our Columbus-based facility. Also in that realm of our service provision for residential addiction treatment services, we have an issue with WellCare in terms of the length of time that it takes for them to provide authorization. When individuals qualify for and are in need of short-term residential, beds are hard to come by. And so when a bed opening comes and we want to be timely in providing life-saving care for them as they're facing their addiction and, you know, seeking to be well and healthy and fully in recovery, we don't delay. We're experts (laugh) and have been experts for a very long time on addictions work, and we know what qualifies folks for short-term res. and we don't ever take anybody in that doesn't qualify for that level of care. And so just recently we yet again encountered where it wasn't until day seven that they responded with an...or that they replied to our call-in seven days earlier about admitting this individual, and they denied. We made contact with them again and the gal that works for them said, oh, gosh, yeah, you know, ask for another...yet another peer-to-peer hearing because you'll get a different doctor and a different response. Now that's just not okay. That's not the way any of this should ever work. It should be done based off of the info that's there about their addiction treatment needs, their health needs, etcetera. So...and it just happened that yesterday WellCare had set up an appointment, a telephone appointment with my business office manager and they specifically asked that I be present because they had heard that I had filed a complaint. And so that came up in the conversation and I said I absolutely did and I will again (laugh) because we still have unresolved items. And we are grateful, though, that on the part of WellCare they identified that they have grown their staff larger so that they could keep up better with what's occurring. And so we have a specifically assigned individual now to work with us and so we're appreciative of that. WellCare is the entity that pays at the slowest rate out of the three MCOs. With UnitedHealthcare, you know, we've got $20,000 outstanding. We don't have any known issues with them. Our claims are filed timely. We're paid timely. We're appreciative of their efforts. Kind of back to discussing WellCare for just a little bit, we've...we just have a lot of different issues that are going on, and so I bullet pointed those. And I know that when you're not a provider in the field that I'm in, some of what I've written might not just kind of let you fully know what all of some of those items are.

But you know we do know that it takes a much longer period of time for us to receive payment from WellCare than it does from others. And for many months we weren't able to get anyone to return calls or respond to our e-mails at all. And we had put in specific calls to the director of WellCare and still have not received a phone call back, and so that was more than four weeks ago.

SENATOR RIEPE: Okay.

CONNIE BARNES: I do want to note that there are some crossover issues that aren't just about the MCOs, so the Division of Behavioral Health, alongside Medicaid managed care, there's this crossover to what's called the CDS system. And we're working really hard through the discrepancies for clients who show as Medicaid managed care eligible who are not, as well as those who are not showing as Medicaid managed care eligible who are in fact eligible. And so that's not, per se, on the MCOs but it's a system issue nonetheless.

SENATOR RIEPE: In fairness to others, can you kind of wrap it up?

CONNIE BARNES: Pardon me?

SENATOR RIEPE: Can you, in fairness to other testifiers, your red light is on.

CONNIE BARNES: I have completed, so thank you.

SENATOR RIEPE: Okay. Thank you.

CONNIE BARNES: Yes.

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

SENATOR LINEHAN: Thank you, Mr. Chairman. I just want you to clarify. You said you registered a...I'm sorry, I wrote it down. I thought I wrote it down. Did you file a complaint?

CONNIE BARNES: Yes.

SENATOR LINEHAN: Is that what you said?

CONNIE BARNES: Uh-huh.

SENATOR LINEHAN: Did you feel like there was pushback from that? What were you saying there? Can you repeat what you said?

CONNIE BARNES: There was the hint of it in the telephone conversation. The telephone conversation yesterday, there was certainly a hint of that, yes.

SENATOR LINEHAN: Okay. Who were you talking to?

CONNIE BARNES: I don't have her name, sorry.

SENATOR LINEHAN: (Inaudible) MCO or...

CONNIE BARNES: No. It was a WellCare rep that's assigned to us.

SENATOR LINEHAN: A WellCare rep.

CONNIE BARNES: Yes.

SENATOR LINEHAN: Not state. Not HHS.

CONNIE BARNES: No. No, no.

SENATOR LINEHAN: Okay.

CONNIE BARNES: No, no.

SENATOR LINEHAN: I just want to clarify who we're talking about.

CONNIE BARNES: No.

SENATOR LINEHAN: Okay.

CONNIE BARNES: No, the state has been very supportive.

SENATOR LINEHAN: And it was just...there wasn't a direct...it was just you felt uncomfortable.

CONNIE BARNES: No, it was pretty direct. It was, gosh, you filed a complaint.

SENATOR LINEHAN: Okay.

CONNIE BARNES: Yes, I did.

SENATOR LINEHAN: Okay. Thank you very much.

CONNIE BARNES: Yeah.

SENATOR RIEPE: Okay. Are there other questions from the committee? Senator Howard.

SENATOR HOWARD: Can you walk me through the complaint process? When you filed a complaint, what was that like?

CONNIE BARNES: I'm not sure I know what you're asking.

SENATOR HOWARD: So what is it...did you send an e-mail? Was that how you did the complaint? Was there a form on-line? How did you file a complaint on WellCare?

CONNIE BARNES: Actually, I am a member of NABHO and I'm on the board for NABHO and so I had provided that information to our executive director of NABHO. And she submitted that

for us alongside other concerns that have been expressed by NABHO members, so that's how that went through.

SENATOR HOWARD: Okay, and that was submitted to the state or it was submitted to this committee?

CONNIE BARNES: To the state.

SENATOR HOWARD: Okay. Okay. And then the other thing is I really appreciate your bullet points, but could you help me with some of the acronyms?

CONNIE BARNES: You bet.

SENATOR HOWARD: So what's an IOP?

CONNIE BARNES: Intensive outpatient.

SENATOR HOWARD: Okay. And a CSP?

CONNIE BARNES: Community support services.

SENATOR HOWARD: Okay. Thank you.

CONNIE BARNES: Yes.

SENATOR HOWARD: I want to be able to use it in the future.

CONNIE BARNES: You bet.

SENATOR HOWARD: STR?

CONNIE BARNES: Short-term residential.

SENATOR HOWARD: And IDI?

CONNIE BARNES: Uh...(laugh).

(WOMAN FROM AUDIENCE): (Inaudible).

CONNIE BARNES: Say it again.

(WOMAN FROM AUDIENCE): Individual diagnostic (inaudible).

CONNIE BARNES: Yes, thank you. Individual diagnostic interview.

SENATOR HOWARD: Thank you. I appreciate that.

CONNIE BARNES: You bet.

SENATOR RIEPE: Any more questions? Okay. I see no more questions. Thank you very much for being here today.

CONNIE BARNES: Yes. Thank you.

TORI SORENSEN: Hello. My name is Tori Sorensen, T-o-r-i S-o-r-e-n-s-e-n. Are you ready?

SENATOR RIEPE: And you're with?

TORI SORENSEN: I am testifying today as a parent of children with disabilities.

SENATOR RIEPE: Okay. Please go forward.

TONI SORENSEN: Please go? Okay.

SENATOR RIEPE: Thank you.

TORI SORENSEN: I have three children in my care that I've adopted through the foster care system with certain levels of disabilities. I also serve as an extended family home placement for a fourth ward of the state. And all of my children have Nebraska Total Care for their management organization. And also full disclosure, I am a physical therapist and I am assisting an agency with prior authorization processes. So I am testifying as a parent but also very well aware of how this process works. First off I want to talk about the involvement I've had in trying to get things approved for my children. My eight-year-old needed to have intensive treatment at Daybreak this year and we initially had a school placement there, so a school contract paid for part of his care. But when it came into the summertime we were trying to get approval from Nebraska Total Care. It took multiple meetings, multiple phone calls. I called the Ombudsman's Office, spoke with them numerous times to get this to a process where it could get approved. It appeared that nobody knew what the rules were so you couldn't provide the right information to get approval. My child was running away. The school was calling police to come get him. He was only seven and with some intellectual disability, so it was a very unsafe environment. I'm thankful that Daybreak kept him in treatment even though they didn't know if they were going to get paid. But I also wondered if I was not as able to advocate for them if they would have been able to do that. Also, with therapy in particular, my twins, boy, girl twins, each had a request for occupational therapy this year, very similar presentation, very similar disability level, and one was approved and one was denied. I thought that was very interesting. My fourth child who is the ward that I provide extended family home placement for, he has severe needs and his therapy services were denied for a significant period of time. The process of going to try to get a prior authorization denial overturned is such a long period of time that my child was without services for a significant period. In addition, when prior authorization is approved, we have a couple of weeks to show progress before we have to ask for more visits. And for these children, progress is so slow, you know, two visits and they're asking for more information about what progress has been made but they missed the whole month of July and didn't have any therapy in that time. And I feel that's really detrimental to their ability to make progress. Also on some of the denials, my child had some significant needs that needed to be addressed by a therapist. We had a wheelchair cushion that was not working and he's developing a pressure sore on his bottom. There really isn't a mechanism to get approval for therapy services that meet that quick need

because the expedited appeal has to do with life-threatening conditions. But if the process takes two to four weeks, we're going to have an open sore on my child. So for me, the thing is, is I'm educated and I can advocate and I know what to talk about and I know who to talk to and I just really wanted to mention that we can spend a lot of money denying and trying not to get therapy and we can spend a lot of money in that way. And I'm fearing that ten years down the road we're going to see that these children are going to need out-of-home placement because they haven't gotten what they need behaviorally. We're going to have significant institutionalization and further needs as these children become adults because we're not meeting this simple thing that we can do right now to provide independence. I think that's all I wanted to say. Questions?

SENATOR RIEPE: Thank you. Questions from the committee? Senator Linehan.

SENATOR LINEHAN: Thank you, Mr. Chairman. This might not be a fair question but I'm going...

TORI SORENSEN: You can ask.

SENATOR LINEHAN: ...to ask you because it's...I'm wondering myself how does it work, the managed care organizations and the schools. You said you have an eight-year-old. Therapy at school, do they have therapy at school, because I'm thinking IDEA and they're supposed to provide...

TORI SORENSEN: Sure.

SENATOR LINEHAN: ...so and then it switches off in the summer? Just kind of explain that, how that works.

TORI SORENSEN: The specific case I was talking about was behavioral intervention, so the school provided, said we're going to pay Daybreak to have this child go to Daybreak during school hours. Then when it hit summer, the school doesn't have to provide that placement, so we went through insurance. And there was medical necessity. It took them two or three months and multiple meetings of the insurance company coming out and trying...well, put this down on

paper and then it will go through. You have to have somebody tell you what to put down on the paper though. As far as other services go, though, the school-based services that are provided generally in our public schools is a consultative sort of service. They go in and talk to teachers and say these are the things we can do to help this child. That's significantly different than the medical-based model that we practice under that you've heard testimony today. Medical-based concerns are to address...educational is simply can I access my educational environment and can I function in that setting. And medical-base covers everything else: prevention of further disease, progression of independence. We may take, say, a 13-year-old who can walk in their home but they can't get between classes. So the school-based therapy might give them a wheelchair and say, here, you can get between your classes with the wheelchair. But medical-based, we still want to work on meeting that full potential and walking. So often there is a huge gap in what medical...or what educational services can provide.

SENATOR LINEHAN: And is there anybody that works between those two gaps? Is there somebody...? That's what I'm afraid you're going to answer is, no, that there's nobody like in the school system that looks out ahead and says, well, what's going to happen to this kid in the summertime,...

TORI SORENSEN: No.

SENATOR LINEHAN: ...except for the parent. And to your point, if you're educated, you know where to go for services...

TORI SORENSEN: Right.

SENATOR LINEHAN: ...is one thing, but if you don't, it's all different.

TORI SORENSEN: Right.

SENATOR LINEHAN: Okay. Thank you very much. That's helpful to me. Appreciate it.

SENATOR RIEPE: Senator Howard.

SENATOR HOWARD: Thank you. Thank you for visiting with us today and thank you for taking care of all of these children. It's really incredible.

TORI SORENSEN: Crazy.

SENATOR HOWARD: I wanted to talk a little bit about your child who is still a ward of the state because I want to make sure, and this really hasn't been a part of the conversation, but how this MCO transition has impacted children who are wards. You're actually one of the first people who's really talking to us about that. And what's great is that you can give us sort of a comparison between kids who are under permanent placement and kids who are still wards. Have you seen a difference in working with the MCOs in that regard?

TORI SORENSEN: Nebraska Total Care was very quick to get us on case management, which I did push for and I do think that was helpful. They're actually coming out quarterly now to assess all of my children. I love that Nebraska Total Care also took all of my children and put them with one case manager. Their involvement with the state isn't significant but I did attend a webinar that they said that they could even attend. IEPs was a specific that they're offering, kind of an intellectual disability, developmental disability team. And so I think they're definitely working into that realm. I do think there's a big gap with foster care. And even as a treating clinician, I am trying to juggle. I do talk to the school therapist and trying to juggle what my role is to help guide the foster care system as to what's appropriate for these children from a physical therapy mind-set.

SENATOR HOWARD: Uh-huh.

TORI SORENSEN: This is not related specifically to this panel but I do also want to point out that this child has reached a level of permanency but we are at a standstill because he's on the infinitely long waiting list for list of unmet needs.

SENATOR HOWARD: Okay.

TORI SORENSEN: But I don't know that that's specifically what your committee is dealing with.

SENATOR HOWARD: Not today but that's all really relevant.

TORI SORENSEN: Yes. So as far as insurance goes, it doesn't seem like there's a gap, but I would encourage you that we're the stopgap to prevent further problems from happening, to help these kids be successful in an environment. And if they don't get the therapy that they need and it's not consistent, we're causing a lot of harm that will cost us a lot more ten years down the road. I can say that from personal experience. (Laugh)

SENATOR HOWARD: Well, thank you so much for what you do.

TORI SORENSEN: Thank you.

SENATOR RIEPE: Thank you very much. We appreciate it. Other people who want to testify?

JACQUELYN MEYER: I had my secretary bring all my stuff and she put names on and that won't work, so I will send you...this is going to be very, very short. My name is Jacquelyn Meyer, J-a-c-q-u-e-l-y-n, Meyer, M-e-y-e-r. I am the director of Counseling and Enrichment Center, which has offices in Norfolk, O'Neill, Kearney, and we are a very small organization. I have therapists in those offices and so we aren't very big. So even though we are in geographically different areas, we're very small. So our amount that we're not getting paid in six-months' time is like $3,000 or $4,000. But I thought at the end of the day, you needed to hear this because this is kind of almost funny. My secretary, business person sent a note off on August 8 concerning the complaints all of these six or ten, over for all the information. That was 8. On August 28 she said I mailed...e-mailed Marianna (phonetic) to see if these complaints had been taken care of. So she called back on August 29 saying that the claim issues...wanted to know what was going on. I responded that nothing had been taken care of and she said she had a list of all the claims that would follow up with that day. Okay? Now that was August 29. On September 6 my gal called back again, asked if she was following up on this. And her comment at that time, she stated they were very busy and backed up and hadn't been able to get to it. As of today,

nothing has been done, and that was yesterday. So we're talking...first of all, she had nothing since March. Then in September we're going, and this is a comment, this Total Care, and I'm so busy, I just can't do anything. So just very simple at the end of the day. Even though we're a very small company with only $3,000 or $4,000, that's a lot of money to us and in comparison to the rest. And this kind of comment is just totally uncalled for: I'm very busy. Well, so are we and it's our life. And they need to look at that. So these are probably training (inaudible). That would be it for me right now. And I will send other things as we go on, on this.

SENATOR RIEPE: Thank you.

JACQUELYN MEYER: You bet.

SENATOR RIEPE: We'll see if there's some questions here. Senator Howard.

SENATOR HOWARD: Thank you for thinking of us. What's your plans on...

JACQUELYN MEYER: Pardon me?

SENATOR HOWARD: ...they don't do anything? (Inaudible).

JACQUELYN MEYER: They don't do anything. That's what she said. She stated that they were busy and backed up and hadn't been able to get to it.

SENATOR HOWARD: So do you plan on...

JACQUELYN MEYER: This is since March.

SENATOR HOWARD: ...just eating the loss? Like what's your plan?

JACQUELYN MEYER: Well, we'll just keep on it, you know,...

SENATOR HOWARD: Okay.

JACQUELYN MEYER: ...just keep doing it and keep calling them back and calling them back. But the first one on this list was the 17th of March.

SENATOR RIEPE: Which managed care was this?

JACQUELYN MEYER: This particular one was Total Care,...

SENATOR RIEPE: Okay.

JACQUELYN MEYER: ...but we have some on this list that were from UnitedHealthcare too. That's what I'm noticing on this. It's not just one of the companies. It's kind of equal opportunity not getting it done. So...

SENATOR HOWARD: Thank you.

JACQUELYN MEYER: ...just at the end of the day, you needed to hear this: I just don't have time, so. (Laugh)

SENATOR RIEPE: Okay. Any other questions? Thank you. Are there others that want to testify? Last chance. If not, Mr. Thompson.

THOMAS "ROCKY" THOMPSON: Thank you again, Chairman Riepe and members of the HHS Committee, for having me. Much of what you just heard this afternoon are issues that my staff and I are familiar with and are actively working with the providers and the plans to resolve as...at least the ones that are still open. As you heard, many of the issues have been resolved and some of these issues are still ongoing that we are working with these specific providers to take care of. I want to ensure that our state's most vulnerable populations receive the care that they're entitled to and my staff will work endlessly to ensure that. So I know there was a lot covered today and we will follow up with specifics about each provider that was raised today. But if you have any questions for me, I'm happy to address those.

SENATOR RIEPE: I have a question right off and that is do you have a process to formally accept and work through that with providers and members if they have a point when they feel like they have gone as far as they can maybe with the managed care organization...

THOMAS "ROCKY" THOMPSON: Well,...

SENATOR RIEPE: ...when they turn to you and say, we've done everything we can here, what can we do now?

THOMAS "ROCKY" THOMPSON: I think you heard today that the providers that have come directly to me, we are working with and we are trying to resolve their issues. There's also the formal grievance procedure that's outlined in the manuals and the appeals procedure, and then there's also the state fair hearing that they can go to after the appeals with the managed care organizations.

SENATOR RIEPE: Okay. I also see that you have a Web page here or e-mail at HeritageHealth@Nebraska.gov?

THOMAS "ROCKY" THOMPSON: The e-mail is for...on any issues and I am on that mailbox also, so those issues do go to me also. They can e-mail me at Rocky.Thompson@Nebraska.gov also. I respond to those. And also we have the specific procedures that are outlined on our Web site. There's a considerable amount of information we are working through trying to make that more user friendly. We would love your input also in how to make it more user friendly.

SENATOR RIEPE: Okay. Senator Howard.

SENATOR HOWARD: Thank you. I wanted to go back to the COBA. For the overpayments that have occurred or are occurring currently, how are those being handled right now?

THOMAS "ROCKY" THOMPSON: Thank you, Senator. When they are identified, I know that the plans have requested for that over...those overpayments to be returned.

SENATOR HOWARD: But to the...from the provider?

THOMAS "ROCKY" THOMPSON: Correct,...

SENATOR HOWARD: Okay.

THOMAS "ROCKY" THOMPSON: ...because the plans cannot identify those.

SENATOR HOWARD: Sure. And remind me how our capitated payments to the managed care companies are decided.

THOMAS "ROCKY" THOMPSON: We work with our actuary, Optumas, to determine the utilization and the acuity of the patients, and the rates are decided that way.

SENATOR HOWARD: So when we look at utilization, are we only looking at the clean claims that have gone through?

THOMAS "ROCKY" THOMPSON: We are looking at the services provided to our members, so, yes, ma'am.

SENATOR HOWARD: Just clean claims. So if we had a large group of unclean claims or claims that had not been paid out by providers, then the cap rate would be lower?

THOMAS "ROCKY" THOMPSON: That would be correct. So it's in their interest to get these claims paid in their system.

SENATOR HOWARD: And so when we talk about the cap rate being lower in the last quarter and saving us, it was a percentage lower (inaudible)?

THOMAS "ROCKY" THOMPSON: It was a percentage lower but that was based on claims data from last year.

SENATOR HOWARD: From 2016?

THOMAS "ROCKY" THOMPSON: Correct. Yes, ma'am.

SENATOR HOWARD: So the MCOs are being paid on the claims data from 2016...

THOMAS "ROCKY" THOMPSON: Yes, ma'am.

SENATOR HOWARD: ...when they were being paid timely?

THOMAS "ROCKY" THOMPSON: I would say that a lot of...I would not say that a lot of the claims are being paid untimely. I think you saw data today that shows that claims are being paid timely. I would say that issues with managed care, there are always going to be some issues that we are trying to resolve and we are trying to resolve any systemic issues, and most of those are resolved. And the issues you heard today are mostly provider specific that we are dealing with.

SENATOR HOWARD: So the cap rates, when will we release their capitation payments?

THOMAS "ROCKY" THOMPSON: The next cap set will be in January 2018 (inaudible).

SENATOR HOWARD: And what will that be based on?

THOMAS "ROCKY" THOMPSON: That will be based on the claims data from the first half of this year.

SENATOR HOWARD: Of this year. And so do you believe that they'll be lower because we haven't...we have these providers who have such large amounts in arrears?

THOMAS "ROCKY" THOMPSON: I do not believe so.

SENATOR HOWARD: You think that the cap rate will go up?

THOMAS "ROCKY" THOMPSON: I think the cap rate will go slightly up but not a large amount.

SENATOR HOWARD: What do you attribute that to?

THOMAS "ROCKY" THOMPSON: I attribute that to just the cost of healthcare. It always increases.

SENATOR HOWARD: Overall. So you think it will go up slightly based on the cost of healthcare.

THOMAS "ROCKY" THOMPSON: Yes, ma'am.

SENATOR HOWARD: Okay. Great. Thank you.

SENATOR RIEPE: Is that formally indexed or is it just (inaudible) assessed (inaudible) increases?

THOMAS "ROCKY" THOMPSON: We actually built that into our budget so we anticipated...

SENATOR RIEPE: But it's not an economic indicator (inaudible).

THOMAS "ROCKY" THOMPSON: Right. We anticipated that would happen.

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

SENATOR CRAWFORD: Thank you, Senator Riepe. And thank you, Rocky. What could the department do to shift the burden on these overpayment situations from the provider back to the MCO?

THOMAS "ROCKY" THOMPSON: I...thank you, Senator. I would say that we need to get those COBA agreements approved by CMS so we can make sure that we won't have the overpayments

in the first place. And that the providers have identified provider...the plans have identified providers that are receiving these overpayments and they're working with them individually.

SENATOR CRAWFORD: It sounds like the providers are having to bear the burden of addressing that issue. Is there any way that we can reverse that, any way that we can take that burden off of the provider? I know you said so you're hoping that many of them will go away as soon as you get the COBA done. But correcting that situation, is there anything the department can do and the department can have the managed care organizations do to address preventing the provider from being the one who bears that burden?

THOMAS "ROCKY" THOMPSON: I would say it's difficult because they cannot identify any over...we can identify providers that are receiving overpayments and provide information to them.

SENATOR CRAWFORD: The MCO cannot or you cannot?

THOMAS "ROCKY" THOMPSON: The MCO cannot.

SENATOR CRAWFORD: The MCO cannot.

THOMAS "ROCKY" THOMPSON: Correct.

SENATOR CRAWFORD: Cannot identify who's getting an overpayment.

THOMAS "ROCKY" THOMPSON: They don't have the information from Medicare on that (inaudible).

SENATOR CRAWFORD: So they're not sending a statement to the providers.

THOMAS "ROCKY" THOMPSON: They are but they cannot identify that those are overpayments. And it's the providers are the identifying those overpayment issues.

SENATOR CRAWFORD: Okay. So the providers are responsible for identifying the overpayment and responding.

THOMAS "ROCKY" THOMPSON: That's correct.

SENATOR CRAWFORD: And the managed care organization doesn't have a way of knowing that.

THOMAS "ROCKY" THOMPSON: Not at this point without the COBA agreement.

SENATOR CRAWFORD: Okay. Well, we had someone who showed us their statement,...

SENATOR HOWARD: We have a statement.

SENATOR CRAWFORD: ...their statement that had all of these overpayments and some...another testifier said that they were being paid and then...paid over and then that was pulled, paid again. So it sounds like...

THOMAS "ROCKY" THOMPSON: I think those are different overpayment issues than the one identified with the COBA agreement.

SENATOR CRAWFORD: So the overpayments are not just tied to COBA.

THOMAS "ROCKY" THOMPSON: That's correct.

SENATOR CRAWFORD: Okay. So it's not the case then that when we address COBA we address all the overpayment issues. It's still going to be an issue.

THOMAS "ROCKY" THOMPSON: There's still some overpayment issues that we are trying to resolve.

SENATOR CRAWFORD: Right. Right. So I guess I'd just come back to the situation of how we can put the burden of addressing the overpayment situations back on the managed care organizations instead of the providers.

THOMAS "ROCKY" THOMPSON: That...and when we identify that there are issues with making accurate payments, we are resolving those issues. And we...and as a state agency, being the contract manager for these plans, we expect accurate payment. And the overpayments, that's not an accurate payment so we're expecting that to be taken care of.

SENATOR CRAWFORD: Right. But it sounds like then they're turning and having the providers correct it manually, is what we were hearing in the testimony today. So I would just ask if we could consider a way that the managed care organizations could be pressured to address the situation in a way that's less burden on the...

THOMAS "ROCKY" THOMPSON: I understand and we don't want to burden the providers with making these reconciliations. And there are specific reasons why an accurate payment is made and we are dealing with those one by one with each provider and with our managed care organizations. We expect accurate and timely payment.

SENATOR RIEPE: Go ahead.

SENATOR CRAWFORD: So I guess I would like just to continue that conversation. And maybe there's not a resolution that you can think of today, but it just seems that's a critical issue of keeping that burden of correcting the situation being on the provider.

THOMAS "ROCKY" THOMPSON: I agree.

SENATOR CRAWFORD: Yeah.

THOMAS "ROCKY" THOMPSON: We don't want to have any more administrative burdens on the providers than they already experience.

SENATOR CRAWFORD: Right.

THOMAS "ROCKY" THOMPSON: You know we have our Administrative Simplification Committee trying to deal with these issues and this is now another issue that we want to resolve. Many of these inaccurate payment issues have been resolved, some have not, and we are working on resolving all of them.

SENATOR CRAWFORD: So I'd say when I'm listening to what we heard today, I think one of the other...I know we've addressed many of the systematic issues. And I appreciate your work on trying to address those one by one and turn many of those around. It sounds like one that we still have not addressed, need to work on, is making sure that providers who receive delayed payments receive interest on those payments. So we heard that some of the systems are set to kick in with that as an automatic in their system. But it sounds like we have a lot of complications, especially in a situation where there's a dispute about the claim, and a concern about how we make sure that a provider in that situation gets that interest payment. And the one I thought that was, you know, interesting is the one that was...the example of the testimony from CenterPointe when they had...their claims were coming in and the WellCare was saying it wasn't in the appropriate configuration. So that was probably coming in and being kicked out as an unclean claim. Then at the end of the day it sounds like they said, oh, well, the format at the beginning would have been a correct one, right? So here's this delay in payment that's not getting recognized in terms of interest payment because it probably isn't a clean claim. And so maybe, maybe that's a situation where if...probably two different situations: one where there's a situation where it's an unclean claim but not the provider's fault that there has to be some compensation; and then the others where it's a clean claim but there's a denial situation or system error. And those are all causing delays that harm the providers, so. And we heard from multiple providers that they haven't received interest payments despite delays. So I don't know what all your...can do to adjustment those interest payments.

THOMAS "ROCKY" THOMPSON: And I heard, I heard those issues with uncertainty about the interest payments from both this morning and this afternoon, and we will address those with the plans, probably through our health plan advisory, just to give some more clarity to the situation. I need to go circle back with my staff on that.

SENATOR CRAWFORD: Okay. And can you provide us with information on how much interest has been paid by the three managed care organizations?

THOMAS "ROCKY" THOMPSON: Yes, Senator. We...

SENATOR CRAWFORD: That's information you have (inaudible).

THOMAS "ROCKY" THOMPSON: ...we apparently do have that in our quarterly financials...

SENATOR CRAWFORD: Okay.

THOMAS "ROCKY" THOMPSON: ...and we can provide that.

SENATOR CRAWFORD: Okay. Okay. And then when we meet, you can come to us and tell us what you are doing to address making sure there is compensation for providers whose claims are denied in ways that are not their fault.

THOMAS "ROCKY" THOMPSON: We will provide some clarification about situations in which interest would be owed and make sure the plans are familiar with those situations so there's not this confusion anymore.

SENATOR CRAWFORD: Okay. Okay.

SENATOR RIEPE: Senator Howard, you look like you have a question.

SENATOR HOWARD: Well, I'm trying to...what is our recourse as a state if these inaccurate payments continue? I mean, as a state we're the ones who are the contract holder. We're the ones who release the cap payments. We're paying them for a service and they're not providing the service accurately. And when it's inaccurate, they're making the providers do it. And so what's our recourse as a state, as the true payer, to help the managed care companies make better decisions when they're asking the providers to do more for less?

THOMAS "ROCKY" THOMPSON: Thank you, Senator. There are different steps that we can take about this, depending upon the severity of the issue. We can do written warnings all the way to a CAP and so those are considerations that we take when we do consider CAPs for our healthcare plans.

SENATOR HOWARD: So when...so if we agree that it's inappropriate to ask the providers to do all this manual inputting on top of what they're already doing, because they're not getting paid for that, they're getting paid for the service that's provided to the patients. If we agree that that's an issue, is that sort of something that you would issue a written warning for?

THOMAS "ROCKY" THOMPSON: I would have to talk to my staff and see if that rises...if they feel that rises a level. And it depends on how severe the issue is. We heard from some providers today. Let's look back and see what other providers are having these issues.

SENATOR HOWARD: And for the nonpayment of interest or the request for resubmission to avoid interest, is that also something that would be appropriate for a written warning or citation?

THOMAS "ROCKY" THOMPSON: If the plans are doing that. And I didn't hear anything today that says that the plans are requesting that, their resubmission, to avoid interest.

SENATOR HOWARD: Well, I'm certain they wouldn't say "to avoid interest," but what we're seeing is that resubmission after a rejection so that they don't have to pay the interest and then start the time, the clock, again. I think there's plenty of evidence for that.

THOMAS "ROCKY" THOMPSON: Well, I think there needs to be some clarity about, okay, I have situations in which interest is owed from...because it sounds like the plans are not on the same page there and that needs direction from the state about times when interest is owed.

SENATOR HOWARD: And what type of direction has the state given them in regards to clean claims? Because I know Lauralie from WellCare says they're using the CMS guidelines and that's what they use, but I didn't hear the same thing from the other two in regards to what the standards are for clean claims.

THOMAS "ROCKY" THOMPSON: CMS has standards and we have a definition in the RFP that was issued (inaudible) their contract.

SENATOR HOWARD: And so which one is the...is binding?

THOMAS "ROCKY" THOMPSON: The state can enforce the one that's in the contract.

SENATOR HOWARD: Not the CMS guidance?

THOMAS "ROCKY" THOMPSON: We have contracted with the managed care organizations so we enforce the one that's in the contract.

SENATOR HOWARD: You enforce the contract.

THOMAS "ROCKY" THOMPSON: And I believe they're pretty similar if not the same.

SENATOR HOWARD: I would guess that they're very similar. But I'm just confused about the outcomes then, because the outcomes seem very different between the different managed care companies. One is using CMS exclusively and the other two appear to be using what's in the contract.

THOMAS "ROCKY" THOMPSON: Senator, I believe all of them are following the contract in the definition of clean claims. Now their systems are configured differently and they might...there might be issues about what they can actually get into the system to be a clean claim.

SENATOR HOWARD: Okay. Great. Thank you.

SENATOR RIEPE: Okay. Senator Crawford.

SENATOR CRAWFORD: Thank you. So can you clarify for us what it takes for a concern, like a concern about interest payments, to reach a level where it would be seen as something that would require a corrective action plan or a sanction?

THOMAS "ROCKY" THOMPSON: Thank you, Senator. You know, the situations are a...differently. If we understand that the plans are not meeting their contractual requirements regarding the payment of interest then that would be an issue that we would consider a corrective action plan for.

SENATOR CRAWFORD: Okay. So the details of the contract. One of...I guess one of the concerns I have on that front that we heard is if they're being requested to resubmit a claim and if that starts the clock again, if...how we will consider that situation as you're assessing the instances in which interest is required. So if someone were to have a challenge and the managed care organization has asked them to resubmit, then contractually are you just going to be considering the new submission as the new clock or would you be considering the time delay of payment from the initial challenge?

THOMAS "ROCKY" THOMPSON: I don't believe that is clear in the contract and that's why we are going to issue clarification.

SENATOR CRAWFORD: Okay. Okay. Great. I'd appreciate that clarification. I think that's a really critical issue for us to be fair to our providers and have a good, clear clean (claim) standard.

THOMAS "ROCKY" THOMPSON: I agree, Senator.

SENATOR CRAWFORD: Thank you. Thank you.

SENATOR RIEPE: Okay. Additional comments? If not, thank you, Mr. Thompson, for being here with us.

THOMAS "ROCKY" THOMPSON: Thank you, Chairman and members.

SENATOR RIEPE: Thank you. We may have some letters. Tyler, do we have some letters to read in?

TYLER MAHOOD: (Exhibits 9 and 10) Yes, I have a letter signed by Brenda Mueller, representing Bryan Health; and Jay Conrad, representing the Houses of Hope.

SENATOR RIEPE: Okay. Thank you very much. I'd like to say thank you for all the people that presented today and all of my fellow senators who have given this day to this. I'd also like to say thank you for the sign language people that have been here and to each of you. I also want to make sure that I thank our two pages, who is Kaylee Hartman and Elsa Knight. They are right there in the corner in their red outfits. That said, this concludes the second quarter of Heritage Health legislative oversight meeting. Thank you and have a great weekend.

SENATOR HOWARD: When are we meeting again?

SENATOR RIEPE: Probably in December would be the next, unless we have something that says we need to in between.