Health and Human Services Committee
December 18, 2017

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The Committee on Health and Human Services met at 10:00 a.m. on Monday, December 18, 2017, in Room 1510 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public briefing and hearing on the Heritage Health. Senators present: Merv Riepe, Chairperson; Steve Erdman, Vice Chairperson; Sue Crawford; Sara Howard; Mark Kolterman; Lou Ann Linehan; and Matt Williams. Senators absent: None.

SENATOR RIEPE: Welcome to the third quarterly Health and Human Services Heritage Health Oversight Committee. We do not have to have a quorum, and so in the interest of your time and our time, we're going to go ahead and get started. My name is Merv Riepe. I happen to be from Legislative District 12, which is Millard, Omaha, and Ralston, and serve as Chairman of the Health and Human Services Committee and the Oversight Committee. I'm going to ask the senators that are here for self-introductions and we will, as additional senators arrive, we will have them introduce themselves too. Kind sir.

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

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

KRISTEN STIFFLER: Kristen Stiffler, legal counsel.

TYLER MAHOOD: Tyler Mahood, committee clerk.

SENATOR RIEPE: And the gentleman arriving is Senator...

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

SENATOR RIEPE: See? We started introductions and everyone is...

SENATOR CRAWFORD: Good afternoon. Senator Sue Crawford from District 45. Good morning.

SENATOR RIEPE: Shows you how eager.

SENATOR CRAWFORD: That's right. Good morning.

SENATOR RIEPE: People are eager to get here. And...

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

SENATOR RIEPE: Thank you so much. We also have a page but we have been advised by Kitty that we're not to introduce the pages. So the anonymous page over here is a hardworking, good-looking guy. (Laughter) You may notice that at times some of the committee members may come and go and that's because...not because they have a lack of interest in what you're presenting but simply the fact that they have other obligations going on at the same time. You'll also see that some may work off of either laptops or iPads and that's the modern folks who have given up on paper, and God bless them for it. Rules of engagement: I would ask you that you please silence your cell phones and that during the hearing session we're going to have a presentation by Interim Director "Rocky" Thompson to begin with. And you do have an agenda, I think, at the door. But if you are going to then, during the hearing part, testify, we'd ask you to move up to the front row just so that we can move along a little bit more quickly in the interest of time. We also ask you to please sign in and, for the record, we will ask you to state your name, we will ask you to spell your name, and then we will ask you to indicate the agency or organization for whom you're speaking. If you do not testify at the microphone but want to be on record, we would ask you to...I believe there are sign-in sheets. No sign-in sheets today? Okay. Well, if you have something you want to share, you just share it. You give it to the guy in the white shirt, okay? Again, we are ready to go so we are going to open with Interim Director Thompson and then we will follow with the open hearing, if you will. Interim Director Thompson, welcome, and thank you for being here today.

ROCKY THOMPSON: (Exhibit 1) Good morning, Chairman Riepe, Vice Chairman Erdman, and other 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 interim director of the Division of Medicaid and Long-Term Care in the Nebraska Department of Health and Human Services. Thank you again for having me to present on the progress of Heritage Health, the integrated managed care program launched January 1 of this year. On slide two we have an outline for today's presentation, including discussing program accomplishments over the first year, our continued focus on quality and improved health outcomes, improvements to our Medicaid system, the review of the measures on our public dashboard, and the oversight the Medicaid Division has over the program. Feel free to ask questions at any point during this presentation. On slide three, I think it's important to remember the purpose of Heritage Health and this is our mission statement. And really, it is the purpose of Medicaid. This is on the back of every badge at our stakeholder committees and is put out before every meeting. It says: Heritage Health is a person-centered approach to administering Medicaid benefits that provides Medicaid and CHIP members a choice of a single plan that provides all their physical health, behavioral health, and pharmacy benefits, and services in an integrated health program. Integrated care through Heritage Health will improve member outcomes, reduce costly and avoidable care, decrease reliance on emergency and inpatient levels of care by providing evidence-based care options that emphasize early intervention and community-based treatment, and addresses social determinants of health and improves the financial stability of the program. This is what my staff and I strive for, working with our plan partners and the provider community. Unlike fee for service Medicaid, which incentivize volume over value, Medicaid managed care has increased oversight over the services received by our members to improve the quality of these services and make sure that our members receive these services at the right time and setting. It also allows us to collect data that we were unable to collect before, allowing us to improve the health of our state's residents. On slide four we have some of the accomplishments over the first year and which I'll also flesh out over the next several slides. I will emphasize that we've had 5.8 million, million, claims paid through physical health, behavioral health, and pharmacy from January 1 through October 31, and this accounts for over $740 million. This is our most recent enrollment total as of December 1. Now this will change somewhat because we just had open enrollment that ended on December 15. While most members did not change plans, the preliminary information I received from our enrollment broker today says that 3,628 members did choose a

new plan during open enrollment. Now this is not the final number because we are still accepting applications that are postmarked by December 15. Now, again, these are...there are other qualifying time periods for which a member can change his or her plan, including if the provider leaves their plan's network. Now this other slide will also be familiar with you. One of the benefits of Heritage Health is availability of care management. This is an option for some of our most in-need members. The plans identify these members who need additional resources or assistance in navigating the healthcare system and they're offered care management. Over 13,000 members have benefited from this service. In previous briefings I've told you before about the value-added services offered by Heritage Health. These are services not traditionally covered by Medicaid and, because of the flexibility of services offered in managed care, are covered by the Heritage Health plans. Now here are some of the highlights by each plan for 2018, including Weight Watchers, YMCA memberships, Boys and Girls Club, no copays, special transportation services, and additional services. For example, UnitedHealthcare's myMoney Connect that offers a reloadable debit MasterCard with wellness rewards. Then slide...the next slide is...goes over the current status of accreditation of the plans with the National Committee for Quality Assurance, or NCQA. NCQA is the industry-recognized gold standard for health plans, and its review encompasses quality, network, utilization management, credentialing, rights and responsibilities, and member connections. Now, UnitedHealthcare, as our only plan that was...worked in our previous managed care market, has been accredited by NCQA since 2005 and has maintained status of commendable. WellCare of Nebraska and Nebraska Total Care have both received their interim health plan evaluations and NCQA will not issue full accreditation until 18 months into the contract. Achieving interim status at this point is an accomplishment. The next slide just shows you some highlights of some of the community events sponsored by the plans. In addition to the health services paid for through the plans, these plans offer tremendous value to our communities across the state. From community baby showers to offering space for meetings to local organizations, there are values that these plans bring to our state beyond medical services. And the next page goes over some of the community events that have been held by the plans in 90 of the state's 93 counties. This next slide goes more into detail about how the plans give back to the communities: working on community gardens, offering grants to 501(c)(3) organizations, free texting programs for new parents, giving foster children duffel bags, offering soccer clinics, having school partners, offering vision vans, and I also coordinated with different state agencies, including my sister divisions in Department of Health and Human Services and the Department

of Education, the Office of Probation, and our stakeholder groups including the Nebraska Association of Behavioral Health Organizations. To receive additional feedback and know what the communities and know what the members and know what the providers need and want, there are different stakeholder groups that are held by the plans themselves. These are in addition to the stakeholder groups that are offered by...that are put on by the state. Each plan is contractually required to have member advisory and patient advisory committees. Now the first slide here goes over the member advisory committee, and these are comprised of members, members' representatives, providers, and advocates who reflect the MCO's population and community served. And there's orientation and ongoing training provided for committee members to ensure they have sufficient information and understanding of the managed care program to fulfill their responsibilities. They have quarterly meetings and it allows to have the members to provide input into the MCO's planning and delivery of services; quality management; program monitoring and evaluation; and member, family, and provider education. This next slide goes over the provider advisory committee that each plan is required to have. It must have representation from the major providers' associations in the state, as well as individual providers. The MCO's provider advisory committee must include behavioral health and pharmacy providers, as well as providers who primarily serve individuals with disabilities. And additionally, each MCO must establish a behavioral health advisory committee to provide input to the provider advisory committee. This next slide highlights some quality metrics that we have. As I said previously, Medicaid managed care allows us to make quality improvements beyond what was possible in a fee-for-service environment. Fee for service has limited oversight and quality metrics. It just pays for volume in utilization. Heritage Health, for the first time, has specific requirements for quality and value-based contracting. These measures allow the state to hold the plans accountable for the quality of care members receive. This is built into our much larger Medicaid quality strategy. Value-based contracting programs that improve outcomes and lower costs are also promoted through Heritage Health. The plans are required to have payment and contractual arrangements with the providers that include two components: provisions that introduce contractual accountability for improvements in defined service, outcome, cost, or quality metrics; and payment methodologies that align their financial and contractual incentives with those of the MCO through mechanisms that include, but are not limited to: performance bonuses, capitation, shared savings agreements, etcetera. Now the Heritage Health plans must enter into value-based purchase arrangements with 30 percent of its provider network by the third year of the contract and 50 percent of the provider

network by the fifth year of the contract. These types of arrangements allow the state to move beyond the fee-for-service mind-set and move towards looking at the care quality received by our members. It also allows the providers the opportunity to negotiate with the plans for arrangements highlighting their strengths. We have started working with our providers, including the Nebraska Association of Behavioral Health Organizations, on what these arrangements might look like. These can include home health models, bundled payments, pay performance models, anything (inaudible) quality. I also want to highlight with this slide that our plans are required to perform annual provider and member surveys and these surveys must be performed by a vendor that is certified by NCQA. And this is for the member survey and it has samples of members that are 18 years of age and older and caregiver family members of children and youth should be included in all member surveys. Samples should be representative of members and caregivers, family members, based on the type of question asked. Each survey must be administered in a statistically valid, random sample of members who enrolled in the MCO at the time of the survey. Analysis must include statistical analysis for targeting improvement efforts in comparison to national and state benchmarks. Survey results and action plans derived from these results are due 45 calendar days after the end of each contract year. Now we also...plans are also required to do provider satisfaction surveys. The MCO must conduct an annual provider survey to assess provider satisfaction with provider credentialing, service authorization, MCO staff courtesy and professionalism, network management, appeals, referral assistance, coordination, perceived administrative burden, provider communication, provider education, provider complaints, claims reimbursement, and utilization and management processes, including medical reviews and support for primary care medical home implementation. The provider satisfaction survey tool methodology must be submitted to MLTC for approval a minimum of 90 days prior to its intended administration. And the MCO must submit an annual provider satisfaction survey report that summarizes survey methods and findings and provides an analysis of opportunities for improvement and action plans derived from the survey results. This report is due 45 calendar days after the end of each contract year. Once we have the information from these surveys, after we do an internal review, we will certainly share them with this committee and evaluate any program changes that might be needed to benefit our members as well as providers. Next slide goes over the EQRO process. The state is required by federal law to contract with an external quality review organization, or EQRO, to monitor plan compliance with quality metrics. Now this process began in the state in September. Additionally, in order to monitor the financial

metrics of the contracts, we will be contracting with a managed care auditor next year. Now just to highlight the EQRO, an external quality review is an analysis and evaluation of information on the quality, timeliness, and access to Medicaid services. Federal regulations set parameters that states must follow when conducting an EQR of the contracted health plans. The EQRO must review the MCO's compliance and standards for access to care, structure and operations, and quality management. The EQRO must also validate performance measures and performance review projects. And again, this process has begun in the state of Nebraska in September. The next slide goes over more issues with quality, financial incentives for quality. In order to further incentivize quality for members, there are financial incentives built into the contracts. There is a contractual requirement of 1.5 percent withhold of total revenue for certain quality metrics. Funds can only be earned by meeting these quality performance program, or QPP, measures. In year one these measures were mostly of administrative function. Actually, I think they were all administrative. In year two we are shifting to a mix of clinical and administrative measures. And again, these can be revisited annually. So the next slide goes over the QPP measures for year one, which I think all of you should be familiar with. These are the ones that are reported on our public dashboard, including claims processing timeliness, pharmacy claims processing timeliness, encounter acceptance rate, call abandonment rate, average speed to answer calls, appeal resolution timeliness, grievance resolution timeliness, and PDL compliance. And again, these were process related. Slide 18 goes over the QPP measures for year two while...

SENATOR CRAWFORD: Is it okay if I ask him a question now?

SENATOR RIEPE: He said you could (inaudible).

ROCKY THOMPSON: Yeah, you can ask me. Yes, ma'am.

SENATOR CRAWFORD: Oh, okay. So I just want...thank you. I appreciate the opportunity to ask a clarification question. So on the QPP measures, year one, we have a payment threshold, and then the next column says percent of payment pool. What does that column mean?

ROCKY THOMPSON: That's the 1.5 (percent), part of the 1.5 (percent) that was withheld that's established with that metric.

SENATOR CRAWFORD: Okay. So that's what...so it is 100 percent of your...

ROCKY THOMPSON: They can earn back partially if they meet the thresholds.

SENATOR CRAWFORD: The threshold applies to 100 percent of what they're doing. This is just...this is the payment pool is what they could earn...

ROCKY THOMPSON: Correct, out of that 1.5 percent.

SENATOR CRAWFORD: ...as an incentive for hitting that target.

ROCKY THOMPSON: Yes, ma'am.

SENATOR CRAWFORD: Thank you.

ROCKY THOMPSON: Okay.

SENATOR RIEPE: Okay.

ROCKY THOMPSON: The next slide is...are the QPP measures for year two. As you can see, there are additional measures equated to quality developed by Dr. Lisa White, right there, our Medicaid medical director. In addition to claims processing timeliness, encounter acceptance rate, call abandonment rate, appeals resolution timeliness, and PDL compliance which we will continue to measure in year two, we have different measures related to lead screening in children, well-child visits in the first 15 months of life, and childhood immunization status. For the QPP regarding the well-child visits, this was chosen because there's a national downward trend for these visits within Medicaid. For those who miss a visit between zero to 15 months, there is often a direct relationship to, for example, behavioral health issue within the family. The lead screening measure was chosen because the CDC is reevaluating national statistics and Nebraska rates for screening are currently below the national average, 62 percent versus 66 percent. We are working with our sister agency, the Division of Public Health, who has received grant funding to increase lead screening. There would be significant impact on reducing learning

disabilities if screening can be improved and early intervention of lead intoxication instituted. For the childhood immunization status, we have key measures related to Tdap and we are currently choosing to focus on pertussis or whooping cough because we have the highest instance of this in the country. It's a major contributor to disease burden in infancy and above, and we may be contributing to our high infant mortality rates by not immunizing every child. And so this is why we incentivize the plans to meet these thresholds because it can make real quality improvements in the lives of our Medicaid members. You know, Medicaid is one of the largest payers if not the largest payers of medical services in the state of Nebraska, and making quality improvements on these measures will increase the well-being of our entire state and our state's health ranking. The next slide goes over some of the system improvements that have been made in the first year working with our provider community. As you know, when we launched Heritage Health, we established an Administrative Simplification Committee. Here are the projects launched this year to ease administrative burdens upon our providers: A review of over-the-counter medications, creating a comprehensive list of over the counters that are preferred by Medicaid; prior authorizations for durable medical equipment based on price limits, which offers consistency across the plans to ease the administrative burden on providers; common form to change the primary care physician selection for members; ease the administrative burden for providers by having one from available to all members who express an interest in changing their PCP assignment on their member ID card. In addition to these improvements, after speaking with several providers, it is apparent that the administrative burdens are not just limited to Medicaid but there are burdens on our providers, especially with small providers, across different payers. And I think that we need to address those systemwide. Just last week we had, again, discussions with the Department of Insurance on ways to help our smaller providers and address issues raised both in Medicaid and commercial products. They were receptive to this and I look forward to collaborating with them over the next year and years for opportunities to address the administrative burden providers face as healthcare becomes more and more complex. This next slide right here regards member health and it just reiterates our goals which I stated before for Heritage Health and that we hope to achieve by specifically focusing on our members. Like always, I have some member stories to share with you in the next few slides that show you how Heritage Health is helping them live better lives. This first slide is about a 29-year-old member with multiple conditions and mobility issues. Her grandmother has taken over her care due to the member's mother passing away a couple months ago. An NTC case manager received a call from

the grandmother requesting our help with getting a lift for the member. The grandmother is elderly and has medical problems and is not able to lift the member. When received, the prior authorization had clinical notes missing and the care manager spoke with staff that was working on the PA and explained the situation. With the help of the NTC case manager prior authorization department, the authorization was able to be approved quickly. When the case manager called the member's grandmother to inform of the approval, she was in tears: Thank you so much for the help you have given us. The next story involves a 57-year-old male member who was diagnosed with uncontrolled Type 2 diabetes, hypertension, chronic back pain, depression, and schizophrenia. And also, there was a 41-year-old family member experiencing mental illness, seizures, and learning disabilities. This couple was homeless and had been living in a shelter for two years. They do not have transportation, which has been a barrier to health and to accessing social supports and resources. The 57-year-old member was a frequent user of the ER and was often hospitalized for infections and diabetes. The UHC Community Plan housing navigator assisted the couple to secure housing and the care management has resulted in improved health and decreased emergency room visits. The next story involves a 55-year-old female referred to case management. She was diagnosed with diabetes, cataracts, and schizophrenia. She was not taking her medications because her income forced her to choose between getting her prescriptions or having enough food for the month. She had not seen a psychiatrist in several months. Her new WellCare case manager coordinated appointments for her with an optometrist, a dentist, and a psychiatrist. He assured the transportation was arranged for each appointment and that she kept each appointment. He ensured that she got her prescriptions filled and also assisted her in identifying and applying for community resources to provide free cell phones and another which helped her lower her monthly utility bills. This WellCare member was formerly facing institutionalization without the case management assistance and now is not. This next slide goes over some of the performance metrics that are on our public dashboard. And as you know from previous presentations, we have over 50 contractually required reports and we closely monitor these reports to ensure compliance with the contracts. In addition to these stories, the stories I told before, I think these metrics add to say what impact Heritage Health is having on our members and our providers. I do want to highlight a few points, though. The first couple slides go over the total claims and the total pharmacy claims received versus paid. And then after that we go into clean claims. I know there's been a lot of discussion about clean claims and so we just want to a make sure that we highlight this for

you again. Now again, clean claims are claims that are able to enter into the payment system of the providers. Now there are certain edits on the systems of the plans that require certain information to be present in order for a claim to enter the system. Just to simplify, the edits present on the plan systems are now very similar to edits on the state system. There's not a whole lot of differentiation. So those claims that we consider clean by the state would be considered clean by the plans. These edits, if you go on to the next page, it goes over the front-end edits of each health plan and type of testing required for the systems. And these are national standards and, you know, there's a lot more information about how these systems work if you want those. I can't explain to you today, but there's manuals and such. They certainly could share that with you. The next slide goes over the top claim rejection reasons. Now these are the top reasons by each plan for claims rejected and not entered into their payment system. These do not mean that the claims will be paid when they enter the system, but that just that they enter into the system to be paid or denied. As you can see, these reasons often have to do with provider taxonomy or the eligibility of the members. Now the next slide goes over the top three denial reasons by plan. Now these are claims that are considered clean. These are claims that do enter into the system of the plans and are denied instead of paid. As you can see, the denial reasons are pretty similar across all three plans. One of the main reasons you can see right there, duplicative claims, for example, WellCare has seen over 47,000 denials for duplicates since January 1 of 2017. Now the next few slides go over performance metrics for the plans, what we've gone over before. They're all hitting their contractual requirements, some even 100 percent, and it's very impressive that many of the plans have got an...had marked improvement over the past year. I do want to mention that if you look at the call center statistics WellCare had a significant uptick over the last few months but they were still within their contractual standard. And preliminary information that we received for November and December show that improvements have been made to the WellCare costs. (Inaudible) there were some individuals that were let go for a low-performing call center. So if you guys have any questions about those, feel free to ask. This is the information that's publicly available on our Web site.

SENATOR HOWARD: You're talking about the call center abandonment for providers?

ROCKY THOMPSON: For providers, yes.

SENATOR HOWARD: Okay.

ROCKY THOMPSON: That showed the uptick.

SENATOR HOWARD: That's...and it was going up in September and it went up again in October.

ROCKY THOMPSON: Correct, and...

SENATOR HOWARD: And you're telling us in November it's going...is it going back down to the average for the other two?

ROCKY THOMPSON: The preliminary information that we have, the information is not technically due to the state until the 15th after the end of the month, but the information that we have received preliminary from WellCare, we haven't been able to validate that yet but we are monitoring that and we are getting that information.

SENATOR HOWARD: Okay. Thank you.

ROCKY THOMPSON: Okay, past all the metrics we then have oversight. First of all, I want to thank you, Chairman Riepe, for your continued work on improvements to our Heritage Health Plans and not only you, Chairman Riepe, the entire HHS Committee. Thank you for your involvement. Thank you for your questions and we have taken those seriously and have tried to work and have worked to improve the system. I think that the improvements made over the past year are in no small part the result of work done by this committee. I do want to go over some additional oversight that the Medicaid program has over the plans. And I've gone over before the regular meetings and conference calls that we have with our health plan leadership, my biweeklies with the plan leadership, our on-site visits by our contract management staff, our weekly monitoring of all active issues, doing specific outreach to providers, getting ad hoc requests for client's payment information with the plans, and reviewing and validating contractual requirement reports. And again--not "recourses," resources should be right there--but we have the managed care auditor which we are procuring for next year and also we're getting

the results of the member and provider surveys, which will impact how we operate the plan based upon that feedback. Now back in August we did issue a corrective action plan to WellCare of Nebraska and we have worked with them and they have done extensive work to improve their systems and ensure claims payment accurately and...but they have to maintain certain requirements, including to provide MLTC with claims payment reports, participate in biweekly calls specific to the cap issues, and maintain a known issues and resolutions time frames log on the public Web site that all our plans are required to have. I also want to point out that our entire Medicaid Division has been reorganized to oversee these plans to ensure they provide their contractual requirements to the people of Nebraska. While there is a dedicated provider...contract management staff for plans, our finance, program integrity, and data analytics teams are intimately involved in making Heritage Health a success. Our Medicaid medical director, Dr. Lisa White, is spearheading quality initiatives with the medical directors of each of the three MCOs and with our quality committee. This is a program that spans our entire division. I do have to say my staff is the best staff the state has to offer and I put a lot of faith in them that they're ensuring our plans' contractual compliance. The next slide goes over committees and forms that we have. I've shared this with you. These have the most recent dates. Again, we have an Administrative Simplification Committee, our Behavioral Health Integration and Advisory Committee, our Quality Management Committee, and our Administrative Simplification Subcommittee, which meets tomorrow. And because of the work done by these committees and also done by this committee, this HHS Committee, here are some of the accomplishments that have happened for our provider community over the past year. We have a common authorization form for behavioral health providers. We have sought feedback and received feedback regarding billing forms, billing instructions, physical therapy authorizations, home health services, and worked with crossover claims. We have improved relations with and continued outreach with providers and provider organizations. And we continue to move forward. We have closed a significant number of issues since June. I would also like to thank NABHO, HCAN, NHCA, NPA, NPTA, LeadingAge, NHA, and other provider organizations for continuing to work with the state and our plans to work out issues identified so we can resolve them in a collaborative manner. We only know about issues if they are reported to us and we would like to thank them for doing that. I'm happy to address any other questions that you may have and Merry Christmas to everybody.

SENATOR RIEPE: Thank you very much. I would like to start out by commending you. You've been very accessible, it's my understanding it's been reported back to me, to a number of providers. You've given your personal time and I think that that's very important and we appreciate that as well.

ROCKY THOMPSON: Thank you, sir.

SENATOR RIEPE: I may have a couple of other questions, but I'm going to allow the committee to go ahead. Senator Crawford.

SENATOR CRAWFORD: Thank you. Thank you, Chairman Riepe. And thank you, Director, for being here and sharing these results. I guess I am still a bit confused on page 9. So I didn't want to take too much time during your report (laugh), but I just want to make sure I understand what that table is telling us. So if you would just walk through the first row, perhaps, we have the claims processing timeliness...

ROCKY THOMPSON: That's correct.

SENATOR CRAWFORD: ...and the payment...so the payment threshold, explain "95 percent within 15 business days." What does "payment threshold" mean?

ROCKY THOMPSON: That means the metric they have to meet to receive that incentive payment.

SENATOR CRAWFORD: Okay. So that's what this column is marking.

ROCKY THOMPSON: That's correct.

SENATOR CRAWFORD: Okay. So now the second column says, "percent of payment pool." What does that column mean?

ROCKY THOMPSON: That is the...that is the amount that they...out of that 1.5 percent payment pool, that withhold that they receive if they reach their metric.

SENATOR CRAWFORD: Okay. That's (inaudible). So the...this is the threshold. If they meet this, they get the 1.5 (percent). No?

(WOMAN FROM AUDIENCE): They get 20 percent (inaudible).

SENATOR WILLIAMS: Get 20 percent of the 1.5 (percent).

ROCKY THOMPSON: Uh-huh. Correct.

SENATOR CRAWFORD: Oh! Now I get it. Thank you.

ROCKY THOMPSON: (Laugh) I was trying to figure out a way to explain.

SENATOR CRAWFORD: (Laugh) Okay. So we have a 1.5 (percent) incentive...

ROCKY THOMPSON: Uh-huh.

SENATOR CRAWFORD: ...and it gets...

ROCKY THOMPSON: And it's divided out.

SENATOR CRAWFORD: ...divided out by these standards.

ROCKY THOMPSON: That's correct.

SENATOR CRAWFORD: Thank you. I now believe I understand.

ROCKY THOMPSON: It's not all or nothing. They have to...these are different metrics. If they reach this metric they get this, but if they don't reach this metric they might not get that...

SENATOR CRAWFORD: Okay. I understand.

ROCKY THOMPSON: ...(inaudible).

(WOMAN FROM AUDIENCE): Can I make a statement?

SENATOR CRAWFORD: Thank you very much. So I appreciate that. I have other questions but I'll let people ask questions and then I'll come back to the others. But thank you for explaining that. I appreciate that.

SENATOR RIEPE: We're going to have to hold off on comments from the audience. We have a witness up here. Do you have...are there other questions? Senator Williams.

SENATOR WILLIAMS: Thank you, Chairman Riepe. And, Rocky, thank you for being here and helping us understand a very complicated area. My legislative district is a little different than some with...but not so much different than others. I have five critical access hospitals and a number of rural health clinics that have experienced maybe some different issues with the whole Heritage Health issue. To start with, I would...we're all on the same agenda here,...

ROCKY THOMPSON: Uh-huh.

SENATOR WILLIAMS: ...meaning trying to get quality healthcare to this population we have in the state and trying to do that in a way that our providers get paid timely in the amounts guaranteed under the plan. Could you describe to me briefly what you believe the role of the Department of Health and Human Services is in that dynamic that we just laid out there?

ROCKY THOMPSON: Thank you, Senator. Our role is oversight over the plans. They are our contractors. They are responsible to us and we are responsible to the people of Nebraska. So we need to make sure that if our providers are having issues that we are made aware so we can ensure that our contractors are held to the level that they deserve.

SENATOR WILLIAMS: So you're clearly the body to hold their feet to the fire to perform, as Senator Crawford was just going through those dynamics.

ROCKY THOMPSON: I (inaudible).

SENATOR WILLIAMS: What would you view the role of the Legislature in this process?

ROCKY THOMPSON: I think the Legislature provides a useful arena to raise different issues that might not reach the...reach us as the contract holders for the state of Nebraska. I think it's useful to hear from you all. You guys have your members that you are elected by that need to...need you to be their voice and sometimes we don't hear from every single person. So it's important for you guys to be the voice and also to conduct, for example, these oversight briefings that do help us in our oversight role over the plans.

SENATOR WILLIAMS: Thank you, and I certainly agree with that. In my particular case, I was asked by several of my critical access hospitals to get involved with coordinating some meetings with MCOs in the legislative district, which we did. A week or so ago in the Omaha World-Herald, you had an editorial that there was a comment in your editorial that says: The vast majority of our state's 30,000 Medicaid providers are experiencing a "business as usual" relationship with the Heritage Health plans. I would have to tell you that my five critical access hospitals and my rural health clinics would disagree completely with that statement in several areas. And I...we were fortunate that we...and I would really like to thank UnitedHealthcare and WellCare, that they were able to participate. Nebraska Total Care has not yet been able to. That's through no fault of theirs. I don't want to reflect negatively on them. UnitedHealthcare brought five of their top people out. They toured three of the critical access hospitals and they met two hours with all five of the critical access hospitals. WellCare met with the five critical access hospitals and...on a different date, and a couple of the rural health clinics that were there. They explained to me and to the MCOs that they have a couple of ways that they have in addressing their issue. The first one is to call customer service and the second is to call their representative that's been designated. I would say that they have given up on customer service, even attempting to call that anymore. So it would be helpful if, in the case of rural health clinics and critical

access hospitals, I think if HHS could make some contact there to be sure that that is working better than it currently is. And I would like your response to that, to start with.

ROCKY THOMPSON: Thank you, Senator. I did hear about that meeting in your district with WellCare and I was very disappointed by what I heard about especially their...the representatives for the providers in that community by WellCare. And I think when I spoke with WellCare leadership about this, there are plans to address this issue and to make sure that there are staff that are more knowledgeable, more responsive to meet those needs in your district of those critical access hospitals.

SENATOR WILLIAMS: Thank you. The second piece of that is in the area of the preauthorizations that came out, and this was with both visits. I don't want to single out one of these MCOs over the other one. Two things that seem to be happening regularly that don't make any sense to a layman like me is when there is a preauthorization for a mom and then all of a sudden there is no authorization for the baby that's born in the circumstance with the mom. The second one is when there is a preauthorization for a surgery and then there is not a preauthorization--I'll use that term--for the anesthesiologist who is required to be there to put the patient to sleep to perform the surgery. And in both cases the critical access hospitals were struggling with those reimbursements in those cases. Have you got any thoughts about that?

ROCKY THOMPSON: I'm not familiar with these specific instances, but I can certainly get back to you about that. From just the way you describe, it doesn't make any sense to me either.

SENATOR WILLIAMS: It would be helpful to me if we had some looking at that. And I know both the representatives from UnitedHealth and WellCare said, yes, that's been a problem, we've fixed it, and then the reports that I was getting back from my critical access hospitals is it was fixed for a time and then it's now unfixed again, which again is something that I heard time and time again about a fix and then not be...staying fixed.

ROCKY THOMPSON: Uh-huh.

SENATOR WILLIAMS: I think we have to understand, and I would respect your response to this, that in the case of the critical access hospitals that I deal with, each one of them would tell you that they have added staff and added time to their operations to collect what are important reimbursements for them but reimbursements at an amount that do not equal what their cost already was. So they are now in a situation where they are spending more time trying to collect money that doesn't cover their cost. I'd like your response to that.

ROCKY THOMPSON: And I think that it's a real concern, an administrative burden on our providers. And, you know, that's why we have the Administrative Simplification Committee. That's why I plan on working with the Department of Insurance to make sure there are more processes streamlined across all payers. I had a critical access hospital in my office about a month ago and talking about not just issues with Heritage Health but issues with payments to...from commercial insurers and they were just going to go to DOI right after that and talk about that. I think we need to have some additional focus in seeing how we can streamline processes and ease administrative burden for our providers, especially those in the rural areas of the state.

SENATOR WILLIAMS: Have you noticed that there may be a difference under Heritage Health with critical access hospitals and rural health providers?

ROCKY THOMPSON: Senator, I don't know if there's a difference because I know the critical access hospital that was in my office was having issues also collecting from the previous managed care entities.

SENATOR WILLIAMS: Okay.

ROCKY THOMPSON: I know there were two out there that...and there's now three.

SENATOR WILLIAMS: Right. Right. And I also understand that, coming from a background of business where technology changes, things happen, and you have people. Many of the billing agents which I'm dealing with locally have been in the business for a long time. And they didn't

ask for this change, they didn't look forward to this change, and they're trying to adapt to that as best they can.

ROCKY THOMPSON: And then, Senator,...

SENATOR WILLIAMS: The ultimate question that I asked at the last meeting, at the end of the meeting, was: Have things improved from where we were early on in this process to where we are now? And it was December 7, the date that I asked that, near the end of the period, certainly right at the time this article in the paper was coming out. And I went around and asked each one of the critical access hospitals and: Gothenburg, no; Cozad, no; Lexington, no; Broken Bow, no. There was not a representative at the meeting at that point from the Callaway critical access hospital. So I appreciate the information you're giving us. I'm looking for feedback from my people with boots on the grounds out there that are the ones that I see every day. So what would be your response to that?

ROCKY THOMPSON: Senator, I heard about that question also at the meeting. I was also disappointed about that. I understand the administrative burden on our providers and also billing. Billing is extremely complicated. People get degrees in billing and so I understand with having a new system being implemented that there are issues like this that emerge. And I also like to hear from...I had Broken...Broken Bow is the critical access hospital that I had in my office a month ago and I would like to hear more from Deb over at Broken Bow and others about improvements that they would like to see in the system and how we can work with them to ease that burden.

SENATOR WILLIAMS: Well, I appreciate your willingness to participate in that because I, when I go back to the first question I asked you, the role of HHS, I believe that's covered under your role. And I really don't think that's necessary...necessarily the role that the Legislature should perform. We're sitting here. That's what we should be doing. I also commend you and the department. These stories of improved health and those kind of accomplishments are tremendous and we appreciate hearing those. For me, at the end of the day, we still get back to the billing issue...

ROCKY THOMPSON: Uh-huh.

SENATOR WILLIAMS: ...and maybe that's because I was a banker all my life. So thank you.

ROCKY THOMPSON: Thank you, Senator.

SENATOR RIEPE: I think we're going to hear from two of the critical access hospital executives when we get down to the hearing side as well. So we'll get an opportunity to even learn more about that. Senator Kolterman.

SENATOR KOLTERMAN: Thank you, Senator Riepe. Director, would you talk a little bit about the interplay between Department of Health and Human Services and the Department of Insurance? Does the department...is Heritage Health looked at as a health insurance plan that is ministered and subject to the same rules as a commercial insurer?

ROCKY THOMPSON: Thank you, Senator. There are certain requirements that they have to receive from Department of Insurance to participate in...under Medicaid. They're not necessarily subject to the same governing authority as other insurance products, but there is that oversight that they have to receive from Department of Insurance before we work with them and contract with them.

SENATOR KOLTERMAN: I just...I'd like to thank you for reaching out to them because it's not only Heritage Health has got...I've experienced the same problems as Senator Williams has had with my four critical access hospitals. But at the same time, we're now experiencing the same type of delays with some of the commercial insurers, and anything you can do to improve that. With the narrower networks and the different fee schedules that are now being proposed and the different MCO-type of organizations that are coming out, it's becoming more and more challenging for our providers. And they're the ones that want to keep their doors open to take care of these people. And so, you know, we've cut their...we've cut their reimbursement rates considerably just last session again and we need to do what we can to make sure that at least they're getting paid what we promised them on a timely basis. I do applaud you for being proactive and making these reports to us, but we need to keep working on it. So anything you can do to help would be appreciated.

ROCKY THOMPSON: Thank you, Senator. And just to clarify, we did that crossover methodology change but it's wasn't an across-the-board rate reduction.

SENATOR KOLTERMAN: Well, it depends on how you look at that. (Laughter)

ROCKY THOMPSON: Again, just to clarify.

SENATOR KOLTERMAN: That's a matter of perspective. Thank you.

ROCKY THOMPSON: Thank you, Senator.

SENATOR RIEPE: I did want to, before I go to Senator Howard, I wanted to...Senator Linehan has arrived and has been here for quite a long time but the opportunity didn't come to introduce her, so thank you very much. Senator Howard.

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

ROCKY THOMPSON: Thank you for having me, Senator Howard.

SENATOR HOWARD: (Laugh) I actually love hanging out with Rocky. Okay. So I wanted to start talking about the Children's Health Insurance Program, because it hasn't been reauthorized on the national level. And so I wanted to get some clarification from you first on when you think that we will run out of our CHIP dollars, and then if we are going to run out of our CHIP dollars, how you plan on handling the transition.

ROCKY THOMPSON: Thank you, Senator. Yeah, as you said, Congress did not reauthorize the Children's Health Insurance Program, or CHIP, on September 30 so our current projections have that the funding that was left over from last federal fiscal year will expire sometime in the spring, depending upon the utilization, so March or April.

SENATOR HOWARD: March or April.

ROCKY THOMPSON: Depending upon the utilization.

SENATOR HOWARD: Okay.

ROCKY THOMPSON: Now, unlike many states, Nebraska operates CHIP as two separate programs. It's all under Medicaid and Long-Term Care, but the main CHIP program is actually operated through Medicaid and has the same benefits as Medicaid, same coverage criteria as Medicaid. And that has approximately 30,000 children. We also have a separate CHIP program for unborn children due to LB599 back in 2012. If CHIP is not reauthorized, which we fully expect it to be reauthorized, you know, there's a vehicle that's going to be voted on, I hope, December 22 or the government is going to shut down. And then there's going to be an end of the year vehicle also, and there's all kinds of vehicles in January. So there's many different vehicles that CHIP can be put on. I think actually on the December 22 piece of legislation, the House version has the CHIP program in it, but there's some additional offsets that do impact other areas of our healthcare system. But if CHIP is not reauthorized, the population that's covered through the Medicaid program, they will continue to be covered, just at a lower federal matching rate, the traditional Medicaid matching rate.

SENATOR HOWARD: How many kids is that?

ROCKY THOMPSON: That's 30,000.

SENATOR HOWARD: So 30,000 are already in Medicaid or 30,000 are in CHIP?

ROCKY THOMPSON: Well, they are in CHIP but it's operated through Medicaid.

SENATOR HOWARD: Right. But so I guess I'm asking the question of how many kids would fall off because they are not going to meet the Medicaid...

ROCKY THOMPSON: Those 30,000 would not fall off. They would not. They would have to be covered by the state due to the maintenance of effort requirement in the ACA that was passed that says that eligibility for child...

SENATOR HOWARD: I thought the maintenance of effort expired.

ROCKY THOMPSON: For adults it expired on January 1 of 2014. For children it expires September 30 of 2019.

SENATOR HOWARD: Nineteen, okay.

ROCKY THOMPSON: So we are required to maintain eligibility levels for children at the level that existed on...in March of 2010 until 2019.

SENATOR HOWARD: Okay. So you would keep...

ROCKY THOMPSON: And that includes that population of CHIP that is covered through Medicaid, those 30,000 children.

SENATOR HOWARD: And then so you would keep those CHIP kids at 200 percent. Would you be able to bring on more kids at 200 percent under the MOE until the...

ROCKY THOMPSON: That's correct...

SENATOR HOWARD: ...the September deadline?

ROCKY THOMPSON: ...because the eligibility levels will remain the same. The same eligibility criteria will be used for new children as with all children.

SENATOR HOWARD: Okay. Great. And then what's...so then there wouldn't be any change. There wouldn't be any requirement that we notify families because they wouldn't be seeing necessarily any change because our CHIP and Medicaid is already combined.

ROCKY THOMPSON: I don't believe we have to do any requirement for these. I would have to check again what the federal requirements are because the federal government has come with additional guidance regarding this.

SENATOR HOWARD: Sure.

ROCKY THOMPSON: But for that population now, they would have...maintain coverage.

SENATOR HOWARD: So for the 30,000 kids that would roll off of CHIP, we'd put them into our Medicaid with a lower match. What is the impact to the budget or what...how would we fill in the gap?

ROCKY THOMPSON: We would have to work with the Unicameral on trying to figure out how to fund that.

SENATOR HOWARD: How much do you think it might be?

ROCKY THOMPSON: It depends. It could, for this fiscal year, it could be $4 (million) to $7 million.

SENATOR HOWARD: Four to seven million dollars in this fiscal year and then...

ROCKY THOMPSON: In this fiscal year.

SENATOR HOWARD: ...the next one. And then for...

ROCKY THOMPSON: It would be more for the next fiscal year because it's not...it's just a partial.

SENATOR HOWARD: Right. So, I'm sorry, $4 (million) to $7 million is what...

ROCKY THOMPSON: Uh-huh.

SENATOR HOWARD: Okay...because kids are cheap to cover. (Laughter) Okay.

ROCKY THOMPSON: Even though they're the majority of our population on Medicaid.

SENATOR HOWARD: So for the LB599 population,...

ROCKY THOMPSON: Uh-huh.

SENATOR HOWARD: ...does the maintenance of effort apply to them as well?

ROCKY THOMPSON: It does not. It's a separate CHIP program...

SENATOR HOWARD: Okay.

ROCKY THOMPSON: ...and these are children that are not eligible for Medicaid. They can't be eligible for Medicaid.

SENATOR HOWARD: Because they're not born yet?

ROCKY THOMPSON: They're not born yet, correct.

SENATOR HOWARD: Okay. So then what happens to the LB599 population when the money runs out in March?

ROCKY THOMPSON: If we don't receive any additional supplemental funding, as you know, some states have already run out of their funding but have received additional federal funding while they work through this process...

SENATOR HOWARD: Uh-huh.

ROCKY THOMPSON: ...and there's additional guidance that has come out about that from CMS over the past month. But if there is that issue where CHIP funding runs out, then the Governor and the Unicameral and me and everybody else, all the policymakers are going to have to get together and create, figure out, okay, what do we need to do with this population. Do we...is this a CHIP population that...does this LB599 CHIP program end or does...do we have to fund it 100 percent General Funds?

SENATOR HOWARD: And so women who are currently in who would maybe give birth in March would be fine, but women who were receiving prenatal care in March would be cut off?

ROCKY THOMPSON: We would have to work on a way because I don't want to see that happen.

SENATOR HOWARD: Right, except that would be well past the bill introduction period for the Legislature.

ROCKY THOMPSON: I think it's more of a funding issue than anything else, because it would have to be a funding decision because we have to authorize some legislation as it exists today.

SENATOR HOWARD: So and the authorized legislation would just continue regardless of whether or not the federal level CHIP was reauthorized?

ROCKY THOMPSON: The statute, it does have different requirements in there, but the statute does exist today to authorize this. But it is a funding issue more than any other issue.

SENATOR HOWARD: So the statute authorizes the program regardless of whether or not CHIP is there.

ROCKY THOMPSON: Correct. We can still maintain, if we get the funding.

SENATOR HOWARD: Okay. And...okay.

ROCKY THOMPSON: But again, we fully anticipate that this will...the CHIP program will be reauthorized. In addition, the states that have run out of funding, they have received additional federal funding. So I know that Colorado started sending out notices and receiving additional federal funding to maintain its CHIP program while the federal government works through its process.

SENATOR HOWARD: Great. And then do you have a plan in place for LB599 if there isn't a legislative fix by the time our CHIP funds run out?

ROCKY THOMPSON: We are working with our federal partners in figuring out what we need to do.

SENATOR HOWARD: Sort of a notice to providers, a notice to clients.

ROCKY THOMPSON: Correct.

SENATOR HOWARD: Okay. And there are no requirements right now on the federal level of how you would provide that notice.

ROCKY THOMPSON: There are certain requirements that we have. There's at least ten-day notice, but we fully anticipate that any notice would go out well before that ten-day notice.

SENATOR HOWARD: Okay. Just trying to get a feel for what that might look like in March when we do run out.

ROCKY THOMPSON: If we do.

SENATOR HOWARD: If we do. If we...I actually appreciate your optimism about our Congress (laugh) because I am...I'm a little more realistic. Okay. So (laughter) last time we met in September, right?

ROCKY THOMPSON: I think so.

SENATOR HOWARD: The good old days. Okay. We had issues around our COBAs, or coordination of benefit agreements,...

ROCKY THOMPSON: Correct.

SENATOR HOWARD: ...because there was an issue of overpayments to providers because we didn't have a COBA and there was maybe a signature issue. And so I was wondering where we are at on our COBAs.

ROCKY THOMPSON: Well, they were approved in October...

SENATOR HOWARD: Perfect.

ROCKY THOMPSON: ...and reprocessing for those claims began in November, November 20 I believe.

SENATOR HOWARD: Okay. And so for the overpayments that occurred while we...

ROCKY THOMPSON: Due to the COBA, those are being...

SENATOR HOWARD: ...due to the COBA.

ROCKY THOMPSON: ...those are being reprocessed.

SENATOR HOWARD: They're being reprocessed. Okay. And then will provider...providers will find out if they were overpaid and have to pay you back?

ROCKY THOMPSON: Right. The plans worked on notifying the providers.

SENATOR HOWARD: Okay. Okay. The one of your slides, now I don't have it up anymore, but I was hoping you could walk me through your grievance process. One of your slides listed that...

ROCKY THOMPSON: Well, there's...

SENATOR HOWARD: ...we were at 100 percent for grievance, (page) 21.

ROCKY THOMPSON: Yeah, there's grievances and...

SENATOR HOWARD: Yeah. So can you walk me through the grievance process?

ROCKY THOMPSON: Well, there are grievances and appeals. And...

SENATOR HOWARD: Okay.

ROCKY THOMPSON: ...appeals are formal actions taken through their appeals process. And grievances are basically any type of issue that's raised to the plan that they need to resolve in a timely manner. And there's more contractual requirements due to that, which I can provide to you, that I don't have in front of me right now.

SENATOR HOWARD: Sure.

ROCKY THOMPSON: And each plan has their own grievance process also.

SENATOR HOWARD: And so what's the time line for a grievance?

ROCKY THOMPSON: This 100 percent is based on the QPP measures, so the QPP measure says that the grievance, MCO must dispose of each grievance and provide notice as expediently as the member's health condition requires, within the state-established time frames, not to exceed 90 calendar days from the day the MCO receives a grievance.

SENATOR HOWARD: Okay. So it's a three-month process for a grievance?

ROCKY THOMPSON: If not shorter, depending upon...

SENATOR HOWARD: Hopefully shorter.

ROCKY THOMPSON: ...dependent upon what the issue is.

SENATOR HOWARD: And remind me, what's the difference between a grievance and an appeal?

ROCKY THOMPSON: An appeal is a more formal process that then it can lead to a state fair hearing.

SENATOR HOWARD: Okay. Okay. And so I noticed one of our plans--and I apologize, our copies are not in color so it's hard to tell which one--but there's one that in September their appeals timeliness went down. Do you know why that happened?

ROCKY THOMPSON: I do not know yet. These are...this information was just validated by our data analytics staff so I have not yet addressed that with the plans,...

SENATOR HOWARD: Okay.

ROCKY THOMPSON: ...with that plan in question.

SENATOR HOWARD: Thank you. And I don't have any more questions.

ROCKY THOMPSON: Okay. Thank you, Senator.

SENATOR HOWARD: Breathe a sign of relief.

SENATOR RIEPE: I think Senator Kolterman had some questions. He had to leave just momentarily, but I wanted to go back a little bit. My question is on Senator Williams talked about a mother that was authorized but not the infant. Would not the infant be qualified under a CHIP program?

ROCKY THOMPSON: Thank you, Senator. There's different eligibility requirements for infants. Usually, if the mother is born with Medicaid, usually they have continuous eligibility to the first year of age.

SENATOR RIEPE: Okay.

ROCKY THOMPSON: So, depending on the parents' income, they could also qualify for CHIP.

SENATOR RIEPE: Okay. So it might have been some unique circumstances or something.

ROCKY THOMPSON: I would have to look into that situation.

SENATOR RIEPE: Okay. Okay. Thank you. Senator Linehan.

SENATOR LINEHAN: On...thank you, Mr. Chairman. On page 9, the bottom slide, I just don't understand this because...so I'm going to probably embarrass myself by asking questions that everybody else gets. So if you go down to the second one from the bottom, "Well-child visits in the first 15 months of life--The percentage of members who turn 15 months old during the measurement year and who had the following number of well-child visits." So the goal is for them to have six?

ROCKY THOMPSON: The...there's different. Depending on your age, you're seen by a doctor at different points in your life, and this was developed by our clinical staff who...based upon the best practices and national standard.

SENATOR LINEHAN: So I guess my question is, 52 percent of them, so everybody is...

ROCKY THOMPSON: Fifty-two percent with six visits or more.

SENATOR LINEHAN: Okay.

ROCKY THOMPSON: That's the goal that we hope to achieve.

SENATOR LINEHAN: That's the goal you hope to achieve. Okay.

ROCKY THOMPSON: And that's what the plan is measured on. If they reach that then they get that withhold amount, that 10 percent of that $1.5 million...1.5 percent of what of they're paid, not million. Sorry.

SENATOR LINEHAN: Okay. So then are the plans being held accountable if a parent doesn't bring the child in?

ROCKY THOMPSON: The plan...

SENATOR LINEHAN: Because they're somewhat dependent on the people cooperating, right?

ROCKY THOMPSON: Right.

SENATOR LINEHAN: So what if the parents don't, not...for whatever reason?

ROCKY THOMPSON: Uh-huh.

SENATOR LINEHAN: I'm not...but that's what I'm trying to figure out here. So the plans are being held accountable if the parents don't, if a parent doesn't bring the child in, then the...so are the plans, is it incumbent on the plans then to make sure? What, they have to call these people and remind them or...?

ROCKY THOMPSON: Thank you, Senator. There's different ways that a plan can encourage a family to make sure their child gets their well-child visits. It can be as simple as calling. It can be providing special mailings. There's text messaging options. There can be gift cards given to families that provide...they can bring their children in for well-child visits. Yes, the plans are being held accountable for a parent's behavior, but the plans have to figure out a way to incentivize that parent's behavior to make sure their child receives these well-child visits.

SENATOR LINEHAN: Okay. So that's kind of all of these things, is we're making it incumbent on the plans to make sure that...which is...that's...I'm just trying to figure it out. The plans are responsible to make sure that the kids get in, so they have to motivate the parents or whoever has got...

ROCKY THOMPSON: Yes, Senator. As you know, we pay the plans a capitated payment for medical services for members, and so we want them, the members, to utilize that benefit that we

are paying for. So we need to figure out a way to make sure that especially these health measures that can impact the rest of the lives of these children, we need to make sure that they can meet these metrics and we can move Nebraska up in our state health rankings.

SENATOR LINEHAN: So, just so I understand it, so it's incumbent on our...all three of the providers to make sure that the parents are getting the kids in for their...

ROCKY THOMPSON: Uh-huh.

SENATOR LINEHAN: Okay.

ROCKY THOMPSON: And I hope that the parents also feel like it's their duty as parents that they need to make sure their child sees a doctor.

SENATOR LINEHAN: Right. Okay. Thank you very much.

ROCKY THOMPSON: Thank you, Senator.

SENATOR RIEPE: I assume there's a high correlation there between well-care visits and immunizations as well.

ROCKY THOMPSON: Yes, sir. That's one of the reasons why the measures are chosen.

SENATOR RIEPE: Okay. Senator Crawford, did you have a question?

SENATOR CRAWFORD: Sure. Yes. Thank you, Chairman. And thank you for being here. And I do appreciate that...your commitment to make sure that we are able to see the results of the customer satisfaction surveys and the provider satisfaction surveys. So one first simple question is what you would expect that time line to be. When should we be watching for these to come to us?

ROCKY THOMPSON: They are due to the state 45 days from the end of the contract year, which...

SENATOR CRAWFORD: Right. So what would that be?

ROCKY THOMPSON: ...that would be 45 days from January 1. Of course, we need time to validate those surveys and to ensure that. We have a data analytics team that looks over these surveys and makes sure that the information provided is accurate, and we need time to do that. I would think that it would be sometime in March or April...

SENATOR CRAWFORD: March of April.

ROCKY THOMPSON: ...we can be able to share some of that information.

SENATOR CRAWFORD: And how does...I understand a primary goal of these surveys is probably quality improvement, but in what way are the managed care organizations accountable for providing satisfaction to the providers and customers? Is that also in the contract in terms of standards for payment or sanctions, or how will you use those results also in terms of accountability?

ROCKY THOMPSON: Thank you, Senator. Well, the plans are required to come in with a plan based upon the results of the survey that they had to submit to the state. And we have to review that and make sure that complies with what we see in those surveys coming from the providers and from the members. And that can be a basis of another contract amendment, for example.

SENATOR CRAWFORD: So what would that look like?

ROCKY THOMPSON: The contract amendment, we just went through a new contract amendment with the new QPP measures and we have another contract amendment that might come up July 1 of next year.

SENATOR CRAWFORD: So if we are not...if we feel like managed care organizations are not meeting the needs of our patients in the state, we are able to make a contract amendment to strengthen the contract and to improve those.

ROCKY THOMPSON: Yes, ma'am.

SENATOR CRAWFORD: Okay. And you mentioned we just have done that recently, so what was the problem and how did we amend the contract and what do we expect to see in result?

ROCKY THOMPSON: This was a contract amendment that had the rates for the next year. In addition, it had the new QPP measures that we went over, that those performance metrics that they need to meet would get that withhold, so those change in this contract amendment.

SENATOR CRAWFORD: In what way did they change?

ROCKY THOMPSON: Those added clinical measures.

SENATOR CRAWFORD: Okay, the added measures. Okay.

ROCKY THOMPSON: Yes, ma'am.

SENATOR CRAWFORD: So is it the...so I'm going to skip now to the clean claims issue. Again, I think it's just one way in which we see an administrative burden on providers that they're having to address and trying to make sure we have...if we have a round of having to make adjustments or resubmit claims if there's not a clear understanding of what's required for a clean claim and good processes. Does our current contract have a standard for the percent of clean claims that the MCO must have?

ROCKY THOMPSON: It does not.

SENATOR CRAWFORD: Okay. Right now, if I understand it correctly from our conversation here, you said that the edits for all three plans are pretty similar to the state edits.

ROCKY THOMPSON: That is correct.

SENATOR CRAWFORD: So what each one would...what each plan should be accepting as a clean claim is very similar. Is that correct?

ROCKY THOMPSON: That is correct.

SENATOR CRAWFORD: And similar to what would have been considered a clean claim to the state form.

ROCKY THOMPSON: Yes, ma'am.

SENATOR CRAWFORD: Okay. So no MCO should be having a lower rate because they have some higher standard that they're expecting from these claims.

ROCKY THOMPSON: That is correct.

SENATOR CRAWFORD: Okay. So any lower performance would be because of process that could be improved. Is that fair to say? If we've got one MCO who is performing close to 97-98 percent, the other MCOs are not meeting that standard, it's technologically physically possible to meet that standard with our providers in the state. And so there must be some...so I would ask you, how would you explain the lower performance by other MCOs if the standards are the same and providers are similar?

ROCKY THOMPSON: Thank you, Senator. Again, it really depends upon the claims that are submitted by the providers. I don't know about the different providers that are submitting these claims that might be not clean. There has been additional reach by our plans to these providers that might have seen every number of unclean claims. I'm sure there are different ways that we can improve the process and we're more than willing to try to improve the process for our members and also for our providers. So if we can figure out some way what they need, as you can see their main reasons for the rejection, then we can figure out ways to try to limit those rejection reasons more than...

SENATOR CRAWFORD: So what pressure do you...what pressure and how do you put pressure on the MCOs to improve those rates, especially when you see them fall (inaudible) variable performance, and those MCOs that are not performing as well. What pressure and how do you exert pressure on them to improve those clean claims rates?

ROCKY THOMPSON: I don't know what we...because it is dependent upon the provider to submit clean claims. And when there is something that we are aware of that they are rejecting claims because of some edit that might be in place that is not what our state is used to, we require changes to their system to make sure they can process those claims. And that's the type of pressure that we have done and we have done throughout this year.

SENATOR CRAWFORD: Say that...I'm sorry. Can you give an example of that?

ROCKY THOMPSON: Some of the behavioral health claims that were...

SENATOR CRAWFORD: Okay.

ROCKY THOMPSON: ...rejecting inappropriately in the first half of the year, we made sure that NTC and, subsequently, WellCare made those system edits so those were accepted and paid or denied.

SENATOR CRAWFORD: Okay. And so at this point we still have, for example, in June we had one MCO down below 70 percent of clean claims and so what process do you use to try to identify when this clean claims is a situation that's going to require a change in the MCO process?

ROCKY THOMPSON: We don't necessarily use this clean claim information because this is also dependent upon the providers. We do have our Administrative Simplification Subcommittee group. We have our provider organizations that have been very willing to share their thoughts and concerns about the different system edits and claims that they feel are being rejected inappropriately. That's what we base upon what we use. We don't necessarily use the clean claim information in itself. It helps back up some of the issues,...

SENATOR CRAWFORD: Right.

ROCKY THOMPSON: ...but we seek that feedback from our provider community.

SENATOR CRAWFORD: So there is a similarity, we do agree. I mean I understand you saying the clean claim, in part, depends upon the provider's process as well. But we also are...do recognize the importance of holding the MCOs accountable for well family visits, and that also depends upon the performance of the parents. So we recognize that we need certain things to function well in our health system and part of the MCO's role may be the education and incentives to make that work well. So even though getting in for five well visits is not totally in control of the MCO, we still hold them accountable for it, right? So the same principle can be true of clean claims. Even though it's not totally within their control, they have a responsibility for education and collaboration and work with the providers to keep that rate high because it's one of the things that adds to the administrative burden. And I appreciate that you're tracking it and providing it so we can keep watching it. I'm concerned that I see it slipping. When we met earlier, we were seeing them go up. Now we're seeing it kind of fall back, which is I think a concern. And so I think it's important that we recognize that even though the provider has a role, it's still the MCO's responsibility to make the process and education and work with the providers effective in keeping those rates high and hold them accountable just like we hold them accountable for parents getting in with their kids. Does that make...does that analogy make sense?

ROCKY THOMPSON: Thank you, Senator. And I think that feedback is important. We can certainly increase education for our provider community. There has been specific providers that have been reached out to by the plans in going over billing procedures to make sure that the claims that are submitted are clean. But additionally, also, the plan systems, they have to reject certain claims because it's...

SENATOR CRAWFORD: And I understand.

ROCKY THOMPSON: ...because there's the integrity of our systems...

SENATOR CRAWFORD: Right. Right.

ROCKY THOMPSON: ...and also we need to make sure that we are economic of its...the claims that are being looked at are claims that can be paid.

SENATOR CRAWFORD: Right. Yeah. I appreciate that and thank you for the...we don't want...we want claims to be clean, just like we want kids to get a real well-baby visit. We don't want somebody doing something just to check a box. But I...it is an important part of the process. Is it true then that because we have this process that allows us to amend contracts that if we feel that this clean claim threshold is a critical one to improve the performance of our system and reduce administrative burden for our providers, that we could use that process to amend the contract to put in a standard for compromise?

ROCKY THOMPSON: A standard could be added to the contracts. Of course, it would have to meet federal approval also because our...

SENATOR CRAWFORD: Okay.

ROCKY THOMPSON: ...contracts are approved by the federal government.

SENATOR CRAWFORD: Okay. But it is possible to add that standard?

ROCKY THOMPSON: It is possible.

SENATOR CRAWFORD: And the process for adding that standard is what? What are the steps that we go through?

ROCKY THOMPSON: A contract amendment.

SENATOR CRAWFORD: A contract amendment. So it would be a matter of you would have to approve? Would it be you...

ROCKY THOMPSON: I would make that decision.

SENATOR CRAWFORD: ...would have to be convinced of that argument?

ROCKY THOMPSON: I would. I would make that decision.

SENATOR CRAWFORD: You would make that decision on whether to add the contract amendment.

ROCKY THOMPSON: I would make the decision. Yes, ma'am.

SENATOR CRAWFORD: All right. And is...what would be...what would cause you to get to that point right now that you would say, boy, we really need to add that standard?

ROCKY THOMPSON: I need to see what standards are used nationwide...

SENATOR CRAWFORD: Okay.

ROCKY THOMPSON: ...and I need to make sure that this won't financially impair the system and make sure that they're systems that are...that do meet these national standards if that is possible.

SENATOR CRAWFORD: Okay. Thank you very much. I appreciate that conversation. Thank you.

SENATOR RIEPE: As statistics run, they get dated, so we have September in front of us. What's your perception in terms of what are the clean claims as of the 18th day of December of 2017? Are we better or worse off than we were, say, in September?

ROCKY THOMPSON: I think that with this information that is in front of us and considering what I'm hearing from our providers--which the issue log that we have, it has significantly gone down--I think that providers are submitting clean claims.

SENATOR RIEPE: Uh-huh. To me on this particular statistic it might be interesting, too, if there's some average or something that runs a line across there and say who's above it, who's below it, and sort of (inaudible).

ROCKY THOMPSON: And also I'd like to see not only managed care plans nationwide but let's also look at commercial insurers and see how it compares with that.

SENATOR RIEPE: I have a little...Senator Erdman, you've been quiet.

SENATOR ERDMAN: Thank you. Thank you, Chairman Riepe. Thank you for coming, Rocky. On that same page, we're looking at that and as I glanced that and look across the last year of clean claims, one of those organizations is doing better than the other two. Have you ever analyzed or looked back and say why does one of them have 97-98 percent clean claims and the rest of them are not? What processes are they using that are different than the other MCOs that they have a better clean claim rate?

ROCKY THOMPSON: Thank you, Senator. I think that there are some less edits; while the plans are significantly similar in what they accept, there are some less edits on one of the plans than other plans in their system that allows them to have those claims enter their system.

SENATOR ERDMAN: Okay.

SENATOR RIEPE: Okay?

SENATOR CRAWFORD: Can I follow up just on that question?

SENATOR HOWARD: No. Senator Crawford.

SENATOR CRAWFORD: Can I follow up on that question?

SENATOR ERDMAN: Yes.

SENATOR CRAWFORD: What does that mean, they have less edits? Because I thought you said the systems all have the same amount of edits and that they're similar to the state.

ROCKY THOMPSON: I said they were substantially similar to...

SENATOR CRAWFORD: Uh-huh.

ROCKY THOMPSON: ...the state system. The plans, some plans might have one or two extra edits and some plans may not.

SENATOR CRAWFORD: Okay. So some...so is it the case that the high-performing MCO has fewer edits in their plan?

ROCKY THOMPSON: I would have to check exactly.

SENATOR CRAWFORD: Could you...would you check on that and get the information back to us?

ROCKY THOMPSON: Yes, Senator.

SENATOR CRAWFORD: Yes. Okay. And if it's true that that is the difference, is it possible we could require or encourage, pressure the other plans to also reduce their number of edits similar to the high-performing plan?

ROCKY THOMPSON: I will look at that.

SENATOR CRAWFORD: Okay. And would you follow up and get...

ROCKY THOMPSON: Yes, Senator.

SENATOR CRAWFORD: ...this information?

ROCKY THOMPSON: Yes, Senator.

SENATOR CRAWFORD: Thank you.

SENATOR RIEPE: Senator Kolterman, some time ago you had a question.

SENATOR KOLTERMAN: Well, yeah. My question dealt with the 30,000 people that are on CHIP. Are they included in the total number that we're looking at here for Medicaid?

ROCKY THOMPSON: Yes, Senator, they're included in the Heritage Health program.

SENATOR KOLTERMAN: Okay. So they're part of that 207,000 in there.

ROCKY THOMPSON: Yes, Senator.

SENATOR KOLTERMAN: Okay.

SENATOR RIEPE: Can you share with me a little bit more? You talked about a managed care auditor early next year. Is that an outside auditor or an inside or...

ROCKY THOMPSON: It would be an outside auditor, Senator.

SENATOR RIEPE: And their direction and their goal is to...

ROCKY THOMPSON: Would be look at the like financials of the plans.

SENATOR RIEPE: Financial sides of it, not the clinical side.

ROCKY THOMPSON: Right. That is correct.

SENATOR RIEPE: Okay. Okay. Also, this is I guess more of a...we talked a little bit--maybe it's more of a statement than it is anything--we talked about a provider survey following the end of

the year and I think what we call members I call patients. I think that was within 45 days of the year. You know, one of my concerns from an oversight piece is it's hard to do genuine legitimate oversight without some validity from coming in from what I call patients to say how are we doing with them. And to me, that needs...that's more of a quarterly thing and not an annual. But that's just what I'm accustomed to I guess.

ROCKY THOMPSON: Thank you.

SENATOR RIEPE: It's more of a comment than it is...

ROCKY THOMPSON: Thank you for that feedback, Senator. The contract requirement is an annual survey. I think that's the industry standard in this. But we can look back and see what might be able to get in order to receive that feedback throughout the year rather than just following the end of the year.

SENATOR RIEPE: Facts eliminate a lot of speculation. Senator Williams.

SENATOR WILLIAMS: Thank you, Mr. Chairman. One final question for me. We've asked our providers to now deal with three MCOs when they used to be dealing with two situations. You're in a situation of having oversight over three MCOs at this point. At the end of day, Rocky, it seems to me your ultimate hammer is a corrective action program. Do you foresee ever a point where you're just going to say I have one more hammer and that's to eliminate an MCO and narrow that scope? Would you discuss the pros and cons of doing that and when we might seriously look at making those kind of tough decisions?

ROCKY THOMPSON: Thank you, Senator. At this point, I don't see us having an MCO leave the market. I think the MCOs, while there were corrective action plans and sanctions, I think that they are doing remarkably better than they were in the first half of the year. To get to the point of getting rid of an MCO, that is more of a process that we would have to go through. You have, for example, corrective action plans and there's always a point where an MCO can choose to leave the market, as happened in our neighboring state of Iowa. Or we can end the contract with an

MCO, which is a process and we need some...we would have to go through that process if we ever reach that point. But I don't see that coming up.

SENATOR WILLIAMS: Are you willing to go that direction if sufficient process has...progress has not been made to the satisfaction of the Legislature and this committee?

ROCKY THOMPSON: If there is that...if there is that feedback and there's that direction, we certainly would look at that option.

SENATOR WILLIAMS: Thank you.

SENATOR RIEPE: Director Thompson, is there a federal requirement that we have three?

ROCKY THOMPSON: Senator, there's no requirement that we have three. We have to have at least two.

SENATOR RIEPE: Okay. I knew there was some requirement.

ROCKY THOMPSON: Uh-huh. The previous MCOs, while we had three MCOs in the state, well, we had Magellan also for behavioral health, but we had the two MCOs per region, so you had United and Aetna and you had Arbor and Aetna in the rest of the state.

SENATOR RIEPE: I think there's some of us that believe with two you get no competition but with three you can, so.

ROCKY THOMPSON: With two there's always...

SENATOR RIEPE: And being a free market kind of guy,...

ROCKY THOMPSON: I would say we can look at our neighboring state of Iowa to see what they're going through with one of the plans leaving the market and their issues with distributing that membership across the other two plans and some difficulties that they're experiencing.

SENATOR RIEPE: Do you know if it's Iowa's intent to replace that one that exited the market?

ROCKY THOMPSON: I understand they plan on procuring two more plans.

SENATOR RIEPE: So they'd go to four?

ROCKY THOMPSON: That's correct.

SENATOR RIEPE: Okay. Senator Crawford.

SENATOR CRAWFORD: Thank you, Chairman Riepe. And thank you, Director. Could we talk a little bit about the external quality review process that's on the slide on page 8? Is this a quality review process for each of the three managed care plans or is this a quality review process for the state of Nebraska?

ROCKY THOMPSON: This is for each of the three plans.

SENATOR CRAWFORD: Okay. Okay. And so for each of the three plans we have this external review organization that assesses these measures that the federal government requires.

ROCKY THOMPSON: That...well, the measures the federal government requires and also the contractual compliance.

SENATOR CRAWFORD: Okay. Okay. And how are those reported to you?

ROCKY THOMPSON: Those are finalized and they are reported and once we have that information I'm sure we will be sure to share that with all of you.

SENATOR CRAWFORD: And what's the time line for when that information comes to you?

ROCKY THOMPSON: I don't have that time line yet.

SENATOR CRAWFORD: Okay.

ROCKY THOMPSON: The process has begun. It began in September.

SENATOR CRAWFORD: Okay. And so those results come to you...

ROCKY THOMPSON: I anticipate probably middle of next year.

SENATOR CRAWFORD: ...and your committing to us you will share those results with us.

ROCKY THOMPSON: We will share with the public and share...and...

SENATOR CRAWFORD: Oh, you're...that was my next question...

ROCKY THOMPSON: ...and also...and also...and also...

SENATOR CRAWFORD: ...is how they would be available to the public. How would they be shared with the public?

ROCKY THOMPSON: I would have to look at them, see what is the best way to do so. Would probably be just post them on our Web site that we post everything else too.

SENATOR CRAWFORD: And I know you don't know an exact day or time. Can you give me an expected month?

ROCKY THOMPSON: I'm thinking probably middle of next year the process will be done.

SENATOR CRAWFORD: July of next year?

ROCKY THOMPSON: And we can clarify also in our follow-up to the committee.

SENATOR CRAWFORD: I appreciate that. Thank you.

SENATOR RIEPE: Okay. Are there additional questions of Director Thompson? Seeing none, thank you very much. I think it was a healthy exchange and we appreciate that very much.

ROCKY THOMPSON: Thank you, Chairman. Thank you, members. And of course you know where to find me.

SENATOR RIEPE: Yes. Yes, we do. We will now go into the hearing session, and so those that have wished to testify under the hearing, please come up. And if you have some documents, please give them to the clerk, and if not, introduce yourself with your name, please, and then proceed.

CORRIE EDWARDS: (Exhibit 1) All right, Senator Riepe and members of the Health and Human Services Committee, my name is Corrie Edwards, C-o-r-r-i-e E-d-w-a-r-d-s, and I serve as president and CEO of Mid-Plains Center for Behavioral Healthcare, and I serve Grand Island and the Central Service Area of Nebraska. I'm here today to provide follow-up information to my previous testimony in June that I provided to this committee. To date my organization has not experienced a "business as usual" relationship with the MCOs. Today I continue to highlight the implementation issues, mostly because they are just simply not resolved. Payment issues: We continue to struggle receiving accurate payments. Sometimes we are overpaid, underpaid and, even worse, we are paid for clients that we never served. Just when I believe a problem has been fixed, a new problem arises or an old problem resurfaces. For example, I had hoped, after almost a year of struggling with an issue of partial payments, that this issue would have been resolved by now. It is not. We struggle with vague denial codes and my administrative staff spend hours trying to guess what needs to be corrected. Sometimes we receive payment for a service and then bill for the same service for the same client the next month and receive a denial code indicating that the service is not included in the fee schedule. Other denial codes instruct us to attach an attachment or documentation, but we have no idea what document they are requesting. If a client has Medicare and Medicaid, routinely Medicare is billed first as the primary funding source. However, one MCO insists that we provide an explanation of benefits from Medicare showing that they denied payment for therapy services. We are happy to oblige. However, the issue with Medicare does not provide an explanation of benefits for the denial of therapy services. To date, this problem remains unresolved and we have not been paid. As of right now we are $68,736

outstanding for unpaid claims. This amount is 30 days past due. We have already written off everything that we can't continue billing for that is now in untimely filings. Prior authorization and reauthorization issues: This issue has been a struggle from day one. I want to highlight, although I respect what the interim director just said, one MCO, only one, requires preauthorization for MST services, multisystemic therapy services. It has become a never-ending struggle to receive authorizations and reauthorizations for this service. It is at the will of this MCO as to whether or not a family is in need of receiving this evidence-based crisis service. Some families are authorized; some are not. The idea of a bureaucrat in an office making the decision about if a family is worthy of this service seems cruel and, quite frankly, unnecessary. These are families in desperate need of immediate help and are in the perils of crisis, yet they must wait in the daunting bureaucracy to push around some papers in order to authorize this service or not. Credentialing issues: Probably the biggest issue other than payment concerns is the provider credentialing. Each of the MCOs uses a different process, contrary to what was just said. To complicate things further, the Division of Medicaid uses their own process. On average--and we actually have timed this--it takes my human resource director eight hours to gather and input the data into the four different portals to credential one provider. Here is the process. First, information is entered into the Medicaid portal called Maximus. Once this is done, each of the MCOs use a different portal for their own information. On average, after the data is entered, it takes about two weeks for the provider to sit in limbo in the "processing" phase of each MCO portal. Once through this phase, the provider then spends about two more weeks in the "ready to credential" phase. After moving through this phase, they are finally credentialed. Now, mind you, an organization is not contacted as to if or when the provider has been fully credentialed with anyone. In order to stay informed, usually my staff must check the four portals daily to review the status. However, if a staff happens to be sick or on vacation and does not check this daily, and a provider is not being credentialed, then we find out the hard way because the claims come back denied. Then this sends us back to the drawing board for another 30-day countdown to be paid but only after we figure out what was wrong with the credentialing. For instance, we finally realized that a provider's license was incorrectly listed in one of the MCO portals. She was listed as an LPN instead of an APRN. Needless to say, the rate structure and payment is very different for an APRN than it is for an LPN. Inaccuracies of this type occur because the Medicaid portal does not talk to the MCO portals. As of right now, each MCO receives weekly updates from Maximus regarding the status of provider credentialing. I'm unclear as to why the

MCOs cannot use the information that is entered into the Maximus portal. The information could be transferred to the MCOs from Maximus, thus saving valuable staff resources and reducing the wait time for families needing services. If the Division of Medicaid is truly on a trajectory toward operational excellence with these MCOs, it would be beneficial if these challenges would be resolved so that organizations like mine can continue providing services to our most vulnerable population.

SENATOR RIEPE: Okay. Thank you very much. I have a couple of questions but I want to see if others do. Senator Williams, please.

SENATOR WILLIAMS: Thank you, Chairman Riepe. And thank you, Ms. Edwards, for being here. Appreciate that. You've been very kind in your statement lumping all three MCOs together rather than singling anyone out. You heard my line of questioning earlier.

CORRIE EDWARDS: I did.

SENATOR WILLIAMS: Are you having the same issues with the same MCOs...

CORRIE EDWARDS: We are having...

SENATOR WILLIAMS: ...or are they differences?

CORRIE EDWARDS: We have this...okay, it's kind of like Whac-A-Mole, the game Whac-A-Mole. And somebody used this term last Friday in a meeting I was at but I have been using this term for several months because the same problem--for instance, the partial payment issue--that is with one MCO. The prior authorization for MST, that is with one MCO. The Medicare...and, see, that's what...that's why I'm always enlightened but very confused when I leave these hearings because what I just heard, and I don't know anything about the healthcare side with your critical access hospitals, but I do know behavioral health and I've done this for 30 years. And what I can say is the same issues...now, credentialing, across the board, is across the board a problem. Right now, right now, because I just had an e-mail come through, we have nine therapists either in the two phases that I recited, the processing phase and the ready to credential

phase. So, nine therapists, we will not get paid. So if every therapist has a base quota in my shop to see, let's say, five patients a day and it takes 30 days in a good month to credential a provider and we've got four portals, well, let's say we're credentialed in WellCare and Total Care, just random right now, but we're not credentialed in United. But let's say that particular therapist has to be...is top heavy with United clients. I mean upwards I could lose easily $20,000, easily $20,000 a month in just waiting. And MST, of course, is way more expensive and so we could lose $50,000. Just waiting on even one therapist's revenue for MST is about $20,000. And if that therapist is caught in this limbo system, that's why the smaller agencies are struggling so much. I am mid-size and we'll make this work. Thank God for lines of credit. But we'll make this work and we will survive this. However, I've got friends and stakeholders that are just not. But I do understand why they're not. You know, we have had to add...I have tripled in six years. In the last year I have tripled the amount of finance staff I have. I have added three more admin staff. I don't...and I don't really see an end in sight with that. I didn't...(inaudible), okay.

SENATOR WILLIAMS: So if I asked you if you're spending more today than you were spending before we started down this path to get your reimbursement...

CORRIE EDWARDS: This has cost me a lot of money.

SENATOR WILLIAMS: Thank you. Thank you for your answers.

CORRIE EDWARDS: Yeah, this has cost me a lot of money. Now I will say we had Magellan under behavioral health and that was one, a one-headed beast, as I call it. We now have got a three-headed beast. And for those of us in behavioral health, we went from one to three and that's a lot of beasts to deal with.

SENATOR RIEPE: What kind of turnover do you have that requires this level of credentialing, because once credentialed, generally, they're there, then it's done.

CORRIE EDWARDS: That is correct. We actually restructured our...I'm glad that you asked that. We restructured our crisis stabilization unit and we went from using nurses to therapists, and so

that is where most of this is. We did have turnover in Lincoln with the MST program. That was one new therapist. But most of this is because of the restructuring of a crisis stabilization unit.

SENATOR RIEPE: So it's more of an episodic thing than it is ongoing.

CORRIE EDWARDS: No, I can say for certain that in the last year, I mean, this is how long it takes to get one provider through the system. Right now it's just this many for me at one time because of the CSU.

SENATOR RIEPE: But it's accelerated because you're transitioning from nurses to therapists.

CORRIE EDWARDS: It is. It is. But again, not to bog down your response, but an MST therapist waiting 30 days on a good month, sometimes...we have one that has now has waited three months. And when you look at $20,000, you know, times that by three for one therapist for MST and that's where you sit.

SENATOR RIEPE: Is there any clearinghouse for credentialing therapists in the state of Nebraska?

CORRIE EDWARDS: It's interesting that you would ask. There isn't, but I definitely see a business opportunity there.

SENATOR CRAWFORD: Uh-huh.

CORRIE EDWARDS: I...actually, I have been approached by the smaller shops in my community is to...if they could borrow our HR staff to help them in their credentialing. I absolutely see business there and that's sad.

SENATOR CRAWFORD: Yes (inaudible).

CORRIE EDWARDS: That's not...I mean but that is a direction that people are going to. Other things that are popping up and really being utilized are the claims clearinghouses. They will outsource the collection of claims.

SENATOR RIEPE: Uh-huh.

CORRIE EDWARDS: Yeah, we have way too many claims to outsource. I like to keep on top of my money and my claims and so I really don't want to outsource that.

SENATOR RIEPE: Okay. Senator Howard, please.

SENATOR HOWARD: Thank you, Senator. Thank you for visiting with us today. So I wanted to go back to the preauthorizations for MST. Are you doing MST and FFT, or just MST?

CORRIE EDWARDS: Just MST. I don't think I could handle both at this point, I just don't.

SENATOR HOWARD: Not right now, no.

CORRIE EDWARDS: Uh-uh.

SENATOR HOWARD: So tell me about the preauthorizations. Is there consistency? Is it...are they preauthorizing only for kids who are in probation or are they preauthorizing...

CORRIE EDWARDS: We don't really see...and I think that that's what we struggle with. It's kind of like the denial codes and some things being not on the fee schedule, whatever. We don't see any consistency. I did ask that question to...I've got two people who do nothing but prior and "reauths" for MST, one in Lincoln and then the other is in Grand Island. And I asked that and they...that's why my statement is kind of at the will. We are getting denials for "preauths" and we are getting denials for "reauths." That was my...that face was the face that I made, too--hmm, interesting--because I don't think I knew that.

SENATOR HOWARD: Can you briefly explain MST?

CORRIE EDWARDS: Multisystemic therapy is an evidence-based crisis service that is...Nebraska has had since 1997. I was actually in Nebraska in '97 when they brought it. The first area to have MST was the Central Service Area. Since then it has really, with the help of the Sherwood Foundation, it kind of exploded in Nebraska as being the go-to service when you have juveniles that have got pretty serious behavior issues and there is a substance abuse component too. And of course my concern always with a denial for that is these are highly trained therapists that have spent months getting pretrained to come on board and then are trained weekly by an MST consultant that I pay to weekly train them. In my neck of the woods, I don't believe that you get any higher trained therapist than you do when you get an MST therapist because of the level that MST International requires. And so obviously, when I get a denial for a prior or a "reauth," that is concerning to me because we're not just asking for this because we might like to have it.

SENATOR HOWARD: And so MST is really one of those things that we use to address costs in our child welfare system so we don't have to do a removal.

CORRIE EDWARDS: Absolutely. Absolutely.

SENATOR HOWARD: And so prior to MST being covered in our Medicaid program, wasn't it paid for directly through Probation?

CORRIE EDWARDS: It was.

SENATOR HOWARD: So it was state funds either way, only this way we get some federal reimbursement.

CORRIE EDWARDS: Yes. We do. And it was also...it also is paid through some of the private...the commercial insurance plans--Blue Cross pays for it pretty routinely, Aetna pays--I mean just depending on the commercial insurance.

SENATOR HOWARD: And so if you don't get an authorization, do you still provide the service?

CORRIE EDWARDS: We do and normally what has happened is we have to go back to Probation and then I leave that to the state to figure out. I mean Probation needs to go then to Medicaid and they can have that discussion but...and figure out, you know, who's going to foot the bill and whose budget it's going to come out of. But we have...we've been successful because of our relationships with Probation to know that, you know, when this child is referred they need service and they need it now, not two weeks down the road, and a "reauth," you know, not 30 days down the road. I mean the "reauth" needs to happen immediately to, you know, for a continuity of care issue and because, you know, then I'm stuck in a very difficult position of what do we really do. And so Probation has come back and taken care of most of this but again one would ask, is that right? I mean is that really right?

SENATOR HOWARD: So, and yes or no, so if it's not authorized by the Medicaid program and you provide the service to a juvenile who's involved in Probation, Probation pays the full cost? We wouldn't get a federal match for that?

CORRIE EDWARDS: That is correct. And if we're lucky, Probation will pay for it. I mean there have been times where the child has gone from getting a MST referral down to getting intensive family preservation, which again you've heard me testify there is nothing similar about those two models.

SENATOR HOWARD: Yes. Yeah. Thank you so much for your work.

CORRIE EDWARDS: Thank you.

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

SENATOR CRAWFORD: Thank you, Chairman Riepe. And thank you, Ms. Edwards, for being here today. I'd like to go to the discuss...I'd like to go to the part of your testimony where you are talking about the explanation of benefits for Medicare.

CORRIE EDWARDS: Uh-huh.

SENATOR CRAWFORD: So it's my understanding from our earlier discussions that the...that requiring an explanation of benefits from Medicare for a service that Medicare does not provide was recognized by the Department of Health and Human Services as a systematic problem.

CORRIE EDWARDS: Uh-huh.

SENATOR CRAWFORD: And so there was then a requirement or the system was changed to identify services that are not provided by Medicare so that this problem would not exist.

CORRIE EDWARDS: Well, then I need...

SENATOR CRAWFORD: Is it the case that therapy wasn't included in that list or is it that that system is still not working and that this is still happening for therapy?

CORRIE EDWARDS: Therapy is not covered by Medicare.

SENATOR CRAWFORD: Right.

CORRIE EDWARDS: And so if...

SENATOR RIEPE: When you say Medicare, it's Medicaid.

CORRIE EDWARDS: No.

SENATOR CRAWFORD: No, Medicare.

CORRIE EDWARDS: Medicare.

SENATOR RIEPE: Medicare. All right.

CORRIE EDWARDS: So if what you are saying is accurate as far as implementation, then what I would be saying would not need to be said because everybody would be on the same page. But I can tell you that I do have one MCO that has not apparently gotten the memo...

SENATOR CRAWFORD: Okay.

CORRIE EDWARDS: ...and who has not, I mean to date, has not paid a dime for therapy that was primarily billed to Medicare because they are saying to us they have to have an explanation of benefits. And this is just driving my finance department insane, I mean, because what do you do? Tell us what you want and then we'll give it to you. But another issue on top of that--and again I respect what the interim director was saying--but we had a huge issue with one MCO, different than the Medicare MCO issue, different MCO, where for months, the entire spring and summer and early fall, we dealt with taxonomy issues. I think you're feeling me back here.

SENATOR CRAWFORD: So can I just clarify?

CORRIE EDWARDS: Uh-huh.

SENATOR CRAWFORD: So the Medicare explanation of benefits issue you're having is with one...

CORRIE EDWARDS: Yes, one.

SENATOR CRAWFORD: ...MCO only. So that suggests that there was some system effort but this one MCO is not coordinating, working well in that system.

CORRIE EDWARDS: Right. And again, so we've got that one MCO, we've got a different MCO requiring the prior and "reauths." What he said about consistency, I think he might really believe. But I'm telling you, as a person with boots on the ground and with 100 people with boots on the ground at my agency, that this is just...this is not accurate in behavioral health. I don't know--my health partner is behind me, will share--I don't know anything about the critical access hospitals. But I, you know, the taxonomy issue is yet another example where one MCO bogged us down

for six months with a taxonomy issue, and my IT director was about ready to pull his hair out and just quit because we could not get out of them what we needed to do to get these claims paid. That same MCO then comes back, was doing payments, full payments. Then all of a sudden sporadically in September and October they decide, oh, well, partial payments, we're going to do that some more. And here's my thought. It could be a ratcheting down issue, you know, again, Whac-A-Mole. And so if you're going to ratchet down and save some money, because maybe you're having a bad month, the way to do that is ratchet down who you're going to pay and what. All of a sudden then, September and October, partial payments. Then I complain about it because I am in regular contact with these MCOs. November it's all good, so Whac-A-Mole, partial payments, beat it over the head, then it gets fixed. Now do I think it's going to be fixed forever? No, because so far nothing has gotten fixed forever. And so that's what I'm saying. When he sits up here and says the three MCOs are consistent across the board, the portals and credentialing, everything is the same, that is absolutely an inaccurate statement.

SENATOR CRAWFORD: Thank you.

SENATOR RIEPE: Have you...you have talked with the managed care organizations.

CORRIE EDWARDS: I talk with them all the time.

SENATOR RIEPE: Have you taken it on...have you talked directly with the department, with Rocky Thompson?

CORRIE EDWARDS: I have not talked with him. I did have conversations with Calder before he left, and then my contact who I seem to get the most done with, and I don't know if she's even in the room because I've never seen her, is a gal named Lisa Neeman.

SENATOR RIEPE: She was here but left.

CORRIE EDWARDS: Was she?

SENATOR RIEPE: I think she was.

CORRIE EDWARDS: I really wanted to see her because all we've done is just e-mail and she helped me with my Magellan settlement. I find that when I e-mail her I get something done where she kind of stirs...but normally though when I go to her, it is really about a Division of Medicaid issue. It's not...the MCOs, I got this, I can handle them. I can handle them. It's just again, as I said in June, this is just pretty much all I do. I, you know, if I want to get paid, then I've got to go after them. I've got to chase my payments.

SENATOR RIEPE: Senator Linehan.

SENATOR LINEHAN: Thank you, Mr. Chairman. So I can just kind of grasp the size of your organization, when you say you have 100 people, does that mean you have 100 employees?

CORRIE EDWARDS: Yeah.

SENATOR LINEHAN: Okay. So what's your client base numberwise?

CORRIE EDWARDS: We...oh, wow, well, oh, my gosh, I...

SENATOR LINEHAN: You can get back to me. I just want...

CORRIE EDWARDS: ...it's 3,000 to 4,000. And we have got a Lincoln office, Ord, Broken Bow, three campuses in Grand Island, a campus in Kearney, and we cover a lot of ground then.

SENATOR LINEHAN: What percentage of that client base is private pay?

CORRIE EDWARDS: Oh, well, between the region and Medicaid, Region 3 Behavioral Health, the region probably right now we bill out more and our biggest funder source is the region because of the crisis stabilization unit because they fund that in its entirety, then definitely Medicaid. However, private insurance is right behind Medicaid. And I will say, again, what my...what I see, because you had asked this question earlier, I don't necessarily...I can look at my old AR reports, my old accounts receivable reports, and tell you that we do not struggle with private commercial insurance, getting payments, like we struggle with the MCOs. I wanted...that

was just something that he addressed and you had asked about. I think maybe Senator Erdman had also. I just wanted to give my feedback on that. You know, Blue Cross may owe us, honestly, $3,000 for the last 365 days. That's just a drop in the bucket of what we're owed with the MCOs.

SENATOR LINEHAN: So it's...can you give a percentage? Medicaid is, what, 40 percent, 50 percent; private insurance...?

CORRIE EDWARDS: I would say that...I would say the region is probably 50 percent, Medicaid is probably 30 percent, and then private insurance makes up the rest.

SENATOR LINEHAN: And is your client base adolescents?

CORRIE EDWARDS: Kids and adults, both.

SENATOR LINEHAN: And adults. Kids and adults. Okay.

CORRIE EDWARDS: Yeah. We do therapy and medication management, and therapy has a gamut of different evidence-based programs, but with children and adults. We have got a sex offender program that actually serves children and adolescents and adults, so we've got a lot of specialties that we provide basically because of the nature of where we're located in the middle of Nebraska and there's not a lot of options.

SENATOR LINEHAN: Great. Thank you very much.

CORRIE EDWARDS: No problem.

SENATOR RIEPE: Okay. Thank you. Not seeing additional, we appreciate very much your coming here.

CORRIE EDWARDS: Absolutely.

SENATOR RIEPE: We appreciate your tenacity.

CORRIE EDWARDS: (Laugh) You say that every time and I appreciate you saying that.

SENATOR RIEPE: Well, thank you.

CORRIE EDWARDS: Thank you, Senator.

SENATOR RIEPE: Welcome.

KATHY NORDBY: Hi.

SENATOR RIEPE: If you'd be kind enough to state your name and spell it for the transcribers.

KATHY NORDBY: (Exhibit 2) All right. My name is Kathy Nordby, K-a-t-h-y, Nordby is N-o-r-d-b-y, and I'm the CEO of Midtown Health Center, a federally qualified health center located in Norfolk, frequently known as an FQHC. I'd like to thank you today, Senator Riepe and all the members of the committee, for continuing to monitor the implementation of Heritage Health and for me to have the opportunity to testify directly regarding our experiences. And I'm speaking on behalf of all of the FQHCs, to the extent that I can, that we share the common problems and have some unique issues. Like all FQHCs in Nebraska, Midtown Health Center provides 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. That's a 10 percent increase over the previous year. Ninety percent of our patients fall below 200 percent of poverty, and 70 percent are from racial and ethnic minority populations. Our health centers are the safety net clinics that provide care regardless of insurance status, and half of our patients are uninsured. They pay for their care by using a nominal fee or a sliding fee service based on their income and the number of people in their household. Twenty-nine percent of our patients receive health insurance through Medicaid. We are the safety net providers in the state. Nearly a year into Heritage Health, we've seen a lot of improvements in a lot of areas, and our longstanding issues, some of them have been resolved. And for the most part we appreciate what managed care companies have done and the department has done to maintain open communication with us. However, we wanted to draw attention to two specific barriers that seem to be persistent and I have to say that Senator Williams hit on both of them as he was talking

earlier with the managed care. First, the LB599 CHIP claims payment has been unresolved since the inception. We are getting current claims paid for the most part, but we have an outstanding bill and it's currently over $200,000 that are past 90 days in receivables from the LB599 claims. What we don't understand is that sometimes it seems to be fixed and then it goes and it will revert back and we'll have some dropped claims again, making it that you have to be persistently vigilant watching the denials to see when they slip into a new area. I think the Whac-A-Mole perception is really relevant to what we're trying to figure out for consistency. So we always are...we struggle with the consistent oversight and watching everything as they go through and all the denials. The other area is the prior authorization process and that seems to bog down all of our health centers. There's the on-line version and we were able to submit. But because of the timeliness of that, for urgent issues and critical issues we are dealing with that on a phone call and then we can expect to wait for 30 to 45 minutes while we're waiting for that critical issue to be taken care of. And then in another level of frustration, if we submit through the on-line process and we submit the documentation, five days later we might get a letter asking for the same documentation to be mailed to them, that it's not...appears not to be going through. And that can delay even on the noncritical prior "auths" for treatments. You could be anticipating by submitting the appointment five days post, and then you get the letter the same day you're hoping to have that appointment to do the follow-up. And again, the consistency of this, it doesn't seem to be...it's a known issue and doesn't seem to be getting resolved. In addition, we are seeing increased denials in the Medicare...the Medicaid secondary payments and some just more sporadic claim payments in the behavioral health and other clean claims. So it comes back and you can get two back, one paid, one rejected, same type of service, same type of issues, and it's unclear as to why that one is coming back but we have to again spend time doing that. We anticipate that there's about $90,000 kind of waylaid in that area. So I guess the biggest impact that these kind of issues have for us is the staffing vigilance that we need to have. And we are one of those smaller clinics and so I have an outsource third-party billing agent. They, through our growth, had actually decreased our rate of compensation that they get for what they're bringing in but because of the extra challenges in having to watch and the inconsistency to not establish a pattern of billing, are unwilling to even negotiate even a better rate as we continue to grow. And so that on our one side, and then I look at do I bring a staff person in internally to watch as well and that's a cost that cuts into any revenue and it's a delicate balance that we deal with. The last thing that I want to bring up that is unique is that I would like to ask this

committee to consider oversight for the managed care organization assigned for dental services. There's one organization, it's MCNA, and we're seeing there, too, some issues related to the documentation required to do claims. And we now, in Norfolk, are doing all paper billing because of the additional information that they need for prior authorization of treatment. So even a simple extraction, if it requires the evidence and the x-rays and all of that, that isn't available to submit through the portal and we end up doing a paper claim on all of those. And so we'd like you to consider looking at that. Think I'm hopping around on my testimony. I apologize for that. But the paper claims process is not intended to be a barrier but that's what it ends up being, and so we think that there's also been some over critiques of dental access. In our community we're now down to two providers in our area, of which we're one, and I was just...when I was asking for information from my staff about this, there was frustration because being...having only two access points in a community of about 32,000 for the county, we can't even get to treatment. We have services right now that we're filling cavities that we've already assessed now in late January. And they only have the two access points and even the other provider is considering not participating. And so I think the dental issues are real and I'd like you to consider taking that under your purview as well.

SENATOR RIEPE: Okay.

KATHY NORDBY: Many of our patients are vulnerable and sensitive to these issues. We appreciate the support that we can have in trying to help them and assist them in getting care. And I think as a primary care provider over a critical access hospital, if we can treat them and keep them healthy in the primary care setting, we can reduce Medicaid costs overall, and I appreciate that.

SENATOR RIEPE: Okay.

KATHY NORDBY: So we appreciate what you're doing to hear us and we appreciate this opportunity. And I'd be happy to answer any questions.

SENATOR RIEPE: Thank you very much. Just for those that are wondering, the intent is to proceed on and push through. I know many of you have come here and so in lieu of taking a

lunch break and coming back, we're going to go on and see how far we can get with the idea we'd...I'd like to have us finish up so that then you're all free to go. Thank you very much. And are there questions from the committee? Senator Howard.

SENATOR HOWARD: Thank you for visiting with us today.

KATHY NORDBY: Uh-huh.

SENATOR HOWARD: I apologize. I ate a granola bar because I'm starving. So I wanted to ask you specifically about your outstanding receivables, so. And I know that this may be a difficult question because you can really only speak to the receivables for your clinic.

KATHY NORDBY: Right.

SENATOR HOWARD: What's your patient population?

KATHY NORDBY: We served...we were at 5,800. We're already exceeding that for this year. We have about 6,200 or 6,200 patients that we're seeing this year.

SENATOR HOWARD: 6,200.

KATHY NORDBY: Uh-huh.

SENATOR HOWARD: And your receivable is $200,000. What's your annual budget?

KATHY NORDBY: I have a $6 million annual budget.

SENATOR HOWARD: Okay. So you're a relatively small FQHC.

KATHY NORDBY: Uh-huh. Right.

SENATOR HOWARD: So what is for some of the larger FQHCs--and maybe somebody is coming behind you--what is the amount of their outstanding receivables?

KATHY NORDBY: I think these, the LB599, is specific to them. We have smaller amounts for that but we're not tracking that. We don't even have the level of sophistication to compile and say we're dealing with it one at a time using our third-party billing agent. And that's part of the questions that we're struggling with as a whole.

SENATOR HOWARD: And so do you know how much you're in arrears with the managed care companies as a whole, not just in LB599?

KATHY NORDBY: As a whole in the state? I'm looking back to see (inaudible).

SENATOR HOWARD: Or even just your FQHC or any of them broken down. That may be something...

KATHY NORDBY: You know, I didn't bring that prepared today and I apologize for that.

SENATOR HOWARD: Yeah, would you mind following up with that?

KATHY NORDBY: I can do that. Uh-huh.

SENATOR HOWARD: That would be really helpful since FQHCs are predominantly a Medicaid biller.

KATHY NORDBY: Right.

SENATOR HOWARD: That would be great.

KATHY NORDBY: You want them each independently by each...?

SENATOR HOWARD: Yeah, that would be great, or separated by LB599 and regular.

KATHY NORDBY: Okay. I will do that.

SENATOR HOWARD: Thank you. I appreciate it.

KATHY NORDBY: Uh-huh.

SENATOR RIEPE: Okay. Senator Kolterman.

SENATOR KOLTERMAN: Thank you, Senator Riepe. The only question I have is...and I understand your concerns. I'm really interested in this dental situation.

SENATOR HOWARD: It's bad.

SENATOR KOLTERMAN: We just rolled out the managed care.

SENATOR HOWARD: Uh-huh.

SENATOR KOLTERMAN: Believe that was this summer.

KATHY NORDBY: Correct.

SENATOR KOLTERMAN: Are you telling me in Madison County, which is where you're at,...

KATHY NORDBY: Right.

SENATOR KOLTERMAN: ...you have two dentists that provide Medicaid?

KATHY NORDBY: Right, two, two firms: Dr. Schroeder's office and then myself, and I have two dentists that work for me, so. And they serve frequently there's a lot of counties around us that don't have dentists at all but (inaudible).

SENATOR KOLTERMAN: So are the other dentists in the community taking Medicaid?

KATHY NORDBY: (Shakes head no.)

SENATOR KOLTERMAN: Not at all?

KATHY NORDBY: (Shakes head no.) And specifically if they're still enrolled, they're not taking new Medicaid. But my understanding is that they were not enrolling with the MCO.

SENATOR KOLTERMAN: Wow. Thank you.

SENATOR HOWARD: Were they not enrolling because it was too difficult to credential or were they not enrolling because the reimbursement was so low?

KATHY NORDBY: Overall, I can't speak for them. There was a...many of them were enrolled as Medicaid providers but not taking new patients anyway, and so any additional burden in accessing that, I think they just said, no, let's not; pretend like we're seeing them and, yeah, move on.

SENATOR HOWARD: Okay.

KATHY NORDBY: And so that were...but we did lose our pediatric dentist. She was taking Medicaid and she's disenrolling, is my understanding, because of the challenge for this, so.

SENATOR HOWARD: Okay. Thank you.

KATHY NORDBY: Uh-huh.

SENATOR RIEPE: Because dental did rollout in October and because it is part of Heritage, we will be...

KATHY NORDBY: Looking.

SENATOR RIEPE: ...talking about that.

KATHY NORDBY: Okay.

SENATOR RIEPE: You know, obviously the traditional Heritage Health has been our main focus.

KATHY NORDBY: Right.

SENATOR RIEPE: Are there other comments, questions? If not, thank you very much.

KATHY NORDBY: Thank you.

SENATOR RIEPE: We appreciate it.

KATHY NORDBY: And I will follow up with the information.

SENATOR RIEPE: Thank you.

SENATOR HOWARD: Thank you.

SENATOR RIEPE: Welcome.

BRITT REYNOLDS: (Exhibit 3) Good morning, Senator Riepe. Members of the committee, thank you for hearing from the providers today. My name is Britt Reynolds, B-r-i-t-t R-e-y-n-o-l-d-s. I am a medical billing specialist for Henderson Health Care Services in Henderson, Nebraska. Our facility encompasses a critical access hospital, so I was glad you said something about that, Senator Williams, and two rural healthcare clinics. We serve the communities of York, Fillmore, Clay, Hamilton, and the surrounding areas. We have 2 physicians, 3 physician assistants, and we host 8 specialty clinics with 14 additional providers. Between January 1 and October 31 of this year, about 6.7 percent of our total patients that we treated have MCO as a primary plan. And in that time frame we have sent approximately $671,000 worth of charges to the MCOs. They have made up between 5 (percent) and 9 percent of our outstanding accounts receivable. So even though it's only about 6 percent of our patients, it makes up a large amount

of our accounts receivable that is outstanding. And below is the aging analysis, just really a broad overview for you to look at. My position with Henderson Health Care Services began ten months ago and I was brought on specifically to handle MCOs. My position was not there prior to this year, so my position was made so that I could handle the MCOs. This project that I do, I track all of the denied claims and all of the incorrect claims, and it requires no less than four hours per day to manage all of the denials that we have coming in. A majority of the errors we are seeing are due to crossover communications from the primary payer, such as Medicare or Blue Cross Blue Shield, to the MCO secondary. And these errors were all on the MCO processing side. The coinsurance portion is clearly figured and shown on the primary EOB, the explanation of benefits, but somewhere in the crossover process the MCOs are disregarding these figures. We have a large, large amount of overpayments from Nebraska Total Care and UnitedHealthcare Community Plan. We also have a significant amount of underpayments from all three of the MCOs. Another crossover issue that we're having with the MCOs is that they all require different information. So I would agree with the prior testimony, that when the interim...Mr. Thompson, I believe his name, Rocky, when he said that they are all requesting similar information, I would find that very, very hard to believe because every single MCO that I deal with requires something different on each of the claim forms. So it's just...it is Whac-A-Mole. It's trying to figure out which one wants what and where they want it. (Laugh) So each and every carrier differs in their filing requirements, which makes it very difficult to put practices into place prior to the claim going out the door. And so when dealing with WellCare specifically, and I will mention them by name, I know some have not mentioned specific MCOs by name but I want to say that specifically I dealt with a customer rep and spoke with three different people regarding a claims filing issue and was sent to their EDI master, which is their electronic department of how to file claims. So it was literally an EDI master, that was her name, and when explaining to this person that we are a rural healthcare clinic and that we have specific rules and regulations that we have to follow to file claims, I explained that to her and she...I asked if she understood what that meant and I never got a clear answer from her. She gave me false information and it wasn't corrected until six months later. I try often to communicate with our reps on many levels, starting with the customer care service number. These operators are of absolutely no help in solving claims issue. They pretty much read why the claim is denied verbatim off of the notes that we receive off of the explanation of benefits, and we can clearly read that ourselves. I then go to our designated provider rep and the turnover rate is ridiculous

with our provider reps. I don't know from one day to who, who I'm contacting from all of our different MCOs. So it's hard to establish that provider relationship and establish that communication when they are turning over so rapidly. And then I take it to their managers. I finally had enough of our issues being ignored and filed state complaints against all three of the MCOs and it was then that I started receiving some finalization with our claims issues. They were all very eager to help as long as I was willing to close the state complaint. I'll kind of, since I see that our time is just about up and I don't want to hold everybody's lunch hours, I will just kind of go to the...to my following or my closing statements. The burden that this has placed on our critical access hospitals is undue. It's a financial concern and a budget issue. Facilities like ours are having to add additional staff just to monitor these MCOs, research, constantly follow up with the MCOs, and it increases the wage in an already tight budget. Likewise, the extensive amount of claims outstanding becomes a cash flow issue. In closing, I would like to say that the first three years of managed Medicaid system presented the hospitals with MCOs that were not knowledgeable and we're forced a tremendous amount of charge write-offs, which is why my position was created. With the new MCOs starting in January, we were reassured at town hall meetings over and over that this year and these MCOs would be different, and we have yet to see that. We are struggling with the same issues as many other facilities so I know that we are not isolated. While the oversight of Nebraska DHHS has much improved this time, the quality of the MCOs has not. Providers are asked every day to stay abreast of the ever-changing healthcare billing and coding regulations. We are held to these or risk losing payment. Why are the MCOs not held to these same standards of being knowledgeable in the industry and having adequate staff and systems in place to address the business they are soliciting? Thank you again for your time and I'd be willing to answer any questions.

SENATOR RIEPE: Okay. Let's see if we have some questions. If not, I have one question.

BRITT REYNOLDS: Yes.

SENATOR RIEPE: Under the underpayments that you noted from all three,...

BRITT REYNOLDS: Yes, sir.

SENATOR RIEPE: ...was that underpayment from the contractual allowance or an underpayment from what you normally bill?

BRITT REYNOLDS: The contractual obligation.

SENATOR RIEPE: Okay.

BRITT REYNOLDS: Yes.

SENATOR RIEPE: Thank you. A second question that I had was of claims management is a function that you would have for commercial and Medicare and everything else.

BRITT REYNOLDS: Correct.

SENATOR RIEPE: But you're saying because of your payer mix the Medicaid with these three managed care organizations became an even larger percentage of your mix? Was that it or...

BRITT REYNOLDS: Prior to...

SENATOR RIEPE: ...or just more problematic?

BRITT REYNOLDS: More problematic.

SENATOR RIEPE: Okay.

BRITT REYNOLDS: We, because of our facility size, we did have claims managers for commercial, for Medicare, and we did have one person who was handling the managed Medicaid and Medicaid system. And because of the amount of charge write-offs last year with Aetna and Arbor Health, they decided that having another person to handle the MCOs was necessary.

SENATOR RIEPE: Okay. Thank you. Are there other questions? Seeing none,...

BRITT REYNOLDS: Okay.

SENATOR RIEPE: ...thank you very much.

BRITT REYNOLDS: Thank you, Senator.

SENATOR RIEPE: Thank you for being here today. As you may have noticed, we are using a five-minute clock, but we're trying to be rather generous with that. If you'd be kind enough to state your name and...

VICTORIA McHUGH: My name is...

SENATOR RIEPE: ...spell it.

VICTORIA McHUGH: Thank you. My name is Victoria McHugh, V-i-c-t-o-r-i-a M-c-H-u-g-h. I'm owner of Key Complete Therapies. We provide physical therapy, occupational therapy, and speech therapy for children through adults in the Omaha metro area. I have been here before. Thank you for the opportunity. I came mostly as an audience member, expect I am compelled to speak based on some of the things that I've heard in the early report from the interim director. I would like to start by commenting on the fact that my business is a small, locally owned organization. We operate with about eight FTEs for our professional staff and one administrative staff member. This year I've added .5 FTE administrative staff support because of the amount of workload that's been assumed by my organization to try to continue to provide services to this population. We've been in operation for coming up on 11 years and while we are seeing changes across all funding sources and through the healthcare access, it is disproportionately burdensome with the MCOs. I know that I spoke at the last hearing that our faxes, we were sending 70 percent of them to the MCOs in the months of June, July, August, and September. That has dramatically improved because there have been changes by the MCOs withdrawing their prior authorization requirements. But I would like to share with you the fact that we continue to have quite a burden in the amount of work that's required to get claims paid. Mr. Thompson spoke about, in a nice discussion with Senator Crawford, and I'm quite sad she stepped away at this moment, but really inquiring about clean claims. And my...the strongest thing that I would like to

say is there's no accountability about who makes a clean claim decision. So when you look at his explanations in talking about what happens with clean claims and the reliance on the providers, to submit a clean claim I really, I as a provider, am submitting claims to all three organizations pretty similarly. I don't submit...I don't change my claims processing depending on the MCO that I'm submitting it to. While there are edits that are specific and make us jump through really unidentifiable, nebulous hoops, I'm trying to figure out which those are. I don't have a different process that makes my accuracy remarkably different. And so I really ask you, and I think you're on it, but I really ask you to look at that discrepancy of that almost 20 percent at times of some of the MCOs that are able to put a clean claim through and other...two thirds of them that are having such low performance on that. That burden, they have no accountability to say whether or not that was an authentic reason to have a claim rejected. That burden falls to us as a provider. We either clean it up with whatever random denial case they give...or, sorry, reason that they give. And if you look at their...somebody, I think it might have been Senator Erdman, asked about that, the top rejection reasons are not clinical, right? So they are all clerical things that are happening. So where is the system solution? I mean as far as a provider, I am not indiscriminately deciding that for UHC I'll have the wrong tax ID number while for WellCare I happen to put the billing of an unqualified service or that that provider...that that patient wasn't covered. The top rejection reasons tie directly to the clean claims and they're clerical things that aren't necessarily...they're unlikely, if I'm using the same billing system, really my problem. But there's not anything that really holds those MCOs accountable for that. Because we get a denial or a rejection and if I don't act on that and spend more time and more money and more processing to try to get that clean claim cleaned up with the best guess I can, I just don't have a claim that's paid. So that burden comes to us. And you can report this clean claim stuff but if you're really not being held accountable for why those claims aren't being clean, and if they really are the providers' responsibility, I just ask you to look more into that, because I really don't think that there's...yeah, I don't think there can be a rational explanation that it's on my desk that I'm making all these errors for just two of the companies. That's the one thing. The other thing that I would like to say is that in a different article that was cited, the business as usual, that was in the editorial but it was also in yesterday's paper, that it was business as usual and that it is individual provider-specific issues, that it's not systemic issues that are persisting. And I would just like to recap for you that from the months of January to September my organization received a total of $5,000 in payment from the three combined MCOs, in total, $5,000. In the month of

October I received a total of $8,000. And in the month of November I received a total of $12,000. Our caseload did not change that much in those nine months to increase to 11...to the month of November to warrant that discrepancy of compensation. Something changed dramatically that these organizations finally started paying these claims. And if they're systemic, they're not systemic but they're provider, I feel like I deserve an explanation why my organization was being targeted to be withheld all of that payment for so long and then all of a sudden something in October or November changed that all of a sudden I didn't have this provider issue anymore. These were aging claims. They were not resubmitted claims. That being said, they were all resubmitted. We have about 40 to 50 percent of our claims have to be touched a second time to get paid. There's recent research that supports the idea that there's probably about $25 per claim every time it needs to be touched after the initial submission. That's a burden. That's a cost I haven't even been able to calculate. It's not business as usual. So...

SENATOR RIEPE: Okay.

VICTORIA McHUGH: Thank you.

SENATOR RIEPE: I have a couple questions. So what I hear you saying is that the definition for clean claims is very evasive and so it's hard to figure out what that is. It might be, and maybe is it viewed as a tool by payers to either defer or avoid any payment at all?

VICTORIA McHUGH: I think it costs them a lot less to deny a claim or reject a claim than it does for them to send it back to us and see if we happen to act on it.

SENATOR RIEPE: The other question that I have is I'm assuming that the $5,000 that you were paid one month, $8,000 and then $12,000 is all based on the same billable charges.

VICTORIA McHUGH: Yes, sir, our practice.

SENATOR RIEPE: So have you considered going back and do you have a right to go back and appeal the $5,000 month?

VICTORIA McHUGH: That is that those payments were collectively paid for our billable services, so that isn't that that was...that $5,000 doesn't match what my billable was correlated to that month. That January to September was just what my revenue from those organizations was. That is not correlated...that's not correlated to what my billable for those nine months were. Well, it was $80,000 is what my billable at the end of September was and I had been paid $5,000 of it. Now that came in, in October and November in large part. We still have...well, this includes the more recent months. But that $5,000 was the cumulative of the first nine months of service that I had been compensated.

SENATOR RIEPE: Okay. And if you feel...

VICTORIA McHUGH: I wasn't getting...

SENATOR RIEPE: ...that that was incorrect, have you not considered going back and...

VICTORIA McHUGH: Our claims aging, it's not that it's an error in payment, it's the amount of time that the MCOs took to pay out.

SENATOR RIEPE: Oh, okay.

VICTORIA McHUGH: Those were aging claims of 60, 90, and 120 days old that just...that I hadn't been being paid because there was some delay and some bureaucrat, I don't even know why we weren't getting paid but we weren't getting paid and then all of a sudden in October we were finally getting paid.

SENATOR RIEPE: So it was cash flow distress.

VICTORIA McHUGH: For the first time in 11 years, I have had to explore a line of credit because I was not going to make payroll.

SENATOR RIEPE: Okay. Okay. Any other questions? Senator Williams.

SENATOR WILLIAMS: Thank you, Chairman. Thank you, Ms. McHugh, for being here. You used the term "business as usual." Evidently part of your business plan is to serve a portion of Medicaid patients. What portion of your total business is served by Medicaid or is Medicaid?

VICTORIA McHUGH: About 40 percent of our population.

SENATOR WILLIAMS: About 40 percent.

VICTORIA McHUGH: And we serve about...we provide about 550 visits a month.

SENATOR WILLIAMS: Have you ever considered changing your business plan to eliminate serving Medicaid patients?

VICTORIA McHUGH: I am in that decision phase right now.

SENATOR WILLIAMS: And what would those patients do if you were not providing that service?

VICTORIA McHUGH: That's a great question and that is where I am held at a very difficult position from an entrepreneur and business owner and a compassionate provider because we actually, just as a review, we do not have an outpatient clinic facility. We go to the patient's environment to work with them. So we are actually serving the clients in the metro area that aren't being served in institution-based or center-based services, most likely because of transportation or family related issues. We are currently seeing people that don't get seen. And so I...I am confident that there would be a lapse of provider..of them being provided the necessary services.

SENATOR WILLIAMS: I'm confident you're right in that. In your business plan, are you actually making money at the current level of reimbursement on this level of the care you're providing for the Medicaid population?

VICTORIA McHUGH: No, I am at about 22 percent deficit on our Medicaid clients for the year.

SENATOR WILLIAMS: And I would assume that's going up because you're spending more time on the collection side now than you were before.

VICTORIA McHUGH: Yes.

SENATOR WILLIAMS: Do you like it when the state makes you create new business models for yourself?

VICTORIA McHUGH: I don't appreciate that direction.

SENATOR WILLIAMS: I'll retract that question. (Laughter) Thank you.

VICTORIA McHUGH: I will tell you, if I may, it does make me a little crazy when I look at the bottom line of my organization and I think about the incentives that are being paid for the MCOs for their performance and I think about people that are cashing their checks as normal and not receiving any sort of financial implication for the way this business...this change has affected organizations. My organization, me, I'm at a 22 percent deficit for the year in this population and there's not very many organizations that can sustain that. And I'm a small organization. I don't have a...we do 40 percent in Medicaid. I don't have a lot of buffer. I don't have a lot of ways to pick that up.

SENATOR WILLIAMS: Thank you.

SENATOR RIEPE: Do you do home visits?

VICTORIA McHUGH: We do natural environment traditional house calls and so we break down the walls and do what are called home visits. But we serve that as an outpatient medical-based model. It's not under a home health plan of care.

SENATOR RIEPE: So you don't go into the homes per se.

VICTORIA McHUGH: I know it's a very unique model, sir. We actually do go into the home but instead of you going to an outpatient...

SENATOR RIEPE: You don't break down the halls or walls when you're in the home.

VICTORIA McHUGH: (Laugh) If I need to I will. (Laughter) We do home modification recommendations. We are a very unique model, sir. We provide outpatient services but we provide them through what would be traditionally called as a house call.

SENATOR RIEPE: Uh-huh.

VICTORIA McHUGH: And so we go to the home on our dime because I don't get paid the home health rates to do that. I get paid as an outpatient clinician to do that.

SENATOR RIEPE: Because you are unique, do you have any subcontracts with CHI or the Med Center or any of the big players?

VICTORIA McHUGH: No, sir, I do not.

SENATOR RIEPE: You don't. Okay. Just curious.

VICTORIA McHUGH: I have had...(laugh) my professional accomplishment has been that I am now a referral...I do have a referral source from Children's. I don't have a formal partnership with them but the providers at the Children's Hospital programs know my name because they're...they have a clinic for immigrants that is very difficult to provide services as recommended. And so for their CDC clinic and we have become a go-to for them because transportation is not required and so their compliance is much stronger.

SENATOR RIEPE: Did you say immigrants?

VICTORIA McHUGH: Yes, sir.

SENATOR RIEPE: So you have a language...so you have to have therapists that understand (inaudible).

VICTORIA McHUGH: That's a whole different conversation but, yes, sir. We do have some language issues and some...and that's a language barrier as it can be a challenge as well.

SENATOR RIEPE: Well, tell Children's to send you some good commercial ones too.

VICTORIA McHUGH: I would take them. (Laugh)

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

VICTORIA McHUGH: Thank you.

SENATOR RIEPE: Thank you for your mission.

VICTORIA McHUGH: Thank you.

CHRIS NICHOLS: Good morning. Good afternoon.

SENATOR RIEPE: Good morning, sir.

CHRIS NICHOLS: (Exhibit 4) I'm Chris Nichols. I'm the CEO of Fillmore County Hospital in Geneva, Nebraska, C-h-r-i-s N-i-c-h-o-l-s.

SENATOR RIEPE: Thank you.

CHRIS NICHOLS: Thank you. Thank you for the opportunity, Senator Riepe and the rest of you, to talk a little bit about our experience with the MCOs. Geneva is, of course, located south of York. We're a 20-bed critical access hospital. We have a ten-bed inpatient behavioral health unit, which makes us fairly unique. We have 175 employees, 11 primary care providers, and about 34 visiting specialists. So we serve Fillmore County and the surrounding areas. The

document that's being passed out is a great summary of our issues written by a person that's really in the front line dealing with this, our revenue cycle director. Her name is Dayle and she is ill. Otherwise, she would be here with me. I guess I will start just to say that we can follow that document. Nebraska Total Care is...probably we've had the most issues with this MCO, most ongoing issues I would say. They're currently they're paying us at a rate of 59 percent on the cost to charge ratio, and that was designated at 61 percent, so there's some underpayment going on there. I think on multiple occasions we have tried to escalate this and work with the director of the network, and for several months now they've told us that this will be fixed. We still continue to be paid at that 59 percent rate. We had a meeting just last week with a new provider representative, which is a little disruptive to have new...continue to have new representatives. Passed along that none of the claims issues that we had been receiving are...I guess basically we passed along our issues to him. We have been experiencing claims being denied for no reason when we had preauthorized it, so preauthorization is a huge issue. They keep saying that they know the issues and they'll be resolving them soon. Moving on to the next MCO, UnitedHealthcare, I think our primary problems with this one have been in behavioral health. We operate quite a lot of outpatient behavioral health services in addition to our ten-bed inpatient unit. We continue to receive repeated denials for behavioral health services, saying that we did not have preauthorization when we did, providers not loaded into their roster, services not covered, etcetera. And we've done...we have done every...we've been meticulous and been crossing our t's and dotting our i's to make sure that's all done correctly, and we're being told otherwise on the backside. I think with WellCare I can say fortunately that our issues have been pretty minimal. We've only had some issues with ambulance claims and maternity, ultrasound claims, and those have been resolved so that's one little piece of good news. I'd say collectively that our issues have had quite an impact on our hospital. We have outstanding balances of over $205,000. That's a significant number. I mean I think that the impact, I mean you think about that overall to our bottom line and our success as an independent critical access hospital in Nebraska. That's a make-or-break type of number and we have not changed a thing and, in fact, we're continually getting better at providing services, but we're...it's not being met on the other side. I think that Senator Williams had a great point earlier that I was nodding my head in agreeance with that this has been stressful on the staff. We don't have the manpower to continue to work with the...work and rework billing claims, trying to get preauthorization, reauthorization. Is the answer to just keep hiring staff, support staff? I don't think it is or we wouldn't have anywhere to

put them. So I think collectively we think that the issue probably is that the MCOs aren't adequately staffed to handle this mass of mess, phone calls and the back-and-forth with the preauthorizations and the billing and the rebilling. We think they have a long road ahead to get up to par but we continue to be...we've worked...our approach has been to work directly with them. We haven't reached out directly to Rocky. We've continued to work with the representatives that they've given us and that approach is getting frustrating, so.

SENATOR RIEPE: Okay. Thank you very much.

CHRIS NICHOLS: You're welcome.

SENATOR RIEPE: A question that I have is on the $205,000, $206,000 that you're down, are you allowed then to include that in your Medicare (sic) cost report so that you recapture some of that?

CHRIS NICHOLS: I would imagine so. I would imagine so. But I'm probably not the right person to answer that question. It's been disruptive, there's no doubt.

SENATOR RIEPE: Okay. Thank you. Thank you very much. Senator Erdman, please.

SENATOR ERDMAN: Thank you, Senator Riepe. So of that $206,000, what percentage is that of your total revenue for a year?

CHRIS NICHOLS: Well, we're...total revenue is we're approaching $30 million and we have 6 percent Medicaid...

SENATOR ERDMAN: I see that.

CHRIS NICHOLS: ...is very favorable. But behavioral health is a different animal. So outpatient behavioral health, it's probably 35 percent Medicaid.

SENATOR ERDMAN: Okay.

CHRIS NICHOLS: So that's where I think we're suffering the most. And I think we're...we offer those services. We're a little unique in that way. Not many critical access hospitals do that, but we've committed to that and it's made it very difficult.

SENATOR RIEPE: Was that a recent decision to enter behavioral health?

CHRIS NICHOLS: Yeah. I've only been there for about a half a year, but inpatient behavioral health started in 2015, outpatient behavioral health started in about 2010 at our hospital, fairly recent.

SENATOR RIEPE: Okay. Are there other questions? Seeing none, we appreciate very much...

CHRIS NICHOLS: Thank you.

SENATOR RIEPE: ...your coming in and have a nice holiday. Other individuals who wish to testify? Okay. Seeing none, that concludes our hearing for the Heritage Health Oversight Committee and we're going to reconvene as the committee. Do we have any letters? Let me cover that one.

TYLER MAHOOD: (Exhibits 5 and 6) Yes, I have a letter signed by Brenda Mueller of the Bryan Medical Center, and a letter signed by Julie Peterson of the Nebraska Physical Therapy Association.

SENATOR RIEPE: Okay. Thank you all very much and have a wonderful holiday.