[LB866 LB867 LB956 CONFIRMATION]

The Committee on Health and Human Services met at 1:30 p.m. on Wednesday, February 14, 2018, in Room 1510 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public hearing on a gubernatorial appointment, LB866, LB867, and LB956. 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 Health and Human Services Committee. Today is February 14, and happy Valentine's Day to all of you. We appreciate that...we know you love us, and that's why you're here (laughter), so we appreciate that; we love you back. I'm Merv Riepe. I'm the service chairman of the Health and Human Services Committee. I represent District 12, which is Millard, Omaha, and Ralston. And I'm going to defer a little bit on announcements. I know Senator Kolterman, who sits to my extreme right, is finishing up some stuff with the Retirement Committee. We have a lot of things going on this time of year; it's a busy time. So we'll come back to the self-introductions of staff. I just wanted...we're going to take up bills today in the order that they're posted outside, and this is your opportunity to participate in the legislative process here in Nebraska and the opportunity to express your position on proposed legislation. The committee members will come and go. Some will come a little bit late, but during the hearing...it's not an indication of a lack of interest in any of your bills. It's simply a matter of conflicting times, that sometimes we have to leave to either testify or open on a bill, and we have those things that just are part of our daily lives. You'll also see a number of our committee members either working on laptops or they will be working on their iPods, and that's just our movement towards the 21st Century, and we're getting there slowly but surely. My request today is that, to facilitate the proceedings, is that you, first of all, please silent or turn off your cell phones. If you are going to testify, to move the process I would ask you to, as it gets closer, to move up to the front seats. That helps us to move along. The order of testifying happens this way, if you haven't been here before. The senator who's introducing the bill has an opportunity to open on the bill, as we call it, and they have an unlimited amount of time. Now if they went on for a couple hours, we're going to have a problem. But followed by that we will call...I will call up for proponents, and we will then go, after that if we've gone through all the proponents, we'll go to opponents. Then we go on to the neutral, testifying in a neutral capacity. I will ask for any letters from Tyler to be submitted, and then the introducing senator will have an opportunity to come back and make closing remarks, or they have the opportunity, if they want to, to waive off the closing. We read the letters in so that the closing senator would have a chance to hear those if there was anything that was controversial there. If you are testifying today, we'd ask you, when you come up and take the seat, to state your name, please spell your name for the record, and share with us the organization that you represent. We will ask you to be concise. Today we're going to be working on what's a five-minute clock. That means you have a green light, just like a traffic signal...a green light for four minutes. Then it goes to amber and then it will go to red. If

you're in the middle of a thought, I will not cut you off. If you proceed on, I may come in and try, as politely as I can, to ask you to try to pull it together, wrap it up. And that's in interest and respect for other people that are here to testify, as well. If you will not be testifying at the microphone but want to go on record as having a position on a bill being heard today, there are white sign-in sheets at each entrance, where you may leave your name and other pertinent information, and these sign-in sheets will become exhibits in the permanent record at the end of today's hearing. As you do come up to testify, we will ask you to have in hand...it's an orange sheet, I believe, and we will ask you to have that completed and share that with one of the pages. And that page will give that to our committee clerk. We will need ten copies and, if you're coming forward but you don't have ten in hand, not to worry; our pages are great and they will have ten copies down here lickety-split, so. I'd also like to bring to your attention a new rule regarding hearings and written letters. If you're not testifying in person on a bill, but would like to submit a written position letter to be included in the official hearing record as an exhibit, the letter must be delivered to the office of the committee chair--that would be my office--or emailed to the committee chair prior to 5:00 p.m. of the last working day. We also ask you to include in the letter, or correspondence e-mailed, that you wish to have this particular information put into the public record. With that, again, we welcome you, and we are going to start off with an appointment, consideration for the Commission of the Blind and Visually Impaired. And on the...okay, very good point here. Good point, good point. We're going to take a pause, and that will...okay, the pause is over. Now we're going to go to an introduction of our committee members. And it's Senator Kolterman who will be coming in later. Yeah, but we will start with Senator Howard.

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

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

KRISTEN STIFFLER: Kristen Stiffler, legal counsel.

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

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

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

TYLER MAHOOD: And Tyler Mahood, committee clerk.

SENATOR RIEPE: And we have one page with us today. We thank her very much. Our pages are really valuable to us in committee hearings and just, we appreciate them very much. And so this is a very...a very busy group. Human health services is a very busy committee, and I...and we appreciate all the time that they give to us. With that, we are going to now go to the appointment for the Commission of the Blind and Visually Impaired. And we have...is it Dr. Robert Newman? [CONFIRMATION]

ROBERT NEWMAN: Well, just Robert Newman, thank you. [CONFIRMATION]

SENATOR RIEPE: Okay, okay. Well, Sir, if you would tell us a little bit about yourself and, if you'd be kind enough, just spell your name, too, for the record, so we make sure we get it right. [CONFIRMATION]

ROBERT NEWMAN: Last name is Newman, N-e-w-m-a-n. [CONFIRMATION]

SENATOR RIEPE: Thank you. Now if you'd just share a little bit and your interest in serving. Is this your first appointment? I believe this is a renewal, isn't it? [CONFIRMATION]

ROBERT NEWMAN: (Exhibit 1) It is a renewal, yes. I have had it for four years, and I would love to have a second four. So I am a blind person. I was in a car accident when I was 15, so I became totally blind. So I went on to a school for the blind (inaudible), finished that out, learned some blindness skills, which was great. Went off and worked as a masseur for a couple of years, and that was good experience. You know, it's pulling away from Nebraska, but yet after two years of that, I wanted to come back to Nebraska, and I've been back ever since. I did attend college, UNO, and started to work for the now Commission for the Blind; it was the Services for the Visually Impaired back then. But that was in December of 1973, and I worked there for 37 years, and I've always said, and I still say this, I enjoyed coming back to work every Monday. It was really good employment because I was helping others adjust to blindness, just as I had to. And I wanted to make that transition a better one for them than what I had to struggle through. I could share what I learned. But of course now that I am retired...I retired at the end of 2010, which has been great. Being retired is a good thing, but I'm still keeping myself very closely involved with my former employer at the Commission for the Blind. As I just said a few minutes ago, I did have pleasure spending the last four years as a commissioner and, hopefully, here again for another four years. That allows me to know what's going on. I get lots of e-mails, I get calls from our customers, you know, the citizens of Nebraska, plus I get to interact with people that I've worked with for 20-30 years and get to meet the new people that they bring in, and sometimes get the chance to interact with them to help them learn what they need to learn so

they can best serve Nebraskans who happen to be blind. And I also am a member of the National Federation of the Blind, which is a very active national group. We have a really active affiliate here in Nebraska, so many times we will come before the Legislature to either introduce a bill or be in support of a bill, you know, that we know would be helpful, you know, for all Nebraskans, especially to make whatever that bill is work better for the blind. And so, hey, I just super appreciate what you guys do in the Legislature. I know it's not an easy job at times, but it's just, I think, super interesting. If it wasn't for you guys, we really wouldn't, you know, have a system here that works. And you know, that's all about me, and I think that's all about what I have to say, unless you have questions. But I just super appreciate, you know, this opportunity to be appointed again, and I really thank you all. [CONFIRMATION]

SENATOR RIEPE: Well, we appreciate you. We appreciate your willingness to serve. Is there one particular thing, over the last four years, that's warmed your heart more than anything else, in terms of being on the commission? [CONFIRMATION]

ROBERT NEWMAN: Well, this was...an important time here was just last year which was, of course, the last year of the last four years. And that is our executive director, Dr. Pearl Van Zandt, retired, so I was there to be able to work through the process. We had 14 applicants. We interviewed 3 and we did hire a new executive director, and it so happened to be a gentleman who had been the deputy director for the commission while Dr. Van Zandt was his boss, the executive director. So it was great to have Carlos Servan be able...show up to be head and shoulders over the other applicants, because we were able to get, again, another person that kind of came up in the commission and knows our philosophy and has the type of drive that we all have developed, working under, first, the Dr. James Nyman, who came back in '73 and really shaped up our commission services for the blind and then Pearl, again, came into that same system about the same time I did, so she learned, you know, the...our philosophy and was able to carry on until she retired last year. And now we have Carlos. So that probably was the warmest glow, knowing that we will continue to be as good as...one of the best commissions for the blind in the country. [CONFIRMATION]

SENATOR RIEPE: Very good. [CONFIRMATION]

ROBERT NEWMAN: All right. [CONFIRMATION]

SENATOR RIEPE: We can tell you have a lot of energy in your voice, so we appreciate that. Are there questions from the committee? Senator Crawford. [CONFIRMATION]

SENATOR CRAWFORD: Thank you, Mr. Newman, and thank you for your many years of service to the state, as an employee, and then also now, as a commissioner. We appreciate that

very much. I wondered if you would tell us if you see one key challenge ahead, when the commission's work. [CONFIRMATION]

ROBERT NEWMAN: Sure. Some...reduced funding is making us step back from some of the things that we've enjoyed doing to the degree we were able to, in recent years past here. So that, of course, is a challenge. And there are fewer...you know, I'm a senior now; I'm 69 years old, which is great. I feel just as good as I did when I was 15, when I went blind. Still look as good as I did back then (laughter) and...but you know, there's just less and less money to work with seniors, and they're the group that's going blind. It's just part of the aging process; more blindness comes with age. So that's a tough area. In fact in this consumer group, I am the president of the Nebraska senior division of the National Federation of the Blind. We hold meetings once a month by telephone. Anyway, we're starting to look around to see where we might be able to get some private funds to help the commission do some more for the senior blind that they're no longer able to do. [CONFIRMATION]

SENATOR CRAWFORD: Excellent, thank you. [CONFIRMATION]

ROBERT NEWMAN: All right. [CONFIRMATION]

SENATOR RIEPE: Are there additional questions from the committee? Seeing none, we thank you very much for being with us. And do you have any questions of us? [CONFIRMATION]

ROBERT NEWMAN: Not at this time. [CONFIRMATION]

SENATOR RIEPE: Okay. Thank you again, and have a great day. And we will proceed on. Thank you. [CONFIRMATION]

ROBERT NEWMAN: All right. You all, too. [CONFIRMATION]

SENATOR RIEPE: Thank you. [CONFIRMATION]

ROBERT NEWMAN: Bye. [CONFIRMATION]

SENATOR RIEPE: Thank you very much. Okay. With that, Senator Crawford is going to open on LB866, as our first bill for the day. Welcome. [LB866]

SENATOR CRAWFORD: (Exhibits 1 and 2) Thank you. I have two handouts for this presentation that can be, I just heard, of unlimited time (laughter). [LB866]

SENATOR RIEPE: I have a little bell back in my office that (inaudible). [LB866]

SENATOR CRAWFORD: Such is the challenge. You know, in my other profession I speak for 50 minutes at a time. [LB866]

SENATOR RIEPE: Is that a threat (laughter)? [LB866]

SENATOR CRAWFORD: Good afternoon, Chairman Riepe and members of the Health and Human Services Committee. For the record, my name is Sue Crawford, S-u-e C-r-a-w-f-o-r-d, and I represent the 45th Legislative District of Bellevue, Offutt, and eastern Sarpy County. And I'm honored to be here today to introduce LB866 for your consideration. Medicaid is, as you know, a program that's critical to over 300,000 adults and children in the state of Nebraska, most of whom are our most vulnerable, low-income citizens. Medicaid waivers, typically 1115 and 1332 waivers, allow states to make major changes to services provided, delivery methods, and payment requirements for Medicaid and children's health insurance programs. And in our state statutes we have passed policies on many of these issues, in terms of service provided and other important key elements of Medicaid that we have in our statutes. And obviously, there are also federal rules about what's required and what can be provided. And then waivers are opportunities for a state to come forward and say, I'm going...we want to change the rules because we're going to try it a new way, all right. And so what is critical is when the...when we put a waiver forward, if we make a major change in policy in how we're going to follow...we're going to run our Medicaid program, we would want to make sure there is key legislative oversight. And that's what LB866 is about. LB866 builds on existing statutory process that we have in place for rules and regulations, to provide a time period for legislative considerations of certain applications for Medicaid waivers before they are submitted to the Centers for Medicare and Medicaid Services. So I also want to repeat this is not a new process. We are just tightening that process to make sure that we're very clear, as a Legislature, that we want waivers to follow this process, as well. Currently the Health and Human Services Committee receives an annual report in December--or September...receives an annual report in December, summarizing proposed rules and regulation changes relating to: the establishment of premiums, copayments or deductibles for eligible Medicaid recipients; limits on the amount, duration or scope of covered services recipients; and implementation of Medicaid state plans, amendments or waivers. And so those criteria are the ones that are in the statute that we're amending, so if that list sounds familiar, it's familiar to the green copy. If there are any proposed rules and regulation changes that have those effects, they're part of what we get in that December report. Along with outlining the proposed changes, this report is also required to provide information on the projected impact of such proposed rules and

regulation changes on recipients of medical assistance and medical assistance expenditures. The statute goes on to say that all changes in applicable rules and regulations covered by this report shall not become effective until the conclusion of the earliest regular session of the Legislature in which there has been a reasonable opportunity for the legislative consideration of rules and regulations. This affords us, as members of the Legislature, an opportunity to review the changes in the December report and see if they have major impacts on costs or services provided by the state's Medicaid program, and then work with the department or introduce legislative bills regarding proposed changes, if we don't agree with the proposed rule changes or waiver changes, if we feel that they are making policy changes that we feel we need to address as a legislator. It came to my attention from work with stakeholders that, although changes to rules and regulations necessary to implement new waivers are part of this process, the actual applications for new waivers, or for the elimination of existing waivers, are not afforded the same time period for legislative consideration. LB866 adds proposed applications for, or elimination of, Medicaid waivers to this process and will, therefore, require that these Medicaid waiver applications could not be submitted until after a session, affording time for legislative considerations. We get the report in December, we have a chance to see if we thought we need any legislative action to, in any way, curtail or change what might be happening and, if not, then it would be going forward after that. Further, after reviewing this annual report in December...and that's one of your handouts is this report that we got in December, that this is the section of the report that is tied to that section of statute that we're amending. After reviewing this annual report in December, it became apparent that information currently provided about the impact of proposed changes to rules and regulations, state plan amendments, and waivers is fairly scarce. So if you open the report, you'll see this...there's a column here that says impact--proposed impact--and then you can see the sentence or so that tends to be offered to explain to us what the proposed impact of that state plan amendment or regulation or waiver would be. It's pretty sparse. Although the department was responsive to inquiries when we asked for more information about these changes, there's not much further detail provided on those changes. So LB866 makes changes to the statute to strengthen this existing process. And first, it clarifies the level of detail to be included in the impact information provided by the department in this annual report. But we don't want to add too much additional workload, so what we do is simply require that the information submitted to CMS be provided to the Legislature and the public. This allows us to ensure access to some in-depth information without putting extra work on department staff. Second, LB866 requires a public notice or comment period on proposed waivers, as well as a public hearing conducted by the HHS committee on the contents of the December report. The hearing provides the director of the division or the CEO of the Department of Health and Human Services to outline details of the proposed changes. Finally, the bill clarifies where information about proposed changes and the public comment period should be posted to ensure the public can easily access these proposed changes. When meeting with the department about this bill, they suggested some technical changes that would help in the implementation of this proposal. The amendment that I distributed, as part of the handouts, addresses these technical concerns

raised at the hearing. The changes in the amendment include: 1) Excluding waiver extensions from this process, extensions that existing waivers only occur in rare circumstances and only last for around 90 days. Recently some DD waivers needed to be extended to continue services while making final changes to a new process about to be implemented. Seeing as there is a limit to how long that waiver can be extended and those extensions are not granted lightly, we felt this change was reasonable. 2nd) The amendment adds permissive language to ensure that a waiver can be eliminated without going through this process if federal DHHS...if DHHS is directed to do so by federal government, CMS. Recently DHHS was directed to eliminate a waiver that they had never used--fine. 3rd) It exempts application renewals with no substantive changes from the process. As you can see starting on page 4, line 12 of the bill, LB866 also does not require a period of legislative reconsideration for changes that are: required by federal law, related to a waiver where participation is voluntary; are proposed due to a loss of federal matching funds or are waivers applied to, or eliminated, because we said so, because we had legislative action to tell them to do so, so they don't have to wait a whole nother year for that, they can do those immediately after our session is out when we pass a bill asking them to pursue a waiver or asking them to eliminate a waiver. So if the Legislature passes a bill directing the department to apply for or eliminate a waiver, they would not have to wait for the passage of another legislative session to implement those changes. Medicaid is a program that impacts the healthcare of thousands of vulnerable Nebraskans. I believe it's important that the Nebraska Legislature play a role in reviewing waiver changes in our Medicaid program that could significantly change services offered and delivery methods of this important program. For these reasons, I appreciate your attention to this important issue, and I'm happy to answer any questions. In this part of the closing, before my "closing" closing, I would just like to say, again emphasize, that this is a change to an existing reporting process that we currently have, and we're asking to be sure that waivers are included in that information that we receive. And we're asking that the impact information that we receive has some detail that they already are preparing and providing for CMS, and so that we can see that, in terms of deciding which ones we might want to follow up with for more information in our process. And we worked with the department. There already were some exceptions, in terms of times when you have to act more quickly, that were already in the bill. And we worked with the department to try to clarify and refine those other possible times when the department might have to act more quickly. And I'd be happy to work with the committee, with the department, if there is some other instance when they might need to act more quickly that we need to consider in that part of the bill, as well. With that, I will close and ask if there are questions at this time. [LB866]

SENATOR RIEPE: Okay. Thank you very much. Let's see if there are any questions from the committee members. Senator Williams. [LB866]

SENATOR WILLIAMS: Thank you, Chairman Riepe. And thank you, Senator Crawford, for your closing (laughter). It sounds like...the serious part of my question... [LB866]

SENATOR CRAWFORD: Yes. [LB866]

SENATOR WILLIAMS: ...when, and not being...having the same level of experience as others with Medicaid waivers, that timing is very critical with this, with the December date,... [LB866]

SENATOR CRAWFORD: Um-hum. [LB866]

SENATOR WILLIAMS: ...legislative session starting. [LB866]

SENATOR CRAWFORD: Right. [LB866]

SENATOR WILLIAMS: Can you help explain to me how long it takes to get a waiver when you have an idea and you have your...who you request it from, and how long it takes to get an answer back? [LB866]

SENATOR CRAWFORD: I cannot answer that question, but it's a great question for the department if they show up. [LB866]

SENATOR WILLIAMS: Whoever is coming up next would... [LB866]

SENATOR CRAWFORD: Right, whoever is. It's a great question for the department. [LB866]

SENATOR WILLIAMS: ...help me understand... [LB866]

SENATOR CRAWFORD: ...just to understand what that time line is, right. [LB866]

SENATOR WILLIAMS: ...that process, because it sounds like the time line on this whole thing is part of what your legislation is attempting to correct. [LB866]

SENATOR CRAWFORD: Right, right. And so, and again, we've tried to rule out times when you'd have to act more quickly, like funding goes away or the department tells you, you have to do it. [LB866]

SENATOR WILLIAMS: Correct. [LB866]

SENATOR CRAWFORD: So we have some of those conditions when you'd have to act quickly already in the bill, and it also is this similar time line that we have for proposed regulations which we know do take some time. So again, we get the report in December and then after a session, so that window from December through a session is the window they have to wait, right? And so, in a short session it would be December to mid-April; in a long session it'd be longer. [LB866]

SENATOR WILLIAMS: Yeah. [LB866]

SENATOR CRAWFORD: Now one way, if they knew in December that they wanted to apply for something and wanted to get it rolling in February, all they would need--or March--all they would need to do is ask a Senator to introduce a bill, asking them to do the waiver. And that would be a way to make that time line much shorter. [LB866]

SENATOR WILLIAMS: Short of changing... [LB866]

SENATOR CRAWFORD: You could...as long as...if we pass a bill saying, yes, please apply for this waiver, then soon as...and put an emergency clause on it, then boom; that would be a way around the time line, as well. So it's just...with all these issues where we're looking to try to make sure there's legislative oversight, and if there's any action by the Legislature, you have the issue of what happens when we're not here. [LB866]

SENATOR WILLIAMS: Right. [LB866]

SENATOR CRAWFORD: So if there's something in...that needs to be done in October,... [LB866]

SENATOR WILLIAMS: Okay. [LB866]

SENATOR CRAWFORD: ...that would be the main challenge. [LB866]

SENATOR WILLIAMS: Thank you. [LB866]

SENATOR RIEPE: Okay. Before we go on with any more questions, I want to introduce Senator Kolterman. He's the chairman of the Retirement Committee, and is doing a spectacular job, in terms of getting our pensions in order in the state. So, would you tell us where you're from, Sir, and... [LB866]

SENATOR KOLTERMAN: Mark Kolterman from Seward, District 24. It's Seward, York, and Polk Counties. Thank you. [LB866]

SENATOR RIEPE: Thank you, Sir. Now, are there more questions of Senator Crawford from the committee? No, evidently not. [LB866]

SENATOR CRAWFORD: Thank you. [LB866]

SENATOR RIEPE: We assume you'd be staying for your other closing. [LB866]

SENATOR CRAWFORD: I will. [LB866]

SENATOR RIEPE: Thank you. We're now looking for proponents. Welcome. [LB866]

ANDREA SKOLKIN: (Exhibit 3) Thank you. Good afternoon, Senator Riepe, members of the Health and Human Services Committee. My name is Andrea Skolkin, A-n-d-r-e-a S-k-o-l-k-i-n, and I am the chief executive officer of OneWorld Community Health Centers in Omaha, and I'm here today representing the Health Center Association of Nebraska and our seven federally-qualified health centers, which includes: OneWorld, Charles Drew, both in Omaha; Bluestem Health in Lincoln; Good Neighbor Community Health Center in Columbus; Midtown Health Center in Norfolk; Heartland Health center in Grand Island; and Community Action Health Center in Gering. Our health centers are nonprofit, community-based organizations that provide high-quality medical, dental, behavioral health, and pharmacy, as well as support services to persons of all ages. Nebraska's health centers serve 85,000 patients annually, and 75 percent of our patients are racial or ethnic minorities. 93 percent live at, or below, 200 percent of poverty which, just recently, moved to $50,200 in annual income for a family of four. We are the state's safety net for low-income Nebraskans, and I'm here to state our support for LB866. 50 percent of the patients that walk through our doors are uninsured. Nationally the average for health centers served...for patients served by federally-qualified health centers is 28 percent. The seven health centers in Nebraska serve 26 percent of this state's uninsured children. Nebraska health centers are second only to Utah, with the highest uninsured population. We are not free clinics but all patients pay their fair share because we use a sliding fee scale for those with no access to health coverage. From a financial perspective, Medicaid plays an important role in the financial stability of the health centers. LB866 allows for the option of legislative consideration of Medicaid waivers before they are submitted to the Centers for Medicare and Medicaid, also known as CMS. This process already exists for proposed regulatory changes that impact Medicaid premiums, copays, or services. Many of those changes require Medicaid waivers in order to be enacted, making LB866 a natural extension of existing practices. Medicaid waivers provide the opportunity for states to implement new or different ways to deliver and pay for Medicaid and

CHIP programs. While waivers offer this opportunity to innovate how Medicaid programs are delivered, they can also result in significant changes in Medicaid policy with no legislative inpact--input. We feel that the Legislature should be give a reasonable opportunity to be involved in these policy changes. Recent waivers approved by CMS have included significant policy changes to Medicaid programs. For example, in Kentucky, CMS approved a waiver that will allow the state to impose work requirements, change premiums to beneficiaries, and retroactive eligibility for most beneficiaries and impose a six-month lockout period for those that do not renew in a timely manner. By Kentucky's own estimate, there will be a significant reduction in the number of months an individual has Medicaid coverage. These are major policy changes with profound impact on beneficiaries, providers, and the state budget. Kentucky, like Nebraska, does not have any laws requiring legislative approval for the submission of waivers. State Medicaid waivers are powerful tools that can enhance or add severe constraints to a state's Medicaid program. We believe that the Legislature should pay...we believe that the Legislature should play a role in that process. And thank you for your time, and I would be happy to answer questions. [LB866]

SENATOR RIEPE: Are there questions? Senator Linehan. [LB866]

SENATOR LINEHAN: Thank you, Chairman Riepe. Thank you very much for being here today. So on your testimony, in the second paragraph, are the children...so 50 percent of your patients who walk through the doors are uninsured, and then it talks about 26 percent of your patients are children. Hopefully the children that come to your centers have...are under CHIP, right? Most of them? [LB866]

ANDREA SKOLKIN: Thank you, Senator. Many of our children are under CHIP but, for example, in our health center, about 30 percent of our children are not. They are still uninsured children. [LB866]

SENATOR LINEHAN: How can they...because their family income is too high? [LB866]

ANDREA SKOLKIN: Their family income may be too high, on the border, or the family immigrated to the United States in a mixed-immigration status, so the children were not born here. [LB866]

SENATOR LINEHAN: So they're not...okay. So that's why they're not on Medicaid--or on CHIP. [LB866]

ANDREA SKOLKIN: That would be perhaps one reason, um-hum. [LB866]

SENATOR LINEHAN: Okay. So all right, thank you. And the adults, they don't qualify for Medicaid. That's why they're not...there...in there. [LB866]

ANDREA SKOLKIN: They don't qualify for Medicaid or they...or the marketplace, or they can't afford insurance. [LB866]

SENATOR LINEHAN: Okay, thank you very much. [LB866]

SENATOR RIEPE: Are there other questions? I guess I have one that's half comment, half question. I know as a government, we're accused of being too bureaucratic and not nimble enough, and yet this seems to be another step in the process for responsiveness that, if it is required to go through a legislative process... [LB866]

ANDREA SKOLKIN: Senator Riepe, I appreciate your comments because I--we, too, are not for too much bureaucracy. However in this instance health centers feel strongly that we would like to have legislative oversight or an opportunity for transparency when a significant change in Medicaid is being proposed and that this, we feel, would give us that opportunity. [LB866]

SENATOR RIEPE: So your interest here, and the bill's interest is to transfer more of the authority away from the executive branch to the legislative branch. [LB866]

ANDREA SKOLKIN: Senator, that might be one way to put it. I think what we are trying to do is have an opportunity for public conversation and dialogue so that, in the best interest and the common good of low-income people, the best decision is made. [LB866]

SENATOR RIEPE: Fair enough. I appreciate your opinion. I appreciate all the hard work that I know you do... [LB866]

ANDREA SKOLKIN: Oh, thank you. [LB866]

SENATOR RIEPE: ...for serving a good population. [LB866]

ANDREA SKOLKIN: Thank you. [LB866]

SENATOR RIEPE: Are there other questions from the committee members? Seeing none, thank you so very much for being here. Additional proponents, please. Do you have an orange slip? [LB866]

JESSICA THOENE: Yeah. I handed it in, over there. [LB866]

SENATOR RIEPE: Oh, I'm sorry; I didn't see you doing that. Thank you. [LB866]

JESSICA THOENE: (Exhibit 4) So good afternoon, Senator Riepe and members of the Nebraska Legislature's Health and Human Services Committee. My name is Jessica Thoene, J-e-s-s-i-c-a T-h-o-e-n-e. I'm a speech-language pathologist and owner of Alpha Rehabilitation in Kearney, Nebraska, and I'm testifying today on behalf of the members of the Nebraska Speech-Language-Hearing Association. We are in favor of LB866, and support the efforts to help to ensure that the public healthcare providers and other stakeholders are involved in meetings, hearings, and other opportunities to provide insight and recommendations when there are proposed changes to rules, regulations, waivers, programs, and other items impacting citizens through the Medical Assistance Act. Speech therapy and audiology services are provided to constituents with a variety of healthcare conditions, including: ALS, MS, cerebral palsy, Down syndrome, swallowing challenges, head and neck cancer, traumatic brain injury, strokes, speech delay, hearing loss, and cleft palate. Audiologists and speech-language pathologists across the state provide services to the constituents to aid them with memory, swallowing, safety awareness, return-to-work skills, and also feeding of babies in NICU. We try to reduce long-term costs by advancing skills, and allowing people to return to work faster, and eliminating the cost of feeding tubes. For these reasons, we feel that it's essential to have the state's speech-language pathology-hearing professionals involved in changes to the Medical Assistance Act, so that constituents are receiving medically-necessary services that allow them to communicate and to maintain their independence. We thank Senator Crawford for introducing this bill. [LB866]

SENATOR RIEPE: Okay, thank you very much. Let's see if we have any questions. Senator Linehan, please. [LB866]

SENATOR LINEHAN: Thank you, Chairman Riepe. Thank you very much for being here. [LB866]

JESSICA THOENE: Um-hum. [LB866]

SENATOR LINEHAN: Is..do you have any interaction with the managed-care organizations now, or HHS? Do you interact with them now on any basis? [LB866]

JESSICA THOENE: Um-hum. So I can kind of speak to that. We, as an organization for the Nebraska Speech-Language-Hearing Association, we reach out, on a very regular basis, to the managed-care organizations and also to the department, especially when we're facing issues, so

we schedule independent meetings with them. As a private-practice individual, I can say, from our firm, that we do also reach out to our provider-relations representatives to assist us when we are having issues with those. [LB866]

SENATOR LINEHAN: But there's no...is there any kind of regular way to interact with them regarding...let's say, for instance, they're thinking about a waiver or even you would be thinking about a waiver that might provide better care. Can you approach them about a waiver? [LB866]

JESSICA THOENE: I guess in the past we've never done that. And I think that's why we're here today, is that is kind of our concern, as voiced before, is the well-being. But sometimes waivers have a major impact on the individuals we serve and, if we don't have that ability or don't have that communication, then we have no means until it's already through, to be able to voice our concerns and our opinions on that waiver. So as of right now, I don't...we have never introduced a waiver and I guess, until there's an issue, we don't have a way to do that. [LB866]

SENATOR LINEHAN: But when you do contact them, are they...do they get back to you? [LB866]

JESSICA THOENE: Sometimes. [LB866]

SENATOR LINEHAN: All right. [LB866]

JESSICA THOENE: It might take multiple contacts and, you know, as, I think, we're here today testifying, we're working to build those relationships that, hopefully, that that contact goes a little bit smoother. But sometimes we're successful and sometimes it does take many attempts. [LB866]

SENATOR LINEHAN: Okay, thank you very much. [LB866]

JESSICA THOENE: Um-hum. [LB866]

SENATOR RIEPE: Okay. Are there other questions? Seeing none, thank you very much for coming in... [LB866]

JESSICA THOENE: Yep. [LB866]

SENATOR RIEPE: ...and for visiting with... [LB866]

JESSICA THOENE: Yep, thank you. [LB866]

SENATOR RIEPE: Okay, thank you. Additional proponents, please. Welcome. If you'd be kind enough to state your name, spell it, and the organization you represent, and then proceed forward. [LB866]

MOLLY McCLEERY: (Exhibits 5 and 6) Chairman Riepe and members of the Health and Human Services Committee, my name is Molly McCleery, M-o-l-l-y M-c-C-l-e-e-r-y. I'm the deputy director of the healthcare access program at Nebraska Appleseed. We are a nonprofit, legal-advocacy organization that fights for justice and opportunity for all Nebraskans. I am here today in support of LB866. Along with my written testimony, I also have a letter in support of LB866 from AARP Nebraska, as well. The Medicaid program is a partnership between the federal government and the states and, in order to receive federal funding, states must comply with provisions of federal Medicaid law. Under Section 1115 of the Medicaid Act (sic--Social Security Act) specifically, the Secretary of Health and Human Services has discretion to allow states to waive certain federal requirements in order to establish experimental, pilot, or demonstration projects that the Secretary deems likely to assist in promoting the objectives of the Medicaid program. The intent behind these demonstrations are for states to be able to experiment with new state-specific or state-driven ways of administering the program. However, the current federal Department of Health and Human Services Centers for Medicare and Medicaid Services has demonstrated an interest in approving waiver projects that could dramatically alter a state's Medicaid program. These projects could create barriers to enrollment and barriers to maintaining coverage, change or reduce the type of benefits offered, and seriously impact the cost of administering the program for the state. Because of how waiver projects could result in such significant changes to the program, it is important that the Legislature, the body that adopted the program that is responsible for its funding, the body that determined the initial set of benefits that would be provided under this program, has oversight of such proposals. As Senator Crawford mentioned in her introduction, this bill really builds on existing state statutory requirements for regulations, and it also builds on the federal notice and comment process for Section 1115 waivers, as well. Because of the oversight that this bill would provide over such potentially serious proposals, we respectfully ask that the committee support this bill. And with that, I'd be happy to take any questions. [LB866]

SENATOR RIEPE: Okay, thank you for being here. Are there questions? Senator Williams. [LB866]

SENATOR WILLIAMS: Thank you, Chairman Riepe. And thank you for being here. Are you implying, in your testimony, that there's been a change federally that's encouraging you to support this legislation? [LB866]

MOLLY McCLEERY: There has been a shift in the type of waivers that states are both applying for and that have been approved. In previous administrations there has been a reluctance to approve certain provisions that would be part of these demonstration projects. Ultimately an 1115 waiver has to test something; it has to be a hypothesis that's tested and data driven. And there has been a reluctance, especially around work requirements and more, sort of, punitive aspects of the program as they...there's data that shows that they aren't necessarily effective for administrating health benefits. There was a letter that was sent to state Medicaid directors this past spring, encouraging states to look at some of these previously rejected proposal types, and then we have seen, in the last two months, proposals from other states that have been approved. So it's really representing a sea change in the type of waivers that are being approved by the federal government. [LB866]

SENATOR WILLIAMS: Have we seen that kind of change before, with a change of administration in Washington? [LB866]

MOLLY McCLEERY: Not to this degree, not in my experience; I haven't seen that. And I think what our perspective... [LB866]

SENATOR WILLIAMS: How long have you been in this? So how many changes of administration in Washington would you have experienced? I asked that very nicely, didn't I (laughter)? [LB866]

MOLLY McCLEERY: Well, I can only speak to two changes. [LB866]

SENATOR WILLIAMS: This one? [LB866]

MOLLY McCLEERY: Yes. [LB866]

SENATOR WILLIAMS: That's (inaudible). [LB866]

MOLLY McCLEERY: But in looking back at the history of the Medicaid program, there really hasn't been this shift in perspective over the previous five decades of the program. So although I have not experienced it personally, I can sort of speak to what I know about that. [LB866]

SENATOR WILLIAMS: Thank you. [LB866]

SENATOR RIEPE: Okay. Senator Linehan. [LB866]

SENATOR LINEHAN: Thank you, Chairman Riepe. I'm just going to follow up, because I haven't been in this job for a great long time. But there was quite a shift in how Medicaid was worked when it went from Bush to Obama, right? [LB866]

MOLLY McCLEERY: There was a shift in eligibility through the Affordable Care Act. [LB866]

SENATOR LINEHAN: Right. And wasn't there...is that when CHIP was expanding? [LB866]

MOLLY McCLEERY: CHIP was expanded in 1996, under the Clinton administration. [LB866]

SENATOR LINEHAN: Okay, okay. So these just kind of...to...it's usual for an administration to make... [LB866]

MOLLY McCLEERY: Yes, yes. [LB866]

SENATOR LINEHAN: So besides Kentucky, which a previous testifier spoke to, what other states have you heard? And what are the waivers they're...or if you have out there examples of other states? [LB866]

MOLLY McCLEERY: Indiana did a similar waiver to Kentucky's, and that was approved, I believe, two weeks ago. And then there are number of other waivers that are pending approval. [LB866]

SENATOR LINEHAN: And can you remind me again what Indiana and Kentucky did? [LB866]

MOLLY McCLEERY: Both states implemented work requirements as part of Medicaid eligibility, so requiring Medicaid enrollees to work a certain number of hours per month to maintain coverage. In addition to that, there's a number of...and both of them, I will say before I get into details, are very complicated schemes to explain, and are different, depending on what income level you, as an enrollee, may be, so if you're above the poverty line or below the poverty line. But generally work requirements, copayments, and premiums, health savings account type arrangements, and then a lot of paperwork requirements, so in order to demonstrate that you're working, you have to submit that paperwork or submit that you shouldn't have to be working and other sorts of administrative requirements. [LB866]

SENATOR LINEHAN: Did Indiana or Kentucky expand Medicaid for adults? [LB866]

MOLLY McCLEERY: Both of them did. [LB866]

SENATOR LINEHAN: So which Nebraska did not, so they're different in that regard, too? [LB866]

MOLLY McCLEERY: Yes, that's true. However, there are states that are thinking about these types of proposals, that have not expanded Medicaid. [LB866]

SENATOR LINEHAN: Okay. Thank you very much. But they're the only ones that have done it thus far. [LB866]

MOLLY McCLEERY: They're the only two approvals, thus far; yes. [LB866]

SENATOR LINEHAN: Okay, thank you. [LB866]

SENATOR RIEPE: Okay. Any other questions from the committee? Seeing none, thank you very much. [LB866]

MOLLY McCLEERY: Thanks. [LB866]

SENATOR RIEPE: Additional proponents. Thank you for being with us. If you'll state your name and spell it and share with us the organization you represent. [LB866]

SARAH RUTTLE: (Exhibit 7) Okay. Senator Riepe and fellow members of the Nebraska Legislature's Health and Human Services Committee, my name is Sarah Ruttle, S-a-r-a-h R-u-t-t-l-e. I am the community relations and grant coordinator for Visiting Nurse Association in Omaha, and I'm testifying today on behalf of the members of the Nebraska Home Care Association. We are in favor of LB866 and support efforts that help improve the communication, transparency, and stakeholder engagement when there are proposed changes to rules, regulations, waivers, programs, or other items impacting citizens through the Medical Assistance Act. Many constituents who receive home health and community-based services have very complex, multiple chronic conditions and very complex long-term care needs. For these individuals careful consultation with their physicians, their home health nurses, case managers, and others involved in their care is highly needed. There will continue to be a need to request waivers or other special considerations for specific populations and constituents who have unique and challenging healthcare needs. Each time those needs arise, we feel it's critical that the Department of Health and Human Services works collaboratively with the Legislature's Health and Human Services Committee and provider organizations to gather input and then propose changes to rules,

regulations, waivers, programs, and other items based on expertise and inside of those healthcare providers. We feel this collaborative approach promotes the best healthcare services and outcomes for Medicaid clients. The Nebraska Home Care Association supports efforts to improve communication and collaboration with all parties involved in providing services and support for our state's citizens, and we'd like to thank Senator Crawford for introducing this bill. [LB866]

SENATOR RIEPE: Okay. Are there questions? I have a question. [LB866]

SARAH RUTTLE: Okay. [LB866]

SENATOR RIEPE: If this bill proceeds forward, as a grant coordinator,... [LB866]

SARAH RUTTLE: Um-hum. [LB866]

SENATOR RIEPE: ...is one of your objectives to have a greater influence, if you will, on what waivers might be brought forward so that it becomes self-serving? Or... [LB866]

SARAH RUTTLE: No, I wouldn't say so. And I mean, in my capacity as a grant coordinator, we're not involved in that Medicaid waiver process. I'd say I'm more of an advocate for access to healthcare for Medicaid recipients and, I guess also in that vein, an advocate for their voice being heard and their providers' voices being heard. And that's why we're really...for us, we see this bill as having that open-comment period and having the opportunity for the hearing, to have their voice heard and ensure that their rights are being advocated for. [LB866]

SENATOR RIEPE: Okay. Are there other questions from the committee members? Thank you very much. Seeing none, thank you. [LB866]

SARAH RUTTLE: Thank you. [LB866]

SENATOR RIEPE: Additional proponents, please. Anyone wishing to testify in favor? Okay, we're going to move over to any that want to testify with concerns or opposition, we would call it. Director Thompson, please proceed. [LB866]

THOMAS "ROCKY" THOMPSON: (Exhibit 8) Pleased to see all of you. Good afternoon, Chairman Riepe and members of the Health and Human Services Committee. My name is Thomas "Rocky" Thompson, T-h-o-m-a-s R-o-c-k-y T-h-o-m-p-s-o-n, and I serve as the interim

director of the Division of Medicaid and Long-Term Care in the Department of Health and Human Services. I'm here to testify in opposition to LB866. First of all, I would like to thank Senator Crawford for meeting with my staff and me on this bill. However, I will speak to the green copy, not to any proposed amendments to this bill. LB866 would make numerous changes to state statutes regarding waiver submissions by the Division of Medicaid and Long-Term Care. Many of these changes would negatively impact the timely submission of waivers to the federal government, which could jeopardize federal funding. These changes include mandating that Health and Human Services Committee hold a hearing within ten days of the department submitting the annual report regarding regulations, waivers, and state plan amendments which, I should point out, the committee can already do under current law. The bill also would require the department to provide public notice for waivers and sets requirements for public notice, but the department is already required to provide public notice under federal law. Finally, LB866 requires that the changes incurred with any new, extended, or elimination of a waiver would not be effective until the conclusion of the legislative session, which would delay waiver submittal and jeopardize continued federal funding. Let me be clear. We do support hearings before this committee and outreach to affected residents. However, the public notice provisions contained within this bill would be duplicative of public notices already given for waiver submissions. Public notice is already required by federal law. In addition, the department provides detailed information regarding the current waivers on its Web site, and publishes public notice online and in print. We also hold regular stakeholder meetings and town halls across the state when waivers are due for renewal. Again, this proposed notice provision is duplicative of current federal requirements and what the department is already doing. Regarding the HHS hearing requirement specifically, this committee knows that I am more than willing to come, at any point in time, to discuss the Medicaid program with you. I'm glad to present to the HHS Committee regarding any waiver, state plan amendment, or regulation. The committee already has the authority to hold a meeting, briefing, or hearing about these matters at any time, and the department is always willing to attend and present, if requested. A duplicative law is not needed. My main concern, however, is that, under this bill, the state would see the delays in submission of waivers, which could cause a loss of federal funding. The Centers for Medicare and Medicaid Services does not retroactively approve waivers. They only are prospectively approved. Now state plan amendments, they can be retroactive, but waivers cannot. CMS requires that waivers be submitted 90 days before the implementation date. But existing waivers must be renewed and submitted 90 days before the renewal date. Delaying the effective date of waiver or renewal of a waiver could cause residents to go without services during the waiver-submission delay, or require services to be paid entirely by state general funds, if a waiver is not approved. Individuals covered by the home- and community-based waivers are some of the state's most vulnerable residents: the aged and the disabled. Any delay or loss in services would be highly detrimental to those residents and the providers that receive payment for the work they perform under these waivers. It is unlikely that CMS would grant us additional time to submit waivers to comply with the proposed law. CMS would only consider requests for temporary 90-day waiver extensions in

very limited circumstances, and this would be...very likely not count as one. In conclusion, current law already requires considerable public notice to residents, and this committee already has the authority to hold hearings. Conditioning the submittal of certain required documents to the federal government on duplicative notice and hearing requirements could jeopardize federal funding for our state's most vulnerable residents. And it is for this reason that I oppose this bill. Lastly, I know that Senator Crawford mentioned the 1332 waivers. I should point out these are not actually Medicaid waivers; these are insurance waivers and would not be submitted by Medicaid and Long-Term Care. I thank you for the opportunity to testify. I'd be happy to answer any question any questions that you might have. [LB866]

SENATOR RIEPE: Are there questions from the committee? Senator Williams, please. [LB866]

SENATOR WILLIAMS: Thank you, Chairman Riepe. And thank you, Director, for being here. I'm sorry I missed the very first part of your testimony. I think you were in the room when I asked Senator Crawford the question about timing and the delay and how long it takes to go through that process. Could you tell me a little bit more about that process? [LB866]

THOMAS "ROCKY" THOMPSON: Certainly, Senator. First of all, the department has not actually submitted a new waiver in quite a few years. Depending on the waiver, it can take a lot of time--probably six months to a year for development and implementation of a waiver--1115s are more complicated because they're not...there's not a kind of preprint form like some of the home- and community-based service waivers. So those take a considerable amount of time to develop and considerable stakeholder outreach before any implementation. [LB866]

SENATOR WILLIAMS: Are you concerned about anything that is different today, with the change of administration in Washington, in how this program is operating that would affect the ability of us to continue providing services to those that need it in Nebraska? [LB866]

THOMAS "ROCKY" THOMPSON: Thank you, Senator. I think you're probably going to the work requirements of the 1115 waivers that have been approved in two states and have been proposed in several different states. Now just so you know, those two waivers, as pointed out before, were approved in expansion states. They were amendments of current 1115 waivers. Most of the states that have proposed that are expansion states. There are some states that are not expansion states that have proposed work requirements. Wisconsin, for example, has proposed work requirements, but they already have Medicaid eligibility for childless adults, up to 100 percent of the federal poverty level. Utah has proposed those as part of its Medicaid expansion. Virginia has been talking about it as a proposal to expand their Medicaid program. [LB866]

SENATOR WILLIAMS: So that we can be clear in terminology, when you say expansion states, could you describe what you mean by that? [LB866]

THOMAS "ROCKY" THOMPSON: Expansion under the Affordable Care Act of 2010. [LB866]

SENATOR WILLIAMS: Thank you. [LB866]

THOMAS "ROCKY" THOMPSON: So those are the states that have been really pursuing these, and they haven't been submitting new waivers; they've been submitting amendments to 1115 waivers that they already have for their current delivery system. And again, these work requirements...it's not just work requirements--work requirements and community engagement--so there's also...if you do volunteer work, that sometimes counts as work requirements. Now those requirements are only applicable to childless adults, and we have a very small population of childless adults, and many of them are already engaged in different programs administered by the department, seeking work. And these really are waivers that are more applicable to expansion states than to any non-expansion states, because a number of...that would qualify in Nebraska is about 8 percent of the Medicaid population. [LB866]

SENATOR WILLIAMS: Thank you. [LB866]

THOMAS "ROCKY" THOMPSON: Thank you, Senator. [LB866]

SENATOR RIEPE: Okay. Are there...Senator Howard. [LB866]

SENATOR HOWARD: Thank you, Senator Riepe. Thank you for visiting with us today. I noted, in your testimony, that you said that you're always more than willing to come talk to us, and I've been really grateful for your briefings. Do you believe that you'll always be in this position? [LB866]

THOMAS "ROCKY" THOMPSON: I...thank you, Senator. I don't believe that I'll always be in this position, but I do believe that this administration and...will always be open to the HHS Committee and its members. [LB866]

SENATOR HOWARD: And how much longer do we have in this administration? [LB866]

THOMAS "ROCKY" THOMPSON: Well, this year is an election year, and then... [LB866]

SENATOR HOWARD: And then four more years after that? [LB866]

THOMAS "ROCKY" THOMPSON: Oh, we can hope. [LB866]

SENATOR HOWARD: So I think one of the aims of this piece of legislation would be to ensure that, if there was ever a time when there wasn't an administration that wanted to work with the Legislature in this way, that we could be sure to have that type of relationship that we enjoy unofficially now with you. [LB866]

THOMAS "ROCKY" THOMPSON: Thank you, Senator. I think that's a good point. However, I don't think that just making law based on what might possibly happen in the future is a great idea. [LB866]

SENATOR HOWARD: Isn't that what we already do? [LB866]

THOMAS "ROCKY" THOMPSON: Sometimes, but I don't see what the problem is that we're trying to solve by that portion of legislation. [LB866]

SENATOR HOWARD: You know...and it's true; we've been very fortunate with you and with Mr. Lynch. Prior to that it was more difficult for this committee to get a person from the department to come and chat with them about how things were going and, specifically, about Medicaid. And so I think it's very easy for me to envision a time when we wouldn't have such a wonderful director as yourself and that this legislation would be very needed. And so I appreciate you coming today, and I appreciate your testimony. [LB866]

THOMAS "ROCKY" THOMPSON: Thank you, Senator. [LB866]

SENATOR RIEPE: Any other questions? My concern is it looks like it has the potential of politicizing it to a point it becomes very difficult. You know, this business you need to move with some speed. [LB866]

THOMAS "ROCKY" THOMPSON: Well, Senator, I know that we were talking about the work requirement 1115 waivers that are currently available through this administration, but there are other 1115 waiver opportunities that might benefit the state and might be worth pursuing and that we need to look at, do our due diligence as a department. There's several--I think about 11 states--that have now applied and have been getting approval of 1115 waivers, specifically regarding the opioid epidemic. And I think that's something that, if we decide to go down that

path and we can move and make sure that additional service might be available to individuals in our state through that waiver authority. [LB866]

SENATOR RIEPE: Okay, that's very helpful. Are there additional questions, comments? Thank you very much for stepping forward. [LB866]

THOMAS "ROCKY" THOMPSON: Thank you, Chairman. Thank you, Senators. [LB866]

SENATOR RIEPE: Additional...any other opponents, anyone speaking in opposition? Is there anyone in a neutral capacity? Seeing none, let's hear if there are any letters and, Senator, you can get prepared for your closing. [LB866]

TYLER MAHOOD: (Exhibits 9 and 10) Okay. I have a letter, signed by Dr. Richard Azizkhan and Liz Lyons of Children's Hospital and Medical Center; a letter, signed by Annette Dubas of the Nebraska Association of Behavioral Health Organizations, in support. Correct, all of these letters are in support. Sorry; I misspoke. [LB866]

SENATOR RIEPE: Okay. [LB866]

TYLER MAHOOD: (Exhibits 11, 12, and 13) I missed these letters: Kristin Mayleben-Flott of the Nebraska Planning Council on Developmental Disabilities; Joni Cover, of the Nebraska Pharmacists Association; and John Else and Sherry Miller, of the League of Women Voters of Nebraska. [LB866]

SENATOR RIEPE: None in opposition or none in neutral? [LB866]

TYLER MAHOOD: None in opposition or in neutral. [LB866]

SENATOR RIEPE: Okay, thank you much. Senator Crawford, would you like to close? [LB866]

SENATOR CRAWFORD: Yes, I would. Thank you, committee members. And I would like to thank Director for his willingness to come to hearings before our committee, and I do appreciate his willingness to do so. And I know we've had him come in to talk about Heritage Health and other issues, and he's been responsive to those requests; and I appreciate that greatly. However, I, as with Senator Howard, was here when that wasn't the case with some other members of departments, and so I think it's important to lay an expectation and best practice. That's part of what we do in statue at times is...here's the process. Again this is an existing statutory process to

make sure that the committee is engaged when there are major changes that may be made to programs through regulations or waivers and, if so, making sure there's a hearing, and that hearing is set, is critical. And if we have to have statutory authority because someone is reluctant to come, we have it. If it's just making sure we get it on our calendars and get it done, we have it with having it in this statute, since it's existing...already an existing process that's in statute. So I think putting the hearing in the statute--in this statute for this process that's already in the statute--is a small change and one that I think is important. But I'm willing to talk to the committee about that. I also want to emphasize that this is not every regulation change or every waiver. It's very clear in the statute that these are only those changes that would make changes relating to premiums, copayments, deductibles, limits on the amount, duration or scope of covered services recipients, and those kinds of changes. So we're not saying every single change to Medicaid or that has to be made but, when they change those fundamental pieces or requirements, that's what we're asking for, to make sure. And it's not asking for a new legislative process, either. All it's saying is, in terms of requirements to approve it or vote on it, what it's saying is we already have this report we get on December 1st. We want to make sure those are in that report, and we'd like to make sure that some of the information they already send to CMS about what those changes are, we get to see as well so we can decide if we think it's important. And then we have an opportunity, at a hearing, to ask questions and learn more about those changes...and again, only those changes. And you can see this is not a burdensome report, in terms of how many they have seen in the past. And we would just be adding those major waivers to that. As the director noted, we haven't applied for any of these for a while, so hasn't...there may not be any that have to be reported in the next year or two. It's also important, as he noted, that this kind of waiver is a more major waiver, so we are talking more about a six-month to one-year time frame. And so I think it is the case that this time frame would fit in a six-month to year time frame, from idea to application; we'd be able to hit it. And again, if you started so that you were further along the way by the time it hit December, we could pass a bill with an E clause. Once you recognize that's a possibility, I think we could get about any kind of six-month waiver out with this process, and it still would work and give us the chance to have that report and have that hearing and have that conversation about that major--possible major change. It is true, as the director noted, that the department is already required to have public notice on their waivers, and so that part of the statute really is trying to emphasize that it's easy to find on the Web site. That's not as important to me as the other parts of the bill and so, if people consider that duplicative, that's a piece that I'm willing to consider as less important than really making sure that we get this information in time for us to respond if we would wish to do so. Also I just want to note, again, that there is public notice and there is public comment, if there's a wayward change. But it's important for us to realize the difference between a public comment period, when people could come and make comments on what they like or don't like about a waiver, and our ability to authorize policy changes, right? So you can have a hearing...the department can have a hearing and people can come and talk about how it will impact their practice or how it will impact patients. And the department can choose how much to listen or not listen. We would have, if the

part...if part of this process and, let's say, put in something like a three-year...a three-year time limit on how long you can be on Medicaid. That would be an important policy change, and we would be able to, if we thought that was a good idea, fine. We don't do anything. If we thought it was a troubling idea, we might bring a bill to say that we would not all have time limit coverages on Medicaid in our state. And then that would stop them from putting that waiver application in. So why now? As has been emphasized by some of the proponents and in the discussion, it is the case that the current administration is much more open to larger changes in waivers through, especially, the 1115 waiver. They're open to changes that are new and different that we haven't seen. And if you're concerned about additional requirements or restrictions in access to Medicaid, those are changes that are currently the kinds of changes that the current administration is allowing in 1115 waivers. And so that's really when this process--an original process--was put in place, It was by legislators who were concerned that regulations would be used to restrict access in ways that the body might not see or have a say in. And so now that same concern is the concern, in terms of 1115 waivers. And I have a reference from Commonwealth Fund on January 11, 2011, and it has ten states with pending Medicaid Section 1115 waiver applications. And five of those states are expansion states, and five of them are non-expansion states. So Medicaid expansion are those states that decided to cover people up to 138 percent of poverty, in terms of all adults. And we are not an expansion state, and the changes that are being proposed in...so there are changes, unlike what the director implied, there are changes in non-expansion states, as well as changes in expansion states that are currently pending. And an example is: Kansas, our neighbor, is a non-expansion state, and they are proposing, in their 1115 waiver, a work requirement and a three-year lifetime limit on coverage. So that's the kind of change that can be made in a Medicaid policy, in a non-expansion state, through a waiver. And that would be different than our statutes on what we are expecting, and how we're expecting Medicaid to operate in our state. Another example is in Indiana, which is an expansion state, but one of their provisions in their 1115 waiver application is a six-month lockout for failure to provide necessary information at re-enrollment. So those are examples of some of the things that are in proposals in these 1115 waivers and why...that's why, I think, looking at this process now is critical because now is the time when there has been an openness to these kinds of changes in Medicare--Medicaid, excuse me--through waivers. And some of those, I think, are key policy changes that I believe we, as a committee, and we as a Legislature, should play a role in determining, or decide...or have an ability to determine if we think that is fine or if we think we need to act before those waivers get submitted. Thank you, Mr. President (sic). [LB866]

SENATOR RIEPE: My one comment with this is that I'm not confident that politicians have the stomach for ever limiting anyone that, once they're on a plan, to be able to take them off. If Kansas, they can talk about that; in three years they won't have the courage to do it, is my opinion. You can react to that. The other one, and it talks about, you know, control over premiums, copays, and deductibles...the only thing that's missing out there is quality and that is, then, total control. I mean those are the levers. Deductibles are major and, if you can't make

those at a actuarial level and have to make them at a political-policy level, I think you're going to be in trouble as a Legislature, as a state...my opinion. [LB866]

SENATOR CRAWFORD: In terms of if a state chooses to use deductibles, what that level should be, etcetera, I wouldn't expect the Legislature would get into that detail. But the policy question of whether you might require deductibles might be something that would be an access-policy question. [LB866]

SENATOR RIEPE: So what... [LB866]

SENATOR CRAWFORD: And to go back to your other point, that you don't think legislators have the stomach to take people off of services after they've been on services, we have all kinds of examples, especially when we went through the fiscal crisis before we got here, where we took away access to Medicaid in many ways. We used to have presumptive eligibility. It used to be that if you showed up, you were able to presume eligibility and get on Medicaid much more quickly; that got taken away. I'm going to blank out now, but I know there are--and I will get them to you--many instances when we have restricted services after we had them for...after we had allowed them to be in place. Longer time periods you could be on, and we shortened them to try to kick people off, so we have had those changes that have happened, and I am...I don't know for sure what all has happened in Kansas, but I imagine that's true...I mean when we are balancing the budget and there are Medicaid policy changes that have happened that have significantly reduced services to people on Medicaid in our own state as well. [LB866]

SENATOR RIEPE: Okay. Maybe it's only in my three and four years here that I haven't seen it. [LB866]

SENATOR CRAWFORD: Well, perhaps... [LB866]

SENATOR RIEPE: And I appreciate your endorsement for direct primary care, in talking about no deductibles. So thank you. [LB866]

SENATOR CRAWFORD: Well, that might be an interesting demonstration project. [LB866]

SENATOR RIEPE: For the whole state? [LB866]

SENATOR CRAWFORD: And it might...you know, yeah. So...or, you know, so if we did a demonstration project of that kind, then you would have a chance to know that they're thinking about it, and cheerlead it and... [LB866]

SENATOR RIEPE: I have some legislation in to pilot it with the state employees, so... [LB866]

SENATOR CRAWFORD: Or...well, I hear you. I hear that you have that. And it's also the case, let's say, if you found a way to pass a...if you thought that was a good idea and you thought it applied for a waiver, there's nothing in this bill that restricts you from doing that. And in fact, if you do that, if you put in a bill to say we should use direct primary care in some way in our Medicaid program, they could start that application right after that you passed that bill with an emergency clause...no delay at all, so... [LB866]

SENATOR RIEPE: I hear you. Thank you so much for your engagement and for being here and for your carrying this bill. Are there other questions from the committee? Seeing none, thank you very much. That concludes the what I consider a full and fair hearing on LB866 and we will now proceed on to LB867,... [LB866 LB867]

SENATOR CRAWFORD: Okay, thank you. One second here. [LB867]

SENATOR RIEPE: ...again with Senator Crawford. [LB867]

SENATOR CRAWFORD: Yes. Give me one minute here to get out my...make sure I have...I have a few handouts in here, too, a few more handouts, want to make sure I have the same ones that you have. Thank you. Oh, and another one--we have a new fiscal note too. We talked to Liz today and there was a... [LB867]

SENATOR RIEPE: Okay. [LB867]

SENATOR CRAWFORD: ...bit of incorrect description in the fiscal note so we have a new fiscal note. It should be uploaded if you're following us electronically. [LB867]

SENATOR RIEPE: Okay, thank you. [LB867]

SENATOR CRAWFORD: (Exhibits 1, 2, 3, 4, 5, and 6) Good afternoon, Chairman Riepe and members of the Health and Human Services Committee. For the record, my name is Sue Crawford, S-u-e C-r-a-w-f-o-r-d, and I represent the 45th Legislative District of Bellevue, Offutt, and eastern Sarpy County. And I'm honored to be here today to introduce LB867 for your consideration. In January of 2017 the Department of Health and Human Services rolled out a new healthcare delivery system that combines Nebraska's physical health, behavioral health, and pharmacy programs into a single comprehensive and coordinated system for Nebraska's Medicaid and CHIP clients. This program, which we all know as Heritage Health, is managed by

contracts with three private, managed-care organizations, or MCOs. Now I want to talk just briefly about some of the advantages of managed care and contracting with managed-care organizations and the shift to bring these three important parts of healthcare together. There's a lot of positive in that shift and I want to acknowledge that at the beginning as we start this discussion of how we might do it even better. So bringing these types of healthcare together is...can provide better coordination of types of care, and particularly, I think, when we're looking at mental healthcare and physical healthcare and pharmacy services and making sure those work together, that's important and valuable. Second, by having managed care in our Medicaid plan, it also allows us to provide proactive care that otherwise would not be allowed by Medicaid. And so you may have heard...we've heard in some of our briefings about being able to provide air conditioning or being able to provide some service that changes someone's life and changes their health but it's not something that traditionally would have been allowed by Medicaid but, because we have managed care and because we're asking them to take care of these people, they see, well, it's better to make sure that this person has access to air conditioning than to go buy a bunch of drugs, I mean if this is going to take care of the problem. Or it may be that...and so it allows more proactive attention to how to improve one's health in the most effective and efficient ways. Now it's also the case since we are asking someone else to do this work for us, the private MCO companies, it's also the case that we can say here are our standards and we expect you to meet them, and if you're not meeting them, then we're going to have consequences. And again, since we're having someone else do this work for us, we can lay out the contract, set up the conditions, and expect that entity to meet those standards. Now I'm pleased that the department has worked on dashboards and standards and has presented that information to us at our briefings. And some areas, like improving overall timeliness of payments and several other areas, we've seen good improvements. And I appreciate the attention to pushing those improvements and making sure that those dashboards are available and reporting to us what's happening in terms of the managed-care organizations meeting those standards that we've set out in Heritage Health. And I want to acknowledge that things are better than they were when we first started and I want to acknowledge that we may very well be doing better than other states. But we can do better and we must do better. So although we are doing better than other states, it's still the case that we can do better and I believe that LB866 (sic) will help push us in that direction to do even better by our citizens and by our patients who most need our help. So through our Heritage Health managed-care contracts, $1.2 billion worth of physical health, behavioral health, and pharmacy services are administered to over 230,000 Nebraskans. Although growing pains can be expected when transitioning such a large program, a year has passed since the program's implementation and many of our state's Medicaid and CHIP providers are still carrying heavy burdens of additional staffing hours and costs because of Heritage Health processes. I've heard ongoing frustration from providers from across the state who want to continue serving this vulnerable population but are concerned about their ability to do so given the administrative demands in Heritage Health. We've also heard of providers who are going out of business due to the stress on their finances due to impacts from Heritage Health delayed payments or additional

costs and following Heritage Health. And this is a concern and obviously providers want to make...be able to keep their businesses open and that requires that they get paid. But I would say we also and quite often hear quite impassioned pleas from our providers on behalf of their patients, concerned about their patients who are not getting treatment, concerned about their patients they will not be able to serve if conditions are not improved, if they don't get their payments, if they're not able to get approvals in time. So in contracting our services we again set standards for our managed-care companies and expect them to meet those standards so that we can have quality patient care and effective use of taxpayer dollars and to maintain a strong Medicaid provider work force and just a strong work...health work force in the state in general. We hear probably most often from providers when we hear people talk about Heritage Health but I will say just the other day I was at a town hall meeting and I did have a Head Start provider come up to tell me that she had heard concerns from parents about issues with their children getting care and asked if on some recess day I could come talk to those parents because she knew they had concerns about the issue as well. So this bill has two parts. One part deals with violations and sanctions for violations and the second part deals with clean claims. So I'm going to start with the sanctions component of the bill. In conversations and meetings with the department to try and address individual providers' concerns the end of last year, it came to my attention at that time that even almost a year after implementation there had not been a single financial sanction imposed on a managed-care organization. According to the department, one financial sanction had been issued. According to the department in a recent news account, one financial sanction has been issued but financial sanctions are mostly waived without payment when the MCO completes their corrective action plans. And this seems like a grave imbalance when we consider the costs that are borne by providers that no financial sanctions or, at most, one financial sanctions have been imposed despite the costs that our providers have had in working through this transition of the system. Although imposing a sanction is left up to the discretion of the department, and that's still true in our bill, LB867 provides a mechanism for transparency in this process. LB867 requires the Department of Health and Human Services to provide the Legislature with an annual report on the number and type of contract violations that are subject to sanctions pursuant to the contract committed each fiscal year by each managed-care organization, so it adds another tracking piece and that is how often each managed-care organization violates their contract in a way that would allow a sanction to be imposed. If no sanction is imposed for that violation, the department must provide in the report explanation of the reason for not imposing a sanction and actions taken to remedy the issues resulting in the violation. So in a couple of the examples, they would have said this is what...the MCO had a sanctionable offense, we issued a corrective plan, and they completed the corrective plan, and that would be the explanation. So per the state contracts with the MCOs, monetary sanctions can be put in place for many types of violations. So one of your handouts for this hearing is...has the...is Attachment 18 and it includes the things for which our contract allows us to sanction managed-care organizations if they don't meet these terms and conditions. And so you can see there are many pieces here where there are standards that we're setting and part of this contract

is, if you want to work for the state of Nebraska, here's what we expect you to do and if you don't meet these standards, here are the fines that we can impose, here are the sanctions we can impose. And you can look at that to see the kinds of things for which sanctions may be imposed. And as I said, in that first year, at most one sanction was imposed. The department may impose civil monetary penalties for failure to meet contract standards, failing to provide satisfactory service, or failing to show improvement in problematic areas. So I just ask you to consider some of the...we have made some improvements in some systematic issues, but are there problematic areas where there is failure to improve where sanctions have not been imposed? Although one problem we've continually heard as a committee, after the implementation of Heritage Health, was late payments, DHHS has yet to impose any sanction on a health plan for having claims that were not paid within 60 days. In a December 2017 survey conducted by the Heritage Health Stakeholder Coalition which surveyed 158 providers, in that survey it was found that among 84 respondents there was a total of 63,000 unpaid/incorrectly paid claims that were submitted over 90 days ago. Being able to issue sanctions that we've put out in this contract, that the MCOs agreed to, is what would help us hold these MCOs accountable for the care they're providing and put urgency on them to make the corrections. LB867 will allow the Legislature to review how these sanctions are being used as we continue moving forward with stabilization of Heritage Health. So that's the contract violation piece. We have standards. We have fines that they have agreed to. We do not appear to be implementing them and I think that's part of having a sense of urgency for the managed-care organizations to correct things that need to be corrected by knowing that they could actually...that these fines are real and they can be imposed. The second part of the bill, LB867, lays out a clean-claim standard for managed-care organizations in statute. Currently there's not a contractually set out standard for the allowable percentage of clean claims, so just to get into the weeds here a little bit, so according to the contract, managed-care organizations are required to pay 90 percent of all clean claims in 30 days. There is no standard outlining what percentage of claims received by the providers need to be accepted for processing, how many they need to get to a level where they have what level of clean claims they need to have versus how many are rejected before processing. So I appreciate the efforts by the department to respond to our request to have more information on clean claims. As you can see from this table that we handed out, this is again part of the department's responsiveness in providing this information to us, which is very valuable as we are watching this program roll out and trying to be a partner with them in making sure it's working well. As you can see in the table, then the says "CLEAN CLAIMS AS A PERCENTAGE OF TOTAL CLAIMS," and also from the most recent numbers on Heritage Health dashboard, show that United and WellCare are rejecting 16 percent of claims as not clean claims while Total Care is rejecting less than 3 percent of claims before processing. And again, in order to be in the time frames where we're talking about timely payments, those are for clean claims. So these are the percent that are coming in that are being treated as clean claims per MCO provider. This is a large discrepancy. Nebraska Total Care has actually accepted over 95 percent of all submitted claims as clean from April to November. This shows that it is possible in Nebraska to hit the 95 percent clean-claim

target. One of our three is doing it. And that's also part of why we have three, so there's competition, so this shows that it's a possible target. It's something that one of our three managed-care organizations is hitting. And so it's possible for all three, I believe, with the proper changes, to hit that target. And neither WellCare nor United has ever hit that 95 percent right. When claims are rejected and cannot move forward to be paid or denied, providers have to go back and work to figure out what corrections must be made. Further, these claims that are not "clean" are not held to MCO payment requirements. Many providers have expressed frustration with the rejection process. Depending on who they speak to at a managed-care organization, there could be a different opinion for why their claim was rejected. Further, in the same Heritage Health stakeholder survey, 72 percent of respondents reported improper denials in the last 30 days. Overall, this seems to be a problem that stems from communication deficiencies between managed-care organizations and providers. While clean claims also depend on the providers doing their role, establishing a rate for clean claims that must be considered clean for processing will create a standard that will require the managed-care organizations to communicate very clearly with providers and provide ongoing and accessible education about claim submission process to ensure that they meet those contractual standards. And so another handout that I'm turning your attention to now is the one that says "QPP Measures Year Two." So one of the arguments against setting a clean-claim standard for our managed-care organizations, they might argue, well, whether a claim is clean or not depends on the provider doing the right things before they submit it, so it is true that a clean claim requires cooperation between the provider and the managed-care organization, but I would say that is...we still, in our contracts, have standards and require behaviors and outcomes that require someone else to act. And the example I'm going to show you here, this is from one of our December Heritage Health briefing and you'll see--it's very small print but hopefully you can see--there is, near the bottom, there is well-child visits and childhood immunization status, so those are also things that require families to act but we still say we want a certain percent of our kids immunized, we want a certain percent of our kids getting these well visits, and so again, your job is to educate and incentivize to make it happen. Same is true for clean claims. We can set a clean-claims rate and we're telling the managed-care organizations, it's your job to make sure it's clear what needs to be done, it's your job to educate and help providers so they and you can reach this 95 percent level. And again, one of our managed-care organizations is already doing that regularly. So we do not have any managed-care organization...we do not have a clean-claims rate in our contract, and one of the other problems with that, one of the kind of perverse incentives that could go on, is, again, the standards that we do have are how many of those clean claims are paid on a timely manner and also interest comes in from when it's a clean claim and getting paid. So there, you know, if an MCO was having unclean claims, those unclean claims don't get counted, and so they don't count against their ability, their timely payment, or wouldn't count in terms of interest. And so all that time that a claim spends unclean doesn't count against that managed-care organization but, obviously, it does count against the financial stability of the provider and their ability to serve their patients. Now I want to address the fiscal note a bit. One, as I noted, we did talk to Liz Hruska and she did

correct the comment about the fact that these clean claims are not in the contract, and so that has been corrected in fiscal note. I also want to say it's my intent that the language about contract negotiation starting on page 2, line 31, would require the department to attempt to negotiate a contract amendment. And I know that is just we're asking them to attempt that. If it's unsuccessful, they simply would require...they would include this as a requirement during the next cycle of contract renewal. You know, the contract has already been offered, so we can try to negotiate that. If it doesn't work, it becomes an important requirement for the next cycle of renewal. It's not my intent to authorize...and it is not in any way intent or language to authorize use of paper claim submissions with our definition of clean claim, so I don't know how that got in the fiscal note that we would somehow be using paper claims. The definition in the bill was found on the Heritage Health Web site and it is the same definition that Heritage Health used in its October 17, 2017, health plan advisory. So we're using their exact definition in this bill and so we are not adding anything to in any way require paper claims. We're using their exact definition. The department states that this is the definition they've used in contracts and that they use it because of federal regulations. My office has worked on amendment if we need it to clarify that paper claims cannot be submitted and that clean-claims rate would simply be a part of future contracts. Now I will note the Nebraska Hospital Association is coming afterwards and they're going to talk to you about a possible amendment with a different definitional option for clean claims and I think they're going to make an argument it could be more objective and may have benefits over the clean claim definition that we're using, which is Heritage Health's definition. With the changes in AM1919, I would anticipate there to be little to no additional cost. MCOs should already be improving their claims processing configuration to decrease the number of rejected claims. This should not be a new cost. They should already be doing that, already be aiming for something close to 95 percent. As for more DHHS staff needed to monitor reporting data, DHHS staff should already be tracking when MCO contract violations take place. So we should not need new staff to be tracking when contract violations are taking place. I hope that's already happening. If anything, perhaps sometime to turn that into a report, but we I hope have staff who are watching and tracking for these kinds of contract violations already. And so the fiscal note assumption that we would need new staff to do that seems to me inappropriate. I certainly hope we have staff tracking and watching these sanctions, sanctionable offenses already. Colleagues, the reality remains that Nebraska's Medicaid providers are still experiencing hardship as they try to navigate Heritage Health. With 64 percent of respondents to the survey, a recent survey reporting that they've had to invest in additional staff time in the last 90 days to handle administrative burdens of Heritage Health--I know that's something you've raised concerns about, Senator Erdman, about these providers having to pay for additional administrative staff time--and in this last report 64 percent of respondents to the survey reported they've had to invest in additional staff time in the last 90 days to handle administrative burdens of Heritage Health, and 17 percent of providers saying they will be reducing the number of Heritage Health clients that they serve. We have an obligation to push for further transparency and accountability and improvements. Frankly, without our Medicaid providers, there are no

healthcare services for our vulnerable Nebraskans. Seeing that we are now over a year into the process, the managed-care organizations need to be held to a higher standard in terms of clean claims and they need to be just held to their original standard in terms of making sure that we are actually sanctioning violations if they're occurring. LB867 puts in place provisions to start increasing accountability and encourage system improvements. And with that, I appreciate your attention to this important issue and I am happy to try to answer questions you may have. [LB867]

SENATOR RIEPE: I guess I would start out by saying I think it's critically important that we have a common shared definition of clean claims. [LB867]

SENATOR CRAWFORD: Yes. [LB867]

SENATOR RIEPE: And whether the Nebraska Hospital Association can bring the pure copy or not, we'll see. We'll have more conversation on this one. [LB867]

SENATOR CRAWFORD: Yeah. [LB867]

SENATOR RIEPE: I'm curious because there is no documented source. I don't know where the source of that is. [LB867]

SENATOR CRAWFORD: Oh, this? This, I'm sorry, this is from the department itself. [LB867]

SENATOR RIEPE: Okay. [LB867]

SENATOR CRAWFORD: Yes, yes. Thank you for... [LB867]

SENATOR RIEPE: The other one that you've commented on and referred to a lot, 64 percent, is from...of the providers and was conducted by an instrument called SurveyMonkey, which is, I would say, is not statistically valid, but it's interesting. [LB867]

SENATOR CRAWFORD: Right. So I'm not going to argue that that is a random sample. But it is still true--let me see--we still had a sizable number of providers responding to that survey and there were...so there were 84 respondents to that survey but of those 84 respondents, there were 63,000 unpaid or incorrectly paid claims submitted over 90 days ago. So it is a small number and the 17 percent is 17 percent of those 84 respondents. And so you are correct, it's not a random sample, but it's a sample of providers who are interested in having their input known. [LB867]

SENATOR RIEPE: But I think with SurveyMonkey it's...I mean I think I only filled it out 20 times. So my point is there is not much integrity in terms of who can or can't get on and fill it out. That's where the, you know, the credibility gets... [LB867]

SENATOR CRAWFORD: I don't know if that organization is coming to testify today or not. I will... [LB867]

SENATOR RIEPE: SurveyMonkey? [LB867]

SENATOR CRAWFORD: No, not SurveyMonkey. [LB867]

SENATOR RIEPE: Oh. [LB867]

SENATOR WILLIAMS: It's going to swing in. [LB867]

SENATOR CRAWFORD: Yeah. I meant the organization that managed the actual survey itself in terms of who was invited and... [LB867]

SENATOR RIEPE: Oh, the managers of it? [LB867]

SENATOR CRAWFORD: ...and what screening they had for multiple entries. [LB867]

SENATOR RIEPE: Okay. I just think when we're dealing with facts it's important to have really highly credible, reliable facts, because we're making huge decisions. [LB867]

SENATOR CRAWFORD: It was the Heritage Health Stakeholder Coalition that surveyed 158 providers, so in their coalition that they have, they have 158 providers, and so we have a little over half of them responded, so that's a decent response rate in terms of get...having people respond to a survey. And so that's still...that's a lot of our providers. Again, our Heritage Health providers, the ones who are providing this care for us, 158 of those are in this coalition and are following and paying attention to what's happening, and it was over half of them that are the ones who responded to this survey and gave those results, so. [LB867]

SENATOR RIEPE: How many did you say responded? [LB867]

SENATOR CRAWFORD: Eighty-four... [LB867]

SENATOR RIEPE: Eighty-four, good. [LB867]

SENATOR CRAWFORD: ...out of 158 though. I mean we only have...we don't have... [LB867]

SENATOR RIEPE: 158? [LB867]

SENATOR CRAWFORD: One hundred and fifty-eight providers. [LB867]

SENATOR RIEPE: What is this number that we see floating around all the time that we have 30,000 providers? [LB867]

SENATOR CRAWFORD: I do not know. [LB867]

SENATOR RIEPE: I don't either. I've been told that and I think I've said that, which maybe I need to get my numbers right too. [LB867]

SENATOR CRAWFORD: But the Heritage Health Coalition, I'm sure there are...that the, in many cases, as you know, many of the health groups that come before us, there are some providers that are more active in these organizations than others. And so the health, the coalition, are the providers who are stepping up and being...agreeing to be a part of this process. So I don't know off the top of my head exactly how many providers there are in the state total, but I do know that these providers have been ones that have been active and engaged and they've gone to the engagement meetings at the...you know, many of them are the ones who have gone to the engagement meetings with the department and worked with the department on administrative simplicity and those other issues. So they are the ones that have been very engaged in this process and that's who was surveyed and over half of them responded and those are the results from that survey. [LB867]

SENATOR RIEPE: And we've talked to a lot of them. [LB867]

SENATOR CRAWFORD: Pardon? [LB867]

SENATOR RIEPE: We've talked to a lot of them... [LB867]

SENATOR CRAWFORD: Yeah. [LB867]

SENATOR RIEPE: ...on a personal level. Are there other questions from the committee members? Senator Erdman, please. [LB867]

SENATOR ERDMAN: Thank you, Senator Riepe. Thank you, Senator Crawford. I was listening to your comments and you made several and one I picked up on you said the most vulnerable needed to be looked after. And on page 2, line 7, you have stricken the word...the two words "most vulnerable." Why would they do that? [LB867]

SENATOR CRAWFORD: Oh. I think that was a cleanup suggestion that we had from Revisor's (Office), so that is not language that impacts who qualifies or how the program is run. It's just a description and I believe that's why that's in there. That wasn't in my intention to change intent in any way, so, but I appreciate you raising that question, so. [LB867]

SENATOR ERDMAN: It looks peculiar to me. [LB867]

SENATOR CRAWFORD: Yeah. [LB867]

SENATOR ERDMAN: You know, and you mentioned... [LB867]

SENATOR CRAWFORD: So it's to ensure the safety and well-being of the state's population. [LB867]

SENATOR ERDMAN: Right. [LB867]

SENATOR CRAWFORD: And again, it's a lead-in sentence to the bill. It doesn't have an impact on the action of the bill, but I have no problem with unstriking it, so. [LB867]

SENATOR ERDMAN: Okay. Then the other question, you say we may be getting down in the weeds. If I remember correctly, last year when we came and I first came here, the contract that we have with the three providers is about 8,000 pages? Is that what I understand? [LB867]

SENATOR CRAWFORD: That's...I don't know how many pages it is. [LB867]

SENATOR ERDMAN: Well, anyway, that was what I... [LB867]

SENATOR CRAWFORD: I'm sure it is large. [LB867]

SENATOR ERDMAN: That's my impression on it. [LB867]

SENATOR CRAWFORD: I did not bring you copies of that as a handout. [LB867]

SENATOR ERDMAN: So it's quite a lengthy contract and I'm thinking that if you can't write a contract in 10 or 12 pages you need a different lawyer. And so by the time you have someone review that, it takes a long time and it costs a lot of money. And some of those providers took a long time to understand that. So this bill looks to me like if they have all the provisions that you suggested, that they already have the penalties and all this stuff is in the contract,... [LB867]

SENATOR CRAWFORD: Right. [LB867]

SENATOR ERDMAN: ...and you said we don't want to get down in the weeds, but it looks to me like this is micromanaging. We already have Heritage Health and we have the people looking after that, and so I don't think it's my place as a state senator to start micromanaging how they organize and manage these. I think as a state senator we look at the performance, at what happened over a period of time. If it doesn't improve, then we decide to do something different. My guess is that whoever we had before we have the system we have now, it probably took a period of time before that became what it needed to be, and I think that will be the same way here. I'm really having a tough time understanding and maybe you can help me with this. I have a tough time understanding how you could put a qualification on an organization, have 95 percent clean claims, when in fact they are not the one filing the claims. So the people making the claims, that are filing them, are making the mistakes and you're going to hold the people who are receiving the claim responsible because someone didn't do it right. [LB867]

SENATOR CRAWFORD: Yeah, so I'll do those two pieces. [LB867]

SENATOR ERDMAN: That's difficult. [LB867]

SENATOR CRAWFORD: So the first piece, it is the case that the contract already provides an ability for the department to impose sanctions and it is...we're not telling them when they have to impose sanctions. I guess from your perspective, so we're letting them use that tool and we're coming...and I'm coming back and saying I don't think it's been acceptable. And I think to have gone through this transition, I understand at the beginning of the transition you might not impose sanctions, but when we have providers and patients suffering and to have no sense of urgency because there aren't sanctions being imposed on managed-care organizations for not making improvements, that is to say, okay, you have this tool and I'm just asking in an oversight way, why aren't you using it? Like, let's talk about how off...you know, and I don't like to

micromanage, but it's the case that they have the tool, they're not seeming to use it, so we're going to ask them questions about what's happening and why it's not being used. So, I mean, we did put in an information request for sanctionable offenses and did not get, you know, a clear list of sanction...of here's who's violating them and here's how many there were for each MCO. That's what we asked just as an information request: Can you give us for each MCO how many times they've, you know, not met one of these standards where they could have been sanctioned but were not? And if that, you know, if we're able to get that information from the department, like we now get clean claims information from the department, that would allow us to track it without having to pass that part of the bill. But again, the reason that we are talking about this is the sense that I have had that there isn't enough sense of urgency in the managed-care organizations to make changes because they're not feeling any financial pain where the providers are feeling the financial pain, and so that's why asking for more reporting to make this more something that we're asking and pushing to say, hey, you know, why aren't you imposing those sanctions? Maybe there's a very good reason why they're not, again, so we're not telling them when they have to do it. They have the discretion to do it. We just are adding some additional reporting. And again, now back to the clean claims, I'm giving you this comparison example to show you that we have in our contracts also standards that require that the percentage of members who turn 15 months old during the year had well child visits to a primary care provider during the first 15 months of life. And we require...our payment threshold is that 52 percent of those members get six visits or more, and there's nothing that the managed-care organization or a provider can do to go force that parent to bring that kid in, but we're still holding them to a standard. We want you to have the education and incentives to make that happen. Same way with clean claims, we want you to have the education and incentives in place to push that rate up. And if nobody was even coming close, then I would say, okay, you know, maybe it is providers just can't learn and can't do this or they're not trying. But when we have one of these three significantly performing better than the others and performing at that rate or better for multiple months, that tells me it's possible. And it's possible one has figured out how to do it, so maybe they can help the others learn how to do it. [LB867]

SENATOR RIEPE: Thank you, "Professor." [LB867]

SENATOR CRAWFORD: Thank you. [LB867]

SENATOR RIEPE: For the record, I... [LB867]

SENATOR CRAWFORD: You're delaying that unlimited time part right now, aren't you? [LB867]

SENATOR RIEPE: It's 50 minutes. For the record, you referred to patient satisfaction. One of my concerns has been we have not done patient satisfaction. [LB867]

SENATOR CRAWFORD: Yes. [LB867]

SENATOR RIEPE: So we have no valid understanding as to whether they are or are not being injured, satisfied, or whatever, and that's a driving piece of... [LB867]

SENATOR CRAWFORD: Right, and I believe we're supposed to get that soon, though, I believe, and get...I'm... [LB867]

SENATOR RIEPE: I know but it's been a long time coming and that's my complaint. [LB867]

SENATOR CRAWFORD: Yes, it has been a long time coming. I appreciate the department's responsiveness to your request, our request that we receive that, as well, as part of what we're looking at as well. [LB867]

SENATOR RIEPE: Thank you. [LB867]

SENATOR CRAWFORD: Thank you. Oh. [LB867]

SENATOR RIEPE: Senator Erdman. [LB867]

SENATOR ERDMAN: Senator Riepe, thank you. Senator Crawford,... [LB867]

SENATOR CRAWFORD: Yes. [LB867]

SENATOR ERDMAN: ...I think about 30 minutes ago you made a comment about you had seen improvement. Are you referring to this chart? Is that what you were referring to when you said they have improved? [LB867]

SENATOR CRAWFORD: I meant more just in general. We...in this past year there have been systematic issues that the department has stepped up to take care of, so we've seen improvement just in Heritage Health managed care overall in some areas. And as I said, I just wanted to acknowledge there have been some improvements, but we still have substantial issues in terms of providers not being paid and many providers having issues with claims being rejected as not clean and then really not, they're arguing, not getting clear instruction and help on how to make

them clean or getting different instructions from different people about what needs to be done to make claims clean. So one piece that I think really needs to be refined is this clean claims piece, one, because we're still hearing a lot of complaints about it; two, because we're seeing one managed-care organization appears to be able to do it so it appears to be possible to do that better; and three, because the clean claims are the ones that they actually get measured on, so it's critical for us to make sure that they're getting those clean claims high; and four, I would say just because if that's delaying all these payments, that's...and adding I think all of...a lot of the extra administrative costs and people having to hire someone new and having the...too many people in the clinic having to spend time on paperwork instead of on patients. [LB867]

SENATOR RIEPE: Thank you. [LB867]

SENATOR CRAWFORD: Thank you. [LB867]

SENATOR RIEPE: I think when and if we move forward, we're going to hear more on clean claims. Thank you so much, Senator. [LB867]

SENATOR CRAWFORD: Thank you. [LB867]

SENATOR RIEPE: Any proponents, any other than the Hospital Association? (Laughter) Welcome, kind of. [LB867]

ANDY HALE: Senator Riepe, members of the Appropriations (sic) Committee, my name is Andy Hale, A-n-d-y H-a-l-e, and I am vice president of the Hospital Association. And not only, Senator, are you going to hear from me, but you'll hear from Dayle Harlow, who is... [LB867]

SENATOR RIEPE: Are we supposed to be flattered that we're (inaudible) Appropriations? [LB867]

ANDY HALE: Well, you're welcome, is what I meant. [LB867]

SENATOR RIEPE: That's the University of Nebraska. Okay, go ahead. [LB867]

ANDY HALE: Dayle Harlow, who will follow me later today, is with Fillmore County Hospital in Geneva, Nebraska, and will kind of give you a breakdown of some of the issues they've been experiencing. And then Kevin Conway, who is our vice president of health data and information, will break down the definition we think that the clean claim which works the best. So the reason

I'm sitting here today is what the Hospital Association has done for our members in regards to the issues we've had with the MCO, we usually let them try to settle it themselves. If there is an issue that they cannot get resolved, we've asked that they write a little summary about what's going on and e-mail it to the association, and what we have done then is we compile that information and send it directly to Rocky Thompson and his staff and Rocky has then notified the MCO. And we've had some pretty good success with that and so I think Senator Crawford did a good job of laying out the issues we've had. I think it was our second oversight hearing, when we started there was $27 million in unpaid claims, $24 million of that belonged to the hospitals. So I think it is...we are getting better but there is some work to go and some improvement and I think Dayle Harlow will talk about some of the improvement. Last thing I want to reiterate is how welcome we are and gracious to have Rocky Thompson and his staff, Heather Leschinsky, available to us to resolve these issues. As Senator Crawford mentioned in an earlier bill, or I believe it was Senator Howard--excuse me--mentioned on an earlier bill, but that wasn't always the case with previous administrations. So we welcome the fact that Interim Director Thompson is available to us and is really interested in getting these claims resolved. So I want to lastly thank Senator Crawford and her staff for introducing this bill and I'll take any questions. [LB867]

SENATOR RIEPE: Okay. Questions? I have a question. Would your person be looking at this, at clean claims for Medicaid and then clean claims for commercial? I mean, you do some different... [LB867]

KEVIN CONWAY: No, I think it's just... [LB867]

SENATOR RIEPE: Again, tell us the...I want to see if we have different standards for Medicaid, or expectations,... [LB867]

ANDY HALE: Sure. [LB867]

SENATOR RIEPE: ...than you do for commercial. [LB867]

ANDY HALE: I'll let him answer that. [LB867]

SENATOR RIEPE: Good job (laughter). Excellent job. Any other questions of Mr. Hale? Thank you very much. [LB867]

ANDY HALE: Thank you, Senators. [LB867]

SENATOR RIEPE: And thank you for being here. Additional proponents, please, so... [LB867]

JESSICA THOENE: (Exhibit 7) Good afternoon again,... [LB867]

SENATOR RIEPE: Welcome. [LB867]

JESSICA THOENE: ...Senator Riepe and the fellow committees of the Legislature's Heath and Human Services Committee. My name is Jessica Thoene, J-e-s-s-i-c-a T-h-o-e-n-e, and I'm a speech-language pathologist and owner of Alpha Rehabilitation in Kearney and I'm testifying on behalf of the members of the Nebraska Speech-Language and Hearing Association. We are in favor of LB867 and support requiring Nebraska Health and Human Services to provide transparency and accountability as it concerns to their processes for issuing fines and sanctions to the MCOs when not meeting contractual requirements. Constituents who receive speech-language and audiology services and their providers have the right to know how the fines and sanctions are imposed. Last year was a very difficult year for providers with the new managed-care organizations. Nonpayment of claims had major negative impacts on speech-langauge pathologists and audiologists across the state. We continue to face issues with administrative burdens placed on providers for providing services with constant changes in procedures and provide services without clear communication on the updated procedures. Administrative burdens placed on providers outweigh the payment for services sometimes and this can't be the norm with/for providers, otherwise discontinue of services will occur. I stress that the issues that the providers have are wide issues, not facing a select few, and we need continued oversight. Transparency and accountability by the MCOs will ensure the provider networks will continue to grow and current service providers will be able to continue to provide services for our most vulnerable patients. We thank Senator Crawford for introducing this bill. I want to talk a little bit because I was part of that survey that went out and kind of how our organization did that survey. We sent out that survey to the entire membership of the Nebraska Speech-Language and Hearing Association. Certain members will respond and certain members won't. I am a business owner and so I know what claims are paid. I know how much outstanding money we have. I know what services aren't being covered. However, my staff that works for me, they are providers of Medicaid but they don't have that knowledge. I protect that knowledge from them because I don't want them to get scared that they're not going to get a paycheck. So I think when you look at who responded to that survey, you definitely have your stakeholders but you have the people that are...that have that intimate knowledge versus all providers of Medicaid for speech-language pathology might not know that their employer is sitting on $50,000 of unpaid claims. So when we look at that survey, we did send it out to our entire membership, but I'm guessing that the ones who replied to that were the ones that had intimate knowledge on claims and claims payment. In regards to clean claims--I know this was brought up-- for us, submitting claims, it was not necessarily that we weren't doing it correctly. It was the systematic problems that were with the MCOs, so, for instance, maybe their authorization numbers in their system didn't match

the authorization numbers that we were given, therefore, our claims were denied, but we were instructed to put the authorization number on the claim to make it clean. So again, when we look at clean claims from the problems that we had faced, it was that we were following what we were given to follow and it wasn't matching in with the system. So again, I think that's where continued oversight needs to occur and that, you know, we talk about moving forward. We can do better and I truly believe that we can do better. I think that we've put a lot of work into this but there's still a lot of work to be done so that providers like me in western Nebraska are not dropping services because there is a select few of us out there and the administrative burdens are not outweighing the cost of payment to provide these services to the people that need it most. So I would take any questions. [LB867]

SENATOR RIEPE: I appreciate your optimism on Valentine's Day. I have one but I'm going to let Senator Erdman go first. [LB867]

SENATOR ERDMAN: Thank you. Thank you, Senator Riepe. Thank you for coming. You're from Kearney? [LB867]

JESSICA THOENE: Uh-huh. [LB867]

SENATOR ERDMAN: Did you know that's not western Nebraska? [LB867]

JESSICA THOENE: No, Scottsbluff is western Nebraska. [LB867]

SENATOR ERDMAN: Yeah, it's not even close. But anyway, so you talked about having the wrong code number on there. Did you get that fixed? [LB867]

JESSICA THOENE: Like, for instance, it took months and months and months to get it fixed. And again, you talk about administrative cost, it took phone call after phone call after provider coming in, provider relations coming in saying to do it one way versus somebody on the phone saying, no, you needed to fax that, no, you needed to check this box--months and months and hours and hours. At this point that issue is fixed, but as we go on these issues aren't going away. There's new issues that are coming up. Now authorizations, how are we going to authorize to get services. Well, last week there was a new fax out, now there's a new procedure, so we don't really know what that looks like. So we have a patient that was denied services for two weeks. We didn't know why. Well, I'm talking on the phone. All of a sudden we're informed that there's a new procedure. So those are the issues that we now continue to face. [LB867]

SENATOR ERDMAN: Okay, thank you. [LB867]

SENATOR RIEPE: I think the one question I have, if you will, you talked a little bit about like with SurveyMonkey--I'm kind of going back to that not because I want to, because I feel compelled to--is that it seems to me that the instrument should have been sent to the organizational members. You implied that not all of your employees fill it out completely. Did it go to all of your employees? [LB867]

JESSICA THOENE: To my employees, yeah, because they're members of NSLHA, so they...it would go to all my employees, so. [LB867]

SENATOR RIEPE: Well, that means the whole population was significantly different between owners and interested people. [LB867]

JESSICA THOENE: Um-hum. [LB867]

SENATOR RIEPE: Thank you. That's all I have. Thank you. [LB867]

JESSICA THOENE: Thank you. [LB867]

SENATOR RIEPE: More opponents. [LB867]

KRISTEN STIFFLER: Proponents. [LB867]

SENATOR RIEPE: Proponents, I'm sorry, yes. [LB867]

DAYLE HARLOW: Good afternoon, Senator Riepe and members of the HHS Committee. My name is Dayle Harlow, D-a-y-l-e H-a-r-l-o-w, and I am with Fillmore County Hospital in Geneva, Nebraska. We are a critical-access hospital in Fillmore County. We testified in front of the committee in December and we just wanted to reiterate the ongoing claim issues we have been having. In December we had $202,000 in outstanding claims and as of today, among all three MCOs, we have $248,000 in outstanding claims. Since our testimony in December, all three MCOs have been proactive in reaching out to us. But as you can see, we are still having ongoing claim issues. Most claim issues pertain to behavioral health services. The MCOs continue to say issues are known issues. That's what their thing is--they're known issues. But they don't ever do anything about them, it seems, and they're ongoing, they know about them, there's a project for them. They have project numbers for all their issues but we never have...we never see resolutions for them and obviously still aren't seeing payment. There's inconsistent billing rules among all the three MCOs. When it was just one company, when it was straight Medicaid, it was easy because they had the same billing rules. All three MCOs have different

billing rules, especially for behavioral health. We had to sign separate contracts for our ambulance services, which they didn't tell us about at time of contracting. And so for months we weren't getting our ambulance services paid, and we just got that resolved recently, wrongly denied claims like that lady was saying. Prior authorization numbers put on the claims were different from theirs and they say that they know that they wrongly denied the claims, they'll overturn those. We still haven't seen those overturned. We have problems with revenue code 510 and 761. They're supposed to pay 761 but they're not. And they know that they're going...they say they're going to pay it but January 1 of '17 we have a claim that hasn't been overturned because of the 510 revenue code, so we still have very...a lot of ongoing claim issues among all three companies. It's not just the one or...it's all three of them. So I just wanted to come and reiterate that we still have problems and we are a small critical-access hospital so it is a huge burden on us. We only have 6 percent Medicaid and so having $248,000 in one year of outstanding claims still is very significant for us and our bottom line. Any questions? [LB867]

SENATOR RIEPE: Thank you. Question? Senator Williams. [LB867]

SENATOR WILLIAMS: Thank you, Chairman Riepe. And thank you for being here. And I care a lot about critical-access hospitals because I have five of them in my legislative district. You mentioned the volume of claims. Are those problems that you're having with that related to the clean claims issue? [LB867]

DAYLE HARLOW: Partly, because of the inconsistent billing rules that I spoke about. For behavioral health claims, all... [LB867]

SENATOR WILLIAMS: Well, this legislation deals specifically with clean claims. [LB867]

DAYLE HARLOW: Right. [LB867]

SENATOR WILLIAMS: So of your dollars, how many of those would be fixed if we fixed the clean claim? [LB867]

DAYLE HARLOW: I believe that the clean claim, I don't know what the definition for the MCOs as a clean claim is because we will file something correctly and they will wrongly deny it saying that it wasn't a clean claim. And then we'll say, well, what do we need to fix? And we fix it and then they... [LB867]

SENATOR WILLIAMS: Okay. [LB867]

DAYLE HARLOW: ...still say it wasn't fixed correctly. So I don't feel like they have specific...a definition of a clean claim to the...you know what I mean? I don't know. I don't know what they consider a clean claim, I guess, because we...they don't offer any suggestions to fix, just that it's a known issue, that it's a revenue code problem, or something like that. [LB867]

SENATOR WILLIAMS: Okay, and I think you said in your testimony that you were experiencing a problem with all of the providers. [LB867]

DAYLE HARLOW: Correct. [LB867]

SENATOR WILLIAMS: And yet the information that we're shown shows that Nebraska Total Care has achieved the excess of 95 percent clean claims issue. [LB867]

DAYLE HARLOW: Right, and I would have to... [LB867]

SENATOR WILLIAMS: So can I interpret from that that you're really not having a problem with Nebraska Total Care? [LB867]

DAYLE HARLOW: Well, I would have to drill down into Nebraska Total Care claims, but of the $248,000 outstanding as of today, $93,076 is Nebraska Total Care, of that. [LB867]

SENATOR WILLIAMS: So pointing out again that clean claims may not be our only problem here. [LB867]

DAYLE HARLOW: Right. [LB867]

SENATOR WILLIAMS: Thank you. [LB867]

DAYLE HARLOW: Yeah. [LB867]

SENATOR RIEPE: Can you tell me, too, with your commercials, do you never run into the problem of clean claims, of them kicking it back? [LB867]

DAYLE HARLOW: Not to this...not nearly this amount. [LB867]

SENATOR RIEPE: What my experience was is that, you know, every...there isn't an insurance company out there that wants to pay if they don't have to pay. [LB867]

DAYLE HARLOW: Um-hum. [LB867]

SENATOR RIEPE: So that's the natural tension between providers and payers, if you will. It's just that is the way it is, is today. My question is this. How much of this $200,000 in accounts receivable, how much of it is behavioral and how much is on the physical side, because we're... [LB867]

DAYLE HARLOW: Um-hum. I didn't... [LB867]

SENATOR RIEPE: I'm sorry, I'll give you a little...give...we're finding that it's much more complicated with behavioral health. [LB867]

DAYLE HARLOW: Right. Right. I don't have that exact number but I can tell you it's a high percentage of behavioral, very high. [LB867]

SENATOR RIEPE: High percentage of behavioral? [LB867]

DAYLE HARLOW: Yes. [LB867]

SENATOR RIEPE: And did it change much when Magellan was in charge or was that still a problem? [LB867]

DAYLE HARLOW: Magellan was an issue, as well, but it was more...it was easier to fix those claims because it was one company to work with where these three MCOs, all three of them want different billing...they want billing differently. Some of them want a UB. Some of them want a 1500 for different levels of licensures between LMHPs, APRNs, and so it's just all over the board of how they want their claims to come in. And so it was a lot easier when it was just Magellan because you knew what they wanted. [LB867]

SENATOR RIEPE: Um-hum. I go back a little bit. I think it was with Principal at one time there were 16 subplans that we had to work with, so, you know... [LB867]

DAYLE HARLOW: Um-hum. [LB867]

SENATOR RIEPE: Unfortunately, it's a tough part of the business that so many payers, so many contracts, so many health plans that each one of them is almost look...they're not uniform, short of single-payer healthcare. [LB867]

DAYLE HARLOW: Um-hum. [LB867]

SENATOR RIEPE: Senator Erdman, did you have a question? [LB867]

SENATOR ERDMAN: Uh-uh. [LB867]

SENATOR RIEPE: No? Okay. Thank you for your hard work. [LB867]

DAYLE HARLOW: Thank you for your continuation and thanks for being here. Additional proponents? Yes, sir. If you'd be kind enough, state your name and spell it for us, please, and then do your representing. [LB867]

KEVIN CONWAY: (Exhibit 8) Thank you, Senator. Chairman, members of the Health and Human Services Committee, my name is Kevin Conway, K-e-v-i-n C-o-n-w-a-y. I'm the vice president of health information for Nebraska Hospital Association, and for this afternoon I'm going to stand in as the expert on clean claims, so don't want to testify on the other aspects of LB867 at this point because I think you've heard enough about it. What I'm passing out is proposed language or suggested language for cleaning up part of the clean claim portions of LB867. It really comprises of several nuances. One of them is, if you notice, we use the word "necessary" versus the word "required" and I think that's one of the issues that our providers, hospitals, and professionals are hitting up with these managed-care organizations. They require information that may not be necessary to pay the claim. It may be for their own internal operations needs or something like that, but there's probably lots of these claims that are outstanding at Fillmore County Hospital that they could pay but they want additional information. The second component is to follow a standard. And, Senator Riepe, you asked earlier about a standard and this may be getting a little bit too detailed in statute, but I refer to what's called the American National Standards Institute: ANSI. ANSI is the nationwide agency that develops basically every standard we follow in this country, whether you go to the hardware store and are looking for a quarter-inch bolt and you know that quarter-inch bolt is going to work or you're buying a roll of paper towels and you know the tube on the paper towel is going to fit in your paper towel holder. They set those standards. That same organization set the standards for electronic billing for healthcare services. These standards were adopted nationwide about 15 years ago. Before that, there were probably 400 different billing formats in the country. I've worked for the state's largest commercial payer. We had our own billing manual that I actually was responsible for maintaining. When these national standards came out, were part of the

Health Insurance Portability and Accountability Act, everybody adopted these standards. So, yes, whether it's Medicare, whether it's commercial insurance, everybody is using these same standards and the same implementation guides to create these bills. There are defined segments in them, segments and loops. It gets kind of techie, but if you have a patient name, that has to be in there; date of birth has to be in there. There's fields like that. There's situational fields. So if you have a revenue code that's a hospital department, like pharmacy, you don't need a CPT code. But if you have a revenue code that describes a radiology service, you have to have a CPT code with that radiology service. And those standards are followed nationwide by all healthcare providers. And that's the second portion that if that claim is structured correctly electronically, then it is a clean claim. So all that information, they can't get it out of their system without those little buckets filled, they can't get it through their clearinghouses and into systems. And Fillmore County Hospital, you know, I haven't looked into their system, but you can almost guarantee that their system is set up to follow those rules through algorithms. So that's the second part that is that if this is filled out correctly, if a patient name is there, that's one component. But there's a huge manual. The Technical Report Type 3 describes all these different fields and what's needed to complete that claim. And obviously you've heard that one payer is able to do it, two are not able to do it, so it's not necessarily a question of a provider filling out the claim differently for different providers. They have the internal process. They have internal structures that they follow and business rules that they follow. So with that, I'd entertain any questions the committee or your Chairman have. [LB867]

SENATOR RIEPE: Are there questions from the committee? Seeing none, thank you very much. [LB867]

KEVIN CONWAY: Thank you. [LB867]

SENATOR RIEPE: Appreciate it. Additional proponents? Okay, you've been here before, so... [LB867]

SARAH RUTTLE: (Exhibit 9) I have. Hello again. Senator Riepe and fellow members of the Nebraska Legislature's Health and Human Services Committee, my name is Sarah Ruttle, S-a-r-a-h R-u-t-t-l-e. Again, I'm the community relations and grant coordinator for Visiting Nurse Association in Omaha, and I'm here today testifying on behalf of the members of the Nebraska Home Care Association. We are in favor of LB867 and support requiring the Nebraska Department of Health and Human Services to provide more transparency and more accountability as it concerns their process for issuing fines and sanctions to the managed-care organizations when they are not meeting contractual requirements. Constituents who receive home-care services and their providers have a right to know how fines and sanctions are imposed. My testimony today will focus on the need for more transparency and more

accountability and the need for fines and sanctions to be issued to the MCOs when there isn't timely and accurate reimbursement of claims for services. The Nebraska Home Care Association is a member of the Heritage Health Provider Coalition. As previously referenced, the coalition conducted a survey of providers across the state. Attached for your reference is the executive summary briefing of those survey results, and I direct you to page 2 that highlights several reasons why providers have experienced improper denials for claims. And at the bottom half of that page you'll see the number of unpaid and incorrectly paid claims of more than 30, 60, and 90 days, and those are broken out by each MCO there for you. We feel providers should not experience delays in receiving reimbursement for services or be required to resubmit claims or file appeals when there are errors made by the managed-care organizations. As some of the others have shared, these are errors on the end of the MCOs, systematic...systemic errors that have been identified. Since January 1, 2017, when the current contracts with the managed-care plans took effect, Nebraska home-care providers have had to reduce the number of Medicaid clients that have been...the number of Medicaid clients receiving services. They've had to request advance payments from the MCOs due to payment delays and have had to take out a line of credit at a bank to cover their payroll. They also have experienced delays resulting in hundreds of thousands of dollars in outstanding claims payments for services that they've provided to constituents. Our association's members continue to experience these delays in reimbursement. Systemic issues need to be addressed and resolved by the MCOs rather than continuing to address these problems one provider at a time as they arise daily. In addition to the measures included in LB867, the Nebraska Home Care Association urges the members of the committee to consider several recommended accountability measures outlined in the Heritage Health Provider Coalition executive summary briefing. We respectfully request careful consideration and implementation of these recommendations, particularly as they relate to issuing interest payments to providers when there are overdue claims, establishing a feedback venue for providers to request a reassessment of potential interest due, requiring the MCOs to report accurate data to the state on claims submitted that are not paid and the reason, and establishing a Heritage Health oversight committee within the Nebraska Legislature to work closely with providers, the MCOs, and the Nebraska Department of Health and Human Services. We thank you very much for your consideration of these requests and I'd be happy to answer any questions. [LB867]

SENATOR RIEPE: Any questions? Seeing none, thank you very much. [LB867]

SARAH RUTTLE: Thank you very much, Senators. [LB867]

SENATOR RIEPE: Before we go on with proponents, how many more do we have testifiers here, either in...one, two, three. Okay. We'll allow for four or five, I guess. If you would be kind enough to state your name, spell it, please. [LB867]

MELANIE STANDIFER: (Exhibit 10) Good afternoon, Senators. My name is Melanie Standifer, M-e-l-a-n-i-e S-t-a-n-d-i-f-e-r. I'm the revenue manager for CenterPointe, a behavioral health provider, operating in both Lincoln and Omaha, and I'm here today to speak on behalf of them and other behavioral health providers around the state. I appreciate the opportunity to testify in support of Senator Crawford's bill, LB867. Despite the fact that we are in month 14 of the implementation of Heritage Health, the program is still experiencing issues that significantly impact providers and clients alike. Claims processing is still fraught with invalid denials and incorrect payment determinations. These issues place an undue administrative burden on providers. Weekly, I spend an average of two to four hours--above my normal 40--simply on the phone with the plans, on their portals, or contacting our provider relations representatives in order to resolve issues that are outside the normal course of our business. Some examples of issues we are facing include: continually erroneous denials--of both claims and authorizations; incorrect payment amounts; and issues with contracts not being loaded correctly. Earlier this week, for example, I spent 25 minutes on the phone disputing two claim denials. During the course of the call, the representative agreed the denials were in error and adjusted the claims to pay. Unfortunately, we will have to wait an additional 15-20 business days before receiving payment. The total reimbursement amount on these claims was only $116.14. I wish I could say this was an isolated incident. Unfortunately, this example is compounded daily and weekly. As a provider already operating on slim margins, issues like these significantly erode or eliminate that margin altogether. Additionally, the member will receive--in error--a notice of denial. Most of our members already suffer from mental health issues and paranoia. These denial notices cause them additional harm. On a monthly basis, we receive letters requesting overpayment on claims that were originally paid correctly. The amount of time and frustration spent in disputing these requests is significant. One of the most significant issues we recently experienced was the discovery that our contract with one plan had never been loaded into their system correctly. This caused claims to adjudicate incorrectly; we had problems obtaining authorizations; and unable to access the plan's portal. While DHHS has continued to facilitate communications between providers and the plans, problems do still persist. Each Heritage Health committee meeting begins with all three plans providing an update to their "Known Issues Log." One of these recent known issues impacts the adjudication of our residential claims. This single issue represents approximately $95,000 in payments due since December. This issue only impacts 41 claims and would most likely not have a significant effect on that plan's clean-claim payment rate. However, it certainly represents a disparate impact on my agency's financial stability. I could provide many more examples of issues that we face on a daily basis. However, in the interest of time, I will simply urge this committee to support LB867. It is necessary to continue to hold Department of Health and Human Services and the managed-care organizations accountable for providing responsible administration of the Heritage Health program. I thank you for your time and welcome any questions you might have. [LB867]

SENATOR RIEPE: Senator Linehan, did you have a question? [LB867]

SENATOR LINEHAN: Thank you, Chairman Riepe. Thank you for being here. How does this compare to other payers? [LB867]

MELANIE STANDIFER: I'm sorry, I'm not quite certain... [LB867]

SENATOR LINEHAN: So there's Medicaid. There's this, the Heritage Health plan, but then there's other insurance company...I only ask that because it seems just recently I have a daughter who got a bill, said she had to pay it, and she paid it. But then two days ago she got a check back saying, I'm sorry, you didn't have to pay it. So how do...you have...it's not unique to Heritage Health, is it, these kinds of problems? [LB867]

MELANIE STANDIFER: It's not unique. However, in comparison, the amount of issues is much more significant with Heritage Health than it is with commercial plans or Medicare. Not to say that it doesn't happen occasionally with other plans, but not at the rate. And particularly in the behavioral health sector, those individuals are predominantly Medicaid-covered individuals. [LB867]

SENATOR LINEHAN: Okay. All right. Thank you very much. [LB867]

SENATOR RIEPE: Senator Williams. [LB867]

SENATOR WILLIAMS: Thank you, Chairman Riepe, and thank you, Ms. Standifer, for being here. First question: In your testimony you say, "This issue 'only' impacts"--this is talking about the last...the $95,000--"impacts 41 claims and would most likely not have a significant effect on that plan's clean-claim payment rate." Would you explain that to me? [LB867]

MELANIE STANDIFER: So in the contract where the MCOs are obligated to pay 90 percent of clean claims, in the grand scheme of all the claims they receive, obviously 41 claims is not significant to them. However, to an agency, to not receive $95,000... [LB867]

SENATOR WILLIAMS: Okay. So it would still hit the clean claims issue. [LB867]

MELANIE STANDIFER: Right. Exactly. [LB867]

SENATOR WILLIAMS: It just wouldn't be...okay. Start down this line. Has the situation with Heritage Health for your organization, after 14 months, has it improved or is it the same where it was? [LB867]

MELANIE STANDIFER: No, it has definitely shown signs of improvement during that time. [LB867]

SENATOR WILLIAMS: Okay. Of your total dollars outstanding, is it relatively equal between the three MCOs? [LB867]

MELANIE STANDIFER: I would say right now, currently, the most significant, and I'd say without having the information in front of me, greater than 60 percent is attributed to WellCare as opposed to the other two organizations. However, WellCare only represents about 20 percent of our Medicaid population, so right now that particular plan seems to be experiencing more significant issues for behavioral health. [LB867]

SENATOR WILLIAMS: Thank you. [LB867]

SENATOR RIEPE: Are there other questions? How does it compare to Magellan? [LB867]

MELANIE STANDIFER: For behavioral health side,... [LB867]

SENATOR RIEPE: (Inaudible.) [LB867]

MELANIE STANDIFER: ...there is a significant difference. [LB867]

SENATOR RIEPE: Better or worse? [LB867]

MELANIE STANDIFER: It's much worse. Obviously the admin... [LB867]

SENATOR RIEPE: Magellan was that good? [LB867]

MELANIE STANDIFER: They weren't that good. Like my predecessor mentioned, only having one plan to have to work with makes a significant difference. The working relationship, you know, all of these three companies all operate in the commercial sector and they're based out of state and they're much larger organizations. Not to say that Magellan was not, however, they seemed to place more emphasis on having Nebraska-based operations and had a much better working relationship with providers. On a daily basis I could make phone calls and talk to people in Tampa, Austin, a number of places outside of Nebraska, in order to resolve issues. [LB867]

SENATOR RIEPE: How long was Magellan in the market? More than a year? [LB867]

MELANIE STANDIFER: Absolutely. [LB867]

SENATOR RIEPE: More than 14 months? [LB867]

MELANIE STANDIFER: Absolutely. [LB867]

SENATOR RIEPE: Thank you. Are there any other questions? Seeing none, thank you very much. We're still on proponents. Welcome. [LB867]

JINA RAGLAND: Hi, Chair Riepe. Chair Riepe and members of the Health and Human Services Committee, my name is Jina Ragland. That's J-i-n-a R-a-g-l-a-n-d. I'm here today testifying in support of LB867 on behalf of AARP Nebraska. AARP is a nonprofit, nonpartisan organization that works across Nebraska to strengthen communities and advocates for the issues that matter most to families such as healthcare, employment and income security, retirement planning, affordable utilities, and protection from financial abuse, especially for those 50-plus. It's the policy of AARP to ensure a continuous Medicaid coverage for vulnerable people of all ages, including people with disabilities, aged, and the working poor. It is also the policy of AARP that Medicaid should remain a vital safety net that guarantees adequate and affordable healthcare and long-term care services and supports the meet the needs and preferences of beneficiaries while also assisting family caregivers. We come today in support of LB867 mainly due to the concern of the potential risks that could be associated with provider access and continuity-of-care issues that potentially could evolve in meeting the needs of some of our most vulnerable aging populations currently being served through the Heritage Health program. Due to the fragile nature and vulnerability of our aging population, we feel it is critical to ensure continuous and ongoing relationship with a high-quality healthcare provider. It's not uncommon for our office to receive calls from members--those, again, age 50 and older--looking for assistance in locating a medical provider that will take new older patients in addition to those with Medicare and Medicaid. Since the implementation of Heritage Health and the ongoing concerns voiced throughout the process by all different providers, we continue to be concerned with the trickle-down effect that could result should providers no longer choose to be Medicaid providers moving forward, especially today as we're talking about those claims, the unclean claims and the processing and the lack of processing and claim payment. There is a need to be concerned about providers no longer participating as part of the Medicaid managed-care plans in Nebraska which, in turn, we feel, will create further access-to-care and continuity-of-care issues in our state. We would also remind the committee as we continue to get closer to approaching the 2020 go-live date for implementation of long-term care/managed care support services in Nebraska, we feel it is critical to ensure that the Heritage Health program is running smoothly. LB867 would assist in advancing the steps to providing additional accountability, oversight, and checks and balances in ensuring that our fragile aging population is not negatively impacted. We

feel it is vital to ensure there are no roadblocks to our aging population, roadblocks that might hinder their ability to access the right care at the right time and allow them the ability to age in place. We thank you for the opportunity to provide comments and thank Senator Crawford for introducing the bill, as well as you, Chair Riepe, for your continued work over the past year that you've done on this issue. And with that, I would be happy to answer any questions. [LB867]

SENATOR RIEPE: Are there questions? I have a question. Can you tell me how many AARP members have expressed concerns about Heritage Health? [LB867]

JINA RAGLAND: Specifically to us, Chair Riepe, I...we have...I've only been in my position since October, so since I've been there I've not heard directly those concerns. However, I could go back and see if there's a log on that. [LB867]

SENATOR RIEPE: Yeah. [LB867]

JINA RAGLAND: I'm not specifically...I have not taken any complaints directly. [LB867]

SENATOR RIEPE: I'm not asking you to do a SurveyMonkey, so we're fine. Thank you. [LB867]

JINA RAGLAND: Sure. [LB867]

SENATOR RIEPE: Thank you very much. Thank you for being here. Other proponents? Seeing none, are there any opponents? Director Thompson. [LB867]

THOMAS "ROCKY" THOMPSON: (Exhibit 11) Good afternoon again, Chairman Riepe and members of the Health and Human Services Committee. My name is Thomas "Rocky" Thompson, T-h-o-m-a-s R-o-c-k-y T-h-o-m-p-s-o-n, and I am the interim director of the Division of Medicaid and Long-Term Care. I am here to testify in opposition to LB867 which would require additional reporting for managed-care contract violations. It would also require managed-care contracts to contain additional requirements for clean claims. Again, I will testify to the green copy and not to any amendments to this, any proposed amendments. First of all, LB867 would require the department to report to the Legislature the number and type of contract violations by the managed care organizations. These violations are subject to sanction every fiscal year. If no sanctions are imposed, the decision must be explained and a plan for improvement initiated. Since I took my position in May of 2017, the program has posted on the Heritage Health Web site a description of violations and actions taken against the health plans through corrective action plans. This bill's requirement would essentially be duplicative of what

the program is already doing. The transparency of this program with the Legislature has been a priority since its conception and continues to be such. Indeed, we currently provide a number of reports and data sets on our Heritage Health Web site, so we want to ensure you, stakeholders, providers, advocates, and the residents we serve are all informed. Our Web site includes actions taken by the department and do corrective action plans. In addition, the contracts with MCOs have a number of reporting requirements that are more comprehensive than this legislation would call for and this additional reporting requirement will require additional staff in order to make sure that everything is correct and that HIPAA-protected information is excluded from any information that's released. Second, LB867 would require at least a 95 percent clean-claims rate with sanctions if this were not achieved. There has been a lot of discussion regarding clean claims over the past year. It's important to remember that a clean claim is a claim that enters into a plan system. Simply put, a clean claim is a claim that a provider has correctly filled out and submitted within the appropriate parameters and time frames. Clean claims are either paid or denied as appropriate. In other words, just because a claim is a clean claim does not mean that it is a valid claim that can be paid. I believe the current language in the bill says that a clean claim, it just has "paid" instead of "paid" or "denied," so that's one issue that I just wanted to address. Requiring a certain clean-claims rate and changing the definition of a clean claim, as this bill proposes, would require one of the following to happen: (1) require the MCOs to take over the provider's responsibility to submit the provider's claims and require you to provide additional money for the MCOs for this shift in responsibility. The department estimates this would increase the administrative load of the rate that are paid to the MCOs from approximately 10 percent to 11 percent, increasing the overall capitation rates to the MCOs by roughly 1 percent, which would be upwards of $5.4 million in State General Funds annually; or (2) require the MCOs to compromise the integrity of their payment systems and allow claims to be paid that should not be paid. Federal law requires the MCOs' claim processing systems to be compliant with HIPAA data transaction requirements. This bill would put the MCOs' systems out of compliance and it would allow fraud, waste, and abuse to slip into the system. For all these reasons, I oppose LB867 and thank you for the opportunity to testify before you today. Happy to address any questions. [LB867]

SENATOR RIEPE: Thank you. Are there questions from the committee? Senator Williams, please. [LB867]

SENATOR WILLIAMS: Thank you, Chairman Riepe, and thank you, Director, for being here. I'm going to start with this one. The Nebraska Hospital Association in their definition of clean claim used the term "necessary" versus "required." Would you help me understand that distinction? [LB867]

THOMAS "ROCKY" THOMPSON: Thank you, Senator. You know, I was not aware the Hospital Association was going to come up with a possible amendment. I would assume that

"necessary" would be something that...you know, I really don't know the difference right now and, again, there's been a lot of confusion over the past year about the actual definition of a clean claim and what a possible clean-claim rate is. I know there's no definition in the current bill as drafted of a clean-claim rate and it has led to confusion even with the Legislative Fiscal Office in preparing their original fiscal note. [LB867]

SENATOR WILLIAMS: Well, that's an issue that I'm having difficulty getting my hands around too. I wanted to ask you, you heard the testimony from Fillmore County Hospital and I think their numbers were...their total outstanding was, round number, $240,000; $90,000 of that was isolated with Nebraska Total Care yet Nebraska Total Care has achieved the 95-plus percent clean claims percentage for a number of months. Is there some explanation of that? What are we missing, or what am I missing, with understanding the difference between...this legislation attacks the issue of clean claims. Is there another, more broad problem that we're dealing with? [LB867]

THOMAS "ROCKY" THOMPSON: Thank you, Senator. And with the last legislative oversight committee, Fillmore Hospital, they did raise their concern and we did open issues with all three plans regarding the...regarding Fillmore's concern. I know the plans have been closely working with them to address their concerns. There's some issues that take longer to fix than others. One of their issues with Nebraska Total Care has been closed per what staff report from when I was texting back there about that. But I think trying to define clean claims as a solution for provider issues, I don't know if that's the way to solve these issues because some of these issues are more complicated. And clean claim, just having a clean-claim rate is not going to solve these issues. The clean-claim rate is not a measure that's normally collected, not used in the insurance industry. And even when this issue first emerged with this committee earlier last year, we had to ask the plans for ad hoc reports about what clean claims were since that...they didn't necessarily gather that information. And some of the plans were able to get better numbers than others because of that. And, you know, Senator Crawford raised that issue at the last briefing back in December and I directed my staff and the plans to make sure that they were providing the best information they can, with the same caveats, so we can make sure that they're comparing apples to apples instead of creating a fruit salad and just confusing us all more. [LB867]

SENATOR WILLIAMS: So it would be your position, and based on a great deal of experience and knowledge in this area, that focusing on the clean claims issue may not solve our larger issue with Heritage Health that we are experiencing. [LB867]

THOMAS "ROCKY" THOMPSON: I would say that I don't know what solution we're trying to solve by trying to create an arbitrary number of a rate that is not used in the insurance industry. [LB867]

SENATOR WILLIAMS: Thank you. Also, this legislation establishes sanctions and it would appear so far that there have not been many sanctions. If there were monetary sanctions and there were money fined and collected, where would that money go? [LB867]

THOMAS "ROCKY" THOMPSON: Thank you, Senator. I would have to check exactly where that would go. I don't assume that's going to...half of it would go back to the federal government because we do pay out half of it to the plan, more than half is to the federal government because our match rate is a little above 50 percent. And I don't know if it would go directly to the Medicaid program or go back to the General Fund of the state. [LB867]

SENATOR WILLIAMS: Okay. I think you've made it clearer for me. Thank you, Director. [LB867]

THOMAS "ROCKY" THOMPSON: Thank you, Senator. [LB867]

SENATOR RIEPE: Additional questions? I think you did point out one thing. We do have a partner in this, and that's the federal government, so... [LB867]

THOMAS "ROCKY" THOMPSON: Yes, Sir. And I don't know if...because this is not something that other states have done, when we share this with our other states, they have never seen any piece of legislation like this. So I don't know how our partners at the federal government would feel about this legislation, especially with the possibility of it leading to greater fraud, waste, and abuse in the system. [LB867]

SENATOR RIEPE: The other partner we have is always the taxpayers. [LB867]

THOMAS "ROCKY" THOMPSON: Yes, Sir. [LB867]

SENATOR RIEPE: Thank you. [LB867]

THOMAS "ROCKY" THOMPSON: Thank you, Senator. [LB867]

SENATOR RIEPE: Any other questions? Thank you very much for being here. [LB867]

THOMAS "ROCKY" THOMPSON: Thank you, Chairman. Thank you, Senators. [LB867]

SENATOR RIEPE: Opponent? Welcome. [LB867]

BRIAN POGUE: (Exhibit 12) Thank you. [LB867]

SENATOR RIEPE: If you'd be kind enough, state your name, spell it, and then who you're with and away we go. [LB867]

BRIAN POGUE: Mr. Chairman Riepe and members of the committee, I am Brian Pogue; that's B-r-i-a-n P-o-g-u-e. I'm here to represent the Nebraska Association of Medicaid Health Plans. Those plans include Nebraska Total Care, UnitedHealthcare Community Plan, and WellCare of Nebraska. I have over 20 years of experience in claims processing for Medicaid and Medicare and commercial managed care. Thank you for this opportunity to testify before your committee. I'm here today to express our opposition to the current version of LB867. The bill would establish a 95 percent contractual threshold for claim submissions to be considered clean claims and would instruct the Department of Health and Human Services to impose sanctions on managed-care organizations if the percentage of claims submitted by providers that are considered clean falls below the 95 percent threshold. We are concerned with the approach taken in this bill to establish what appears to be an arbitrary standard for claim submissions when it is ultimately the provider who is responsible for ensuring that the claim for payment that they or their billing service submits meets required criteria for payment. The standard industry definition of a clean claim as it relates to Medicaid coverage comes from the federal Medicaid managed-care rule 42 CFR 447.45 and defines a clean claim as one that can be processed without obtaining additional information from the provider of the service or a third party. This well-established rule is also in place in current Nebraska Statute Chapter 44-8002. LB867 would modify that industry standard definition to at the very least imply that a clean claim would be paid simply by being deemed clean. The expanded definition of clean claim in LB867 includes on line 3 of page 3 of the bill language that reads "in order to be processed and paid" that we believe unnecessarily complicates the standard definition. Our claims process is established to appropriately pay claims based on the state and federal requirements in accordance with applicable contractual provisions. Our systems are configured to include "claim edits" to ensure claims are submitted with state and federally required elements. This configuration assures that where a provider's claim does not include the appropriate elements, we can return that claim or determine it is not clean so that the provider can correct the claim and resubmit with a minimum of disruption and without unnecessarily pulling our members into the middle. While we recognize that the healthcare claims process is inherently complicated, we believe that the better public policy approach would be to establish a partnership involving provider organizations, the Medicaid and Long-Term Care Division of DHHS, and the managed-care industry to develop simplified claim submission processes that work for all yet meet existing federal and state requirements. In fact, there is an avenue today for this simplification work. At the start of Heritage Health, the Medicaid and Long-Term Care established the administrative simplification committee which is comprised of providers, associations, MCOs, and Medicaid and Long-Term Care. The purpose of this committee is to simplify the administrative burden for providers. Some

examples of the work that has been completed or is in process includes establishing a consistent dollar threshold for DME before a prior authorization is required. The committee is working on developing a simplified process for over-the-counter medication brands and a consistent PCP transfer form. Our organization and its representative MCOs are already engaged in efforts with our provider partners to improve the healthcare system in Nebraska. As an example, UnitedHealthcare uses an early warning system to proactively and in real time contact certain providers when they are missing required information on a claim which would prevent payment. A specific example is where a chiropractic clinic was proactively contacted in January because their primary diagnosis did not indicate a level of misalignment of the spine. This allowed the provider an opportunity to quickly correct the issue, which sped up payment. Nebraska Total Care regularly monitors the volume of unclean claims and noticed that there was an unusual spike of unclean claims submitted over three days in January. After researching the matter we identified that the cause of the spike was related to a single provider accounting for more than 1,000 unclean claims submitted those days. Nebraska Total Care was able to proactively contact the provider with the necessary claims education so that the provider could submit clean claims for payment. In 2017, WellCare placed an average of 80 outbound calls per month to educate providers whose claims were consistently rejected due to billing errors. Additionally, the managed-care organizations have hosted numerous provider town hall meetings, webinars, and one-on-one information sharing with offices for hundreds of providers across the state from Gering to Omaha, providing education on many topics, including effective billing practices, to help reduce the number of unclean claims. We're committed to a stronger partnership to ensure that providers have the information they need to ensure that they submit claims with all required information the first time and that the overall process works smoothly for all. Thank you for the committee to testify...thank you for the opportunity to testify before the committee. I'd be happy to answer any questions you may have. [LB867]

SENATOR RIEPE: Thank you very much. Are there questions from the committee? What efforts do you take to try to educate your providers in terms of how the...like the visual that you shared with the committee, I mean, how much...it sounds to me like there's a need for (a) just how the clean process...claims process works,... [LB867]

BRIAN POGUE: Right. [LB867]

SENATOR RIEPE: ...at least for your three managed-care organizations. [LB867]

BRIAN POGUE: Yes, Sir. [LB867]

SENATOR RIEPE: It sounds like you've come to an agreement. Has that been communicated on and so that the...then the providers have an opportunity to look at that and say I either understand it now or I disagree with it and they challenge that? [LB867]

BRIAN POGUE: Right, so thank you for that. So all three of the MCOs, we do have a process which we detect front-end rejections which is what we would...we monitor and determine, such as the example I pointed out, where if there's a spike we still proactively will reach out to those providers. Now unfortunately some of the providers that may not have the higher claim volume submissions, those are some things that I think we have an opportunity to look at some of those smaller submitters maybe and find out how we can help those, because we want to help everybody, not just the people who are sending in the most claims and get the most errors. [LB867]

SENATOR RIEPE: We'd like to have this be like the new tax plan and get it on a postcard. [LB867]

BRIAN POGUE: We do have billing changes that we do post that information on our provider portals. Sometimes we do fax blasts, as we heard another constituent earlier today mention. [LB867]

SENATOR RIEPE: Okay. I do find it very helpful. I like flow charts. That way I can...it helps me process rather than just narrative. [LB867]

BRIAN POGUE: Thank you. [LB867]

SENATOR RIEPE: Are there any other questions from the committee? Seeing none, thank you very much. We appreciate you being here. [LB867]

BRIAN POGUE: Thank you. [LB867]

SENATOR RIEPE: Additional opponents? Anyone speaking in opposition? Seeing none, is there anyone that wants to speak in a neutral capacity? Seeing none, Tyler, would you tell us about any letters so that Senator Crawford has privilege to that. [LB867]

TYLER MAHOOD: (Exhibits 13, 14, 15, 16, and 17) Yes. We have a letter signed by Dr. Richard Azizkhan and Liz Lyons of Children's Hospital and Medical Center, in support; Amy Behnke of the Health Center Association of Nebraska, in support; Kristin Mayleben-Flott of the Nebraska Planning Council on Developmental Disabilities, in support; Joni Cover of the

Nebraska Pharmacists Association, in support; and Joshua Keepes, of America's Health Insurance Plans, in opposition. [LB867]

SENATOR RIEPE: Would you...okay. [LB867]

SENATOR CRAWFORD: Thank you, Chairman Riepe, and thank you, committee members. I know this has been a long hearing and it is technical but this is, as I say, this is really a key issue that impacts our providers and impacts our patients and it's very important, I think, for us to make sure that we're being attentive to what our role may be in encouraging and pushing improvement. And I want to thank all of the folks who have come to testify and I appreciate the providers who have come to tell a bit about what it looks like in their business and how it impacts their provider business and also how it impacts their patients, and AARP for talking about how it impacts those patients as well. So I want to just first follow up on something that Mr. Pogue mentioned when he said that they've got some markers to try to help them work with the larger providers. And I think one of the reasons that we've seen this transition hit behavioral providers so hard is two things: One, they were used to just one provider before for Medicaid, now they have three; and the other piece is they're those smaller providers. So they're the smaller providers that are on the phone trying to get through, whereas the large providers are the ones that may be getting some of this more proactive help. So what I would like to do is I just want to clarify a few things that I think might be getting confused. So what I want to do first is to have you look at this handout which says: Contract Violations and Fines. And I want to clarify this is not what our bill does. Our...this...these are the contracts and fines that are spelled out in that 8,000-page contract, okay? So our bill is not putting in new...it is not putting in these fines. These are fines that already exist. And I want to just draw your attention to partly address Senator Williams' issue about what else is the problem and I want to draw your attention to the row that says, "Claims Processing." And if you look at that row, you'll see: 90 percent of all clean claims must be paid within 15 business days of the date of the receipt. So it is true that a clean claim might get denied, so that actually is probably a contract problem that needs to be fixed. But let's just say for now pretend like the rejections aren't a part of it. Ninety percent of all clean claims must be paid within 15 business days of the date of the receipt. If not met, subject to $5,000 for...each month that an MCO's claims performance percentages by claim type fall below this performance standard. So as the one provider was trying to explain, like let's just say one of the providers, Total Care, they might meet 90 percent of their clean claims; 90 percent of their clean claims might be being paid, but now you still have 10 percent that aren't being paid and could be getting later and later and later. Now there are interest payments if you're delaying payments. But this standard that they have to meet is 90 percent, so one is the issue of, you know, the 10 percent that might be falling through. But the other is if we are not sanctioning managed-care companies, if they're not meeting this standard, then that again has less...they have less urgency to meet that standard. So even if...so it is not all just about clean claims. Even if all claims were clean, you could have some claims not paid. And if you're not paying attention to or sanctioning or

requiring those payments to be made on time, that's critical. The next paragraph down there, Senator Williams, "99 percent of all clean claims must be paid within 60 calendar days of the date of the receipt. If not met, subject to $5,000 for...each month," so those things that are clean claims that are sitting there delayed, we're saying...that's a pretty high standard, 99 percent, and so but again, if they are...may be paying interest on those late payments. But if we're not subjecting them to fines, as well, to put urgency and push to make sure those claims are getting paid, you could have late claims, delayed claims, even if they were all clean. Does that make sense, that difference between a claim can be clean and could still be delayed or late? And so someone might not be getting paid, even if that's the case. All right, so clean claims are one part, not the only part, of what might cause someone to be...have delayed payments or not get paid. So another important piece is the difference between necessary and required. So my...I think what they are trying to say is that...and also what I want to say is there...before I go there, is the definition of clean claims argument by both opponents is the definition of clean claims is not appropriate because it indicates that they must be paid. And I'll repeat again, the definition in the bill of clean claims comes right off of the Heritage Health Web site and right off of the Department of Health and Human Services Health Plan Advisory, so we took their language for clean claims. If this is not appropriate language, that's, again, part of this confusion that needs to be addressed. And the definition of clean claims needs to be clear and understood. Whether it's in statute or somewhere else, it needs to be something that is understood and, again, measured the same across those plans so that it is true that it's not the case that one plan looks like they're doing better because they're measuring it differently. And so having that definition, we used their definition in the bill. If it needs to not say the word "and paid" then that needs to also be changed and everybody needs to know what that definition is. So what it says is the managed care "for adjudication, that requires no further information," and I think the point of some of the providers is, well, the MCO requires no further information, that's a pretty open-ended standard. They might decide, well, today we require--and that's what you're hearing with testifiers--today we require this number, today we require this additional piece of information. And so to say what the MCO requires allows the MCO to change what's required over time and not have a set standard. If it's what's necessary, we're saying it's what necessary for CMS. And so that would be saying to the...that would be putting that standard in as what's necessary to be paid, not what they decide today or yesterday is required. And I believe the point of the Hospital Association's amendment is to get to a more objective, clear standard and industry standard, so, and if it is what is acceptable to Medicaid and Medicare, to CMS, all the better and we are then also making sure we don't have the waste, fraud, and abuse problem that Director Rocky...Director Thompson said would be a problem. If we're using industry standards and if it is an industry standard that is allowed and seen as appropriate by Medicaid and Medicare, then we all know what we're talking about and it should be built into their electronic healthcare systems and it should not be subject to waste or fraud and it should make sure everybody knows what we're measuring. And so again, whether it's in statute or not, I think the idea of having that clean claims be defined to an industry standard and so that the...and one that especially fits well with electronic payment systems would

be appropriate. And so I urge the department to consider that as part of trying to make sure we're being very clear about what a clean claim is. Whether or not that's a part of a bill, it's really critical that everybody knows what we're talking about. And again, the bill tried to help raise that issue by, again, using the definition that's currently used. And you've heard some of the issues with that. So the reason why...so, again, that's not the only issue, but I again want to bring you back to this contract violation. The reason a clear definition and clear understanding of clean claims is critical is that all of our sanctions about payment are tied to clean claims. So if an MCO is able to tell you, I'm sorry, that's not a clean claim, they don't have to meet these...all of these other standards. That's why the clean claims matters. And also, the clean claims matters because that's part of why things get rejected and returned and returned. So the requiring that they have a high standard for working and educating their providers to make sure they know what's required and that it works well with systems is to reduce that repeated rejection and steps that then require all this added administration cost on the part of providers. So those are why the clean claims are critical and what the percentage means, in terms of what that formula is, I'm happy to work on clarifying the formula. And again, I think the idea of clarifying the definition, again, it's the one that Heritage Health uses and the department uses. If it needs to be clarified, that is an issue that should be addressed as well. So those are a few of the points. Again, I want to make the point that although clean claims...a clean claim requires work by both the MCO and the provider, without any incentives to push MCOs to have strong clean-claims rates, there's no push for them to make it easier for providers to have clean claims. As Senator Riepe noted, insurance companies don't want to pay and all you have to do to not have to pay is have it not be a clean claim. So there is a perverse incentive to not have clean claims and to let...to reject the claim, send it back. And so without some way of pushing hard on clean claims, I believe we're leaving that incentive in place for payments to get denied by rejected claims. Again, payments are also getting denied and delayed for other reasons, as well, but the clean claims is a big piece because it also is a standard that we're using to evaluate and can be a standard by which we're using to determine when sanctions would be imposed. Thank you. [LB867]

SENATOR RIEPE: Okay, in your enthusiasm,... [LB867]

SENATOR CRAWFORD: Yes. [LB867]

SENATOR RIEPE: ...blowing right by corrective action plans. [LB867]

SENATOR CRAWFORD: Oh, yes. Okay, yes. So the director mentioned we were talking about the bill is asking for more information about when MCOs violate these contract provisions, where they could be fined. And that's information that we have requested and have not been able to receive. He notes there is other information that is available. They post known issues, and that's information that is available. And I believe...and also, if an MCO has a corrective action

plan, then that is public information and visible. My concern is that do we...we don't know. It appears, given all of the challenges that we're having, that surely some of these plans are not hitting these standards that are laid out in the contract. And if they're not hitting these payments laid...standards laid out in the contract, why aren't some of them getting fines now that we're, you know, well into a year past? And if it was the case and understanding that, you know what, the first year there's just no sanctions, that's our policy, then that I think creates some perverse incentives, but that would be a policy explanation. But I think the...we have sanctions in the contract and I guess I would wonder why they haven't been imposed when it appears that they're...from what we're hearing, that payments are not...payments and performance and improvements in performance aren't meeting these high standards we set out when we ask these companies to come in and provide this service for us. [LB867]

SENATOR RIEPE: Okay, thank you very much. With that, I think it's been a full and fair hearing. I would like to say before I...any questions? Do we have questions? Okay, any letters...oh, Senator Williams, please. [LB867]

SENATOR CRAWFORD: Oh, Senator Williams, ask me a question. [LB867]

SENATOR WILLIAMS: Certainly I have questions (laugh). You passed out a new fiscal note. [LB867]

SENATOR CRAWFORD: Yes. [LB867]

SENATOR WILLIAMS: Would you like to talk about that? [LB867]

SENATOR CRAWFORD: The new...the change in the fiscal note is just the explanation part. Originally... [LB867]

SENATOR WILLIAMS: I know you talked about the part with the paper filing and that but... [LB867]

SENATOR CRAWFORD: Right, right. So that's not changing this fiscal note. The only part that's changing the new fiscal note is that Liz Hruska had misunderstood the...and thought that there was a standard already in the contract that 90 percent had to be clean claims. So it was just a misunderstanding of the bill that she corrected. It's the explanation about what's in the contract or not. [LB867]

SENATOR WILLIAMS: Okay, so we still have a significant fiscal note. [LB867]

SENATOR CRAWFORD: So the fiscal note, so we did not change the numbers in the fiscal note. And so what I would say again is that the...what...I have no idea how the fiscal note got an interpretation that it required paper copies because, again, we use the same exact definition we're using now. [LB867]

SENATOR WILLIAMS: I understand. [LB867]

SENATOR CRAWFORD: So that all I think is not...doesn't have any merit, at all, that there would be cost for paper copying. So I think you discount all of that. [LB867]

SENATOR WILLIAMS: Right. [LB867]

SENATOR CRAWFORD: Then the other piece is saying they need more staff to track and report sanctionable offenses. And so my question back is, aren't we tracking the sanctionable offenses now? Clearly, maybe sometime, to put that in a form and verify it if you're reporting it. But if we're not tracking sanctionable offenses now, then that seems a problem. We have a contract. We have clear performance standards. And if we're not watching it, if we don't already have staff doing this now, then how are we saying that we are holding these managed-care organizations to this, these standards? [LB867]

SENATOR WILLIAMS: In your original opening you started out by thanking a lot of people for all the work that they... [LB867]

SENATOR CRAWFORD: Um-hum, yes. [LB867]

SENATOR WILLIAMS: ...they have done in this area. [LB867]

SENATOR CRAWFORD: Right, exactly. [LB867]

SENATOR WILLIAMS: And then you used the word "but." [LB867]

SENATOR CRAWFORD: Uh-oh. And... [LB867]

SENATOR WILLIAMS: And I just want to go on the record thanking all those same people. [LB867]

SENATOR CRAWFORD: Yes. [LB867]

SENATOR WILLIAMS: I think this whole issue has been one that has been bothersome and troublesome and costly to many,... [LB867]

SENATOR CRAWFORD: Yes. [LB867]

SENATOR WILLIAMS: ...many of the providers in my district, your district, and others. I would like to thank the three MCOs. Two of them have already made trips to my legislative district, met with providers, hospitals, physical therapists that...the third one has that trip calendered... [LB867]

SENATOR CRAWFORD: Good. [LB867]

SENATOR WILLIAMS: ...that we will do as soon as I'm back there after the session. So I appreciate that and I appreciate the continued work by the providers in trying to deal with this too. So thank you for bringing this to us. [LB867]

SENATOR CRAWFORD: Yes. Yes. And I appreciate that you're very correct and it's very important to express our gratitude for the work that the department has done in trying to resolve issues and the work that managed-care organizations have done and meeting with us and talking to us and working on many of these issues and the work of the providers on the administration, administrative simplicity committee and all the other committees, in trying to work together to improve this system. Yes, I am grateful for the work that so many are doing to try to improve this system. [LB867]

SENATOR RIEPE: I would also add now, we did the letters I think before. We did letters, didn't we? [LB867]

SENATOR HOWARD: Um-hum. [LB867]

SENATOR RIEPE: Thank you. I'd also, I think, in addition to all this maybe is weaved in there thanks and appreciation to Director Thompson... [LB867]

SENATOR CRAWFORD: Yes. [LB867]

SENATOR RIEPE: ...and his staff. You know, they've been very transparent. I think it's something as I've heard. I wasn't here with the past administration so I think it's a whole different attitude/environment and hopefully we can build on that. [LB867]

SENATOR CRAWFORD: Yes. Yes. Yeah, as I...yeah, as I noted, yes, I greatly appreciate his time and responsiveness in terms of providing information about clean claims and the other information and his willingness to come in for hearings and be responsive. And I appreciate your work, Chairman Riepe, in terms of holding those hearings and working with providers and working with the department, as well, and your legal counsel. [LB867]

SENATOR RIEPE: Well, we know we've got big issues and we're all interested. [LB867]

SENATOR CRAWFORD: Thank you. [LB867]

SENATOR RIEPE: Thank you. Thank you very much for being here. What I'd...and that concludes the hearing on LB867. And with that, I would like to have us...we've been here three hours. I'd like to take a ten-minute break and when the big hand is on the eight and the little hand is on the five, we'll start up again. Thank you. [LB867]

BREAK

SENATOR RIEPE: We are going to reconvene, because we do have an Executive Committee and a little educational session.

SENATOR WILLIAMS: You're on the clock.

SENATOR RIEPE: That's right. Welcome back to the hardy, to the strong of heart. We are going into...we are back in session and this is LB956, from Senator Howard. So please, Senator Howard. [LB956]

SENATOR HOWARD: Thank you. All right. Good afternoon, Senator Riepe and members of the Health and Human Services Committee. My name is Senator Sara Howard, H-o-w-a-r-d, and I represent District 9 that encompasses midtown Omaha. Today I'm introducing LB956, and I'm not asking the committee to kick it out, so we're just going to have a brainstorming session about this wonderful bill. No, keep sitting there, Senator Williams. [LB956]

SENATOR RIEPE: Is this your opening or closing? [LB956]

SENATOR HOWARD: This is my opening (laughter). As you know, I like thinking of innovative things for us to do that are interesting and wonderful. So we're going to (laughter)...this bill would allow any person who's not currently eligible for Medicaid to buy in or purchase Medicaid

for their primary insurance. Through LB956 the benefits that a person who purchases Medicaid would receive would be the same as current recipients. And Senator Erdman, what you missed is that I am not asking the committee to kick out this bill, so you can just take a nap or take a walk or something, because this plan would be accessed through the application of an 1115 waiver. It would be required that we utilize no federal funding as we carry out LB956. So we have some parameters about how much the premiums could cost--no more than 150 percent of the median expenditure paid on behalf of a Medicaid recipient. But I'd like to explain the impetus behind this bill, and I'll look at Senator Kolterman more because, really, the idea is around pooling, so insurance pooling, right? So the bigger your pool, the more stable it is, the more people are paying into it so that if somebody has a medical emergency or has a high-expenditure illness, the people that are paying into the pool, the more people that are paying into the pool, it doesn't upset the pool as much if there are larger expenditures. When you look at our Medicaid program, the only people who are in it are aged, blind, disabled, children, or very, very low-income parents, and it's very few low-income just adults, regular adults. And so when you think of the ABD population, that is our most expensive population. And then the children who are healthy are really supposed to even out that pool, right? So they're essentially paying it and they even out the pool. And so, when you think about pooling, it would behoove us to have a bigger pool with healthier people who are paying their premiums. So...and right now we have, on average...based on 2017 numbers, we have about 237,000 people on our Medicaid program. And just in terms of numbers, there are in 2016, our most recent numbers, we have 161,000 who are still uninsured and about 97,000 who purchased on the exchange last year. So those are just sort of giving you an idea. We still have a lot of people who are uninsured in the state and are looking for options. But our uninsured rate is close to 9 percent, while our unemployment rate is close to 3 percent, which means that there are a lot of people who are working who still don't have health insurance. And there have been similar proposals in other states. Nevada is the one that we...that I got this idea from. They passed it in both chambers and then it did...and then there was a gubernatorial veto. And so Wisconsin also tried to a plan like this, and it set their premiums at the rate similar to the rate paid by the state or their MCOs. New Mexico did this, Arizona is trying something like this. But nobody has seen it to full implementation because it is a big question. I mean essentially you would be allowing our Medicaid program to function as an insurer, which is a fascinating idea, but an innovative one. And so, as a state, we must innovate and find new ways to make sure that healthcare is affordable and accessible. And using this approach, this is one method to get us to my dream goal, which is that nobody...everybody has access to health and healthcare coverage in some way, shape, or form. The fiscal note is a normal fiscal note for a Howard bill, I would say (laughter). A hundred people for the department, you know, millions upon millions of dollars...just, you know, just my monthly income, basically, here. So you know, obviously... [LB956]

SENATOR KOLTERMAN: You're getting one...oops. [LB956]

SENATOR HOWARD: I'm sorry. Obviously this is a test balloon. This is for us to really consider how we meet that aim of ensuring healthcare coverage for everybody in the state of Nebraska. And other states are looking at this as an opportunity. I'm happy to try to answer any questions you may have. [LB956]

SENATOR RIEPE: I assume this is not your priority bill. [LB956]

SENATOR HOWARD: You know...fun fact: It is not. Opioids...I'm doing opioids--spoiler--in case anybody was curious. [LB956]

SENATOR RIEPE: Do you have any idea of the...you know, there would be a significant--or possibly, I better say--significant movement away from existing commercial insurance... [LB956]

SENATOR HOWARD: Oh, just like a woodwork effect? [LB956]

SENATOR RIEPE: Yes. [LB956]

SENATOR HOWARD: Yes, so...yeah. [LB956]

SENATOR RIEPE: That...and so I would think the commercial insurers will, you know, set their hair on fire. [LB956]

SENATOR CRAWFORD: Well, their own hair. [LB956]

SENATOR HOWARD: I don't see anything burning right now. [LB956]

SENATOR CRAWFORD: Yeah. [LB956]

SENATOR HOWARD: That being said, I could see a commercial insurer being concerned; however, we only have, I think, one insurer now in the exchange, so this would just be another option for them. And obviously, I don't think this would be appropriate for...like Blue Cross Blue Shield provides group coverage; this would just be an individual purchasing our Medicaid program. [LB956]

SENATOR RIEPE: Will you think about, maybe naming this like Pete's Health Insurance or something like that (laughter)? [LB956]

SENATOR HOWARD: Yeah, I think we could definitely brainstorm some great names. [LB956]

SENATOR RIEPE: Some great...I...yeah. [LB956]

SENATOR HOWARD: In Wisconsin I think they call it Badger Care. [LB956]

SENATOR RIEPE: Okay. [LB956]

SENATOR HOWARD: So we definitely work out something with that. I appreciate that. [LB956]

SENATOR RIEPE: Okay, I will be quiet and ask the committee for questions. Questions? [LB956]

SENATOR LINEHAN: Thank you, Chairman Riepe. So why would we have 161,000 uninsured? Because I thought you had...I thought...or maybe we've done away with that. So they don't have to buy insurance now? Because I though you had to. [LB956]

SENATOR HOWARD: Under the Affordable Care Act... [LB956]

SENATOR LINEHAN: Yes. [LB956]

SENATOR HOWARD: ...there is the individual mandate. The ways to bypass the individual mandate is if you made less than $10,000 a year or if you had a religious... [LB956]

SENATOR LINEHAN: But if we have...but to your point, if we have 3 percent unemployment... [LB956]

SENATOR HOWARD: And 9 percent uninsurance. [LB956]

SENATOR LINEHAN: And you're assuming that if we have three at $10,000, it doesn't take very long to make $10,000. I mean (inaudible)... [LB956]

SENATOR HOWARD: I mean unless you work in the Legislature. [LB956]

SENATOR LINEHAN: Right, unless you work here. So these numbers confuse me. [LB956]

SENATOR HOWARD: And I can appreciate your confusion. The 161,000 is actually from the department's fiscal note. And that number is from the Department of Insurance, which monitors health insurance (inaudible). [LB956]

SENATOR LINEHAN: Okay. Do we have a number of how many people are insured, covered by...? [LB956]

SENATOR HOWARD: Oh, I can get that for you, absolutely. [LB956]

SENATOR LINEHAN: Okay. And then my other question is...we spent most of the afternoon hearing how this... [LB956]

SENATOR HOWARD: Oh, managed care. [LB956]

SENATOR LINEHAN: Medicaid is not particularly working well, and a lot of complaints and concerns. So why would be dump more people into it? [LB956]

SENATOR HOWARD: No, that's an excellent question. Yeah...no, that's a great question. I think if we had systems in place that encouraged the managed-care companies to clean up their act in regards to payment and the clean claims, I wouldn't have any second thoughts about putting more...having...letting them have a broader pool. The other part, though, is that if there are more people, their cap rates are higher. [LB956]

SENATOR CRAWFORD: Um-hum. [LB956]

SENATOR HOWARD: And so you would think that their service provision would improve at that point. [LB956]

SENATOR LINEHAN: But how do you...the other thing I don't understand...you said that it would cost how much per month for an individual? [LB956]

SENATOR HOWARD: How much per month...oh, the premiums. [LB956]

SENATOR LINEHAN: The premiums, yes. [LB956]

SENATOR HOWARD: No, that's an excellent question. So that's cribbed from Nevada. And basically it...the cost couldn't exceed 150 percent of the meeting expenditure paid on behalf of

the Medicaid recipient. So the meeting expenditure--and I had that number--I think was around two... [LB956]

SENATOR CRAWFORD: $195.63. [LB956]

SENATOR HOWARD: What was it? [LB956]

SENATOR CRAWFORD: $195.63. [LB956]

SENATOR HOWARD: A hundred and nine... [LB956]

SENATOR CRAWFORD: A hundred and fifty is $293.45. [LB956]

SENATOR HOWARD: Exactly. [LB956]

SENATOR LINEHAN: But isn't the reason that's as low as it is, is because the vast majority of people on Medicaid are kids, when it comes to the numbers--raw numbers? [LB956]

SENATOR HOWARD: Raw numbers. [LB956]

SENATOR LINEHAN: Out of the 237,000...I don't know what percentage, but a large percentage of them are children. [LB956]

SENATOR HOWARD: Um-hum. [LB956]

SENATOR LINEHAN: So children are cheaper to insure, because... [LB956]

SENATOR HOWARD: Always. [LB956]

SENATOR LINEHAN: ...most of them, you just keep them healthy. [LB956]

SENATOR HOWARD: Um-hum. [LB956]

SENATOR LINEHAN: But when you open up a program like this... [LB956]

SENATOR HOWARD: Um-hum. [LB956]

SENATOR LINEHAN: ...to the older population--baby boomers who maybe have not had the best lifestyles for the last 30 years of their lives... [LB956]

SENATOR HOWARD: I mean, they're not eating Tide pods or anything, but yeah. [LB956]

SENATOR LINEHAN: ...or young people who are unemployed or people who...because you're not talking people here who are fully employed and have group healthcare. [LB956]

SENATOR HOWARD: Right. [LB956]

SENATOR LINEHAN: So wouldn't that cost explode? [LB956]

SENATOR HOWARD: It could explode. Although what's interesting about the fiscal note is that they don't show...they don't acknowledge the premiums. [LB956]

SENATOR LINEHAN: I don't...I don't trust the fiscal note. [LB956]

SENATOR HOWARD: Right, me neither. [LB956]

SENATOR LINEHAN: Okay. [LB956]

SENATOR HOWARD: They don't show any income off of the premiums that folks would be paying. I mean, essentially we would be operating an insurance company. [LB956]

SENATOR LINEHAN: Right, but...but then I... [LB956]

SENATOR HOWARD: And they would be getting 150 percent of the cost. [LB956]

SENATOR LINEHAN: I would...you can't take a group which is mostly young people, healthy people... [LB956]

SENATOR HOWARD: Um-hum, young invincibles. [LB956]

SENATOR LINEHAN: ...and then dump in a bunch of older people. [LB956]

SENATOR HOWARD: Oh, okay; I see where you're going. I'm with you. [LB956]

SENATOR LINEHAN: And then say your cost is going to...your cost per person is going to go up. [LB956]

SENATOR HOWARD: So what we really need to know is what the demographics of that 161,000. [LB956]

SENATOR CRAWFORD: Um-hum. [LB956]

SENATOR LINEHAN: Right. [LB956]

SENATOR HOWARD: Yes, because I will tell you that most of the baby boomers are phasing into Medicare, and so we wouldn't... [LB956]

SENATOR LINEHAN: Not as fast as you'd think (laughter). [LB956]

SENATOR HOWARD: We wouldn't necessarily see as many of them, but I would venture a guess--and this is just a guess based on previous statistics from other states--that a lot of our uninsured tend to be young invincibles. They tend to be people who think, I'm 26, I'm 27...now I'm not on my parents' health insurance, I'm super healthy; I don't need this, I'm not making $10,000 a year. [LB956]

SENATOR LINEHAN: But will...we would force them to buy it. [LB956]

SENATOR HOWARD: Well, I mean... [LB956]

SENATOR LINEHAN: Because if... [LB956]

SENATOR HOWARD: No, we wouldn't force them to do anything. [LB956]

SENATOR LINEHAN: Because we're already trying to force them. And they're not, because... [LB956]

SENATOR HOWARD: Right, yeah. [LB956]

SENATOR LINEHAN: Okay, all right. [LB956]

SENATOR HOWARD: Kids these days don't do anything we tell them to. [LB956]

SENATOR LINEHAN: Okay. Well, thank you very much. [LB956]

SENATOR HOWARD: No, these are great questions. [LB956]

SENATOR RIEPE: Okay. Other questions? Senator Kolterman. [LB956]

SENATOR KOLTERMAN: Thank you, Senator Riepe. Senator Howard, thanks for bringing this bill for discussion. [LB956]

SENATOR HOWARD: Well, thank you for having me, Senator Kolterman (laughter). [LB956]

SENATOR KOLTERMAN: One of my concerns is that I like the concept of the pooling. [LB956]

SENATOR HOWARD: Right. [LB956]

SENATOR KOLTERMAN: But one of the concerns that I've shared over the last six years as I promoted a local...having a local--I can't even remember the name of it--exchange,... [LB956]

SENATOR HOWARD: Yes...state-based, state-based. [LB956]

SENATOR KOLTERMAN: ...state-based exchange. And then once we got into this and all the people that came on board through the program, the Medicaid program is highly subsidized, and the other side of it is, it's a very, very rich benefit... [LB956]

SENATOR HOWARD: Um-hum. [LB956]

SENATOR KOLTERMAN: ...to the point where, if you were to go out to the private sector and ask the public, can I get on Medicaid and pay a little bit of a premium to do so, they'd gobble it up, simply because... [LB956]

SENATOR CRAWFORD: Yep. [LB956]

SENATOR KOLTERMAN: It'd break the insurance companies, but that's...they think it's a great deal... [LB956]

SENATOR HOWARD: Um-hum, um-hum. [LB956]

SENATOR KOLTERMAN: ...because they don't...the deductibles are very low. [LB956]

SENATOR HOWARD: Copays are miniscule. [LB956]

SENATOR KOLTERMAN: Yeah. [LB956]

SENATOR HOWARD: Um-hum. [LB956]

SENATOR KOLTERMAN: And they also have benefits that far surpass anything you can buy on the commercial market. [LB956]

SENATOR HOWARD: Um-hum, um-hum. [LB956]

SENATOR KOLTERMAN: That's what I have said, all along, is unfair about the program, because we're giving people--and I don't want you to take this wrong--but we're giving people that aren't paying any premiums one tremendous benefit, and the people that are subsidizing the premium payments by paying their taxes can't even afford to go out and buy insurance any longer. [LB956]

SENATOR HOWARD: Um-hum, um-hum. [LB956]

SENATOR KOLTERMAN: So while I like the concept of what you're saying here, in expanding that pool, that was the idea behind the exchanges, the federal exchanges. [LB956]

SENATOR HOWARD: Right, right. [LB956]

SENATOR KOLTERMAN: But it didn't work because, by the time we got involved, we're down now to one company, Medica in Nebraska. [LB956]

SENATOR HOWARD: Um-hum. [LB956]

SENATOR KOLTERMAN: If you were to go talk to UnitedHealthcare and Centene, which only is group care, and WellCare, if you would let them underwrite, to a certain extent, I think they'd still provide some of the benefits that you can get under a regular health insurance policy. But at the same time, you can't expect...I mean the reason Blue Cross got out of the business, UnitedHealthcare got out of the exchange business, they couldn't afford to do it. [LB956]

SENATOR HOWARD: Um-hum. [LB956]

SENATOR KOLTERMAN: And they are in the business to make money. And even if we're looking at our current Medicare--or Medicaid--I'll bet if you went and looked at the profits on Centene, UnitedHealthcare, and WellCare, there isn't anybody that's making money in those programs. [LB956]

SENATOR HOWARD: On our managed-care programs? [LB956]

SENATOR KOLTERMAN: Yeah. So my point is, while I like the concept of making something available, I don't think this is the way to do it. [LB956]

SENATOR HOWARD: Well, you're in luck (laughter). [LB956]

SENATOR KOLTERMAN: Yeah. And...yeah. And I don't mean...I think we need to figure that out. Now on the other hand, there are some programs that are starting to work... [LB956]

SENATOR HOWARD: Um-hum. [LB956]

SENATOR KOLTERMAN: ...that kind of accomplish what you're trying to do here, and I think we're going to hear about one of those next week, as we have another hearing. [LB956]

SENATOR HOWARD: Um-hum, um-hum. [LB956]

SENATOR KOLTERMAN: But they all...but all three of the companies that currently do our managed care in Heritage Home (sic--Heritage Health) do have other entities that could market insurance in Nebraska, but not if they can't price it right and make a buck. [LB956]

SENATOR CRAWFORD: Right. [LB956]

SENATOR HOWARD: Right. [LB956]

SENATOR KOLTERMAN: So what we'd be doing is doing some more subsidy work. [LB956]

SENATOR HOWARD: So I will meet you in the middle. [LB956]

SENATOR KOLTERMAN: Okay. [LB956]

SENATOR HOWARD: So we definitely have a very robust Medicaid plan, in terms of service provision; that's true. [LB956]

SENATOR KOLTERMAN: Um-hum. [LB956]

SENATOR HOWARD: And then conversely, unlike other states, we have a very limited eligibility. [LB956]

SENATOR CRAWFORD: Hmm. [LB956]

SENATOR HOWARD: So we really only limit it to kids below 200 percent, pregnant women, parents, but they've got to be super low-income, and aged, blind, and disabled, which are the people that we want supported by this program. Under a buy-in program, if we were able to receive a monthly, we would get...we would meet our cost for that monthly premium and get 50 percent more in that premium on...that's essentially what it calls for. We would be able to put that back into the program. When...it is heavily subsidized, right? [LB956]

SENATOR KOLTERMAN: Yeah. [LB956]

SENATOR HOWARD: We're at 50-52 cents on the dollar now... [LB956]

SENATOR KOLTERMAN: Um-hum. [LB956]

SENATOR HOWARD: ...for our FMAP, and 89, I think, for our CHIP program, for our CHIP population. And Director Thompson can correct me on that. But I think we do need to figure out ways to improve healthcare coverage and healthcare access for people who are uninsured. [LB956]

SENATOR KOLTERMAN: No question. [LB956]

SENATOR HOWARD: And those are the folks that really tend to drive a lot of our costs when they can't pay their bills at the end of the day. And one of the reasons why our Medicaid program is not affordable is because our provider rates are extremely low, as well. And that would also make it difficult for a Medicaid buy-in program to be popularized... [LB956]

SENATOR KOLTERMAN: Yeah. [LB956]

SENATOR HOWARD: ...because providers don't necessarily want to take Medicaid patients: 1) if they're not sure they're going to get paid and 2) if their payment is incredibly low. [LB956]

SENATOR KOLTERMAN: Yeah. [LB956]

SENATOR HOWARD: Yeah. [LB956]

SENATOR KOLTERMAN: Well, anyway, I'm not trying to throw cold water; I just... [LB956]

SENATOR HOWARD: Well, we're just spitballing here today, Sir. [LB956]

SENATOR KOLTERMAN: I'm a realist. [LB956]

SENATOR HOWARD: No, I appreciate that. [LB956]

SENATOR RIEPE: And Senator Crawford. [LB956]

SENATOR CRAWFORD: Thank you. And thank you for bringing this idea. And I appreciate the opportunity to think it through. Now it would be true with this buy-in that you would not have to meet any income requirements to buy in. So any taxpayer, or I mean anybody in the state who's, I suppose, a citizen, would qualify to, if they wanted to buy this plan, they could buy it. [LB956]

SENATOR HOWARD: Right. [LB956]

SENATOR CRAWFORD: Okay. So one other issue, in terms of bringing more revenue in, or affordability,... [LB956]

SENATOR HOWARD: Right. [LB956]

SENATOR CRAWFORD: ...is whether you could go to sliding-scale premium. So I mean...because the two, you know, yeah...less than $300 a month is pretty...it is high for some people but not other people who might like the package of benefits, like say it's a pretty rich package of benefits. [LB956]

SENATOR HOWARD: Right, right. [LB956]

SENATOR CRAWFORD: And so you could probably charge more for people who have higher incomes,... [LB956]

SENATOR HOWARD: Um-hum. [LB956]

SENATOR CRAWFORD: ...if they want to buy in to the program. Now again, I think it's important to remember this...the percent of the population that's in this individual market is pretty small, right? [LB956]

SENATOR HOWARD: Um-hum, um-hum. [LB956]

SENATOR CRAWFORD: So...but it would be interesting to know. You know, it would be interesting to have it as an option. Are you envisioning that this option would be on the marketplace? [LB956]

SENATOR HOWARD: I...that was my initial thought, was that it would be...my unicorn dream is... [LB956]

SENATOR CRAWFORD: Okay. It's...it's... [LB956]

SENATOR HOWARD: ...is that it would end up on the exchange. [LB956]

SENATOR CRAWFORD: Okay. So does that reduce the administrative costs at all, if...is the exchange then really...the exchange then would be doing the administrative work and enrollment things, right? [LB956]

SENATOR HOWARD: The enrollment process. [LB956]

SENATOR CRAWFORD: So that should reduce the costs. We shouldn't be... [LB956]

SENATOR HOWARD: Yeah, you wouldn't see... [LB956]

SENATOR CRAWFORD: ...having Medicaid pay those costs if...that's a question, I mean, for us to consider. [LB956]

SENATOR HOWARD: They probably still need a hundred people to do it, regardless. [LB956]

SENATOR CRAWFORD: So but... [LB956]

SENATOR HOWARD: No, that's a good question. Well, the other piece of that, though, is that this...the bill actually wouldn't allow them to rate like insurance companies rate. [LB956]

SENATOR CRAWFORD: Ah. [LB956]

SENATOR HOWARD: So insurance companies rate...they used to rate for gender; they don't anymore. [LB956]

SENATOR CRAWFORD: Okay. [LB956]

SENATOR HOWARD: They can rate in an age band so you can charge your oldest person three times what you charge your youngest person, which is how they decide how much people get charged. [LB956]

SENATOR CRAWFORD: So you're not allowing Medicaid to do that. [LB956]

SENATOR HOWARD: To do any rating. [LB956]

SENATOR CRAWFORD: All right. But you could... [LB956]

SENATOR HOWARD: So...and then you would have this flat fee. But you could do a sliding scale... [LB956]

SENATOR CRAWFORD: But you could do a sliding scale... [LB956]

SENATOR HOWARD: ...based on that fee if... [LB956]

SENATOR CRAWFORD: ...to raise more revenue, and... [LB956]

SENATOR HOWARD: That's an interesting idea. [LB956]

SENATOR CRAWFORD: Right. Well, I think part of the idea is not only to increase the pool, but to increase revenue. [LB956]

SENATOR HOWARD: Right, yeah. [LB956]

SENATOR CRAWFORD: I mean...so I think that's an important piece of it. Now one of...so one of things is the subsidy. I assume that these new people... [LB956]

SENATOR HOWARD: (Inaudible) I don't know... [LB956]

SENATOR CRAWFORD: ...we wouldn't get any federal match for. [LB956]

SENATOR HOWARD: No. [LB956]

SENATOR CRAWFORD: So they would not be subsidized. [LB956]

SENATOR HOWARD: No, there would be no match, and there would probably be no subsidy on the exchange either. [LB956]

SENATOR CRAWFORD: Yeah, probably not. So it wouldn't have that competition. [LB956]

SENATOR HOWARD: Um-hum. [LB956]

SENATOR CRAWFORD: Now the other competition problem for private plans is Medicaid pays a lot less. [LB956]

SENATOR HOWARD: Right, for the providers. [LB956]

SENATOR CRAWFORD: So the Medicaid...the provider rates. [LB956]

SENATOR HOWARD: I know. That's the stinky part. [LB956]

SENATOR CRAWFORD: We need to use some of this increased revenue to increase provider rates... [LB956]

SENATOR HOWARD: To increase provider rates. [LB956]

SENATOR CRAWFORD: ...so they're not so unequal, in terms of compared to private providers. [LB956]

SENATOR HOWARD: Right, right. [LB956]

SENATOR CRAWFORD: And that would both help the providers and reduce this competition problem. [LB956]

SENATOR HOWARD: Right, right. [LB956]

SENATOR CRAWFORD: As we're in our unicorn dream. [LB956]

SENATOR HOWARD: Since we're having...talking about innovative ideas, yes. No, thank you. Those are great comments. [LB956]

SENATOR RIEPE: Okay. Are there other questions from the committee? If not, thank you very much. [LB956]

SENATOR HOWARD: Thank you. [LB956]

SENATOR RIEPE: Are there proponents? If you'd be kind enough to state your name, spell it, and tell us the organization you represent, and... [LB956]

KATHY WARD: (Exhibit 1) I would be glad to do that. Good afternoon at this late date, Senator Riepe and members of the Health and Human Services Committee. My name is Kathy Ward; that's K-a-t-h-y W-a-r-d, and I'm here today testifying on behalf of AARP Nebraska, in support of LB956. I should note I'm retired from 35 years of working in public health for the Nebraska Department of Health and Human Services. I had the opportunity in that job to see the consequences of being uninsured, and it certainly has made an impact on me throughout my life. I am retired now. I'm an AARP volunteer because AARP stands for a lot of the things that are important to me as a long life...you know, a lifelong public health advocate. AARP is a nonprofit, nonpartisan organization. It works across Nebraska to strengthen communities. It

advocates for issues that matter most to families, such as: healthcare, employment and income security, retirement planning, affordable utilities, and protection from financial abuse, especially for people who are 50 and over. It's AARP's policy to ensure that everyone has access to health insurance and that all public and private health insurance should offer adequate coverage. Costs, like premiums, deductibles, and other out-of-pocket expenses shouldn't be burdensome on consumers, and it shouldn't limit access to coverage or necessary services. And we also believe that sufficient financial assistance should be available to lower-income consumers so that there is affordability for everybody. According to an AARP Public Policy Institute report in 2016, there were 29,713 uninsured Nebraskans between the ages of 50 and 64. The Affordable Care Act, implemented in 2010, provided additional options for people 50-64, to obtain health coverage; however, premiums for those on the exchange that don't qualify for the subsidies, and they fall in what we call the coverage gap, have seen an increase in premiums for 2018 plans ranging from 16.9 percent to 31 percent. This is really sad, but individuals in the coverage gap are too young to qualify for Medicare, they earn too much to get help from Medicaid, and they earn to little to receive any subsidy through the health marketplace exchange. Obviously most uninsured individuals think having health insurance is important, but cost is the main barrier. A 2015 study by the Robert Wood Johnson Foundation found that those 50-64 with insurance are likely to spend a significantly higher share of household income on healthcare and insurance than younger adults, especially if they obtain health coverage in the private individual market. And, of course, that leaves less disposable income to meet the basic life needs of food, housing, and transportation. Older adults share many of the same challenges as younger adults when it comes to accessing coverage and care. For older adults, the challenges to financial and health security are greater and longer lasting. The AARP Public Policy Institute report tells us older adults are particularly vulnerable to deterioration in function and health status if they don't have health coverage. And that increases their need for the use of healthcare services. The research shows that if people are uninsured in their 50s and early 60s, and particularly those with cardiovascular disease and diabetes, which is quite a few people...experience worse health outcomes and use more health services when they enter the Medicare program than those who are insured. LB956 is an interesting idea to provide an affordable avenue for those unable to access and purchase affordable and comprehensive health insurance coverage in our state. It would provide an avenue to better preventive care, saving lives, reducing the unnecessary use and overcrowding of emergency rooms, providing overall reduced costs in the healthcare system by insuring more individuals. We ask you to strongly consider supporting LB956 and to advance the bill to General File. And I thank you for the opportunity to provide comments on this important issue. We thank Senator Howard for introducing the bill and would be happy to answer any questions that you have. [LB956]

SENATOR RIEPE: Are there questions from the committee? Senator Linehan. [LB956]

SENATOR LINEHAN: Thank you, Chairman Riepe. Thank you very much for being here. I just have one quick question to try to kind of figure out the scope of this. You say that in--I think it's page 2 at the top paragraph, full paragraph--there were 29,713 uninsured Nebraskans between the ages of 50 and 64 in 2016. Do you have any idea of what percentage of people that represents? Is it like 10 percent or 20 percent or 30 percent of the people in Nebraska that are between 50 and 64? [LB956]

KATHY WARD: Hmm. [LB956]

SENATOR LINEHAN: Does that question make any sense (inaudible)? [LB956]

KATHY WARD: I understand the question. I don't have the information but will be glad to get it for you. [LB956]

SENATOR LINEHAN: Okay, that would be good. Thank you very much; appreciate it. [LB956]

KATHY WARD: You mean the percentage of total population of Nebraska who are between the ages of 50 and 64? [LB956]

SENATOR LINEHAN: Right. So if it's 29,713 people... [LB956]

KATHY WARD: Right. [LB956]

SENATOR LINEHAN: ...between 50 and 64, what...how many total people are there between 50 and 64? [LB956]

KATHY WARD: Right. [LB956]

SENATOR LINEHAN: That's what I'm trying to... [LB956]

KATHY WARD: I...My job is working with the Every Woman Matters program. For quite a few years of my health...public health time, a lot of those people were in that age of 50-64, and a lot of them were working two or three jobs to try to get by. But the...none of the jobs provided health insurance coverage, so it was sad to me to see so many people. What I...we would do...as for letters of support, so many people said this is the only healthcare I get all year. That was just astounding. [LB956]

SENATOR LINEHAN: Right. I understand it's very expensive, if you're between 50 and 64, to get health insurance. [LB956]

KATHY WARD: It is, yeah. [LB956]

SENATOR LINEHAN: I'm very aware of how expensive it is, so...but I'm just trying to figure out what the percentage is of people that do have it. [LB956]

KATHY WARD: That's a good question, and we'll get that answer for you. [LB956]

SENATOR LINEHAN: Okay; thank you much. [LB956]

KATHY WARD: Um-hum. [LB956]

SENATOR RIEPE: You stated that the AARP is--and I think it's a quote--that your concern is that all have access to health insurance. Is that different than--in your opinion--than to healthcare? [LB956]

KATHY WARD: That's a good question, too. Healthcare is certainly important. You're thinking like things like the community health centers or something other than health insurance? Is that...I'm not... [LB956]

SENATOR RIEPE: I just see...health insurance is over here and healthcare is over there. [LB956]

KATHY WARD: Healthcare is over there, yeah. [LB956]

SENATOR RIEPE: They're (inaudible) totally separate, different things. And you know... [LB956]

KATHY WARD: Yeah, me too. [LB956]

SENATOR RIEPE: ...I would argue that AARP is incorrect in focusing on health insurance and not on healthcare. [LB956]

KATHY WARD: Okay. [LB956]

SENATOR RIEPE: But that's me. [LB956]

KATHY WARD: Okay. [LB956]

SENATOR RIEPE: Any other questions? Thank you very much for being here. [LB956]

KATHY WARD: Thank you. [LB956]

SENATOR RIEPE: We appreciate it. I know we have another proponent over here. We appreciate your staying around and being patient. [LB956]

MOLLY McCLEERY: Hello. [LB956]

SENATOR RIEPE: Welcome. [LB956]

MOLLY McCLEERY: (Exhibit 2) Chairman Riepe, members of the Health and Human Services Committee, my name is Molly McCleery, M-o-l-l-y M-c-C-l-e-e-r-y, and I'm the deputy director of the healthcare access program at Nebraska Appleseed. We're a nonprofit organization that fights for justice and opportunity for all Nebraskans, and we just want to thank Senator Howard for bringing this bill to start this important conversation about opening up more health insurance options for folks in Nebraska. I included some information about marketplace enrollment, in my written testimony. In the past two years, we've had pretty steady marketplace enrollment and pretty high for a state of our size. In 2017 we had 88,351 Nebraskans purchase marketplace coverage, so going through healthcare.gov and purchasing from the federal marketplace. And then in 2016 we had 84,371. Despite that steady enrollment, we've had limited options on the exchange for the past two years. And this approach would allow for the creation of an additional option. I think part of this, the reason why this conversation is so important is getting to some of that brainstorming that was happening during Senator Howard's opening of figuring out who the remaining uninsured folks in Nebraska are. The Department of Insurance figure in the fiscal note notes that there are roughly 160,000 people who have a...are uninsured. And that figure has been fairly steady for the last couple years. I would say that, in our research in trying to figure out who remains uninsured, we found that a good chunk of those folks are people who are in the Medicaid gap, who do not make enough money to qualify for subsidies in the marketplace but who are over income or don't fit into a Medicaid eligibility category, so they really don't have an affordable insurance option at this point. A lot of folks are people who take the penalty for the individual mandate fine...they just pay the fine instead of purchasing coverage. And then there are others who choose not to have insurance and can get an exemption for various circumstances in their lives. It's also worth noting we do have a 95 percent child insurance rate. So we do pretty

well with children, but adults...we still have some work to do. I think I can also speak to some of the thought process where this has been looked at in other states that Senator Howard has mentioned, like Wisconsin, Nevada, Missouri. This idea really started popping up because of limited options on the exchange and looking at addressing bare counties, so where folks had...were able to access subsidies in the marketplace but didn't have an insurer that would sell them insurance where they could use those subsidies. So the thought was, could states create some sort of option if there's no insurer in the state that wants to sell? That would require people being able to use the subsidies to purchase insurance which, I think, could get to some of those cost questions. The premium, at this point...in some of the other states that have looked at it, the premium has been set higher, both to address provider rates, making sure there isn't a gap between what the person is paying individually and what their actual health costs are, and then, also, to see if there's a way to--for lack of a better word--to turn a profit on it and have that money go back into the Medicaid program. If folks are able to receive marketplace subsidies, then that would significantly drive down their premium on a Medicaid plan. And then that sort of gets to that sliding scale concept, where marketplace subsidies are based on income, so lower-income people get higher levels of subsidies and higher-income people get lower levels of subsidies. So ultimately we just want to thank the committee for engaging in this conversation and looking at different ways to increase access to insurance coverage. [LB956]

SENATOR RIEPE: Thanks very much. Are there questions from the committee? [LB956]

SENATOR WILLIAMS: Thank you. Oh, go on. [LB956]

SENATOR CRAWFORD: Go ahead. [LB956]

SENATOR RIEPE: Senator Crawford, go ahead, and then we'll do Senator Williams. [LB956]

SENATOR CRAWFORD: Okay, thank you. Thank you for your testimony today and, also, thank you for that background and just trying to understand what's happening other places. I really appreciate Ms. McCleery, and I appreciate you providing that for us. So as we're talking about the concept and philosophy, I think one of the questions that was raised was the question of, well, if you're having challenges with, you know, getting...with some challenges in your current system, why would you add more people to the system? And now one of the arguments back is that one of the things that's important often for having strong services, is that you have mixed-income people getting that service. And so if you had paid customers in Medicaid, along with the people who are not paying and have much more difficult lives,... [LB956]

MOLLY McCLEERY: Um-hum. [LB956]

SENATOR CRAWFORD: ...to make a fuss if it's not working. If you have paid people in Medicaid, they would be part of what...who would be demanding higher...better services. [LB956]

MOLLY McCLEERY: Um-hum. [LB956]

SENATOR CRAWFORD: And so I wonder if you could comment on that proposition, in terms of what might happen to Medicaid or its analogy like to schools, where we argue, or housing, where we argue. If you have mixed income, you have better conditions and more pressure for higher quality just because you have a mix of people and you have some higher-income people in that mix to push changes. [LB956]

MOLLY McCLEERY: Yeah, I think that's a great question and, as Senator Howard mentioned in her opening, this hasn't been actually tested anywhere, so there's not really data to back up these assumptions. But there...in the conversations that are occurring in other states, that is one thought, is that we're always having conversations about network adequacy in Medicaid or the number of providers that are taking Medicaid or system issues. And that's not something that's unique to Nebraska; that's across the U.S., in making sure that our systems function well. And the thought is that, if you do get a more mixed-income base in there, or you have incentivizing providers to take it through increased rates through a different population, that perhaps that that would shore up system function across the board. So I think that is a proposition that makes sense. [LB956]

SENATOR CRAWFORD: Thank you. [LB956]

SENATOR RIEPE: Okay, Senator Williams. [LB956]

SENATOR WILLIAMS: Thank you, Chairman Riepe. And thank you for being here. I think you used the term "marketplace subsidy"... [LB956]

MOLLY McCLEERY: Um-hum. [LB956]

SENATOR WILLIAMS: ...in using to pay for this. Where does...do marketplace subsidies come from? [LB956]

MOLLY McCLEERY: So where does the funding for marketplace subsidies come from? [LB956]

SENATOR WILLIAMS: Yeah. [LB956]

MOLLY McCLEERY: It comes through the federal government, through the Affordable Care Act. [LB956]

SENATOR WILLIAMS: Where does the federal government get their money to pay for that? [LB956]

MOLLY McCLEERY: Through tax dollars. [LB956]

SENATOR WILLIAMS: Thank you. [LB956]

MOLLY McCLEERY: Um-hum. [LB956]

SENATOR RIEPE: Okay. Any other questions? Seeing none, thank you for being here. [LB956]

MOLLY McCLEERY: Thanks. [LB956]

SENATOR RIEPE: Additional proponents that would like to testify? Seeing none, is there anyone speaking in opposition? Third time is the try. [LB956]

SENATOR WILLIAMS: Pushing the red button today (laughter). [LB956]

THOMAS "ROCKY" THOMPSON: (Exhibit 3) I'll see you tomorrow and next week, too (laughter). [LB956]

SENATOR CRAWFORD: Come on. [LB956]

THOMAS "ROCKY" THOMPSON: Good evening, Chairman Riepe and members of the Health and Human Services Committee. My name is Thomas "Rocky" Thompson, T-h-o-m-a-s R-o-c-k-y T-h-o-m-p-s-o-n, and I serve as the interim director of the Division of Medicaid and Long-Term Care in the Department of Health and Human Services. I'm here to testify in opposition to LB956, and thank you, Senator Howard, for allowing me to be part of this conversation. LB956 would require the department to create a new state government-sponsored health insurance program delivered in the same manner and with the same benefits as Nebraska Medicaid. All residents of the state not otherwise eligible for Medicaid would be allowed to participate. Unlike our current Medicaid program, federal funds would be unavailable and unable to be used for this

new insurance product, both according to this bill and federal law. Since federal authority is not needed to establish this new insurance product under the Social Security Act, a Section 1115 waiver is not necessary. As written, LB956 directs the department to use expenditures by the Nebraska Medicaid program as a financial basis for determining the premium that should be set for participants in this new insurance program. The legislation also caps the premium amount. This would impose a significant financial risk on the state budget. Before I detail those risks, and it's in your written testimony...I'll skip over the how rates are developed for the Medicaid program. As written, LB956 does not allow the department to set premiums using an actuarially-sound process that anticipates the use of medical services by the population the program would likely serve. The legislation instead sets a premium at 150 percent of the median expenditure paid on behalf of a current Medicaid beneficiary, and mostly children, as was said before. The failure to utilize an actuarially-sound process could result in a premium that does not accurately anticipate the utilization of benefits by this new population. LB956 will pose a significant financial risk to the state, as the premium it requires would be based on previous expenditures for traditional Medicaid populations that may be very different from the population the program would likely serve. Any cost overruns resulting from this failure of the premium to accurately anticipate costs will be borne entirely by the state, and that cost is not reflected in the department's fiscal note. To understand the financial risk, it may be instructive to look at the experience of the health plans on the federal health insurance marketplace, as those plans serve a population similar to the population likely to participate in the LB956 program. The Nebraska Department of Insurance has reported that premiums for health plans in the individual market have increased 153 percent from 2013 to 2017, as insurers have struggled to accurately anticipate the costs associated with covering this population. For some plans that have participated in the ACA marketplace, cost overruns, due to insufficient premiums, have resulted in financial losses that run to tens of millions per year. Should current Medicaid health plans be required to participate in the LB956 program, the financial stability of those health plans could be jeopardized. LB956 would grow government by requiring the department to hire numerous new employees to administer this new health program. In order to ensure that participants in the LB956 program are not otherwise eligible for Medicaid, as required by the bill as written, each applicant for the new program would have to undergo a Medicaid-eligibility determination. This is because the bill requires them not to be otherwise eligible for Medicaid; that's why we need the extra 100 staff members. [LB956]

SENATOR CRAWFORD: Hundred staff members. [LB956]

THOMAS "ROCKY" THOMPSON: And where it's a process, a Medicaid application makes sure they're not eligible for Medicaid, and then thus eligible for this program. [LB956]

SENATOR RIEPE: And a new building (laughter). [LB956]

THOMAS "ROCKY" THOMPSON: I don't know where we'd keep them. We spent about five evenings trying to figure out what the fiscal impact of this bill would be. And one of the things I brought up was building space. [LB956]

SENATOR CRAWFORD: Yeah (laughter). [LB956]

THOMAS "ROCKY" THOMPSON: Furthermore, this bill does not prohibit participation by individuals with access to employer-provided health insurance. As written, the legislation may encourage some employers to cease offering health coverage and attempt to transfer employees to the LB956 program. So you were talking about the benefits in Medicaid. Those would be available at a pretty low cost for employers. Regardless of whether program participants move from the individual market or from employer-provided insurance, LB956 would transfer the financial risk of covering these individuals from private insurers to the state of Nebraska. The creation and launch of this program would also require the time and attention of current department employees and leadership, which may result in reduced oversight of the current Medicaid program. Remember that Medicaid serves some of the...Nebraska's most vulnerable citizens, including elderly, persons with disabilities, and low-income mothers and children. Resources dedicated to this mission would be taken away to administer this new insurance product to a population that may already have the resources to purchase health insurance either in the individual or group markets. We believe that the finite resources and department personnel are best utilized to oversee those programs already entrusted to us on behalf of the state's most economically-disadvantaged and medically-fragile individuals. While I am proud of the quality of care offered by our Heritage Health plans to the most vulnerable in our state, we should not divert from our mission to provide the best health services to low-income families and persons with disabilities to create a new insurance product for a population who already has the ability to purchase healthcare coverage in the existing market. For these reasons I oppose LB956. And thank you for allowing me to be part of this conversation again. [LB956]

SENATOR RIEPE: Thank you. Are there questions? Senator Erdman. [LB956]

SENATOR ERDMAN: More or less a comment. If Patrick ever decides to hang it up as clerk, you should apply for that job (laughter). [LB956]

THOMAS "ROCKY" THOMPSON: Thank you, Senator. [LB956]

SENATOR ERDMAN: You can read fast (laughter). [LB956]

SENATOR RIEPE: Thank you. [LB956]

SENATOR ERDMAN: Thank you. [LB956]

SENATOR RIEPE: Are there other...Senator Crawford. [LB956]

SENATOR CRAWFORD: Thank you, Chairman Riepe. And thank you, Director, for being here today. And I really do appreciate your thoughtful opposition to the bill. I think those are really important points for us to consider as we deliberate this idea. So one I want to point to, and I think you're correct in pointing out, that they would need to be able to use an actuarially-sound process to anticipate the...what the actual costs would be. So I think what you'd like to see with the buy-in is that you're actually helping the program by getting revenues to it. So if we were...if it was on the exchange, it could use an actuarially-sound process. Then you would be able to have money to cover those costs. You wouldn't be putting yourself in that financial risk. But I understand you do have that risk. [LB956]

THOMAS "ROCKY" THOMPSON: And then there...and you know, this bill is not clear about participation in the exchange. [LB956]

SENATOR CRAWFORD: Right, yes. Correct. [LB956]

THOMAS "ROCKY" THOMPSON: The cost-sharing subsidies and the other subsidies available are only available for participants in the exchange. And I should note that there are other states where Medicaid products actually participate in the exchange--not through Medicaid, but through their private businesses. Centene is one of the examples. [LB956]

SENATOR CRAWFORD: That's true; that's true. So one way of making sure that it actually creates more revenue. And, if we stress that it had to be on the marketplace, that would also take care of the people getting in who have other options, because the marketplace would screen them out. And the marketplace would also take care of 50 of those 100 people who you now say would have to do Medicaid eligibility, because the marketplace would be doing that. [LB956]

THOMAS "ROCKY" THOMPSON: Well, I should point out that when somebody signs up through the marketplace... [LB956]

SENATOR CRAWFORD: It still (inaudible). [LB956]

THOMAS "ROCKY" THOMPSON: ...and they still, if they might qualify for Medicaid, they're still sent down to Medicaid... [LB956]

SENATOR CRAWFORD: Right. [LB956]

THOMAS "ROCKY" THOMPSON: ...and we have to an eligibility determination to see if... [LB956]

SENATOR CRAWFORD: Okay. [LB956]

THOMAS "ROCKY" THOMPSON: ...they qualify for Medicaid. [LB956]

SENATOR CRAWFORD: So if having this option pushes a few more people to the marketplace, that's going to push a few more people to you that you would have to check up on. [LB956]

THOMAS "ROCKY" THOMPSON: Right. And also, I should point out that the subsidies available in the marketplace are only available for those above 100 percent of the federal poverty level. [LB956]

SENATOR CRAWFORD: Okay. That's a good point. So we have to find a way to... [LB956]

SENATOR RIEPE: Okay. [LB956]

SENATOR CRAWFORD: But if it's a sliding...well, so we'd have to make some accommodation for if we were below that; that's right. [LB956]

THOMAS "ROCKY" THOMPSON: Well, if you were seeking federal subsidies. [LB956]

SENATOR CRAWFORD: Yes, that's true; that's true. Interesting. So...and so right now, just to be...just to clarify, if someone comes on...if someone applies to the marketplace, if there's a question about their Medicaid eligibility, it gets moved to you. [LB956]

THOMAS "ROCKY" THOMPSON: They're sent down to... [LB956]

SENATOR CRAWFORD: They're sent down to you, right; right. [LB956]

THOMAS "ROCKY" THOMPSON: That's correct. [LB956]

SENATOR CRAWFORD: And then...and so that process is already come...in place for the marketplace. [LB956]

THOMAS "ROCKY" THOMPSON: That's correct. That was a requirement of the Affordable Care Act. [LB956]

SENATOR CRAWFORD: Yeah, yeah. Right, right. So we already have that set up. So if this is on the marketplace, they only kick back if they didn't go down to you. [LB956]

THOMAS "ROCKY" THOMPSON: There is that process that is in place. Of course we would need additional staff to handle that load, because... [LB956]

SENATOR CRAWFORD: If more people came onto it. [LB956]

THOMAS "ROCKY" THOMPSON: ...we do see that when we have open enrollment for marketplace coverage. We see a large number of applications come our way. [LB956]

SENATOR CRAWFORD: Okay, excellent. Thank you. [LB956]

THOMAS "ROCKY" THOMPSON: Thank you, Senator. [LB956]

SENATOR RIEPE: Senator Kolterman has a question. [LB956]

SENATOR KOLTERMAN: Thank you, Senator Riepe. Is Medicaid actuarially sound at the present time? [LB956]

THOMAS "ROCKY" THOMPSON: It is, Senator. We have to get our rates approved by the federal government after our actuary works through them with all these considerations. [LB956]

SENATOR CRAWFORD: Hmm. [LB956]

SENATOR KOLTERMAN: Would it be actuarially sound if we were paying for it as a state, in other words, if lost our subsidy from the federal government? [LB956]

THOMAS "ROCKY" THOMPSON: Well, we would have to...I would still...there would not be the federal requirement to accept actuarially-sound rates. I would still hope we would do that. Of

course, we would need additional general funds in order to make up whatever federal funding was lost or we would have to consider what services and population we serve in the Medicaid program. [LB956]

SENATOR KOLTERMAN: When people apply for Medicaid, you don't underwrite those people, you don't ask them health questions, do you? [LB956]

THOMAS "ROCKY" THOMPSON: Well, Senator, there's two different types of Medicaid eligibility types. There's...since ACA there's MAGI, non-MAGI. MAGI is just income-eligility determination. Non-MAGI takes in some considerations like disability, so there's health questions that are asked for that. [LB956]

SENATOR KOLTERMAN: But if someone has a disability, you just pay more for it, and they don't have to pay as much. [LB956]

THOMAS "ROCKY" THOMPSON: Well, we pay more for...they're a different rating cohort than, let's say, somebody who might be a child or a caretaker adult. So we do pay more, as a state, for that care. [LB956]

SENATOR KOLTERMAN: So you are underwriting, to a certain extent, based on...the benefits don't change either way, do they? [LB956]

THOMAS "ROCKY" THOMPSON: Senator, there's some slight differences in, let's say, if they're in a waiver program, they have access to different benefits than if they're under the state plan. But of course, we...that's what we anticipate in our budget for that. [LB956]

SENATOR KOLTERMAN: Oh. [LB956]

THOMAS "ROCKY" THOMPSON: And again, while we set the rates and we ensure they're actuarially sound, if there is...if there are costs that are more for certain individuals on the Medicaid program, that's either taken care of...that's either paid for by the managed-care organization for those that are managed care, or our Medicaid program. We still are...we still have to eat those costs, if that's what you mean. [LB956]

SENATOR KOLTERMAN: If we were able to do this program, would that then open up an opportunity for the three managed-care companies to renegotiate their rates? [LB956]

THOMAS "ROCKY" THOMPSON: We would have to create a different rate for this population, maybe a couple of different rates, depending upon what the uninsured population, what we can anticipate their health status and health needs are. And doing this program would require contract amendments to the managed-care organizations; yes, Sir. [LB956]

SENATOR KOLTERMAN: And so they wouldn't necessarily...would they necessarily have to participate in this if we pass this type of legislation? [LB956]

THOMAS "ROCKY" THOMPSON: We would have to do a contract amendment. If they don't accept the contract amendment, then they would not participate. Since this is not bound by federal law, we could administer this program in many different ways. [LB956]

SENATOR KOLTERMAN: So in essence they could pick and choose if they want to participate. [LB956]

THOMAS "ROCKY" THOMPSON: Right. For example, there's a requirement for multiple plans, for good reason, under federal law, let's say if a plan leaves and then there's only two plans left or one plan left, in certain circumstances. But this program would not be bound by federal law since we're not seeking federal funds for it. [LB956]

SENATOR KOLTERMAN: Okay, thank you. [LB956]

SENATOR RIEPE: Okay. Thanks, Senator Kolterman. Senator Crawford. [LB956]

SENATOR CRAWFORD: Thank you, Chairman Riepe. And thank you, Director. Just one other variation on the idea of leveraging Medicaid to improve marketplace options. Do any states require that, if you have a contract to provide managed care for Medicaid, that you must also offer a plan on the exchange? [LB956]

THOMAS "ROCKY" THOMPSON: I haven't looked into that recently, Senator. I know that there was talk, at one point, for certain states to do that. I believe certain states might have required that, especially those states with state-based marketplaces. [LB956]

SENATOR CRAWFORD: Um-hum. [LB956]

THOMAS "ROCKY" THOMPSON: I can't name any, offhand. [LB956]

SENATOR CRAWFORD: Okay, thank you. [LB956]

THOMAS "ROCKY" THOMPSON: Thank you, Senator. [LB956]

SENATOR RIEPE: Okay. Any other questions or comments? Okay. Thank you, Director Thompson. [LB956]

THOMAS "ROCKY" THOMPSON: Thank you, Chairman. Thank you, Senators. See you tomorrow (laughter). [LB956]

SENATOR RIEPE: Okay, we'll all make sure to wear different clothing. Are there other opponents, anyone speaking in opposition? Anyone speaking in a neutral capacity? Seeing none, Tyler, do we have any letters? [LB956]

TYLER MAHOOD: (Exhibits 4, 5, and 6) Yes, I have a letter, signed in support for...I have a letter, in support, from Amy Behnke of the Health Center Association of Nebraska; a letter of support from Kelly Keller of the National Association of Social Workers-Nebraska Chapter, in support; and a letter from Director Bruce Ramge of the Department of Insurance, in opposition. [LB956]

SENATOR RIEPE: Okay. Senator Howard, would you...you're going to waive closing, okay. [LB956]

SENATOR CRAWFORD: Oh. [LB956]

SENATOR LINEHAN: All right. [LB956]

SENATOR RIEPE: Bless you. [LB956]

SENATOR KOLTERMAN: Cool (laughter). [LB956]

SENATOR HOWARD: I can test the room; I know what's going on (inaudible). [LB956]

SENATOR RIEPE: With that, we conclude the hearing on LB956 and thank all of you for your attention. Due to necessity, we are going to go into Executive Session, because we have work to get done. So we will ask everyone (recorder malfunction). [LB956]