Health and Human Services Committee
March 19, 2018

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The Committee on Health and Human Services met at 9:00 a.m. on Monday, March 19, 2018, in Room 1510 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public hearing on quarterly briefing of Heritage Health and Nebraska Dental Medicaid. Senators present: Merv Riepe, Chairperson; and Matt Williams. Senators absent: Steve Erdman, Vice Chairperson; Sue Crawford; Sara Howard; Mark Kolterman; and Lou Ann Linehan.

SENATOR RIEPE: This is the Health and Human Services Committee and this is our quarterly hearing for both the Heritage Health and today for the first time we're going to look at Dental Medicaid. And we appreciate everyone being here. We will be recording. I'm Merv Riepe. I'm the Chairman of the committee. Today, because this is a busy time in the legislative session and it's also a recess day, we have my fellow colleague, and I will let him introduce himself and talk a little bit about his district, if he would.

SENATOR WILLIAMS: I'm Senator Matt Williams from Legislative District 36 which is Dawson County, Custer County, and the north portion of Buffalo Counties.

SENATOR RIEPE: Thank you. I want to go to the point here and talk about a quorum. And I quote, "Committee Quorum. A majority of the members of a committee shall constitute a quorum. A quorum must be present for the transaction of any committee business except a public hearing." So we have that exception that we're functioning under. We wanted to get that into the record. I also want to acknowledge that we will, following this hearing, get all of the recording transcribed and we will make those available to all of the members on the committee so that you're not just...be talking to the two of us. We'll be having others that will at least get that information. With that, I would ask all of you to silence your cell phones, if you will. And if you plan on a hearing, we will...we don't have such a large crowd that we won't...you can move from where you're sitting if you choose. With that, I would like to start off with our new director, Director Matthew...Dr. Matthew Van Patton. And should we call you Dr. Matthew or just Matthew or...?

MATTHEW VAN PATTON: You know what, Mr. Chairman, I told my staff if the Honorable Reverend Dr. Billy Graham can be just "Billy," I think I ought to be just "Matthew."

SENATOR RIEPE: Okay.

MATTHEW VAN PATTON: So that suits me just fine.

SENATOR RIEPE: Okay, but it is "Matthew." Thank you.

MATTHEW VAN PATTON: Yes, sir.

SENATOR RIEPE: With that, for the record, if you'd be kind enough to give us your name, spell it for the record, and then proceed forward.

MATTHEW VAN PATTON: (Exhibit 1) Yes, sir. Mr. Chairman and members of the committee, it's a pleasure for me to be here with you again today. I am Matthew Van Patton; that's M-a-t-t-h-e-w V-a-n P-a-t-t-o-n, and I am the acting director of Medicaid and Long-Term Care at the Nebraska Department of Health and Human Services. I am here today to share with the committee an update on Heritage Health and the work undertaken by the Division of Medicaid and Long-Term Care Services with our three managed care organizations, or MCOs: Nebraska Total Care; UnitedHealthcare; and WellCare of Nebraska. In the two weeks I've been on the job, I've had three opportunities to engage with the executive teams of each MCO and am very pleased to report what I consider to be the beginnings of a very cooperative and collaborative relationship. Each of you should have a copy of today's presentation for your reference and review. Before I begin I would like to thank the staff at Medicaid and Long-Term Care who have helped me prepare for today's presentation. I applaud their work ethic, expediency, and patience with me as I continue to learn and ask questions. I also ask the committee's indulgence and forgiveness as I read much of today's presentation from my notes in an effort to keep facts, figures, names, and acronyms straight and correctly communicated. That said, with your permission, Mr. Chairman, we can begin on page or slide 2. And here you will note the topics we will cover as we advance through the presentation. On page or slide 3, you will note the Heritage Health Mission Statement which reads: "Heritage Health is a person-centered approach to

administering Medicaid benefits that provides Medicaid and CHIP members a choice of a single plan that provides all of their physical health, behavioral health, and pharmacy benefits and services in an integrated health care program. Integrated care through Heritage Health will improve member health outcomes, reduce costly and avoidable care, decrease reliance on emergency and inpatient levels of care by providing evidence-based care options that emphasize early intervention and community-based treatment, address social determinants of health, and improve the financial sustainability of the system." This mission statement is shared whenever there are stakeholder meetings, and achieving this mission is how we will gauge success with Heritage Health. To that point, using data at our disposal to guide best practice, programmatically and operationally, will be a top priority. Today we can share with the committee data from the first year of Heritage Health operations, as well as a few highlights and accomplishments. On page or slide 5, you will note there were 3,583,726 health claims paid in 2017 totaling more than $720 million. There were 3,416,633 pharmacy claims paid in 2017 totaling more than $223 million. In addition to these figures, Heritage Health has a number of other accomplishments, including the addition of value-added services, community engagement across the state, and communication with stakeholders, points I will elaborate on in the slides and pages to follow. Turning to page or slide 6, you will note the total enrollment as of February 2018: 233,295 Nebraskans were enrolled in Heritage Health. The distribution of enrollment between the three managed care organizations remains relatively even with each to the three companies holding approximately a third of Heritage Health's total involvement. Heritage Health's first open enrollment period occurred between November 1 and December 15, 2017. During this period, 3,556 Heritage Health beneficiaries enrolled into a new plan. Moving on to page or slide 7, we begin to profile some of the aforementioned value-added services of the MCOs. Such services stand out as a hallmark benefit of participation in managed care. The services are additional benefits that are supplemental to the benefits Medicaid requires the MCOs to offer. These services changes over time in accordance to the needs of the market. Here you see a few of the programs Nebraska Total Care provides for its members: 24-hour nurse advice line mobile app to view resources; breast pumps, baby showers, and "diaper days" to provide educational opportunities on prenatal and postpartum care for mothers and newborns and pediatric care for babies; ConnectionsPlus provides a free cell phone for members without reliable access to a phone; and Hope Bear is an incentive program for participation in post-hospital appointments. On page 8, you will note United Healthcare's value-added services which

include: purchase of breast pumps; Healthy First Steps; baby showers to educate on prenatal and postpartum care; and a 24-hour crisis and Nurseline with a debuting Health4Me mobile app to view to view resources. Lastly, on page or slide 9, WellCare's value-added services are profiled. Their offerings include: free car seats for pregnant members; Pursuant kiosks for complete health risk assessments at a local Walmart; family support specialists who provide families with counseling through a partnership with Nebraska Family Support Network; and a community room/concierge offers community support needs such as free meeting space, personal assistance, and computer kiosks. In addition to providing healthcare, the MCOs contribute to Nebraska by engaging their communities. On page or slide 10, you will note several community events hosted by the MCOs. These events are an important addition to the Heritage Health program. The first photograph, to the far left, is from WellCare's Dental Day event on March 2 in Kearney where an outreach worker taught attendees about the MCNA, the Managed Care North America dental program, Heritage Health's new dental benefits manager. This was the first event where an MCO collaborated with MCNA. The second, middle photo is from Nebraska Total Care's Vision Van event in Omaha this past September. The last photo is from one of UnitedHealthcare's community baby shower events. Here you see staff educating young mothers on ways to promote a healthy pregnancy. This picture was from an event in February of this year at Northwest High School in Omaha. On page or slide 11, you will note from the map our efforts to reach out to communities across the state. Outreach to members, providers, and stakeholders is an essential part of making Heritage Health a success. Since the last presentation to the committee, Heritage Health providers have held stakeholder meetings in Adams, Box Butte, Cass, Dawson, Dodge, Fillmore, Hall, Knox, Madison, and York Counties. Similarly, a member outreach was held for the first time in Webster County. Lastly, I would like to note the importance of provider orientations and to state that helping providers engage with the managed care system effectively and efficiently is of critical importance. This map notes our efforts to date across the state. Next page, or slide 12, I have asked the MCOs to begin providing regular updates on their marketing, communications, and education efforts at our regularly scheduled meetings. Assessing these efforts in tandem with other programmatic and operational assessments will help us better identify successes and opportunities for improvement in the program. Quality review: MCOs are responsible for ensuring that persons enrolled in their plans receive quality healthcare. In addition, MCOs publicly funded through Medicaid are required by state and federal government to meet certain quality standards. If you will turn to page or slide 14, you will see how we ensure

quality standards are met. An EQR--or external quality review--is a federally required analysis and evaluation of aggregated information on quality, timeliness, and access to Medicaid-covered services. We have contracted with IPRO, an external quality review organization whose logo you see there to the right, to conduct our EQR for 2017 operations. Results of their review are expected by this summer 2018. On the next page, or slide 15, you will note three of our performance improvement projects, or PIPs for short. While each of these plans are required...excuse me. While each of the plans are measured on federal and state Medicaid adult and core child measures, as well as HEDIS, healthcare effectiveness data and information set measures, PIPs represent an opportunity for stakeholders to collaboratively engage to identify data-driven opportunities that address Nebraska-specific population health initiatives. Currently Heritage Health has three PIPs in development. They are: (1) emergency department, or ED, follow-up for mental illness, alcohol, and other drug dependency; (2) 17P, as it's known for short, or the hydroxyprogesterone caproate initiative for pregnant women; and (3) Tdap, the tetanus, diphtheria, and pertussis vaccine. Our medical director, Dr. Lisa White, has played a leading role in the PIP work development. Next page, or slide 16, we profile the future of the Quality Performance Program. In the second year of Heritage Health, we will be focused on quality-of-care improvement. Moving forward, Quality Performance Program measures will be tied to a financial withhold of 1.5 percent of total revenue. The MCOs will only receive certain payments when they meet these measures. Evidence-based guidelines and performance measures help ensure patients receive the most appropriate and timely care, thus enhancing the value proposition of participating in the plan while strengthening the taxpayer's return on the investment. By using systemic, valid, and reliable methods for providing quality of care, measuring the depth and breadth of success and reporting results, our MCO partners are best positioned to demonstrate to all stakeholders the extent to which the care provided to members has been maintained and improved. On pages or slides 17 and 18, we note Quality Performance Program measures for year two of Heritage Health. In these tables you will see the performance requirement, the payment threshold, and the percent of payment pool. On page 17, these measures are dedicated to operational performance and are similar to year one QPP measures. They are claims processing timeliness, encounter acceptance rate, call abandonment rate, and appeal resolution timeliness. On page 18, these measures are dedicated to healthcare quality. They include: preferred drug list, or PDL, compliance; lead screening in children; and well visits in the first 15 months of life; and childhood immunization status. On page or slide 19, we

transition into reports on the provider and member experience with the MCOs. Turning to page or slide 20, I would like to note the MCOs in Heritage Health are required to conduct an annual survey of their members and providers. These surveys provide valuable insight into the member and provider stakeholder perspective. They also help us define, refine, and assess the value proposition of participation within these stakeholder groups. We'll begin by reviewing the provider surveys which the MCOs are contractually required to conduct to assess provider satisfaction with provider credentialing, service authorization, MCO staff courtesy and professionalism, network management, appeals, referral assistance, coordination, perceived administrative burden, provider communication, provider education, provider complaints, claims reimbursement, and utilization management processes including medical reviews and support for PCMH--patient-centered medical home--implementation. I would also like to note that each MCO constructs their own provider survey to assess their practices with their providers and these surveys are not necessarily for statistical comparison with the other MCOs. On page or slide 21, we note highlights from Nebraska Total Care's provider survey. The survey was conducted by SPH Analytics with an initial sample size of 1,500 and a response rate of 11.1 percent mail and Internet respondents. A phone survey was completed to 998 office managers of nonrespondents with a 20.5 percent response rate. Noteworthy findings from the survey are 70 percent of Nebraska Total Care's provider respondents would recommend Nebraska Total Care to other practices. Two, over 70 percent of solo practitioners would recommend Nebraska Total Care to other practices. And three, with physicians practicing greater than 16 years, over half would recommend Nebraska Total Care to other physician practices. In point four you note case management as an opportunity for improvement. A case manager is usually a clinical employee within the MCO who engages with the provider, patient, and other community resources to ensure greater continuity of care and effectiveness of care as a patient transitions within the continuum of care. Moving on to the next page, or slide 22, you see the provider experience report for UnitedHealthcare. United's survey was conducted by the Center for Study of Services, Market Strategy International, with a sample size of 1,335 and a response rate of 5.4 percent. Highlights of the survey include: a marked increase in response rate in 2017 over 2016; an increase in the number of respondents who identified as satisfied and very satisfied increased over 2016; and overall provider satisfaction increased by nearly 10 percent in the last year. Areas of high satisfaction among providers with United includes specialty networks, timeliness of information exchange, clinical practice consultants and their provider administrative guide. The

last provider experience report is on page or slide 23 and it's from WellCare of Nebraska. WellCare's survey was conducted by SPH Analytics with a sample size of 1,163 and a response rate of 13.9 percent. Overall satisfaction was similar to the other plans with 64.6 percent saying they would recommend WellCare to other physician practices. Here again, respondents noted access to case management as an area for improvement. Let me conclude comments on this section by saying it is my desire to report these results in the future in a more normalized manner and will be working with the MCOs to create common metrics that will allow for a statistically valid comparison of performance between the MCOs as it relates to the provider experience. Moving on, page or slide 24 begins the section on MCO member surveys. Federal regulations require member surveys. Each MCO follows the CAHPS, which is the Consumer Assessment of Healthcare Providers and Systems methodology, and each reports their results to the National Committee for Quality Assurance, NCQA. Following a standardized assessment and submitting the data to a national repository allows us to compare plans' performance to one another, as well as to national performance levels. In the following slides each MCO reports member experiences related to children with chronic conditions child rate and adult rate of care based on ease of getting care and getting care quickly. Nebraska's survey results appear to be above previous national averages but it will be some months until updated national figures are released. On page or slide 26, you will note the results from UnitedHealthcare and on page...excuse me, or slide 27, you will note the results from WellCare of Nebraska. Now on page or slide 28, improving health outcomes of members is a mission-oriented goal of Heritage Health. Also mission-specific is the person-centered approach to administering benefits, the integration of services with the improvement of quality, and the managing of cost. Beginning on page or slide 29, we share three member stories from each of the MCOs. These stories help us to pull the people from the data and qualify the human experience associated with the work of Heritage Health care. You can see the story of a Nebraska Total Care member who enrolled in case management with a goal of losing weight. As of February 26, 2018, the member had lost more than 62 pounds and reduced her BMI to 39.9. She reports pride of progress, that she feels better, and has a more positive outlook on life. She attributes case management as playing a role in her success. On page 30, WellCare Nebraska shares an experience with a member who called their community assistance line in search of food. WellCare's community liaisons were able to use database resources to locate a Salvation Army near where the member lived. The member was able to receive the food assistance needed. And on page or slide 31, UnitedHealthcare describes an experience with a

member who was very ill and did not speak much English. The care manager was able to connect the member to the Phone-a-Pharmacist line where the member was able to speak with a pharmacist in her native language. This service provided the member with a greater understanding of the prescribed medications and how to take them. The case manager also helped the member in scheduling all of her needed health appointments. On page or slide 32, we begin the section on performance management. In the slides that follow we talk about how Heritage Health and the team at Medicaid and Long-Term Care engage with the MCOs to assess our performance, outcomes, and business practices against our mission directive. Turning to page or slide 33, you will note we closely monitor data for more than 50 contractually required reports. In the coming weeks I will be looking at these reports to evaluate their usefulness in terms of measuring the value proposition and their return on investment. Every report we require and collect should have a defined usefulness and the underlying metrics should be ascribed to a role in defining value and assessing overall return on investment. Also worth noting are the 800 contractually...contractual requirements overseen by the MCO's specific Medicaid/Long-Term Care teams assigned to their contract management. As a result of a collaborative process with the MCOs last year, MLTC started using new reporting templates as of January 2018. You will note on page or slide 34 that certain reports were consolidated and dated definitions were clarified. The reports updated were grievances, appeals claims, and behavioral health. On the next page is slide 35. This flow chart from the Nebraska Association of Medicaid Health Plans outlines the entirety of a claims work flow. You will note from this graphic in the center-right column a clean claim is defined as one that does not require additional information to correctly adjudicate it in the system. Next page, or slide 36, in 2017 clean claims data was gathered on an ad hoc basis because it is not a normal measure in the insurance industry and there has been some confusion on how to measure it. Therefore, beginning this year, 2018, Heritage Health is gathering information on clean claims via standardized reporting templates which have been shared with the MCOs. This new methodology in reporting will provide more accurate data and make it possible to compare the three MCOs. Next page, or slide 37, you're presented with charts outlining the total number of claims paid, pharmacy and medical, and their associated monetary amounts. There were a total of 7,000,359 claims paid at a total cost of $943,716,369.06. On page or slide 38, you are presented with data on claims in 2017 that were filed on time per the MCO's contractual requirements. The contractual requirement which this chart is based on is 15 days. You will note that Nebraska Total Care trailed its peers in early 2017. In May Nebraska Total

Care entered into a corrective action plan with MLTC. This data shows the plan was effective in improving performance as NTC quickly normalized to levels in line with other MCOs. If you will now turn to page or slide 39, you will see the top claim denial reasons as of December 2017. As described in the aforementioned flow chart, claims may either be paid or denied. Here you see the top three reasons for health claim denials as reported by each of the Heritage Health MCOs. For Nebraska Total Care the top three are coverage not in effect when service was provided; (2) duplicate claim service; and (3) the service was not covered. For UnitedHealthcare, the top three reasons were: (1) duplicate claims service; (2) the time limit for filing had expired; and (3) missing or incomplete/invalid prior insurance carrier, EOB, or explanation of benefits. For WellCare Nebraska, their top three reasons were: (1) prior authorization required but not obtained; (2) duplicate claim service; and (3) must submit an EOB from the primary insurance carrier. These reasons have remained largely consistent through the first year of Heritage Health's operations. On the next page, or slide 40, these figures outline pharmacy claims filed on time per contractual requirements with the MCOs in 2017. The contractual requirement which this chart is based on is seven days for pharmacy claims. On page or slide 41, you're provided the top three reasons why pharmacy claims were rejected among the MCOs. For Nebraska Total Care, the top three are: member not valid at date of service; (2) rendering NPI/10--that's the National Provider Identifier or the tax ID number--on the date of service not enrolled with the state; and (3) invalid member. For UnitedHealthcare: (1) subscriber and subscriber ID not found; (2) the patient not found; and (3) not eligible for benefits on the submitted date. For WellCare Nebraska: (1) patient was not eligible for benefits under the plan on date of service; (2) billing or rendering provider not on state roster; and (3) no taxonomy to accompany the National Provider Identifier. Beginning on page or slide 42, the following slides address statistics related to members' telephone interactions with the MCOs. This slide tracks the average answer speed. On slide or page 43, you can see the average hold time measured in seconds members can expect with the MCOs. On page or slide 44, average call length in minutes is profiled. Lastly, on page or slide 45, the average abandonment rate of calls made to the MCOs is reported. The abandonment rate should be taken in context with hold times as high hold times could be related to customers disconnecting from the call. In 2018, there will be a change to the reporting for this statistic as the threshold drops from 3 percent to 2 percent. Beginning page or slide 46 and then the following three slides, the same call statistics are reported for providers. Here on 46 you see a graph tracking in seconds the average answer speed. Of note, WellCare's spike can be

attributed to a number of factors such a new staff and system outage. The MCO recognized the issue and worked quickly, bringing it to a resolution. On page or slide 47, this graph provides data on average hold time in seconds. You will again note the WellCare spike, as just mentioned. I also note the UnitedHealthcare climb at the end of the year and will simply note it could be attributed to the overlap of their dual eligible special needs product lot which coincided with Heritage Health's open enrollment period. Moving on to page or slide 48, we see here a graph tracking in minutes average call length with the MCOs and providers. Lastly, on page or slide 49, you see the call abandonment rate reported by each MCO and providers. These calls represent a small percentage of all calls made to the MCOs by providers. Again, in the instance where there was a spike with WellCare, the MCO self-identified their issue and corrected without a Heritage Health intervention. If you will now turn to page or slide 51, we continue to work closely with MCOs to improve administrative systems. Heritage Health has a number of standing committees such as the administrative simplification committee. Our objective is to reduce unnecessary burden on the MCOs. Our committees have several projects in various stages, some complete, some in progress, but focused on improving the overall performance of Heritage Health. Here you see four administrative simplification projects in process: one pertains to over-the-counter medications; the second is related to prior authorizations for durable medical equipment based on price limits; the third, development of a common form to change primary care provider selection for members; and lastly, prior authorization for wheelchairs. On page or slide 52, we provide for your reference meeting dates for 2018 for the administrative simplification committee, behavioral health integration advisory committee, and the quality management committee. As I now bring this presentation to a close, I will note for the committee my tours of each of the MCO facilities set for March 22, 2018. I'm looking forward to meeting with each of the MCOs in their place of business and to meeting their teams personally. I also look forward to meeting with providers and other stakeholders in the weeks and months to come. I now conclude my prepared remarks by saying I am happy to answer questions from the committee. However, given the short tenure of my service to the state at this juncture, I will put forth the disclaimer that I have asked staff to collect questions for follow-up after the hearing. Where I have enough understanding to answer questions, I will gladly do so; if not, I will note for the committee that we will follow up with an answer. Thank you, Mr. Chairman. Senator Williams, I appreciate your time and allowing me to present to you this morning.

SENATOR RIEPE: Thank you very much. I wanted to clarify for the record and for the audience that you had introduced yourself as the acting director, and you have been through hearing. It just has not been through confirmation and so until the confirmation is done and the Governor signs, you will be acting,...

MATTHEW VAN PATTON: Yes, sir.

SENATOR RIEPE: ...hopefully with no decrease in pay.

MATTHEW VAN PATTON: Yes, sir (laugh).

SENATOR RIEPE: Okay.

MATTHEW VAN PATTON: I prefer that as well, as does my wife. Lesson learned: Don't approach the desk without a cup of water and read 22 pages again. That was a press on the boundaries of human capacity, let me tell you.

SENATOR RIEPE: Well, we'll try to be more sensitive to that on our part. I'd like to start off just a little bit. We have a few questions and...

MATTHEW VAN PATTON: Yes, sir.

SENATOR RIEPE: ...Senator Williams is welcome to jump in here at any time. You talked a little bit about the analytics of...is that an internal/external, and can you tell us a little bit more about what they do and what level of independence they might have?

MATTHEW VAN PATTON: Can I ask for a little bit more information from you, which...or did you...were you referencing a specific report or a specific slide, just so I can ground myself in the question.

SENATOR RIEPE: You had talked someplace along there and I just kind of picked up on the analytics of something and my immediate question was is, is this an internal or an external

group, or do we have any external groups that are doing oversight internally within the department?

MATTHEW VAN PATTON: Senator, after my two weeks of understanding, let me give you a perspective of a new person coming in to define how I see things working. There are lots of reports that are required. There are lots of data sets that are collected, and some of these reports do go into, as we noted, into some national repositories. There are also some data sets that we're collecting and from those data sets we can begin to pull, in particular, data to partner with the MCOs and other stakeholders to identify some of those performance improvement projects or those PIPs that were referenced, and that very much is...bless your heart, you're my new favorite person in Nebraska.

SENATOR RIEPE: Better late than never.

MATTHEW VAN PATTON: That was a very southern thing of me to have said, "bless your heart." Thank you. So I'll speak specifically to the PIPs because that's a very interesting notion and a point of work that I very much like. NEHI, with the health exchange, is collecting lots of data from different providers running through the state's health exchange, and I did have the opportunity to meet with them this week to determine how they're working and what their data collection efforts are and who all is involved in that. And it's from that that some of our PIPs have been derived and our medical director, Dr. Lisa White, is very engaged with that work. So some of those projects moving forward, again, are self-derived and some of those data and analytics are coming from reports that we are required or surveys that the MCOs, as we've noted in the presentation, are collecting on their own. What I would like to do is in the next coming months to really dive deep into all of the data sets that we are collecting, all of the different surveys, all the different reports, and get a baseline understanding of what data is available to us and then from there begin to move forward with a plan of utilization. How are we using this data to drive performance metrics effectively? How are we using this data to guide us in terms of service delivery or those performance improvement projects? Those in particular, because they do allow us to focus on Nebraska-specific population health needs, are very important to me and I want to really begin to work with Dr. White on getting ahead of those types of initiatives.

SENATOR RIEPE: Okay. Do you want to go ahead and then...

SENATOR WILLIAMS: Absolutely.

SENATOR RIEPE: ...we'll jump back and forth here.

SENATOR WILLIAMS: Well, I might get on a roll.

SENATOR RIEPE: That's okay. We have to be out by noon.

SENATOR WILLIAMS: Thank you for being here.

SENATOR RIEPE: That's supposed to be funny.

SENATOR WILLIAMS: And appreciate all of your involvement. We'll be out before noon.

SENATOR RIEPE: Oh, okay.

SENATOR WILLIAMS: One of the things I wanted to go back to and just be sure we're clearly on the same page is this state and in particular this Legislature has made a commitment to support the concept of managed care and to do that together as partners in this thing, not as adversaries, even though sometimes sitting around this table we are asking question that may seem adversarial and it's certainly not my intent ever to do that. I note in the mission statement something that bites me a little bit. It talks about "Heritage Health will improve member health outcomes, reduce costly and avoidable care, decrease reliance on emergency," all of these things, but the calls that I get all relate to--virtually all relate to--how providers are being taken care of in the system, not so much how members are being taken care of. And I know we have to balance that and I guess my statement with that is I think we all have to balance that and work very hard for the provider side of this also. You mentioned using that mission statement as a method of determining success. Mission statements are notoriously subjective rather than objective. Would you talk just a little bit about your experience and bringing that to the table of how we can more objectively look at measuring the outcomes that we're having.

MATTHEW VAN PATTON: Very fair question and I do agree with you. I think mission statements, Senator, sort of set the direction for where you're going. They give you a sense of purpose in the marketplace. And I'll also say mission statements over time are meant to be modified to keep track with time and current events and how the marketplace is shifting and I think we can all agree that the marketplace in terms of health services delivery has rapidly changed. I know in my career starting out in the mid-'90s in a provider, in a hospital, I watched technology rapidly transform not only the therapeutics that patients were receiving and the way diseases were diagnosed but also the way the consumer was engaged in the care management of the patient. So I do think that mission statements do set forth your guidelines as to what you hope to accomplish but they should also keep pace with market trends. Let me go back to your other...the opening statement about the providers being engaged and let me give the committee and the audience here my perspective after a couple of weeks. I see managed care as a collaborative effort among multiple constituencies or stakeholders. And my question that I have gone back to after two weeks, and it's written on the wall, my whiteboard wall in the office--not...I have not defaced government property--let me clarify--is: What good have we done with the dollars spent? And that goes into the ROI proposition and the return-on-relationship proposition, so return on investment and return on relationship, and the relationships among those stakeholders that are going to be managed in addition to the investment are that of the taxpayer, your perspective as their advocate, that of the providers in the marketplace as they're delivering services, that of the beneficiaries, the patients who are receiving those services, and that of the MCOs who are in the marketplace helping coordinate care and providing the managed care and the evidence-based medicine practices which really do in time drive outcomes and drive it in a positive way, and also the value proposition for the agency as it is a partner in this. You know, after having met with all three of the MCOs, and I've just had the opportunity to meet the dental plan management group, I can tell you we're off to a good start. I came here to make friends not enemies and I want to work collaboratively with everybody, and that goes to communications, that goes to candid dialogue, that goes to free sharing of data and information so that we all use it with good minds around the table to make good and informed decisions. Exactly where we will go in the coming months, at this point I'm really not prepared to say exactly. I need a little more time to study the history and to get a better understanding of what's in place that I am inheriting, as well as to look out to the horizon and to see where we need to be future casting to begin to turn in that direction. But again I go back to data and what data we can

collect, collaboratively share with one another. And I don't just mean the MCOs and the agencies, but how can we engage the providers who now are moving into this area of population health as a way of managing care within their own systems? These, to me, those dynamics represent exciting times to really redefine what the return on investment means, especially as it can then be contextualized back to quality improvement, which does show marked increase in health for the populations we're managing.

SENATOR WILLIAMS: Thank you. And I want to get to the quality performance in a minute, and I would echo what you have said. I've said it before in here. I appreciate all three of the MCOs' willingness to engage in conversation with providers and do all those kind of things. You mentioned on slide 6 the total enrollment that was...and we went through an open enrollment period. Did we experience any significant shift of people from one plan to another during that open enrollment period?

MATTHEW VAN PATTON: Out of all the enrollees in those plans, there were, as I recall, 3,556 enrollees that shifted between the plans for whatever reason.

SENATOR WILLIAMS: So you would...that's not a significant number.

MATTHEW VAN PATTON: It is insignificant, in my opinion.

SENATOR WILLIAMS: On slide 16 you have the financial withholding for quality and you mentioned corrective actions. You mentioned one of the MCOs that was at one point under a corrective action. I...can you bring our committee up to date of where we are with any corrective actions that are out there and how you would choose to use financial withholding for quality going forward.

MATTHEW VAN PATTON: If I recall my notes correctly, the corrective action, I believe--let me just flip here very quickly, Senator--I believe it was early on with Nebraska Total Care and it was with claims, the timeliness of claims.

SENATOR WILLIAMS: Right.

MATTHEW VAN PATTON: And that the intervention that was made.

SENATOR WILLIAMS: Right.

MATTHEW VAN PATTON: And then they corrected and normalized (inaudible).

SENATOR WILLIAMS: We've seen a significant improvement (inaudible).

MATTHEW VAN PATTON: Right. Right. And I think that goes back to the willingness of those MCOs to sit in those meetings with staff and to have those candid dialogues and...

SENATOR WILLIAMS: But am I correct that there is no corrective actions issued right now?

MATTHEW VAN PATTON: Senator, I do not know that for certain...

SENATOR WILLIAMS: Okay.

MATTHEW VAN PATTON: ...so what I can do is take the question and then, as I promised, respond to you and follow up with a full report.

SENATOR WILLIAMS: I would like to know that and also how, and maybe this is more of a philosophy than a current situation, is how you would see using the withholding of the financial payments in a corrective action situation. Do you think that's a viable alternative for making corrections?

MATTHEW VAN PATTON: You know, I think it's a natural incentive for goals that are established with the MCOs to be reached and met because there's a cash payout for them if they hit those goals. I would prefer not to look at it as a corrective action but more as an incentive to improve performance, especially as you look at where we are within those quality measures and those data sets. What is our baseline for this year? And then where do we move forward? And then how are you hitting, how are you as the MCO hitting those measures to earn that? It's more

of a carrot versus a whipping stick and then in my opinion I think that's a better way of managing in a collaborative relationship than a whip. I...that's not...

SENATOR WILLIAMS: More of the philosophy of catching people doing something right...

MATTHEW VAN PATTON: You got it.

SENATOR WILLIAMS: ...versus catching them doing it wrong.

MATTHEW VAN PATTON: You got it. You've got it.

SENATOR WILLIAMS: Thank you. You talked about the surveys and I'm particularly interested in the surveys that the three MCOs did concerning the providers.

MATTHEW VAN PATTON: Yes.

SENATOR WILLIAMS: Why do I seem to find it strange that each MCO would put together their own survey and do their own survey and not have HHS put together some unified survey that's fair across the board.

MATTHEW VAN PATTON: Yeah. To be fair, I had to really do some digging into understanding how this was constructed in the beginning, and it's my understanding that the provider surveys were constructed to gauge the provider's experience unique to that MCO, not necessarily at the onset, to compare the performance of each MCO within that data set, one to another. As I understand it from staff, there is movement now, in 2018, to normalize this survey and to allow us to begin to compare in the future the MCOs' performance, one to another, in this space. And I think that is a fair and reasonable thing to do--it certainly makes sense to me--as you're measuring it, especially if you follow the logic on the member experience and how you collect that according to a nationally standardized survey and you report that data to a national registry for future benchmarking. That makes sense to me, so as I understand it, Senator, then that is going to be normalized to be comparative in 2018.

SENATOR WILLIAMS: In the future. Okay.

MATTHEW VAN PATTON: Yes, sir.

SENATOR WILLIAMS: If we go specifically--and again, I know, two weeks on the job and I'm asking you more these questions from bringing this from your experience coming to this job with things that you have--under Nebraska Total Care, slide 21, "physicians practicing 16+ years, more than half would recommend" Nebraska Total Care "to other physician practices," I would like to hear your response to that survey answer.

MATTHEW VAN PATTON: That seems...

SENATOR WILLIAMS: Is that normal?

MATTHEW VAN PATTON: It is. It seems to be well in line. And here's the comparison from my past experience that I would also contextualize that to. A lot has changed since some of these physicians started practicing healthcare, managed care being a new--relatively new--marketplace initiative. If you tracked the same responsive rate among those same physicians in terms of computerized physician order entry and utilization of electronic health records, you'd probably find that it tracked about the same, maybe even less, on those, because there's...the longer the physician has been in practice, the more difficult it can be sometimes to change to the marketplace.

SENATOR WILLIAMS: Thank you. That's helpful. I looked at that and said, wow, that means 50 percent are maybe the other way. UnitedHealthcare provider experience, I noticed you mentioned their response was, for their survey, was 5.4 percent and WellCare's was 13.9 percent--more than twice. Five-point-four percent response rate to a survey, would you think that's adequate?

MATTHEW VAN PATTON: I'd like to see that a little bit higher. And let me also say I'm not a statistician. I'm going to give you my experience with surveys conducted in the institutions that I'm familiar with working in and I think the sample size could be increased and I would like to

see that response rate pushed up. But there again, as we move forward to standardizing these survey tools and as we push them out in 2018 around normalized measures, we can I think expect to see a more normalized rate among the providers as they are being surveyed.

SENATOR WILLIAMS: I just think it would be helpful if we saw a way that we could use a survey to not only survey the providers and get good information but be able to help the MCOs use that information to see where they could perform better, where they're doing great, you know, all of those kind of things. Jumping to slide 39 on the claims denials--because these are some of the questions, again, that I think I certainly get--would you see those as what would be normal in your mind, that those would be normal reasons to have claims denied?

MATTHEW VAN PATTON: And I'm going to reference this from my past experience on the provider side.

SENATOR WILLIAMS: Right, right.

MATTHEW VAN PATTON: Yes, those seem very, very logical. They're things that in an automated system, if those data points are not there, not entered into, or they are out of sync with what is in the patient's benefit profile and it's not there, it's going to be bounced out. So, yes, those things seem very reasonable and normal to me, Senator.

SENATOR WILLIAMS: And just one quick pitch here: In my legislative district, we have five critical access hospitals and a number of rural health clinics. And the word that I have received more recently is that we are seeing improvement in that area from all three MCOs. I think that's worth noting on the record here today. And that was an area I think that the whole Heritage Health system was lagging behind and probably because there were more pressing needs on the front end of the system. So that's the questions from me for now.

SENATOR RIEPE: Okay. Thank you. Thank you, Senator Williams. I would like to I guess address what's possibly the 800-pound gorilla in the room and that is the question about accounts payable that are outstanding. I know some of our providers have upwards to $100,000 in accounts payable. And although the processes may be going well, if...it's a tremendous burden on

some of the smaller providers to have to carry that kind of a, you know, credit line at a bank if they're able to get that.

MATTHEW VAN PATTON: Right.

SENATOR RIEPE: And so I don't know whether we're making progress on our actual payouts to the providers, legitimate payouts, of course.

MATTHEW VAN PATTON: And, Senator, again, I'm going to say I can't really comment on the exact mechanics or the exact numbers or statistical figures on what has occurred over the last year in that space, but it is something that I am digging into and beginning to get a better understanding of. So if you will give me some time, I will give you a report back on that in detail...

SENATOR RIEPE: Okay.

MATTHEW VAN PATTON: ...if you'll permit me that indulgence.

SENATOR RIEPE: Well, I just...you know, we've heard, and I think it's very important, we want...not only do we want to take care of our members, but we need to take care of our network, our providers, as well.

MATTHEW VAN PATTON: I agree.

SENATOR RIEPE: Also, I don't know whether you have any comments in terms of, do the managed care organizations have the ability to manage in pharmacy the providers, if you will, the PBMs, if you will, as they're referred to? Have you...or maybe I could ask you to look into that because I understand that there are some difficulties in the sense of who has final authority and who is responsible and are their PBMs being responsive to them. And if they're not, obviously, they can't be responsive to the members and to Heritage Health.

MATTHEW VAN PATTON: Noted. And we will certainly follow up with you on that, Mr. Chairman.

SENATOR RIEPE: I was also intrigued a little bit about the opportunity to get Walmart gift cards and free cell phones. You know, being...coming from a healthcare background, you know, it was just alien to me but...oh, also, I think I read in here someplace there were over 800 contractual requirements. I'm, you know, I'm a believer that you can manage about three to five things, not 800, so I'm not sure whether that's...those break down into some subcategories underneath that.

MATTHEW VAN PATTON: It's some light reading that I've had over the weekend as I've prepared is really beginning to dive into what all of those reports are and what they entail. And as I noted in my prepared comments, I will reiterate again, if the contractual obligation has merit in the overall value proposition of what is done and what is delivered, or a report that is collected and performed has meaningful data that can help us drive the metrics of performance and the overall return on investment, then, by all means, let's do it; but if not, dig into those reports, let's see what's working, what's being utilized, how it's being utilized. And if it's not worth keeping on the books, then let's certainly find ways to alleviate that burden on the MCO and on the agency and get to what's meaningful. That's...I guess that's the point: what's meaningful, what gets used to actually make decisions that define our value proposition and help us assess the return on investment. That's...that is my very clear, simple, and precise perspective on that.

SENATOR RIEPE: Also, there was a note in the report about the public dashboard and what...is that dashboard now available? And if so, do we have any idea if it's being accessed?

MATTHEW VAN PATTON: I believe the dashboard you're referencing is on the Medicaid Web site. As far as its updates, I know several of the reports that have...the data that's in what you have here is in some of those reports that is there. How often it is updated or who manages that, I don't know at this point, but I'll find out. We can certainly report back to you on that as well.

SENATOR RIEPE: Okay. Fair enough. I think you had another, Senator Williams.

SENATOR WILLIAMS: Just one follow-up. We all hear anecdotal stories of those providers that have a choice of whether they take/see Medicaid patients or not, see some of them dropping out because of the managed care situation. And from my own case, it's only anecdotal stories. Are there any statistical benchmarks that are kept by HHS to see that all of a sudden we...this person has...this provider is no longer seeing...because the stories that I get are, you know, then that throws a larger burden on those remaining providers that in many cases can't make that choice, our critical access hospitals as such.

MATTHEW VAN PATTON: Yes, sir. I understand.

SENATOR WILLIAMS: And I would like to...if there is information like that and then longer term see if there is some follow-up that could be made with those providers to see if they would reverse that decision when we can now hopefully at some point guarantee them that you're going to get paid timely, you're going to...it's no different than any other private insurance that you're dealing with,...

MATTHEW VAN PATTON: Yes, sir.

SENATOR WILLIAMS: ...those kind of things, I think that would be helpful.

MATTHEW VAN PATTON: Yes, sir. And specifically, I would hope that this data in terms of provider attrition is kept. I'm quite sure it is but what it is I don't know. We'll follow up with you on that. It brings a point that I'd like to bring back to a point made earlier and tie it together. When I said I was going to be asking the MCOs for updates on their communications, community outreach, and marketing plans, part of that is related to how are you engaging with those providers, what are you communicating with them, how often are you communicating with them, how are you communicating process improvement initiatives so that they know what's expected, so that we do ease their burden of participation, if you will, in the program. And then you take that, because you can go back and look, well, this is what we've done and this is a measure here that we have, whatever that benchmark is, and if we can show that those outreach initiatives can be contextually tied to a stabilization of attrition or a reduction in attrition, then I know that I've done something good with those outreach programs. That's sort of my mind-set

around why we're asking our MCO partners to provide those reports to us, and all three have agreed to do that. I'm very appreciative of that, so.

SENATOR WILLIAMS: Thank you.

MATTHEW VAN PATTON: Yes, sir.

SENATOR RIEPE: Okay. I look down the panel and I forget there's just the two of us here. Did you have anything more, Senator Williams?

SENATOR WILLIAMS: No.

SENATOR RIEPE: Okay. Obviously this is a very important thing to us, 230,000 covered lives, $1.2 billion in an annual, a lot of vulnerable people that we need to and want to take care of and in an automatic, orderly way. And so with that, we appreciate you being here and I think that unless...do you have more to...that you want to share with us?

MATTHEW VAN PATTON: No, sir, simply just to say thank you for allowing me the opportunity to serve the people of this state. As I said, there are...those member stories pull out the faces from the data. They're not just numbers. They're not just data points. Those data points are tied to real people. And I took this job hoping that I could help improve the lives of people and I sincerely appreciate the opportunity to be here, your willingness to work with me and let me get my...the wind under my wings, so to speak, as I settle into the job. I've already learned a lot and look forward, as I said, to the time that I'll have on this Friday with the MCOs in their environments, looking at their operations and meeting their teams and gaining that understanding of how they're working. But I also will say, Senator Riepe, I appreciate you allowing me...as I've prepared for this presentation, I'm going to let our deputy, "Rocky" Thompson, with your blessing, give the presentation on the dental benefits plan and give that report to the committee today, so.

SENATOR RIEPE: Certainly. Thank you very much.

MATTHEW VAN PATTON: Yes, sir.

SENATOR RIEPE: I think the one thing that we all share is a common interest in having a good outcome in an effective, quality way with good cost numbers as well.

MATTHEW VAN PATTON: Yes, sir.

SENATOR RIEPE: We are now going to open...and thank you very much for being here.

MATTHEW VAN PATTON: Yes, sir.

SENATOR RIEPE: We are going to open the testimony to anyone who would like to testify at this time. The intent here is to not just be totally informative but we want to hear from anyone that has concerns they want to address to the committee. Are there anyone...is anyone here that wants to testify? Yes, please, come forward. You've met with us before, but we would ask you to please state your name and spell it for the record and then proceed forward.

LEISHA EITEN: Okay. My name is Leisha Eiten. It's spelled L-e-i-s-h-a; my last name is spelled E-i-t-e-n.

SENATOR RIEPE: Please go ahead.

LEISHA EITEN: (Exhibit 1) Thank you for the opportunity to testify this morning. Senator Riepe, we talked just a few weeks ago, just you and I more one-on-one. Senator Williams, just appreciate your comments, before I make mine, about the support and concern for the providers. I am the cochair of the insurance and reimbursement committee for the Nebraska Speech-Language-Hearing Association, NSLHA. I'm testifying on behalf of our speech-language pathology and audiology members across Nebraska. As you know, NSLHA members have testified several times, both for bills and in front of you on HHS oversight, the Medicaid Heritage Health plan, so I'm going to just summarize some continued areas of concerns for our members who provide both speech-language and audiology services for Medicaid recipients in Nebraska. So both small-practice providers and larger clinic systems continue to report a high

administrative burden when working with Heritage Health and I think it's due both to the variable processes of preauthorization for services with each of the three MCOs but also the problems of having to repeatedly appeal denials for payment, even when it appears that the services are provided on the fee schedule and the claims were submitted properly. So we feel like we have a very clear claims process. There isn't a lot of wiggle room on what you provide for claims. So because we are a smaller service in the bigger picture of healthcare, we have a very prescribed way that goes, that it has to go through. So I'm finding this is both true for our speech-language pathology members providing therapy services and also for audiology providers, more specifically, providing hearing aid services, not so much of a difficulty with audiology, diagnostic hearing testing, that sort of thing. So I just want to illustrate some of those by talking about audiology/hearing aid-specific things. I work at Boys Town National Research Hospital. I'm the associate director of audiology there; very close communication with our billing department. Our billing department is right on top of things. They have noted on our side that the preauth process with WellCare and with Nebraska Total Care is improving. It has improved consistently over the past year and some months that we've started, but it has taken and continues to take lots of communication. So they have established their lines of communication but it also means there is a lot of dedicated staff time to make that work properly. It does work but the staff time is an issue. We continue to experience difficulties with UnitedHealthcare though. UnitedHealthcare Community Plan does not preauthorize hearing aid fittings, so hearing aids are in a strange category. They're not technically durable medical equipment but they are, so they have sort of their own special rules and regulations. Each plan handles it a little bit differently. So UnitedHealthcare will not authorize a hearing aid even when an authorization is provided. So we just regularly provide all our preauth information right up-front. UnitedHealthcare rejects it and says no authorization is needed. However, when everything is submitted, then they deny payment; it's not every single time but consistently deny payment and say, well, this wasn't authorized. So you can see we're in a very difficult Catch-22. The physician fee schedule requires that for children, specifically, children under 18 must have a preauthorization that includes medical clearance. So you submit it, then it's denied. You go ahead and you fit the equipment. You provide all the services. You are on the hook for the expense of the hearing aid, the device that you fit, and now you have to go through a denial and appeal. And we've had some cases where it actually went into peer-to-peer review just to get a payment for something and it's because we're in a strange Catch-22 with UnitedHealthcare. So as you can see with that kind of

administrative burden, particularly with smaller practices, they will not dispense hearing aids, so they're listed as providers in Medicaid because they are doing the diagnostics part of it. So it doesn't look from the Medicaid side that there are lack of providers. But when it comes right down to dispensing the hearing aid itself, especially in the Lincoln area, it has restricted the number of providers really severely. So if you are in the Lincoln area but you are further west and there are no audiologists in your area, so you might be a pediatric family with a child who needs hearing aids, then you come to Lincoln and there's maybe only one or two providers. They're so backed up with Medicaid patients they've had to ration the amount of services that they can provide. So it's not unusual for families who could be seen in Lincoln who have to come to Omaha to find a provider to do that. So we feel that that pressure on the providers really isn't good but it also restricts access to care for the patients who really need it. So for those who need communication services, now you're driving hours and hours to get that service, and any follow-up services, it's back to Omaha, potentially. So we would really ask for your help. We appreciate that you are continuing to provide oversight and careful oversight of what happens. And obviously you are concerned about the provider experience, but this also impacts the Medicaid recipient experience as well. So just wanted to thank you for your time.

SENATOR RIEPE: Thank you.

LEISHA EITEN: Yep.

SENATOR RIEPE: We may have some questions. What's your level of participation on the administrative simplification committee? Have you been involved with that at all?

LEISHA EITEN: I have been. I have...

SENATOR RIEPE: Has that been productive or...?

LEISHA EITEN: I feel like the administrative simplification committee, from my perspective, DHHS and the MCOs are pretty much...they have their own priorities and they are working on their simplification projects. When other members, parts who are on like the stakeholders group, our Heritage Health stakeholders group have tried to provide some insight or say maybe we

should be looking at this, we're kind of small voices within that bigger group that's making decisions on what needs to be simplified. And honestly, when you look at it, audiology/speech-language pathology, it's a pretty small part of the pie. But if you want those services provided, it's important to us. So, you know, they are working on a project for preauthorization for DME, but audiology and hearing aid services are specifically carved away from DME so we're not part of that, what happens with that simplification.

SENATOR RIEPE: Feel like an orphan (inaudible)?

LEISHA EITEN: Little bit.

SENATOR RIEPE: Well, I'm going to yield to Senator Williams because I think he has a question, and I might come back.

SENATOR WILLIAMS: And thank you. And thank you, Ms. Eiten, for being here. You mentioned most of your problems with the preauthorization are with United and it's handled differently there than it is with the others...

LEISHA EITEN: Um-hum, right.

SENATOR WILLIAMS: ...and the rationing in Lincoln. The anecdotal story that we have been told is that in Lincoln they will only take one new Medicaid person when they get paid on one, if that makes sense. Is that...

LEISHA EITEN: We can understand the rationing view.

SENATOR WILLIAMS: Do you know if that's the case?

LEISHA EITEN: I would...I don't know of a specific office where it's doing it. I think some of the discussion just among the audiology community is limiting it to how many per month you could actually afford to handle and still keep yourself in a positive cash flow situation. So to take more and more Medicaid with the administrative burden and the poor reimbursement, frankly,

you know, it is low reimbursement rates, you do have to ration the services, especially if you are in a more of a private clinic, even if you wanted to provide services to Medicaid recipients.

SENATOR WILLIAMS: Um-hum. Do you have evidence that more of the private clinics are just simply not taking Medicaid?

LEISHA EITEN: I can get you the actual numbers.

SENATOR WILLIAMS: Okay, I'd...I mean that's the...that's what I hear.

LEISHA EITEN: Yeah, that tends to be what happens.

SENATOR WILLIAMS: Right, and that was my question to...

LEISHA EITEN: I work at Boys Town. We are a nonprofit. We are...we cannot refuse Medicaid patients.

SENATOR WILLIAMS: Right. Right. (Inaudible.)

SENATOR RIEPE: I guess the terminology of "rationing" is alarming and I would hope that some of these are based on acuity levels not...I don't...I'm not criticizing the use of it. It's just troubling to me that one of the things I think constantly in healthcare delivery that's concerning is the idea that at some point in time we have to ration healthcare to recipients. That's very alarming.

LEISHA EITEN: Well, I know that some offices will continue to work with pediatrics but they won't work on the hearing aid side with adults. They'll provide the diagnostic services. They don't ration the diagnostics. It really comes...where it really comes into play is on that, the side of the hearing aids.

SENATOR RIEPE: Um-hum. You also talked about people having, at least in one case, people having to travel from Lincoln into Omaha where these providers who didn't have an Omaha and a Lincoln, if I may use the term, store service.

LEISHA EITEN: Well, there isn't a lot of systems that operate in both locations,...

SENATOR RIEPE: Really? Okay.

LEISHA EITEN: ...at least not on the audiology side. So you would travel into Omaha to go to Children's Hospital but Children's doesn't have an audiology/hearing aid service in Lincoln; same thing for Boys Town. We have a clinic that's on the west side of town but we don't have services in ear, nose, and throat and audiology in Lincoln.

SENATOR RIEPE: Okay. So they would then have to back...I know Children's has some operations here in Lincoln as well.

LEISHA EITEN: Not audiology.

SENATOR RIEPE: Not in audiology, okay.

LEISHA EITEN: And that requires a...you know, there's a lot of support and equipment that would come in to setting up that clinic.

SENATOR RIEPE: Okay. Is there any other thing that you'd like to make that we have, we have on the record, that you share with us?

LEISHA EITEN: Nope, that...I just wanted to summarize and just illustrate kind of what happens then. As you take the administrative burden down the line, this is kind of what we're seeing.

SENATOR RIEPE: Okay. Are you aware that this may be getting a little bit of...are there others that face similar, other than audiology, that...or is it because of your uniqueness of not being DME and not being...you're kind of an orphan, as I guess I described it?

LEISHA EITEN: Yeah, we are a little. Well, I think the hearing aid side...

SENATOR RIEPE: Is there anybody else that's an orphan out there that we're not tuned in on?

LEISHA EITEN: Not that I'm aware of. Speech-language pathology has very similar problems with the other therapy services, physical therapy and occupational therapy, just in their prior authorization burden and recertifying that someone is eligible.

SENATOR RIEPE: Um-hum. Are you finding that you're providing very expensive hearing aids that then end up being a collection problem?

LEISHA EITEN: Well, there is a maximum limit within the fee schedule so we're always fitting the devices that fit into the Medicaid fee schedule. So unless there was a special reason to do a very expensive device, no. But if you are seeing several hearing aid patients that are Medicaid and you're not getting paid for it, you have to pay your supplier, your manufacturer on a monthly basis, so you may be paying out and then not being reimbursed even for the equipment that you purchased.

SENATOR RIEPE: And they're not inexpensive, by any means.

LEISHA EITEN: No, but they're not the most expensive devices that are out there either. We work within the Medicaid guidelines.

SENATOR RIEPE: Okay. Okay. Senator, do you have...

SENATOR WILLIAMS: Nope.

SENATOR RIEPE: Thank you very much for being here.

LEISHA EITEN: Thank you.

SENATOR RIEPE: Thanks for coming forward. We...that's what oversight hearings are all about. We appreciate that. Are there other people that would like to testify? Okay, we see...Tyler, thank you. I failed to mention, I think, given the limited number of people that we maybe have that want to testify, we're not really using the light system and we'll just try to move forward.

KATHY HOELL: Thank you.

SENATOR RIEPE: Okay, thank you. Thank you for being here. I know that you've testified before, but if you'd be kind enough to state your name and spell it so we have it for...

KATHY HOELL: I've never been here before (laugh).

SENATOR RIEPE: Well, you have a twin then.

KATHY HOELL: Yeah, really. I must, a doppelganger.

SENATOR RIEPE: Okay.

KATHY HOELL: (Exhibits 2 and 3) Okay. My name is Kathy Hoell, K-a-t-h-y H-o-e-l-l, and I am the executive director of the Nebraska Statewide Independent Living Council. The Statewide Independent Living Council is a nonprofit but it is mandated by the federal government under the Rehab Act and the Workforce Innovation and Opportunity Act of 2014. And we work to promote a philosophy of independent living for people with disabilities. Working with people with disabilities is different than working with the average population that the MCOs are seeing. We do things differently. We're not sick. We're disabled. And being disabled is okay. But we need people to realize that there is a difference. We take medications that most people get to provide a cure. For us, it's not a cure. An easy example is that I take an antibiotic daily and the reason I take that antibiotic daily is because it prevents me from going into the hospital and having to have IV antibiotics because I have an infection throughout my entire body, so it keeps me from getting worse. And recently...we consistently are receiving complaints, contacts from

people with disabilities who are being turned down for services because they're not being cured. Well, they're not going to be cured. That's just not a fact of life. And one...I have encouraged people who reach out to me to contact their MCOs but they're afraid to contact their MCO because they feel like there's been a target put on the backs of people with disabilities in this state and nationally and if they complain too much they're going to lose what services they do have. A prime example of one of these cases where it was a woman who had mobility impairment who was receiving a medication that's designed for multiple sclerosis. And it's an expensive drug but what it does is maintains her from getting any worse. She's essentially in a kind of remission. The MCOs stopped that medication. As a result, within three weeks, she lost her sight. She had contacted me and some other advocates in the state and we had contacted the MCO and they...the drug got reinstated but by that time it was three weeks later before she started getting it and six months later she is still blind and mobility impaired. It's really difficult to drive a wheelchair when you can't see. Sometimes you say I can't see but that's...that's (inaudible) sometimes. But, you know, I think the MCOs need to make a real concerted effort to reach out to the disability population to talk to the disability population, to find out where our differences lie, because they cannot just assume we're like everybody else because we're not and they need to have a really active plan for outreach to that community, and it needs to be written down and it needs to be a living, breathing document. We're not seeing that happen. They are trying to lump us in with everybody else and it doesn't work. But I want to thank you so much for continuing to focus on this and if there's any questions I'd be happy to answer them.

SENATOR RIEPE: Okay. Does your council transcend the entire state or is it focused?

KATHY HOELL: It...we are required by law to have people of all kinds of disability and from all parts of the state.

SENATOR RIEPE: Okay. That was my question. Senator Williams, I don't know, do you have a question?

SENATOR WILLIAMS: Well, Kathy, I want to just thank you again for being here and thank you for your consistent and constant advocating for people with disabilities. I know it's not easy for you to make it here when it's rainy and cloudy and dreary outside, but...

KATHY HOELL: It's not easy for anyone.

SENATOR WILLIAMS: ...your voice is not falling on deaf ears in here. Thank you for your advocacy.

KATHY HOELL: Well, thank you very much.

SENATOR RIEPE: Thank you. Thank you very much. Tyler, if you can help us. We are open for others that would like to testify and we're still talking about Heritage Health, if you will. Okay. If you'd be kind enough to state your name, spell it for the record, and then proceed on.

CYNTHIA CARLSON: (Exhibits 4 and 5) Thank you very much. My name is Cynthia Carlson. I'm a public health dental hygienist here in Lincoln: C-y-n-t-h-i-a C-a-r-l-s-o-n. I am here representing the Nebraska Dental Hygiene (sic--Hygienists') Association. I personally work full-time at Bluestem Health, which is a federally qualified health center here in Lincoln. I work at the main clinic, but I also work at their satellite site in the medical component. So dental is totally integrated into that medical situation, which is unique. I've also worked with Four Corners Health Department with the fluoride program, serviced York and Seward. And I personally provide preventative dental hygiene care at an Alzheimer's clinic here in Lincoln and have done that for three years. Basically, I'm here to speak to you about increasing and expanding Medicaid reimbursement for public health hygienists that are providing the preventative dental care to children and to the elderly in our state, basically those that are not able to receive needed dental care in traditional settings. I've given you a copy of a letter that NDHA has sent to the Division of Medicaid and this shows that this has been a priority of our association for an extended period of time. We all know that prevention is the ideal way to avoid problems with our health and is typically less expensive. A dental example would be that proper cleaning of dentures reduces pneumonia in the elderly and, thus, will reduce the high costs of hospitalization. A dental hygienist can provide this procedure, but better yet we could train the staff on site in various situations to that proper dental care in denture cleaning. Emergency room visits for tooth and oral pain could be lowered by prevention and education. The large amount of dollars spent on hospitalization for children's dental care could be greatly reduced by reaching children as infants in the use of actually a new fluoride that stops decay in the process, which is wonderful. Public

health hygienists are mid-level care providers. As such, we're able to provide care in many setting outside of the traditional system. We access those who are falling through the cracks. Many programs are working with public health hygienists, but they're having a difficult time keeping their programs sustainable due to the inadequate reimbursements for services that are rendered. Reimbursements for screening and assessments would be wonderful to help these programs. Medicaid has resources that are available to the patient which has multiple health conditions, allowing that patient to have a health coach to change health behaviors. A hygienist can provide such services as offering tobacco cessation, nutrition counseling, along with the dental health component. A small reimbursement can really make a big difference in the sustainability of a program. We need to come together and agree on the common goal, which is to improve healthcare, yet to reduce the healthcare expenses, and to allow better reimbursements for prevention. Public health hygienists can contribute to that common goal and with collaborative care between dental hygiene and healthcare we can help it happen. We can also provide you statistics for your review on the effects of preventative services a public health hygienist mid-level provider can produce on the reduction for healthcare costs for patients. And I'd entertain any questions.

SENATOR RIEPE: Okay. Thank you very much. I think what we will do, if there are questions we'll do that, but for the record we are going to have a second hearing on dental Medicaid legislation and we will put this in that...

CYNTHIA CARLSON: Okay.

SENATOR RIEPE: ...segment of the presentation or the hearings today. Senator Williams, do you have...?

SENATOR WILLIAMS: I do have some questions. And thank you, Ms. Carlson, for being here. I've been made aware very acutely recently...

CYNTHIA CARLSON: Oh.

SENATOR WILLIAMS: ...from one of your people about the public health problems in this area. Could you go into a little bit more detail in the long-term care...

CYNTHIA CARLSON: Uh-huh.

SENATOR WILLIAMS: ...context of what it can mean and what health issues can be avoided by helping people with their dental needs,...

CYNTHIA CARLSON: Well, like I said, I...

SENATOR WILLIAMS: ...in particular, daily cleaning,...

CYNTHIA CARLSON: Uh-huh.

SENATOR WILLIAMS: ...and those kind of things?

CYNTHIA CARLSON: I think so often when someone is in a nursing home, Alzheimer's care situation, dental care falls to the bottom of the list of that services that are provided. It's something they're not trained a lot on. And if you're unable to provide that care for yourself, you're relying on somebody else. As far as health conditions, dental healthcare can be directly tied into diabetes. It can...is direct connection to heart disease, strokes, the whole systemic connection. Because once that infection from the mouth gets into the bloodstream, it's going to go everywhere.

SENATOR WILLIAMS: So as I understand it right now, and correct me where I'm wrong on this and add to the explanation, a public health hygienist may go into a nursing home and...

CYNTHIA CARLSON: Uh-huh.

SENATOR WILLIAMS: ...go around and provide this help. But right now there maybe is not a coding for the right to ask for reimbursement from Medicare...Medicaid?

CYNTHIA CARLSON: Well, I think there are reimbursements for the Medicaid but probably not covering everything that they do as far as the simple cleanings, fluoride they can put on. Denture cleaning would be one that there is a code for that is not reimbursed at this point. And I can get you maybe a list of other things that are. But it's...you just don't...and I go into the Alzheimer's care facility and it's so difficult to see somebody that's taken care of their mouth their whole life and then not get the care that they need, because it's so difficult for them to get out. And bringing that care to them but also training the staff to that education that maybe they don't have is going to make such a difference in their lives and not complicate any further health.

SENATOR WILLIAMS: Training staff.

CYNTHIA CARLSON: Uh-huh.

SENATOR WILLIAMS: Would you talk about that a little bit too? Because I think the care staff in long-term care facilities is well-trained...

CYNTHIA CARLSON: Uh-huh.

SENATOR WILLIAMS: ...in many areas...

CYNTHIA CARLSON: Yes.

SENATOR WILLIAMS: ...but not necessarily in going into the mouth.

CYNTHIA CARLSON: Yes. We can provide in-services. What I really think works well for me is when I'm working on a client I often will have staff with me that provides direct care to that patient. So I can give them tips on how to get into the mouth and what to do, maybe what not to do, what to look for that's health versus something of concern that they would maybe want to, you know, refer on.

SENATOR WILLIAMS: Thank you.

CYNTHIA CARLSON: So, yeah. Thank you very much.

SENATOR RIEPE: Thank you very much for being here. Are there other individuals that would like to testify in terms of Heritage Health? Seeing none, that concludes our fourth hearing of oversight hearing on Heritage Health. We appreciate everyone that's testified and everyone that's be here. We will now move into the hearing, our first hearing, if you will, on the dental side of the...of Nebraska Dental Medicaid Legislative Oversight (inaudible) correct (inaudible). And the other acting...are you still the acting director or are you acting (inaudible)?

ROCKY THOMPSON: No, Chairman. (Laugh)

SENATOR RIEPE: You're the (inaudible) interim or...?

ROCKY THOMPSON: No, Chairman. I am deputy director for Policy Communications.

SENATOR RIEPE: Okay. Very good. You know the drill. If you'd give us your name and spell it for the record.

ROCKY THOMPSON: (Exhibit 1) Thank you, Chairman. Good morning, Chairman Riepe, and good morning, Senator Williams. 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 deputy director of Policy Communications in the Division of Medicaid and Long-Term Care. Thank you for having me today to give a grieving on the new dental benefits manager for our Medicaid program, MCNA. Today's presentation will go into the Medicaid dental benefit, why we decided to move to managed care for dental services, details on the services provided by MCNA and how the state oversees the program, challenges and success of the program after six months, and metrics from the first quarter the program was operational. And I understand that I will be followed by representatives of MCNA and they can go into more details about any issues I might not be able to fully explore. On slide 3 we have some details about the launch of the Dental Benefits Manager, and the Dental Benefits Manager launched on October 1, 2017. The state's contractor is Managed Care of North America, or MCNA. Unlike the Heritage Health plans, only services delivered by MCNA are dental benefits. Previously, these benefits were delivered by fee-for-service Medicaid, managed by the Medicaid Division.

Dental providers in Nebraska contract with MCNA as part of its network. They are still enrolled in Nebraska Medicaid through us. MCNA handles claims payment, prior authorization, and coordinates all dental care. On slide 4 we have some information about the switch to managed care for dental benefits. Nebraska Medicaid decided to move dental services to managed care for several reasons, as discussed on the slide. Nebraska Medicaid previously covered dental service through our fee-for-service program. Claims adjudication was administratively burdensome and strained limited resources. MCNA had...MLTC had contracted with two dentists part-time to review more clinically complicated claims. This was a manual process that was labor-intensive and inefficient. Contracting with a Dental Benefit Manager has allowed the enforcement of Nebraska Medicaid regulations on the front end, rather than the pay for (sic--and) chase operations necessitated under the fee-for-service dental program. Though the regulations for the program were already in place, we have found that the capacity for enforcement of all of them by Medicaid was limited, and it has increased through the use of a Dental Benefits Manager. The technology behind processing of authorizations, claims, and provider or member resources allows for the Benefits Manager to work towards achieving performance and quality goals that were not as attainable with Medicaid staff and system constraints. We have on slide 5 the DBM enrollment through December 31, and as you can see, the vast majority of Medicaid members have dental benefits through managed care. Unlike many states, Nebraska also provides dental benefits for adults in addition to children. The same populations carved out from Heritage Health are carved of the Dental Benefits Manager, including aliens only eligible for services due to emergency circumstances. But you can see the total enrollment for Nebraska Medicaid and CHIP services, compared with the benefits, the enrollment under the DBM is very close. And also an important fact to note from this slide is that we have had over 80,000 unique members treated with dental services from October 1, 2017, through March 8, 2018. On slide 6, it goes over the services provided to both adults and children through MCNA, and these are the same services that (inaudible) fee-for-service. But the Dental Benefits Manager has allowed us to further do client outreach about the availability of these services for Nebraska Medicaid clients. MCNA provides dental benefits to cover the dental needs of most children and adults. This includes preventative and diagnostic benefits, which are dental cleanings, exams, x-rays, fluoride, dental sealants to prevent cavities. And it also includes therapeutic benefits to treat cavities, gum or tooth pain, or other dental problems, including fillings, extractions, root canals, and dental emergencies. And also MCNA offers children many more services through the mandated Early

and Pediatric (sic--Periodic) Screening, Diagnostic, and Treatment--our EPSDT program which helps children and young adults under the age of 21 receive regular healthcare services. Furthermore, adult services are limited to a $750 annual limit, per Nebraska law. And this benefit, this annual limit, went into effect on October 1, 2017--previously the benefit was $1,000 per year--and that was done through the appropriations bill last session. Slide 7 goes into the financing of the Dental Benefits Manager. Like the Heritage Health program, MCNA is paid a per member, per month capitation rate. These rates are developed by our state's actuary, Optumas. Additionally, MCNA is required to meet an annual 85 percent medical loss ratio, or MLR. If costs for benefits, services, and specified quality expenditures is less than 85 percent, then MCNA must return the difference to the state. On slide 8, it goes to some details about the oversight that the state has over MCNA. The state takes oversight of the Dental Benefits Manager seriously, as the same as with the Heritage Health plans. We have a team of staff that are dedicated to overseeing this contract. The team is led by our plan administrator too, and then under that there's a program manager and a program specialist. Additionally, MLTC must comply with extensive federal regulatory oversight requirements, including the requirement of an EQRO, as Director Van Patton went over earlier today. And then the contract, the same with the Heritage Health plans, has different requirements that must be met or the state can impose sanctions. And then there's also regular meetings with our staff and stakeholders that MCNA is required to participate in. Slide 9 goes over some of the opportunities that we see coming from our contract with the Dental Benefits Manager, MCNA. And MCNA manages costs through increased member outreach and education, increased use of preventative services, and improved care coordination. Now we have seen increased numbers of Medicaid clients utilize the dental benefit than we have seen in the past, and that is part to the outreach that MCNA has done for the state to our Medicaid members. And MCNA is improving access to routine and specialty dental care, increased personal responsibility and self-management, and going towards better dental health outcomes through this increased outreach. And there's also an overall savings to the Nebraska Medicaid program and the Nebraska budget by preventing or reducing treatable dental conditions before they become more costly. Slide 10 goes over some of the challenges that we've seen through the implementation. While the implementation of the Dental Benefits Manager has been very successful, there have been certain challenges in ensuring provider access in more rural and frontier areas of the state. As you all know, you've all driven the drive, Nebraska is geographically a large state with rural and frontier areas. Maintaining a robust network with

strict access standards will always be a top priority and something we're closely monitoring. And also MCNA has a provider network team constantly monitoring all Nebraska to ensure proper access. When we are notified that there might be a provider shortage in a certain area or providers that may not be willing to participate in Nebraska Medicaid then we have MCNA create action plans to try to improve those access for our Medicaid members. When a member has difficulties finding an available provider, MCNA has a care coordination team to help provide...find providers and schedule appointments. Slide 11 goes through some highlights that we've seen by the move to the Dental Benefits Manager. Before the...we've always had a pretty low number of dentists participate in the Medicaid program, but we've seen that MCNA providers have increased from 609 at launch on October 1 to nearly 770 by December 31, 2017, and they continue to grow their network. And then also by contracting with a Dental Benefits Manager, these providers can provide many services that MLTC simply did not have the resources to provide. As I've mentioned before, more Medicaid-eligible Nebraskans are aware of their dental benefits and are taking proactive steps to care for their own oral health with preventative, cost-effective care. Also, MCNA utilizes many Nebraska dentists and other dental providers on their staffs to review prior authorizations, perform peer-to-peer reviews, or discuss appropriate treatment plans. Additionally, I think MCNA is going to go more into detail about this, but they also have a searchable provider directory, easily available resources, a check...a easy check of member eligibility, and electronic submission and tracking of prior authorizations, required documentation, and claims through their provider portal, which has been extremely popular with our Medicaid dental providers. Slides 12 and 13 go into some of the performance metrics and the withhold. Like with Heritage Health plans, there is a similar withhold with the Dental Benefits Manager of 1.5 percent of total payment, and this 1.5 percent is not eligible to be paid unless certain metrics are met. Also like the Heritage Health plans, year-one metrics are focused on operational performance. The first-year metrics include claims processing timeliness, timeliness of standard service authorization, metrics for their call center, and timeliness of appeals and grievances. On slide 14, goes over some highlights from the key operational metrics for the first quarter and this is about call center numbers. They've answered more than 9,000 calls. There have 67 calls that were abandoned, and calls have averaged 15 minutes or fewer for members. For providers, they've answered more than 4,000 calls: 110 of those were abandoned, and calls averaged 13 minutes or fewer. I should also note that average wait and hold times for members were nearly identical, averaging four seconds in October and one second in November

and December. On slide 15 we go and reiterate that MCNA has educated Medicaid members about the availability of the dental benefit. We've seen utilize of preventative services has been strong across all age groups on Medicaid: 81.4 percent of clients 18 and under have utilized these services. And again, we have the EPSD requirements for children and also the majority of our Medicaid members are children. Sixty-three percent of all clients 19 and older have utilized these services. The pie chart shows that children make up 77.2 percent of all Medicaid members who have utilized services available through MCNA. Adults make up the other 22.8 percent. Slide 16 breaks down MCNA claims by month. MCNA has processed more than 60,000 claims from October 1 to December 31, a little bit less than...because the total claims was 61,380 and then the claims are adjudicated, it was 60,605 that was adjudicated within contractual time frames with 99 percent of them being adjudicated within 15 days of being submitted. On average, claims had a one-day turnaround time and had an eight-day payment turnaround time. So thank you very much for the ability to present before you guys again, and I'm happy to answer any questions that you may have. I also know that, as I said previously, representatives from MCNA will be testifying next. So anything I cannot answer, they likely can.

SENATOR RIEPE: Okay. Thank you very much. One of the questions initially I have is dental benefits, is that common in other states'...

ROCKY THOMPSON: I know that...

SENATOR RIEPE: ...Medicaid programs?

ROCKY THOMPSON: Thank you, Chairman. I know that MCNA is in several states. There's other competitors that are in other states. So the Dental Benefits Manager are common in other states.

SENATOR RIEPE: Okay. And I know that we have three managed care organizations on Heritage Health side and yet we have the one provider on the dental side. Can you educate me on that?

ROCKY THOMPSON: Certainly, Senator. As you know, these services were provide through fee-for-service before. To help out that transition to managed care, it was decided early on in the Heritage Health RFP development to separate these services from the other services that were delivered through Heritage Health. So that's why there's a separate Dental Benefits Manager, because these were providers that were new to Medicaid managed care.

SENATOR RIEPE: Okay. Do you anticipate some...at some time in the distant future that you might integrate dental health into what was referred to earlier, and I appreciate, was population-based healthcare? I think sometimes the term "managed care" comes out of the 1970s and has a dark cloud on it, unlike population-based healthcare.

ROCKY THOMPSON: Thank you, Chairman. I think that's something that can be evaluated in the future as this provider community gets more used to managed care. And additionally, as we consider greater integration between primary care, behavioral healthcare, pharmacy, and dental care, I know that my dental coverage is separate from my main insurance coverage. I don't know what type of integration has traditionally been used with dental versus other services. And I see that improving over the next several years so I think that can be evaluated at that time.

SENATOR RIEPE: Okay. The other one that I have next is the management of services is one thing; the management of a contract is another thing. And how do you feel that you're doing in making that transition away from service management and the control of that over to management of a contract?

ROCKY THOMPSON: Thank you, Chairman. We have a full team that is staffed to oversee this contract. We have taken lessons learned from contract management with our Heritage Health plans and we have probably one of the most competent contract managers in the state overseeing this contract to ensure that the contractual metrics are maintained and that we continue to provide and oversee this contract to make sure that our Medicaid members receive the services to which they're entitled.

SENATOR RIEPE: Of the contract, not necessarily directly with the services.

ROCKY THOMPSON: That is correct, Senator.

SENATOR RIEPE: Okay. In your opinion, how has the MCNA worked with the three managed care organizations?

ROCKY THOMPSON: Thank you, Chairman.

SENATOR RIEPE: Or is it too early?

ROCKY THOMPSON: Well, thank you, Chairman. We have encouraged the Heritage Health plans the MCNA to work together. There have been meetings between the two. It's still in the early stages as we figure out how they can work together to better management...manage the health of our population.

SENATOR RIEPE: Okay. Thank you very much. Senator Williams, you have a question.

SENATOR WILLIAMS: Thank you, Chairman Riepe. And thank you, Rocky, for being here. Managed care has a number of assumptions under it, one being that we can contract out cheaper than we can do it ourselves. I want to be sure I understand this contract versus our Heritage Health. There is a member monthly capitation rate that is set by Department of Health and Human Services.

ROCKY THOMPSON: It's set by DHHS. We use the actuary Optumas to develop the capitation rate, which we set and then we have to get federal approval for that.

SENATOR WILLIAMS: Okay. So once that number is set, then MCNA is paid that on a monthly basis and they are required, I believe under this contract, if I'm reading this correctly, to pay out at least 85 percent of that in medical losses.

ROCKY THOMPSON: That's correct, Senator. And you know that is a federal requirement so that's the same threshold as with our Heritage Health plan.

SENATOR WILLIAMS: So that's...that's (inaudible). Okay. It looks like...I wonder if you had any explanation of why the number of providers increased from the roll-out date of October 1 to the end of the year. Do you think there's a reason for that?

ROCKY THOMPSON: Thank you, Senator. I think that some providers might have been reluctant to sign up with Medicaid in the past and that MCNA, because they are required to maintain a robust network, that they've been able to reach providers that have traditionally not been Medicaid providers.

SENATOR WILLIAMS: We still, though, would seem...I don't know if you'll agree with this or not, but it would appear to me with 770, roughly, providers and providing benefits to in excess of 230,000 Members in this group, that we are still undersupplied--I'll use that term--in this area. Is that...?

ROCKY THOMPSON: Thank you, Senator. One of the reasons why we moved to Medicaid managed care for dental was to increase our provider network and they can utilize resources. They have this portal that providers can use to submit claims that fee-for-service wasn't able to utilize. We have seen dental providers have a reluctance to sign up with Medicaid in the past and we still see that reluctance due to several factors, including the adult cap which, you know, was reduced to $750. And that's one of the main reasons why we've seen dental providers not sign up with Medicaid. So we have...

SENATOR WILLIAMS: And I'd go on with the providers, and you mentioned in your testimony the rural or frontier areas. Sometime I'll discuss with you what's rural and what's frontier. (Laughter) But are those...do we have...are we...do we have a shortage everywhere or is the shortage greater in the rural areas?

ROCKY THOMPSON: Thank you, Senator. I think that we can utilize more dental providers all across the state and I would be open to discussing with you innovative says that we can try to increase access to dental services, not only for Medicaid members but for the entire state's population.

SENATOR WILLIAMS: We could start by giving more money to the University of Nebraska to expand their Dental College, but that will be a discussion we'll have on Wednesday in that Chamber up there.

ROCKY THOMPSON: (Laugh) Well, just so you know, Senator, we are working very closely with the College of Dentistry and MCNA is also working very closely with them. We've had several meetings.

SENATOR WILLIAMS: You heard the testimony earlier from Ms. Carlson...

ROCKY THOMPSON: Yes, sir.

SENATOR WILLIAMS: ...about the public health clinics and their plight with this. And as I'm taking a little bit from that, if there is a recognized shortage in a reimbursement number or if there is a recognized problem with how certain things are coded because...but yet it is understood that by doing this we are saving substantial money in the future, how does something like that get addressed? Who addresses that and who has the ability to make a change that would effectuate a better situation?

ROCKY THOMPSON: Thank you, Senator. There are several ways you can address financial issues that different providers might have and that might have an effect upon access. First of all, you can do it at the Medicaid state agency level. We can work together and see what kind of available funds are to increase this and increase appropriations for the state Medicaid program for this purpose. You can also go and work with MCNA to create a special agreement. They contract separately with different providers and they negotiate different rates for different providers. If a provider is...has a good case for an increased rate, they have the ability to negotiate that with MCNA.

SENATOR WILLIAMS: Thank you.

ROCKY THOMPSON: Thank you, Senator.

SENATOR RIEPE: Thank you. Thank you very much.

ROCKY THOMPSON: Thank you, Chairman.

SENATOR RIEPE: We appreciate it.

ROCKY THOMPSON: Thank you, Senator.

SENATOR RIEPE: And we would like to now hear from MCNA.

SHANNON TURNER: There are a couple of us. Do you mind if I pull a chair over?

SENATOR RIEPE: I think we probably need to have you testify one at a time if we can. Otherwise...

SHANNON TURNER: Okay.

SENATOR RIEPE: ...I'm afraid we won't get it on the record.

SHANNON TURNER: Okay. Well,...

SENATOR RIEPE: Can we do that?

SHANNON TURNER: ...we can probably not have to put Doctor...he was going to chime in and talk about some of the dental things but...

SENATOR RIEPE: Well, we'd probably like to hear that...

SHANNON TURNER: Yeah.

SENATOR RIEPE: ...and maybe we can sequence that. And if you would be kind enough to give us your name and spell it, please, and then tell us a little bit about your background because I think you have been a director of Medicaid prior to your role now. That would be helpful.

SHANNON TURNER: (Exhibit 2) Thank you, Chairman Riepe, Senator Williams. My name is Shannon Turner, S-h-a-n-n-o-n T-u-r-n-e-r, and I'm the vice president of operations for MCNA, the Dental Benefits Manager here in Nebraska. As Chairman Riepe noted, I'm actually past-Medicaid commissioner of Kentucky Medicaid, so I have a great deal of admiration and empathy for the MLTC team here. I wanted to just briefly give you an overview of MCNA, since it's their first time before the committee. I will try to go pretty quickly through my slides in the interest of time. Feel free to stop at any time if you have questions. MCNA has been providing dental benefits management for over 25 years. We're primarily focused on Medicaid and CHIP managed care. We were founded by a dentist, Dr. Jeffrey P. Feingold, who is a periodontist. Dr. Feingold trained in New York and New Jersey and he opened a series of multispecialty dental clinics in Florida where he really noticed that there were great disparities in oral health delivery. So MCNA was founded out of his experience as a dentist. We serve over 4.2 million children and adults nationwide and we have Medicaid and CHIP contracts with the state of Texas, the state of Louisiana, the state of Florida's CHIP program, Iowa, Idaho, Nebraska, and Arkansas. We're the largest holder of dental contracts direct with state agencies in the country in the Medicaid and CHIP space. Our mission is to deliver value to our clients and providers by providing access, quality, and service excellence that improves the oral health outcomes of our members. We focus on prevention to improve health and reduce cost. We take a very proactive approach to utilization management by evaluating the need for services before they're provided. As Mr. Thompson noted, one of the main differences between MCNA's program administration compared to the state's administration during fee-for-service, which has been, I will say, one of our biggest challenges in terms of implementation and education, is that due to the very, very antiquated state system, which you all are familiar with, there wasn't an ability to really enforce the state's benefit limitations on the front end. And so that's something that we have been...we have implemented and we have enforced those limitations of, like, for example, a cleaning once every six months or dentures only every so many years. And this has been a sea change for some providers, not because the policy changed but simply because due to resources it was unable to be fully implemented on the front end. MCNA maintains a quality assurance focus. We are the

first dental plan in the nation, and currently the only, to receive full dental plan accreditation from URAC. We just went through reaccreditation in 2017. And we've been accredited by NCQA, National Committee for Quality Assurance for Credentialing and Recredentialing, since 2011. We're also a member of the Dental Quality Alliance, which is a subset of the American Dental Association, dedicated to advancing performance measurement in order to improve oral health. We really focus on operational efficiency in terms of utilization management because we have a program that's overseen by general dentists and specialists. We follow nationally accepted clinical guidelines, and we have a proactive quality improvement program to educate members and providers in order to try to increase clinical outcomes and operational efficiency. We provide continuous provider support and ongoing education through an array of communications tools, our phone hot lines, and dedicated representatives. We have clinically focused leadership here in Nebraska. Dr. Scott Wieting, who is behind me, serves as our executive director and lives in York, Nebraska. Dr. Bob Roesch serves at dental director and lives in Fremont, Nebraska. They are supported by a team of six clinical reviewers who are all Nebraska licensed dentists, including a periodontist, pediatric dentist, oral surgeon, and orthodontist. All clinical reviews are performed by licensed dentists and providers can request a peer-to-peer discussion on any clinical decisions we make. This is very different than what you'll see with other dental benefit administrators. We don't just bring in a provider to look at something that's going to be denied. They look at all clinical cases, regardless of whether they're approved or denied, to ensure that we're following the standard of care and that we're truly having a peer-to-peer evaluation of clinical criteria. MCNA provides leading edge technology and one of the things that was noted previously is our free, Web-based provider portal. Providers can submit claims, prior authorizations, and referrals; verify eligibility, view patient rosters and dental histories; and download document and resources. At the close of the first quarter, our provider portal access rate was 87.9 percent. It's currently over 90 percent, so we have a great deal of utilization of our provider portal as a tool. We have a dedicated customer service approach. We have integrated call centers in Texas and Florida, and we focus on first call resolution. The majority of our member services are multilingual and we offer translation services in nearly 300 languages. Our call center operational statistics go to the same information that Mr. Thompson provided earlier. We received 9,736 calls on our member hot line with an average speed of answer of less than two seconds, an average abandonment rate of less than 1 percent, and an average hold time of less than two seconds. Our provider hot line received 4,745 calls with an average speed of answer of

2 percent...of two seconds, an abandonment rate of less than 3 percent, an average hold time of two seconds. We also focus on targeted member outreach. We use member handbooks, an informative and interactive Web site and social media platforms, targeted outbound telephonic and text message campaigns, and we also participate in health fairs and community events. We're really focused on increasing the oral health literacy of our members and the community at large. So far we've received for the quarter in question for 55,599 unique members. The majority of those seen received a preventive service. To date, in total, we have over 80,000 unique individuals having received services in the program. The next slide is a depiction of our provider network. You'll be able to see the coverage that we have. Red dots are general dentists; blue are pediatric; green is "ortho"; pink is oral, orange is "endo", purple is prosthodontist, and I think that's sort of a lime green-yellow periodontist. As you note, in the state of Nebraska there are a lot of shortages among these specialty types in general. So, for example, there are limited numbers of periodontists, limited numbers of endodontists, and limited numbers of prosthodontists all across the state. This is due to the fact not that they just don't participate with MCNA but they're not present in general. And on the Medicaid side of the house, it's not terribly uncommon, especially given that most of the services performed by these providers are also performed by general dentists. That's one of the things that's a little bit different about dental in comparison to medical in that a general dentist can provide periodontal care, a general dentist can do extractions and they do perform a lot of extractions. They make dentures which is prosthodontists usually do complex bridgework, which is not routinely covered under the Medicaid program. So this is what we've seen in terms of your provider experience. We're now up to 800 providers in total. We have exceeded the number of providers available prior to taking on the dental program and it's something we're very focused on. Rene Canales, our associate vice president of network development, is here with me in the audience. He takes his commitment to Nebraska very seriously and we recruit continuously. Our goal is to be an experienced, reliable partner to the state. We're committed to quality of care. We're grateful for the opportunity to partner with the state of Nebraska to serve the Medicaid program, and we encourage you all to visit our Web site at MCNANE.net. It includes our most up-to-date information, including your comprehensive provider handbook, our member handbook, and other frequently asked questions about the program. And with that, I'm happy to take any questions you may have.

SENATOR RIEPE: Okay. Thank you very much. So far you talked about having 800. Have you had any certain number and a percentage that have dropped out? I mean when they sign up do they...is it kind of an at-will and they're not under a year's contract, dentist and...

SHANNON TURNER: Once they sign up with us, the contract allows them to leave at-will with 90 days advance notice.

SENATOR RIEPE: Okay.

SHANNON TURNER: We have had a couple of terminations. For example, there was an oral surgery group. One of the things from the clinical standpoint that I will tell you is a big issue in any new market is the ability for providers to have healthy wisdom teeth removed. This is always something that comes up as a concern. CMS and the American Academy of Oral and Maxillofacial Surgeons both have put out guidance that there is no benefit to removing asymptomatic teeth. Now I'm not a dentist but our dental team can let you know that they look at eruption patterns, they look at teeth that are going to be a problem in the future, and all of these clinical decisions are made by the clinical team that we have here in Nebraska. So I understand that this was not something that was able to be enforced with the limited number of resources before, so it has resulted in some terminations by oral surgeons.

SENATOR RIEPE: Uh-huh. I know historically a lot of times people with...or students with fewer resources would go to the local dental college for services. Are you saying that they're now...I assume a number that are not on Medicaid are still going in that direction. But have you seen any disruption to that flow?

SHANNON TURNER: No, we still see the underinsured accessing care through FQHCs and through universities. What we have seen is an increase in terms of demands on the system for adult members. We did a lot of outreach as part of our launch and so we've seen for the first time several adult members seeking services for preventive care and seeking services in general. They didn't realize they had a benefit. We've educated them about the need to use their benefit. And it's sort of been, in terms of a dynamic, we educated adults about benefits and encouraged them to seek services and at the same time the cap for adults was limited from $1,000 to $750. So that

has put some pressure on the system in terms of more adults are showing up, providers are adding capacity to see those adults, but then they're also sort of caught in the situation where someone needs services but has exhausted their $750 limit. We look over that for things such as palliative care, pain, if you have an infection, if you need an extraction, if you have to have all of your teeth removed. So there are situations where that cap is exceeded but I can tell you that we've heard consistently from providers that we have more people showing up, and a lot of that is due to the fact that we've educated them about their benefits and encouraged them to seek care early rather than just when they are in pain and need care.

SENATOR RIEPE: Should we put in the record that you're a pain-free dental group?

SHANNON TURNER: No. No.

SENATOR RIEPE: Okay. (Laughter)

SHANNON TURNER: I wish we could say that.

SENATOR RIEPE: Senator Williams.

SENATOR WILLIAMS: Thank you, Chairman Riepe. I just received, just about ten minutes ago, a text message from one of the senators that can't be with us this morning because they're sitting in a dental chair right now and not claiming it's pain free. Rolling out in October and here we are just a few months later, have we met the expectations that you set for the company?

SHANNON TURNER: As far as meeting expectations for the company, I think that we have greatly met our expectations. I think that the biggest challenge, as I noted previously, is the fact that our system is enforcing the state's benefit. That was a huge sea change. So we had a lot of dentists, and the department did an excellent job as did the Dental Association. David O'Doherty with the Nebraska Dental Association was very helpful in sort of getting the word out because in the beginning we had providers who would say, you all said you weren't going to change your benefits and now you've cut services, to which we responded, no, this is your benefit, but because of the system limitations that benefit had not been enforced. So we had to really kind of

overcome in the first couple months this perception that somehow a new company had come in to Nebraska and changed everyone's benefit, and that was probably for the first quarter of operation the biggest obstacle that we were overcoming.

SENATOR WILLIAMS: You, in your mission approach, you talk about being proactive. And you heard the questions we had earlier concerning preventive care, in particular in the long-term care setting. Have you also taken into consideration that I've always been told if you've seen one Medicaid program you've seen one Medicaid program? Are there other states that you are dealing in that do things different in that particular area of providing like the public health clinics going in and helping with that situation?

SHANNON TURNER: There are some differences. One of the things that was noted in the earlier testimony was the ability to do silver diamine fluoride. That's the fluoride that arrests decay if properly applied. In two of the programs that we administer, that benefit is covered. The CDT code is covered. In Idaho it's a pilot project just for long-term care facilities with a couple of particular dentists. And in Iowa, next door, it is covered just as part of their benefit. So there are some things like that, that in the future we could evaluate with MLTC to maybe see about altering the benefit to allow for a couple of targeted services for that population.

SENATOR WILLIAMS: Thank you.

SENATOR RIEPE: Okay. I know you've been in a relationship with the MCOs for a short period of time. Do you track, in terms of the patients, in terms of which managed care organization that they're being provided their physical and behavioral services from so that you...and have you had experience then in having to communicate back and forth with those managed care organizations?

SHANNON TURNER: We do. We actually, from a dental standpoint, we offer a very comprehensive case management, care management program and our director of utilization management and case management, Megan Hinkle (phonetic), actually came to Nebraska and participated in three separate sessions with each of the MCOs. We've executed business associate type agreements to enable data sharing. We have had a very receptive approach from two of the

three MCOs. We're working on the third one. In terms of the integration on the medical and oral health side, that's sort of what we consider, as an organization, our sweet spot and that is Megan (phonetic) is a nurse so she has the medical side background and then we have our dental team here of the eight dentists in Nebraska. So we're able to identify members who have a special need who are looking for something on the medical side to assist them. And Megan (phonetic) has developed relationships with all of their care management program people so that we can contact them if we have one of their members in our program and vice versa. Typically on the oral health in the medical side what you see in terms of integration is around high-risk prenatal patients. We have a program for pregnant women called Bright Beginnings where we send them a dental kit and information about how to care for their oral health and the oral health of their child. We also do a Walmart gift card here in Nebraska to try to encourage receipt of care and timely visits to the dentist. The gift card for us is limited just to oral health supplies so you can only use it at Walmart to buy a toothbrush, toothpaste, mouthwash, dental floss, oral health supplies.

SENATOR RIEPE: Okay. Thank you very much.

SHANNON TURNER: Thank you.

SENATOR RIEPE: Is it Dr. Wieting?

SCOTT WIETING: Yeah.

SENATOR RIEPE: Would you like to testify?

SHANNON TURNER: And Dr. Wieting and Dr. Roesch are not two that talk about themselves, but both are past-presidents of the Nebraska Dental Association.

SENATOR RIEPE: Very good. We're impressed. Thank you very much.

SENATOR WILLIAMS: Your emcee just introduced you.

SCOTT WIETING: That's right. Thank you, Senator.

SENATOR RIEPE: That's right. We'll have a little drum roll. If you would, again, state your name and spell it for the record, please.

SCOTT WIETING: Okay. My name is Scott Wieting, S-c-o-t-t W-i-e-t-i-n-g. I really don't have anything prepared so I'm just going to kind of tell you about what my role is and kind of my background, and then if you have any questions I'd be glad to answer them. I've been a general dentist in York, Nebraska, for 39 years. I've been a provider of Medicaid for all 39 of those years. So getting on this side of it has been kind of a transition for me because I've been looking at it from the provider side for so many years. I graduated from the University of Nebraska, (inaudible) as past-president of Nebraska Dental Association, and I guess my role was...my first thing I did was I was given the task of coming up with a team of dentists to do the claims reviews, the preauthorizations and that type of thing. Once I had identified and got them on board, the next challenge was to get them trained so that we want to have a certain amount of consistency, you know, about...among the reviews. If one viewer looks at one claim and one looks at a similar claim, we want them to be reviewed the same. And so that's...I mean I think that's getting better all the time, obviously, as we get more and more into it. We constantly, the reviewers as well as myself and Dr. Roesch, constantly are looking at the provider manual, seeing where we can make changes to help, for lack of a better term, take roadblocks away from providers to make it so they want to provide, they want to be a provider. They want to participate in the program. And we just did it. We just, in the last week or two we did a manual update and we, like I said, we provide several things to make it easier. I just had a peer-to-peer with somebody last week and they hadn't seen these yet but I mentioned a few of them to them and they were just relieved that, you know, that was going to make it easier. There's still a lot of things we're going to look into and we still want to do, but it just...as I'm finding out as a provider and kind of a practice manager my whole life, when I made a decision in my practice, kind of the next day it was done. And in this situation, you know, if we make a decision it doesn't seem to get done quite the next day. So that's been a little bit of a challenge. But we're just at the end of our six months. We have a great team of reviewers. We have a periodontist, an orthodontist, and pedodontist and, what am I missing, an oral surgeon, then there's four general practitioners that do all the reviews, all the preauthorizations. And we have our turnaround times,

which are two days. That's another huge issue when in years past the preauthorization could take who knows how long, you know, till you send in, get it back, and then by the time you get it back and try to get that patient engaged, sometimes that was a challenge. Our preauthorizations are all turned around in two days. And so, for instance, an orthodontist sends in a preauthorization; two days later they can put those braces on and...well, two days, it might be three or four days, and get busy rather than two or three months later, you know, type of thing. So that's been a huge, you know, advantage and an upgrade. I really guess I don't have anything else. If you have any questions, I'd be glad to try to answer them.

SENATOR RIEPE: Okay. Senator Williams.

SENATOR WILLIAMS: Thank you, Chairman Riepe. And thank you, Dr. Wieting, for being here.

SCOTT WIETING: Uh-huh.

SENATOR WILLIAMS: And my question kind of stems from the fact that you've been practicing general dentistry for a lifetime and now you're in a little bit different role. How do you see, from a practicing general dentist sitting out in Cozad, Nebraska, how the process was working before and how the process is working now? And are you seeing that this is an improvement from where we were a year ago?

SCOTT WIETING: Oh, I think, and have touched on it already, is something I never saw in my practice, almost never, was members calling up and asking to do a recall, you know, an initial recall type appointment, so an initial examination type appointments. Most, most, a high percentage of my Medicaid members would be emergency type things, you know, or I'm missing some teeth, I would like to have a denture, or that type of thing. And in my particular office, and I'm still practicing, we see a lot more calling up, making appointments to come see our hygienist to get their teeth cleaned, you know? And then they get in, then we look at their entire situation and come up with a treatment plan. So that has been a big increase, for me particularly, and I think that's kind of overall what we're seeing too. So that's a huge plus. I mean I think I would...I would limit that to the adults. We see a lot of...I've always seen a lot of kids that came in for

checkups and recalls and stuff, but the adult population I think is much more in tune and much more aware of the, you know, the coverage they have and they're taking advantage of it a little better.

SENATOR WILLIAMS: Again, as a practitioner, do you see the reimbursement rates as being fair?

SCOTT WIETING: (Laugh) Gee.

SENATOR WILLIAMS: That was loaded, wasn't it?

SCOTT WIETING: I got to change my answer. You know, this is my personal feeling. The reimbursement rates, to me, were never an issue. I mean obviously they're low and everybody is going to complain about them. The things that bothered me more were the roadblocks that were put in your way. The...and you're all aware of the RAC audits we had a few years ago. That turned off a lot of dentists to Medicaid, the thought of going through those kinds of audits and those kinds of things. The, you know, the...even now we still have some things in our provider manual that, documentationwise, that take up a lot of time, lot of staff time, and providers look at them as unnecessary. You know, so we're constantly looking at those and seeing how many of those we can remove, how many of those can we get out of the way so that they can do their claims cleaner and without having to get them back and add this, that, or that or the other thing, and just make it smoother. So I think from a provider standpoint, you know, it's much, much smoother. I mean I...we get paid more regularly or quicker, it seems like. The preauthorizations are obviously quicker. So I'm...you know, I think you're still going to have the issues with why in the world do I need to put a number on that, you know, that type of thing. But we'll work through that and we'll get that solved.

SENATOR WILLIAMS: Okay. Thank you.

SCOTT WIETING: Uh-huh.

SENATOR RIEPE: Thank you. Thank you, Dr. Wieting.

SCOTT WIETING: Very good.

SENATOR RIEPE: There are no more questions.

SCOTT WIETING: Thank you, both of you. Thank you.

SENATOR RIEPE: Thank you very much. We will take others who wish to testify. Do we have others wishing to testify? Seeing none,...

ROLLIN DAVIS: Are you doing the just invited testimony now or are you taking from the public?

SENATOR RIEPE: We will take...we're taking any testimony,...

ROLLIN DAVIS: From the public?

SENATOR RIEPE: ...not just invited.

ROLLIN DAVIS: Okay. Thank you.

SENATOR RIEPE: It appears you've been preparing for a while here.

ROLLIN DAVIS: I've never done this before.

SENATOR RIEPE: Well, welcome.

ROLLIN DAVIS: This is my first time, so.

SENATOR RIEPE: Welcome. If you'd be kind enough, sir, to just state your name and spell it for the record purposes and then tell us a little bit about who you are and then proceed forward, please.

ROLLIN DAVIS: (Exhibits 3 and 4) Good morning. My name is Rollin Davis, R-o-l-l-i-n D-a-v-i-s.

SENATOR RIEPE: Thank you, Mr. Davis.

ROLLIN DAVIS: I'm a citizen of the state of Nebraska. I earned my Ph.D. degree in sociology at the University of Nebraska. I've taught at Nebraska Wesleyan University and Concordia University in Seward, and I've also taught at the American University of Central Asia in Bishkek, Kyrgyzstan. I'm (inaudible) in the sociology of healthcare, in general, and I'm speaking to you today about dental care specifically. There is a problem in the United States. Many low-income citizens of Nebraska, Nebraska citizens, who need expensive dental care, for example, root canal surgery and gold crowns, are not eligible for Medicaid. Consequently, they are forced to have their teeth extracted. I propose a solution to this problem: creation of the Low-Income, Non-Medicaid Eligible Dental Care Act, which will include one or more of the following options to make it possible for low-income Nebraskans, who are not eligible for Medicaid, to save their teeth. First, require the College of Dentistry at the University of Nebraska-Lincoln to allow monthly partial payments, not exceeding $100. Second, authorize the Department of Health and Human Services to establish a loan fund for low-income dental patients who are not eligible for Medicaid. Third, authorize banks in Nebraska to establish low-interest, short-term loans, with no credit check required, for dental patients who are not eligible for Medicaid. Option number three is not really a new idea. I've given you a photocopy of an article that was published in the Lincoln Journal Star on March 11, 2018, the article's head, "Some hospitals promoting quick loans." Several years ago, BryanLGH partnered with Union Bank to make loans to hospital patients. Since the institutional framework is already in place to make these types of loans to patients, it would be very simple and straightforward to extend this program to apply to the College of Dentistry at UNL. Save one's teeth is a basic human right. It shouldn't be a luxury reserved for those who can afford it. A few hundred dollars makes all the difference. I've been to the College of Dentistry at UNL and I remember sitting in a dental chair. If you've never been there, the dental chairs are very close together because it's a teaching opportunity and learning opportunity. And I heard a patient in an adjacent dental chair--I couldn't help but to overhear--I heard that patient actually breakdown and cry when they said that they would have to have their teeth extracted because they couldn't afford to have root canal surgery and gold crowns. And my

heart went out to that person. And so, because of that, I'm here today speaking to you. Poor people are taxpayers and voters. They're citizens too. They're your constituents. Many poor people are actually very conservative and they vote for Republican candidates, they support conservative issues. They are your constituents and I'm sure they'd appreciate the opportunity to save their teeth so that they can eat food in their old age. Thank you very much for your time and consideration.

SENATOR RIEPE: Okay. Thank you, Dr. Davis.

ROLLIN DAVIS: If you have any questions, I'll be happy to answer.

SENATOR RIEPE: I have a comment. Under the proposed solutions you had say require the College of Dentistry at the University of Nebraska to allow monthly partial payments not to exceed one...that sounds like direct primary care, which is close to my heart, so.

ROLLIN DAVIS: I can't hear you very well. I'm 74 years old and I'm starting to lose my hearing a little bit.

SENATOR RIEPE: Well, we appreciate your being here. I was just saying that your number one requirement relates to or is very similar to direct primary care, which I have been a proponent of for some time.

ROLLIN DAVIS: Yeah. I was just thinking it would be nice if the college would accept these monthly partial payments of $100, because right now they just demand full payment of services that are done. And if someone has several hundred dollars worth of dental work done and they can only afford about $100, then they're forced to have their teeth extracted. Otherwise, they're faced with the uncomfortable possibility of just having to apologize and walk out the door. (Laugh) I don't know what the legal consequences for that would be because in a sense it's theft of services, I suppose. But on the other hand, desperate measures, you know, call for desperate actions. And people do want to save their teeth so that they can eat food in their old age.

SENATOR RIEPE: Well, you know, I...we're very appreciative of your continued engagement and you're thinking all the time, obviously. Senator Williams, do you have any questions?

SENATOR WILLIAMS: Don't think so. Thank you for being here.

ROLLIN DAVIS: I heard you say that you are going to address this issue on the floor of the Legislature on Wednesday with regard to the College of Dentistry, or perhaps I misunderstood.

SENATOR WILLIAMS: The budget issues facing the Legislature will...the mainline budget will be brought back to the floor of the Legislature on Wednesday, is my understanding.

ROLLIN DAVIS: I thank you, sir. Also I...

SENATOR WILLIAMS: And there will be a discussion about a lot of things that are in that budget.

ROLLIN DAVIS: I urge you all to support the College of Dentistry and their mission to provide dental care for low-income people. Thank you so much.

SENATOR WILLIAMS: Thank you for those comments.

SENATOR RIEPE: Okay. Thank you, sir. Thank you very much for being here. Others that would like to testify? Okay. Again, thank you to all of you that are here. That concludes the first hearing of oversight for the dental Medicaid legislation. We appreciate very much being here.