Health and Human Services Committee
June 26, 2018

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The Committee on Health and Human Services met at 9:00 a.m. on Tuesday, June 26, 2018, in Room 1510 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public hearing on a Heritage Health quarterly briefing. Senators present: Merv Riepe, Chairperson; Sue Crawford; Mark Kolterman; Lou Ann Linehan; and Matt Williams. Senators absent: Steve Erdman, Vice Chairperson; and Sara Howard.

SENATOR RIEPE: (Recorder malfunction)...just in respect for all of you that are here. We appreciate...the number of people that have shown up this morning shows the importance of this particular functions of this oversight committee, and the commitment to Heritage Health and Medicaid in the state of Nebraska and the 240,000 people that are beneficiaries, and also the interest of all of the taxpayers, if you will, in terms of the size of the budget for Medicaid in the state of Nebraska. By means of opening, this is a Heritage Health oversight committee and part of the Health and Human Services Committee. My name is Merv Riepe. I happen to be the chairman of the committee, and I am from the 12th District, which is Omaha, Millard, and Ralston, if you will. I would like to have the self-introduction by our Health and Human Services Committee members, and I'm going to start--and the staff--and I'm going to start over here to my far right: my friend, Mark.

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

KRISTEN STIFFLER: Kristen Stiffler, legal counsel.

SENATOR CRAWFORD: Good morning. Senator Sue Crawford, from the Bellevue area, District 45.

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

TYLER MAHOOD: Tyler Mahood, committee clerk.

SENATOR RIEPE: And I'd also like to introduce our two pages that we have with us today, helping out, that's Austen and Grady. And so, gentlemen, we thank you for being here, very much. I want to start out with just a few remarks, and that is that today is our fifth quarterly meeting for Heritage Health and Nebraska's Medicaid oversight. At the second oversight we asked the interim committee, Director--Interim Director Thompson to return to the microphone, following testimony by providers. The process proved to be not a good time to staff to...not allow enough time for staff to determine facts regarding allegations that might be brought forward. I felt the process was not constructive and elected not to continue on that process, and we've had some discussion, as committee members. Medicaid in Nebraska is not a new process. We've had managed care in for Medicaid since the 1990s. In the most recent Heritage Health, we did make some major moves, in terms of being able to "intervate" (sic--integrate) the physical, behavioral, and pharmacy into one big change. As providers, all of you, the managed care organizations and also those that are providers, serve 240,000 Nebraskans, the most vulnerable of our fellow citizens, with an FMAP of 51 percent federal and 49 percent state. In total, we spend $1.2 billion each year, so it is significant. In our past oversight hearings we have heard of start-up challenges, certainly not unique to any large and complicated service. But we cannot be content thinking that it's just the way it is, and we will continue for continuous improvement. We are a legislative-branch oversight function and not--I repeat, not--operationally in charge of the administration of Heritage Health which, as all of you know, is a function of the executive branch. That said, we have a fiduciary duty to represent--having a hard time this morning--the service beneficiaries, providers, and taxpayers to promote good outcomes, good experiences in the form of adequate access and affordability for taxpayers. The provider network is an essential ingredient in providing access, and we must continue to improve our systems and our processes. Anecdotal stories are interesting from the managed care organizations and from the providers. My concern continues that we have not completed a benefits--or a beneficiary satisfaction--survey to enhance access to get a bigger, broader picture than the anecdotal notes, nor have we determined if efficiencies show proof of having slowed the cost curve or even cost reductions, for the benefit of the taxpayers. Those are things that we need to look to, so we have a lot of work in front of us. We're not going to accomplish all of that today, I might add. But we will be working diligently and going forward. That said, I want to invite Director Dr. Matthew Van Patton to the mic for our presentation.

MATTHEW VAN PATTON: I remembered my bottle of water this time, Mr. Chairman (laughter).

SENATOR RIEPE: No emergencies, huh?

MATTHEW VAN PATTON: (Exhibits 1 and 2) Although I forgot to bring it from home, and it ended up costing me $1.50 out of the vending machine, which I did not particularly like paying for. But anyway...good morning, Chairman Riepe and members of the Health and Human Services Committee. My name is Matthew Van Patton; that is M-a-t-t-h-e-w V-a-n P-a-t-t-o-n, and I am the director of Medicaid and Long-Term Care services for the state of Nebraska, within the Department of Health and Human Services. Today we, the team at Nebraska Medicaid and Long-Term Care, are pleased to submit for your review, the FY18 third quarter report on Heritage Health, Nebraska's Medicaid managed care program. This report is organized into four sections: business performance; stakeholder engagement; quality management and performance improvement; and the future, a road map of Medicaid and Long-Term Care's path forward. While business performance is certainly an important part of MLTC's management oversight of the Heritage Health program, it represents only one side of the evaluative equation. The Triple Aim is a widely recognized approach to optimizing health system performance created by the Institute for Healthcare Improvement. It is a framework developed around the belief that new designs must be developed to pursue three dimensions of performance: 1) improving the patient experience of care, including quality and satisfaction, 2) improving the health of populations, and 3) reducing the per capita cost of healthcare. The objectives of The Triple Aim and managed care are aligned in the marketplace and allow for an evaluative shift beyond business performance to a broader quantification of value focused on cost, quality, and satisfaction with outcomes assessed at both the individual level and across populations. The formalization of the Heritage--excuse me--of the health management program organizes MLTC resources to enhance, expand, and add to our clinical, statistical, economic, and ethical evaluative capabilities, provides a mechanism for improved collaboration and coordination with internal and external stakeholders to best achieve The Triple Aim, foster market innovations, and drive performance improvement, and position MLTC to share our knowledge and accomplishments through publication. I would like to thank the three MCOs and their leadership teams for their spirit of collaboration and customer-oriented responsiveness shown to MLTC. The three MCO CEOs are

here with us today: Michael Heifetz from Nebraska Total Care, Lauralie Lee Rubel from WellCare, Kathy Mallatt from United. I would also like to recognize Sherry Husa from Nebraska Total Care, who has acted as the immediate past interim CEO. Lastly, I want to thank the staff of MLTC for their hard work over the last month in compiling this report. I am honored to lead a team of devoted and hard working public servants. Let's begin on page 5, in the section labeled "Business Performance." MLTC closely monitors the performance of each of the three managed care organizations, MCOs, and Heritage Health. The MCOs are currently putting into use a new biweekly dashboard for reporting important performance data which will become increasingly useful in assessing performance trends over time. This new dashboard was launched in the spring of 2018. As such, the data included here will reflect similar metrics, but was pulled from existing reports between January and March of 2018. A template copy of the MCO's new biweekly dashboard is available in the appendix. In figure 1, you see the number of new contracts executed with providers. I will note that the data reported is specific to account of signed contracts and not the number of individual providers included in that contract, as contracts may include multiple providers. In figure 2, we report on the number of providers terminated from each of the plans. It is not uncommon for providers to leave networks. The top trending reasons for this quarter include: the providers left the practice, retirement, and voluntary removal from the network. Turning to page 6, we begin a section report on claims. In figure 3, we report the number of claims received by each MCO. This information is representative of the volume of claims for the member mix of each health plan on a monthly basis. Moving down the page, figure 4 reports on the number of claims adjudicated. This data set shows all claims that were successfully entered into the health plan's billing systems. After a claim is entered into the system, the plans are either able to either pay or deny the claim. It is not uncommon for the MCOs to adjudicate more claims than they receive in a given month, because the adjudication number includes reprocessed claims. Claims can be reprocessed for a variety of reasons, including retroactive rate changes. Figure 5 reports the percentage of claims rejected within the noted time period. Rejected claims are claims that do not meet basic legibility, format, or completion requirements and, therefore, are not received into the MCO's system for adjudication. Common reasons for rejected claims include clerical errors and missing information. Turning now to page 7, we see in figure 6 the percentage of claims denied. A clean claim can be adjudicated and denied by the MCO for various reasons. The denial reasons are submitted by each plan on a monthly basis and separated out into behavioral health claims and physical health claims, with the top ten reasons specified

for both. Trending denial reasons include: duplicate claims, need to bill the primary insurance, service not covered by Medicaid, and the member not being eligible for benefits at the time of service. In figures 7 and 8, we note the claims dollars paid for the time period. The spend is reflective of the populations assigned to, and managed by, each of the health plans, and shows the volume of claims being paid out to providers on a month-to-month basis. The processing of pharmacy claims is unique in that pharmacy operates as a point-of-sale system, whereas the claims for medical and behavioral health are filed after the member has been seen by a provider. On the next page, page 8, in figures 9 and 10, we report on the percentage of claims adjudicated within 10 and over 60 days. The health plans all require to process their claims in a timely manner, and MLTC monitors the progress through reporting. Per the contracts, 90 percent of claims must be adjudicated within 15 business days. The Quality Payment Program threshold is 95 percent within 10 business days for both physical and behavioral health claims. Furthermore, the plans are contractually required to adjudicate all claims within 60 days. Any claims paid over 60 days are subject to being paid with interest. On page 9, you see in figures 11-13, members in active care management. Active engagement with patients and their families helps patients successfully navigate the continuum of care to achieve better health outcomes, improve experiences, and reduce the cost of healthcare, otherwise again known as The Triple Aim. Each plan is able to identify for itself which of its members are in high-, medium-, and low-level care management per MLTC guidelines. Turning to page 10 under the section heading labeled "Pharmacy," figure 14 reports on the percentage of generic drugs dispensed. The use of generic drugs may reduce spend and increase cost savings in the Heritage Health program, as generic prescription drugs are typically less expensive than brand name drugs. In figure 15, we report on preferred drug list compliance. Through the pharmacy and therapeutics committee, MLTC creates and manages a preferred drug list, or PDL. The importance of the PDL lies in the professional review of each drug for safety, efficacy, and cost savings. While most generics are priced lower than brand names, expenditures can be reduced even further with drug manufacturer supplemental rebates, which makes the brand names more cost effective than generic. Let me conclude this section by saying MLTC is monitoring the pharmacy spend through Heritage Health and will be working with stakeholders to identify strategies which address increasing costs. MLTC is also involved in the national conversation around increased pharmacy costs, and is committed to ensuring an effective and efficient delivery system of the pharmacy benefit. Stakeholder engagement...if you would flip with me now to page 11, and I'm going to take a

moment to take a sip of water. We now enter the next section of the report titled "Stakeholder Engagement." Engagement between the MCOs and both Heritage Health providers and plan members is an essential part of making Heritage Health a success. These events bring additional value to members and providers and serve as important arenas for feedback, which can lead to program improvements. The following maps, pages 13-15, figures 16-18, detail the locations of various provider and member-engagement events by each MCO throughout the state in the first three months of 2018. These events include: provider orientation sessions, community baby showers, and health fairs. On pages 16 and 17, each of the three health plans share a member story to highlight some of their recent member and provider outreach efforts. At the request of WellCare, we have also included in the appendix of this report a copy of a submitted letter from Cirrus House, regarding their experience with the MCO. In the last presentation for the committee, we noted provider survey results and how those surveys were constructed. In a effort to improve MLTC's engagement with Heritage Health providers, efforts are underway to standardize the yearly provider survey distributed by the MCOs to providers. A standardized survey will allow MLTC to draw more accurate comparisons to provider experiences among the three health plans. The standardized survey tool is anticipated to be in place by calendar year 2019. The 2018 survey will be implemented under the existing arrangement, whereby each MCO constructs their own provider survey per MLTC guidelines. Next section..."Quality Management and Performance Improvement". On page 18 we begin the section on quality management and performance improvement. On page 19 we start by noting that MLTC has partnered with Island Peer Review Organization, Inc., or IPRO, to perform a federally required, yearly quality review conducted by an external quality review organization. And by the way, we've included, for your benefit, in the back of this report and the appendix, a list of acronyms that I felt would be helpful for everyone as we make our way through it. And we'll continue to add to that and give it to you as we report overtime. I learn a new one every day. IPRO's evaluation of Heritage Health 2017 performance was finalized on March 30, 2018, and these findings will be posted publicly by July 1, 2018. Figure 19 presents a high-level summary of IPRO's findings from their aggregate report of all three health plans. The evaluations of each MCO were performed between January 1 and August 31, 2017. Definitions of each compliance domain and levels of compliance are available in the appendix, as attachment 4. For the two MCOs that were found to be minimally compliant in the subcontracting category, a plan to correct the deficiency was submitted to MLTC and will be reviewed to ensure the MCO has come into compliance with the standards. Moving on to

page 20 under dashboard metrics, the 800-plus reporting requirements included in each of the MCO's contracts with the state of Nebraska allow for highly measurable results and outcomes from the Heritage Health program. The following information includes highlights of some of the health outcomes from Heritage Health. These metrics were developed in consultation with the Medicaid medical director, Dr. Lisa White, who is also here with us today. The objective of the treatments being measured is to promote better health outcomes in a manner that is both clinically and cost effective. In figure 20, we present Tdap immunization rates for adolescents. Here we note the number of adolescents who have received a tetanus, diphtheria, and pertussis, or Tdap immunization prior to their 18th birthday. This data is split into two age categories: adolescents ages 11-15 and those ages 16-17. This is an administrative measure looking at Medicaid claim data, and these rates may be affected due to missing data where members received vaccinations outside of the Medicaid program. MLTC knows more adolescents may have the Tdap vaccine, but this metric is the most consistent way to measure immunization rates without performing chart audits. America's health ranking data showed that Nebraska, on the whole, ranked 34th in the nation for Tdap vaccinations in 2017, with 86 percent of adolescents age 13-17 years having had the Tdap vaccine. In 2017 Nebraska had 22--excuse me--27.2 cases of pertussis per 100,000 within the population. MLTC is working with the plans on a Tdap performance improvement project, a PIP, for calendar year 2018. Efforts are underway by each of the MCOs to improve the statistics. For example, Nebraska Total Care sends out reminder mailers to schedule well child exams before children reach one year of age. On page 21 in figure 21, the chart presents the data specific to the count of members receiving medication-assisted, treatment-related drug prescriptions from Nebraska Medicaid by month. MLTC has exceeded its target for this measure since the beginning of Heritage Health in January 2017. Medication-assisted treatment, MAT, defined by the Substance Abuse and Mental Health [Services] Administration, is the use of a combination of behavioral therapy and medication to treat substance abuse disorders. A successful MAT program is one component in fighting the national opioid crisis, although MAT can also be used to treat alcoholism and tobacco addiction. Turn now to page 22...performance improvement projects, or PIPs are collaborative projects between MLTC, the MCOs, and the external quality review organization, aimed at improving the health outcomes of Nebraska's Medicaid beneficiaries. MLTC currently has three PIPs in place: track...1) tracking follow-up visits after emergency department visits, for mental illness or alcohol or drug dependency; monitoring Tdap immunization rates in pregnant women, and 3)

monitoring 17P injection rates in pregnant women. MLTC is currently developing, or has in place, overall target goals for these three projects. A goal for ED followup is currently being developed, as 2017 was the first full year that HEDIS data was available for these measurements. With Tdap immunizations, MLTC is aiming for 85 percent and 75 percent for indicators 1 and 2, respectively. Finally, MLTC is aiming for a 35 percent 17P injection rate. In figures 22-25 on pages 22-24, we report our progress in achieving these measures with the MCO and EQRO partners. I now invite you to join me on page 26 of the report as we begin a section titled "Future Road Map." The last year and a half has seen a great deal of change for the Nebraska Medicaid program. Medicaid in Nebraska is now on a newly charted course in managed care. A Medicaid managed care system, more so than a fee-for-service system, is designed and organized to manage costs, utilization, and quality of healthcare services. The ongoing strategic vision of MLTC will be driven by managed care's strengths. The ability to manage cost, utilization, and quality today is key to balancing the interests of all stakeholders in the Nebraska Medicaid ecosystem, from beneficiaries and providers to the taxpayers who financially support the program. The fulfillment of MLTC's strategic vision will be enhanced by informatics systems, both current and in development, which have the ability to collect and utilize the large volumes of data created by Heritage Health and other Medicaid programs on a daily basis. This data can be used to guide and manage the cost, utilization, and quality of services available through the Medicaid program. Strong leadership will be essential to carrying out the strategic vision. Currently MLTC is recruiting a new deputy director for health informatics and business integration who will be instrumental in the development of new informatics systems to continue to modernize the division. The current operational infrastructure at MLTC is focused on business performance, contract management, regulatory compliance, finance, and remaining fee-for-service program management. As MLTC has transitioned primarily into managed care, it is more important than ever to build an enterprise that makes it possible to quantify the value of dollars spent in real economic terms, terms that define the value proposition assessed in both cost and consequences. These evaluations are key to the other side of MLTC ongoing function: outcome management. The objective of our developing health management program, established under the direction of Dr. White, is to create a management and intelligence infrastructure for quantifying the value of managed care coordination activities within the patient populations identified and managed by the MCOs. By fulfilling this objective, MLTC is better able to deliver on its Triple Aim for Heritage Health members. The Triple Aim again seeks to improve the

patient care experience, improve the patient's health, and reduce the per capita cost of healthcare. This new infrastructure will fulfill several important functions, specifically: enhanced clinical, statistical, economic, and ethical evaluation capabilities; mechanisms for improved collaboration and coordination to better fulfill The Triple Aim, foster market innovations, and drive performance improvement; and 3) publication of information to share our knowledge and accomplishments within the marketplace. Figure 26 illustrates how the cost and consequences of every action and decision MLTC makes with the health management program impacts beneficiaries. A full economic evaluation requires the identification, measurement, and valuation of both cost and consequences, in terms of both benefit of taking an action and the effectiveness of taking said action. For example, forgoing a less expensive medical treatment--cost--could lead to negative health outcomes--consequence--that would require a more expensive medical treatment--cost. Ethics come into play when evaluating either side of this dichotomy. Within this program, and through active stakeholder engagement, MLTC and the MCOs will ensure that chosen healthcare services have benefits that outweigh their opportunity cost, or the most beneficial activities are chosen within the resources available. This decision-making process is known as the economics of member benefits. When working inside the framework of the health management program, a full economic evaluation is the only type of economic analysis that provides fully valid information. Noted here are the four health economic evaluation methodologies: cost-benefit analysis, cost-utility analysis, cost-effectiveness analysis, and cost-minimization analysis. A central component of the new intelligence infrastructure MLTC is developing will be the data management and analytics tool, or DMA. This tool, currently in the design-build phase, will assist with coordinating and putting into use the vast amounts of data generated by Heritage Health and other MLTC programs. The tool's capabilities will be enriched by the collaborative contributions of MLTC, the MCOs , and the Nebraska Health Information Initiative, or NeHII. MLTC contracted with Deloitte Consulting LLP to assist with the development of the tool. The DMA is expected to launch in June of 2019. In conclusion, the infrastructure being built at MLTC will take Nebraska Medicaid well beyond the capabilities of traditional Medicaid managed care. With the improved utilization of larger amounts of data, MLTC will be able to pursue initiatives focused on enhancing care for populations, aligning payment incentives with performance goals, and building an accountability for high quality care across the entire continuum of care. To be clear, MLTC is not building a program for firm administrative direction of the MCOs in the marketplace. Rather, through this intelligence

infrastructure and other initiatives, MLTC is setting a programmatic direction by which we evaluate, collaborate, and coordinate, to best achieve the broad principles of The Triple Aim: reduce cost, give better care, and create better patient and provider experiences. Thank you, Mr. Chairman and members of the committee, for your time here today. This now concludes my report.

SENATOR RIEPE: Thank you, Director Van Patton. I would like to open it up now for committee questions and then, following that, we will then go to an open hearing. So, Senator Kolterman, did you have a question?

SENATOR KOLTERMAN: Certainly I did (laughter). Thank you, Senator Riepe. Matthew, on page 6 you started out and you talked about claims rejected. And I was looking at...it was so long ago I have to relook at my notes now. I was looking at the loss ratios of the different companies there. I mean it's not really stated there, but it's obvious that there's got to be a huge difference in loss ratios. And it looks like Nebraska Total Care, on page 6 down towards the bottom there, they're significantly higher in percentage of claims rejected versus UnitedHealthcare and WellCare. Is there a reason for that? You know, are they...I mean that jumps out at me because we're looking at 2.5 to 3 percent versus...I guess well, well--I'm sorry--WellCare is higher as well. But UnitedHealthcare is doing exceptionally well. Is that because they've had broader networks throughout the state and more in tune to what the state has been doing? Or what's the rationale behind that?

MATTHEW VAN PATTON: You know, Senator, it could be a number of reasons. It could be each individual MCO operates an individual business with their individual claims processing system, and so it could have been, over that time, that you had new providers coming into network who were orienting to those systems, and that could have been a reason for the bumps that you see there. It could have been that you had individuals who've changed within the provider world, those on the billing side. Those positions tend to have a pretty high turnover rate. So there's a time period that you have to train those individuals to enter those claims, and so you could have had that dynamic in the marketplace. And then you could have just had some issues as the individual MCOs were refining their claims adjudication process. And so, as I look at these rates for this particular time period, I think that, you know, where Heritage Health is at this

point, in particular in the marketplace and then moving forward, I think that this process has really normalized in comparison to where it was at the beginning through the first year of implementation. So I can tell you, as I said and as you...if you look at the dashboard that we've created, one of the reasons we created that dashboard is to keep a close eye on this metric. And so we can monitor it, over time, very consistently. And so this is an important metric for consideration as it involves a high level of customer service on the back end. I'll also tell you that our biweekly meetings that we have with each of the MCOs and their CEOs, in my office every two weeks, is very much focused on what I would consider the customer experience across the ecosystem. And so within the construct of that time, we're focused on issues that have arisen during that particular time period of those two weeks. We keep an issue log which, by the way, if you look at the issue log in comparison to where we were in implementation, we were at a point where we were in the triple digits of issues, and it may please you all to know that, as I checked the issue log as of yesterday, we had 33 open issues out of...and now that's across all of our MCOs. So I think our internal process for addressing issues that exist within the provider community and the marketplace, on a whole, there's an internal process for identifying those issues and responding to those issues, as we know them in very specific terms and can address them strategically, based on what we know about the specificity of the issue. And that process seems to be working well at this point. But to your question, Senator, it is something, again, that we do watch very carefully, and we want to make sure that, if those rates get out of what we would consider norm, then we want to address it proactively.

SENATOR KOLTERMAN: All right. I've got some other questions, but I'll give somebody else a chance and I'll come back.

SENATOR RIEPE: Okay, Senator Crawford, and then we'll come back to you.

SENATOR CRAWFORD: Thank you, Chairman Riepe, and thank you, Director, for being here. This is very helpful.

MATTHEW VAN PATTON: Yes, ma'am.

SENATOR CRAWFORD: And I'm very excited about your plan to hire someone to help with the data; I think that's very valuable.

MATTHEW VAN PATTON: Me, too.

SENATOR CRAWFORD: Just so I understand the numbers we were just talking about on page 6, is it true that the opposite of this number, 100 minus this number, is the clean claims? Like these are the percent of claims that are not clean, is that true?

MATTHEW VAN PATTON: You know, I want to give you guys, just to...

SENATOR CRAWFORD: Just to clarify...so okay.

MATTHEW VAN PATTON: It helped me, so I had staff construct a grid.

SENATOR CRAWFORD: Okay.

MATTHEW VAN PATTON: I like to go back to the basics and get it in visual form.

SENATOR CRAWFORD: Okay, okay.

MATTHEW VAN PATTON: So if I can, if I can approach, I'll pass this out to you.

SENATOR CRAWFORD: We had been seeing that measure over time, and so that's helpful. I think this is kind of the opposite...

MATTHEW VAN PATTON: Yep.

SENATOR CRAWFORD: ...the opposite of that, which is good to track, but maybe it's not. Maybe I'm misunderstanding.

MATTHEW VAN PATTON: Well, I want to make sure that the...because this is a very interesting process. And so what we did is sort of build out of a basic box. So a claim is submitted and, if you see it, just imagine that coming from the provider, going into the adjudication process that each of the MCOs have created. So the claim is rejected again, based on those very basic reasons that we said.

SENATOR CRAWFORD: Um-hum.

MATTHEW VAN PATTON: It may be that it's missing key elements of data. For example, it may be missing an x-ray...

SENATOR CRAWFORD: Sure, right.

MATTHEW VAN PATTON: ...that's needed to make the decision. Or it may be that it has an inaccurate provider number, and sometimes that's just a keying error on behalf of the data entry clerk who's doing the billing. And so that can bounce it back out.

SENATOR CRAWFORD: Um-hum.

MATTHEW VAN PATTON: And so we also, on the MLTC side, we have started looking at those experiences to make sure that, if we do see a particular provider who has a number of claims that are bouncing, that we can try to be responsive.

SENATOR CRAWFORD: Good.

MATTHEW VAN PATTON: It's a...I will say, Senator, it's still a challenge for us...

SENATOR CRAWFORD: Um-hum.

MATTHEW VAN PATTON: ...to have a process that let's us identify that, because we process millions of claims.

SENATOR CRAWFORD: Sure.

MATTHEW VAN PATTON: But we're doing the best we can to improve that experience. But...so the claim either goes into the system or it's rejected. And it's rejected up front, okay?

SENATOR CRAWFORD: Right, okay.

MATTHEW VAN PATTON: Once it enters the system for adjudication, the path is either/or. It's either paid or it's denied. And so the reasons for denial there again, the top reasons include duplicate claims submitted,...

SENATOR CRAWFORD: Um-hum.

MATTHEW VAN PATTON: ...the provider must build a primary coverage, since Medicaid is the second payer in most cases, if somebody else has another coverage, time limit for the claim has expired, and the service is not covered by Medicaid. So again, the rejection rate is on the front end, so...

SENATOR CRAWFORD: Right.

MATTHEW VAN PATTON: ...if it bounces back, something is missing, and it just can't get into the system, and that's what that's looking at.

SENATOR CRAWFORD: Correct, okay.

MATTHEW VAN PATTON: And so on the back end, it's either going through, either paid or it's denied, and then if it's denied, those are the top reasons. And we do monitor those reasons for denial so, again, and I would say to you that part of that two-week, that biweekly meeting...

SENATOR CRAWFORD: Um-hum.

MATTHEW VAN PATTON: ...is for us to look at the customer experience and, where those issues exist, to begin process improvement initiatives. I think it's widely known that Governor Ricketts is very much focused on operational excellence and performance improvement, which is a perspective that I've had throughout my entire career and experience in the provider world at the hospital. So where we can make those process improvements, we do seek to do that.

SENATOR CRAWFORD: Okay. And just to clarify from this chart then, too, when you...on figure 9, where it says the percentage of claims adjudicated within ten days, that would mean paid or denied, like people are getting...

MATTHEW VAN PATTON: Right.

SENATOR CRAWFORD: ...paid in ten days...

MATTHEW VAN PATTON: Correct.

SENATOR CRAWFORD: ...or the denial notice in ten days.

MATTHEW VAN PATTON: Correct, that adjudication.

SENATOR CRAWFORD: That's what that number means. Great.

MATTHEW VAN PATTON: That's correct.

SENATOR CRAWFORD: So then I have another question on the...on page 9, and this also is to try to understand the difference between numbers that you give us that may be for all patients in the system, and then numbers or results that may be the value-based contracts in the system. So as I understand it, we're trying to better manage care for everyone with some of these measures, and then each MCO is supposed to be also creating some value-based contracts and, like by year three, 30 percent of those...

MATTHEW VAN PATTON: Correct.

SENATOR CRAWFORD: ...should be value-based contracts. So are the numbers on page 9, are those the value-based?

MATTHEW VAN PATTON: Not all. No, ma'am.

SENATOR CRAWFORD: No, okay.

MATTHEW VAN PATTON: No, ma'am, that is not.

SENATOR CRAWFORD: Okay. So I'm just trying to understand that difference between the numbers that are everybody in the...are all these numbers really everybody?

MATTHEW VAN PATTON: So if I could...

SENATOR CRAWFORD: Yeah.

MATTHEW VAN PATTON: ...back up and give you the concept of care management, and this is also a primer for going into the back end of this report as we began to really look at what's happening within the Heritage Health program in care management. Care management allows us to begin to set the baseline of individuals as they begin to become emblematic of populations, and how we can begin to track the outcomes of those populations and the services that we provide and the outcomes those services achieve within the marketplace for those populations. So you look at these different levels, and these are represented at three different levels: high, medium, and low.

SENATOR CRAWFORD: Um-hum.

MATTHEW VAN PATTON: So it could mean that care management is an extension of the onboarding of a new beneficiary to a program, and the program reaches out and introduces themself to that beneficiary and says: May I help you by setting up your first appointment with XYZ physician? Now that's good care navigation to me. I think that's one of the enhanced benefits of managed care. Again, going back to The Triple Aim patient experience,...

SENATOR CRAWFORD: Um-hum.

MATTHEW VAN PATTON: ...helping get those individuals within a care situation where they get the care they need and, hopefully, get to the outcomes while also effectively managing the cost. So what's important to note about this and why I made a very specific point in the back of this report by saying we're not creating a system by which we create administrative direction. We have hired the MCOs to manage their populations as they see them. What we want to see is that they are managing them within the context of managed care. So each of the MCOs have very different patient populations.

SENATOR CRAWFORD: Um-hum.

MATTHEW VAN PATTON: And so what we want to do is give them the latitude for driving those populations, as they see fit, into these various levels of care management. And so you'll see differences among those three providers--three MCOs--simply because they have different populations that they're managing, too.

SENATOR CRAWFORD: And so on this table on page 9, UnitedHealthcare has pretty high numbers that they've assigned into these slots, and the other two are pretty...I mean, if you add up their total, they surely have more patients than total on these three levels. So they just haven't assigned those patients yet.

MATTHEW VAN PATTON: Correct.

SENATOR CRAWFORD: Correct. Okay, okay.

MATTHEW VAN PATTON: Or they're working in different care management strategies with different populations.

SENATOR CRAWFORD: Okay. So with all of this data, is there a, like a data audit strategy? Or how do we confirm or check the data that we get on these kinds of measures from the MCOs?

MATTHEW VAN PATTON: So that's when I noted the importance of, number one, hiring the new data management--or health informatics and business systems--deputy which, by the way, we've made an offer and hopefully...

SENATOR CRAWFORD: Yeah.

MATTHEW VAN PATTON: ...that will be accepted. That will be a tremendous benefit to us, so we'll keep you informed if that person...hopefully they'll be onboarded soon. But also the DMA tool, so I think it's no surprise to anybody on this committee, we have an aging MMIS system which is, in large part, tracking our encounter data and also our claims brokerage. I think the long-term vision and objective for me clearly is to find a pathway to sunset that enterprise and how we "offboard" ourselves from that. Phase 1 of that is certainly migration over to the DMA tool that we are creating with Deloitte, and that tool will help us begin to look at our data in a much more comprehensive manner and to be able to make meaningful extractions and to do better statistical analysis.

SENATOR CRAWFORD: And is part of that work with them to establish an audit function or a check function?

MATTHEW VAN PATTON: It can be. Yes, ma'am.

SENATOR CRAWFORD: I hope it would be. Thank you; thank you.

MATTHEW VAN PATTON: Yes, ma'am.

SENATOR CRAWFORD: I have other questions, but I'll let somebody else ask some questions (inaudible).

SENATOR RIEPE: Okay, before we go any further, let me introduce Senator Lou Ann Linehan, who's a member of the committee. And Lou Ann, we're glad to have you here; thank you. Senator Williams, I saw your hand.

SENATOR WILLIAMS: Thank you, Chairman Riepe. And thank you, Director, for being here today. One specific question to start...on page 7, with your percentage of claims denied. With your experience in looking at other states and other Medicaid programs, and your personal experience, are those numbers in line with what you would see nationally?

MATTHEW VAN PATTON: Yes, sir, I believe they are. And I will tell the committee that just two weeks ago, I went and participated in the first...my first event with the National Association of Medicaid Directors, which gave me, I think, insight into the broader happenings of the marketplace. And what I quickly found is that every Medicaid program across the entire country is different in some aspects. Some populations are in managed care, some populations are not; it's different. But when you begin to look at the claims processing side of the equation and you look at where the industry is on the norm, I do believe that we are entering a phase of Heritage Health where our business practices are beginning to normalize. That's not to say there aren't issues. That's not to say that you aren't going to have, within the normal course of business, Senator, issues that pop up. We do, we will. I think the question of our performance now should be measured on how we respond to those issues as they pop up, and it is my discerned objective. And again, going back to the process we have on that, every two-week session is to make sure that those processes allow us to identify those issues when things do begin to get out of normal business parameters, that we're able to quickly address those issues and move forward with a very high level of responsiveness.

SENATOR WILLIAMS: I appreciate that comment. I think it is clear to us, at least to me, that our responsibility also is to foster an environment for resolution of these issues. One of my concerns, and for those that are here today, is the fact that the hearing process itself, an oversight hearing like this, isn't always conducive to finding resolution. It's a good process to get some information, but a specific problem that a provider, or a Medicaid recipient, is having doesn't get resolved in this text. I applaud your ability to continue having those two-week meetings that I...seems to me, from what I'm hearing, are productive. I think what we have to get beyond is the concept of a provider that is saying: I just don't like it, which is different than having a specific problem that they have had. Now to that, on page 8--figure 9, with your claims adjudicated with ten days--within ten days--and your answer to Senator Crawford was that's what...that's the point where the claim is either paid or it's denied,...

MATTHEW VAN PATTON: Um-hum.

SENATOR WILLIAMS: ...but it's also where a provider knows whether they're getting paid or not. I'm still mystified when I hear from constituents and providers that are telling me they have these issues, and then I look at a chart that says it's nearly perfect, 99 percent.

MATTHEW VAN PATTON: Yeah.

SENATOR WILLIAMS: Is there any explanation that you can add to that?

MATTHEW VAN PATTON: Sure. I think, when you look at the volume of claims that are processed--it literally is in the millions--and so, and again, I'll go back to...it's no secret to anyone here in this room, as I've had the privilege of meeting with a lot of the folks now behind me, that I come out of the provider world, out of the hospital world. And so I understand the pinch that you can feel when you have...maybe it's just 25 claims. That may seem like a very large and significant issue that you're trying to push through, and that's...I appreciate that. So when you look at it in context of 25 claims juxtaposed to the millions of claims that are going through, I can understand how one provider may, especially if they're a smaller provider, that may be a significant issue to them. But again you know, Senator, I want to reiterate and I think I've had the opportunity to just say it, I know, to you and to Senator Riepe and some of your other peers, I want to create an infrastructure and a door policy that says: bring me those issues. If I don't know about them, and I don't know about them in specifics, then I can't address them in specificity. And I think, to your point of the anecdotal, it just...it's we don't like this methodology. That, I think, nationally, if anything, came out of that experience that I had with my peers, is that the quality train and the focus on the patient experience and the focus on delivering better care at a reasonable cost, that's national now. And so what I want to make sure of is, in our processes, if we do have these outlier events with any provider, that may be significant to them; I get that. I want to make sure that they know that they can call me anytime, and that we will work their concerns into our issues chart and we will address it very quickly.

SENATOR WILLIAMS: Well, I appreciate your willingness to have that policy because I think that brings us to a resolution stage rather than just further talking about and analyzing the

problem, which is where we're trying to go. Do you know if, through either information that you have or that any of the separate MCOs would have, if we would go back and look at an individual provider and see what their--I'll use the term "accounts receivable"--but what their reimbursement from Medicaid only would be,...

MATTHEW VAN PATTON: Um-hum.

SENATOR WILLIAMS: ...back when we initiated the Heritage Health process, and what that dollar amount would be today, is that a similar amount or has that amount grown?

MATTHEW VAN PATTON: Ooh. Senator, I don't know that I'm equipped to answer that question with specificity here. It would have to be something that we would have to really begin to get into the data and look at and, of course, (inaudible).

SENATOR WILLIAMS: Is that information that could be received, or you would have knowledge of, or the MCOs would? Or is that something that would just be so provider-specific that it would have to be the individual? I'm asking that question because I am hearing, from providers in my area, that the amount of the total dollars that are sitting out there, that they're waiting for resolution on, is higher today than it was when we started this process.

MATTHEW VAN PATTON: I'm thinking through...you know, every provider in the marketplace is functioning differently because they're carrying...number one, they're geographically different, so their patient populations are different and their payer mix is different, and that could attribute to their financial performance, not just across Medicaid, but all of their...

SENATOR WILLIAMS: Yeah.

MICHAEL VAN PATTON: ...commercialized payers, so there are, I think, a lot of, in terms of individual facility performance, that would have to be considered at that level. But in terms of just Medicaid, I'll have to go back, Senator, and get with my folks in finance to figure out how we could look at that and get back with you, if you'd permit that for me.

SENATOR WILLIAMS: And that would be fine because I think that's an important piece to me, because that's the business model piece that everybody on the provider side is trying to deal with. The...you know we certainly have the issues of providing high quality care to their patients and all of that, which is primary. But if they don't have a business model that allows them to be profitable, they won't be able to do number one, long-term. And I continue to hear some of that. So I would appreciate some additional conversations on that. Thank you, Director.

MATTHEW VAN PATTON: Yes, sir. Thank you, too.

SENATOR RIEPE: Going to the point that Senator Williams makes is, it seems like we have a wide spread, in terms of the providers between...you and I come from a hospital background, which affords us probably an easier or a greater cash flow, so that we can get over some of the bigger, more difficult bumps. Plus I think some of the providers end up with a very challenging payer mix that, if you have...I talked with a nursing home yesterday. It happened to be a nursing home, not a provider here but, you know, they're at about 30 percent Medicaid. I know some of our homes in the state are, and maybe even, I know some of the clinics at Children's are upwards to 75 percent Medicaid. That's a tough model.

MATTHEW VAN PATTON: Um-hum.

SENATOR RIEPE: That's a very tough model.

MATTHEW VAN PATTON: It is.

SENATOR RIEPE: The second one that I had is, a question was, we talked about a new director for information technology. Will there be upgrades in software or hardware or everything else that's on the heels of that? Or is that happening at this time so that we get more diagnostic tools, if you will, that we can share and all work together to say yes, we do have a real problem, or we think we can make these changes to resolve some of the existing problems?

MATTHEW VAN PATTON: So if we go back to MMIS, and probably within the first month and a half, my focus on assessment was: Where are we, with our capabilities and our tools and our

toolboxes, to function, to continue to build out this evaluative process that we've outlined for you here today? So when the new deputy comes in, I've already listed out three key elements that that individual is going to have to focus on. The first one is the completion of the EES, the enrollment eligibility platform, phase two. We need to get that product moved out and get it deployed within the marketplace, but we have to do it in a methodology that we are anticipating our staff integration and also how we begin to wean ourself off of our existing system. So that's priority one for that individual. Second is the ongoing deployment of the DMA tool and the picking up of the continued design-build phase, which we've already started, and getting that into the marketplace on that June 2019 deadline; and we're pushing for that very, very hard. The third piece that that individual will be focused on is creating a sunset plan for the MMIS system. And so how do we begin to look at what is remaining in that, in terms of encounter data and in terms of the claim brokerage system which is there? Currently if you take the MMIS system as it is today and as it is functioning, we're still processing about 1.5 million fee-for-service claims over some very limited populations within that enterprise, and the annual cost of just maintaining that IT infrastructure of the age system is about $4 million a year. So if you break that down, in terms of the actual cost of processing those claims that are written in that system, it's about $2.65 per claim, and I think any of these MCOs would tell you and agree with me, that is significantly high in terms of a cost-per-claims transaction. So we know, just from a cost management standpoint, that sustainability of that program and its lack of interoperability with other systems, it has to come off. So we are looking at the number of claims, again, that are in there and where they are, within certain populations, still processing through that, so building that strategy for weaning us off of MMIS also has to coincide with the strategy for what we do and how we manage their forensic populations that are still in that old system. And we're working on creating that plan and that, again, would be an important priority for the new deputy director coming in. At the same time that will have to cross over into some operational and management strategies for the (inaudible) relations.

SENATOR RIEPE: Do we have the funds earmarked for that?

MATTHEW VAN PATTON: We'll be planning for that. Yes, sir.

SENATOR RIEPE: Okay. The other one...I have a keen interest in some what I call administrative diagnostic tools. I have found, over the years, I like the kind of a month-after-month, which gives you a trend, and a month-over-month gives you your growth or shrinkage...kind of two ways to look at these things. And I know that we have three months in here, but I kind of look at it and say okay, the further we go out, the better trend marks (inaudible) on every issue. Are we trending in the right direction, or are we just more of the same? And I think that that's always frustrating; we all want to move forward in a positive way.

MATTHEW VAN PATTON: Yes, sir.

SENATOR RIEPE: So that's something we can talk on...off-line, in terms of there's a million ways to slice and dice these things.

MATTHEW VAN PATTON: Yes, sir.

SENATOR RIEPE: But information is absolutely essential.

MATTHEW VAN PATTON: Well I think, too, Senator, in the universe of data, we can drown in data.

SENATOR RIEPE: Yes.

MATTHEW VAN PATTON: I think the dashboard that's there that we provided to you, that's the baseline; that's where we start. Where do we begin to say this is basic performance and quality improvement baseline? This is where we start; this is what makes sense, in terms of how we assess where we are in the marketplace at this time and show that we're normalizing. I did take that dashboard, by the way, and shared it with a couple of my peers at the NAMD conference, and they all quickly asked for the PDF files: Well, let me see how you're doing that; I'd like to have that tracking. And again, I think that goes to that objective of sharing the knowledge that we have here. I also realize that there's a thirst for what other Medicaid programs are doing and how we're doing it and how we're improving our ability to monitor and assess. And so I was able to share that with a couple of peers, and that, you know, was a good experience to profile

something that we're doing that I think is a very strong direction to your point of how we begin to measure and assess. I think there are some other tools, in terms of the ability to do statistical analysis of very large data sets that my team will probably need, and we're looking at that and building those tools into our budget. So I do think we are, on that point, headed in the right direction. But I want to go back to the benefit of what we're moving towards with health management, and why I say it is coordinated and it's collaborative because, again, you can take the data and you can go into 100,000 different directions. But how do we begin to, among our stakeholder ecosystem, and that being providers, that being beneficiaries, that being the MCOs and taxpayers, all to look at what our capabilities are and our future directions and say this makes the most sense for moving in the next direction, the next directive step, because this is what we see being most relevant? And that's the objective, really, is that infrastructure to create an intelligence mechanism by which we can assess, and then a mechanism for facilitating those broader conversations for collaboration and, frankly, through the marketplace innovations.

SENATOR RIEPE: I like your point in the sense of saying we can drown with too much information. I'm reminded of Mark Twain, who said, you know, a man who drowned in a river that averaged two foot in depth, so it's a matter of trying to stay focused on the critically important things and not just get overwhelmed by mounds and mounds of information and mounds and mounds of work that never get read to get put in a file someplace and that's it. Senator Kolterman.

SENATOR KOLTERMAN: Thank you, Senator Riepe. Matthew, I appreciate all the work that you're doing on this. From day one since we started this, I've had some serious concerns about stakeholder involvement, and when we're talking about that, I go to pages 13, 14, and 15, and look at your Community Connections. And we're talking about provider interactions, member outreach events, and stakeholder meetings. And as I look at the three different MCOs that are working here, it becomes very evident that we're doing a great job along the I-80 corridor, we're doing a great job in the eastern part of the state. But when we start getting in...other than UnitedHealthcare, I've got to give them credit there; they've done a lot of provider interaction. But I think, again, that goes back to the fact that they've been here the longest.

MATTHEW VAN PATTON: Um-hum.

SENATOR KOLTERMAN: But I look at Heritage Health and I look at WellCare, and you get up into Cherry County and Sioux County and Valley...I mean, they're not...those people aren't being serviced, it looks like to me. And that's probably been my biggest concern from day one. Are our networks in place to take care of the people that are in the system? And along with that, I guess I have one question: Are we all...are we still equal in how many patients each provider takes care of? And if that's the case, it looks to me like several of our MCOs are not doing a very good job of reaching out to the rural population; and they deserve to be treated just like the people in eastern Nebraska. So could you address that for me?

MATTHEW VAN PATTON: I'm happy to, Senator, and I have to tell you, I had one point of reticence in putting these maps into this report for you today, and it's because it's not emblematic of what's happened from January until now. And I think, if you were to see these maps with the current efforts of the three MCOs, you'd find that their efforts are much more diverse, and the saturation has really reached every corner of the state. And I'm happy to ask them to update it and provide that to you so you can see it. You also want to know, again, one of the measurements in those biweekly meetings, for me, is we talk about where they're going and what they're doing. And so we keep a comprehensive log of every point of engagement that the MCO has with the provider and with the stakeholder community. And so those logs are available, and we'll be happy to share those with you, and so you can see exactly where they were, what they did when they were there, and what their intent was when they went there. And I think that's a very valuable mechanism for me, again, to keep tabs on that effort to make sure that we are reaching every corner of the state. And I agree with you, we can't just focus on our population centers, because we have Nebraskans in every corner. So how are we reaching them? And so I think, if you see that list and comprehensive total, I think that that will help go a long way in "alleving" (sic--alleviating) some of your concerns.

SENATOR RIEPE: For those of you in the room who don't know, Senator Kolterman is a huge champion of telemedicine, and I thought he was going to a shameless promotion of telemedicine to reach out, but...

SENATOR KOLTERMAN: Well, but I do have one additional comment.

SENATOR RIEPE: Please have at it.

SENATOR KOLTERMAN: And I tell my colleagues this all the time. The state line doesn't end at the Lancaster County line (laughter).

MATTHEW VAN PATTON: Well, that's a good thing. I don't know enough about where that line is, at this point in my juncture, so I just see all of Nebraska, Senator.

SENATOR KOLTERMAN: Thank you.

MATTHEW VAN PATTON: Well, you had one other question in there, which was: Is the patient distribution mix or the beneficiary mix, even across the three MCOs? And yes, it currently is.

SENATOR KOLTERMAN: And along those same lines, do you evaluate the claims load of individual MCOs amongst that spread? In other words, is one organization getting adverse selection against another because of certain types of illnesses that they might have and, if so, how do you address that? So in other words, let's say that one organization has a whole bunch of heart transplant potentials...

MATTHEW VAN PATTON: Right.

SENATOR KOLTERMAN: ...or cancer. Is that just the luck of the draw, or do you try to equalize that in some way? Because a business model has to take a look at that and, finally, somebody might say: We can't do it in Nebraska; we're going to pull out. And then we got additional problems.

MATTHEW VAN PATTON: Right.

SENATOR KOLTERMAN: So how do you deal with that?

MATTHEW VAN PATTON: Well, there are different patient populations served by each. And within a capitated, risk-based model, you know, to some degree there's...early assigned

populations were just part of that mix, and so ongoing, there is a random assignment, as new beneficiaries come into the population. I think there are some issues that exist out there with certain populations, that are very costly and very difficult to manage. And so we have been informed that there are certain populations that are becoming a bit of a burden for at least one of our MCOs right now. And so we're working directly with that MCO on some strategies that could help address that issue for them ongoing. But in terms of an exact answer to that situation, I don't have it at this point, but there is an awareness; we do track and we do monitor that.

SENATOR KOLTERMAN: Okay, thank you.

SENATOR RIEPE: Senator Linehan, please.

SENATOR LINEHAN: Just one, and I don't expect you to have...thank you very much, Mr. Chairman. I don't expect you to have this answer, but--at your fingertips--but when you go to page 7 and the percentage of claims denied, is there a way that you could provide the committee with the percentage of claims...let me, I'm...back up a second. I've been...it's been brought to my attention that there is a feeling that behavioral health, mental health claims get denied at a higher rate than physical health. Is there a way you could provide, for the committee, the breakdown of behavioral health, mental health claims denied versus physical health, because I assume this is all of them together, right?

MATTHEW VAN PATTON: Yes, ma'am. And we can do that; we'd be happy to do that (inaudible).

SENATOR LINEHAN: Okay. I just think it would be helpful because sometimes perceptions are not reality, and sometimes they are. So I would appreciate having those numbers.

MATTHEW VAN PATTON: Yes, ma'am, very happy to do that for you.

SENATOR LINEHAN: Thank you.

SENATOR CRAWFORD: That's a very good question.

SENATOR RIEPE: Senator Crawford, please.

SENATOR CRAWFORD: Thank you, Chairman Riepe. And that's...I think it's a great analysis, so I hope you'll share it with the entire committee.

MATTHEW VAN PATTON: Yes, ma'am.

SENATOR CRAWFORD: Excellent, thank you. So again, I appreciate the emphasis on data and the analytics and trying to make sure we're being intentional about the values and behind that. So I just want to say that they...it's important that we know whether those numbers are real or meaningful, because we can get distracted, or have a very, you know, wrong picture if they're not. And when you're thinking about the...as Medicaid you have a lot of data but, maybe even your Tdap example shows you that there are vaccinations that happen that don't show up in your claims data.

MATTHEW VAN PATTON: Right, right.

SENATOR CRAWFORD: And then in part because also Medicaid patients churn in and out of Medicaid, whether they got their immunizations or wellness check, you might not know that just from Medicaid claims data.

MATTHEW VAN PATTON: That's correct.

SENATOR CRAWFORD: So that, then, suggests part of this thinking of data and collaboration has to be thinking how to check or supplement Medicaid data with other data on that churn. And then I'm assuming that that's...now, so that's one picture of if we're just expecting MCOs to manage care. Now my understanding is that we're...well, that's kind of the base. We're trying to push to more value-based contracts, and a value-based contract would be asking the providers to manage the care so that they would be knowing...they would know more about the patient even as they might have churned in and out of Medicaid, the patient might have stayed with them.

MATTHEW VAN PATTON: Um-hum.

SENATOR CRAWFORD: I mean they still have data holes, too, but so, like I said, I think by year three, we're supposed to have 30 percent in value-based care. By year five, we're supposed to have 50 percent in value-based care. So it looks like we're kind of...we would be shifting, over time, to a data system where the providers would be doing more of the management.

MATTHEW VAN PATTON: Um-hum.

SENATOR CRAWFORD: And so, and that's...I'm...that's a big picture as we're moving forward, thinking how are we setting up all these systems with that recognition that we're hopefully moving in that direction of the provider doing more of the managing. And so I guess my question is, is whether that's part of that...whether that is the vision, that we're moving in that direction. And the second thing is to make sure that you are aware of a very successful, patient-centered medical home provider group...

MATTHEW VAN PATTON: Um-hum.

SENATOR CRAWFORD: ...that we've had in our state actually was focused on primary care management, and we had all payers at the table and the providers at the table, agreeing on a small set of measures, so that they could altogether work on improving care and really focus on having the providers helping to shape those measures and, again, the providers gathering the data and being a part of that data discussion so that...with the recognition that really the...I think what we know from most of the research is when the ACO, or the patient-centered medical home is managing the care, you're going to get the best, high-quality managed care, and when it's an insurance company managing care, maybe a little more like that old HMO system, right? So I guess I'd just ask for your comments, in terms of moving toward value-based and, on top of that, maybe if we have any sense of progress on that front, where we are moving in that, and how that fits with your data picture.

MATTHEW VAN PATTON: Well, I think each of these MCO's CEOs will tell you that the effort to facilitate greater collaboration and coordination is a priority for me, and that's...and really, it's an underpinning of the health management program as it's been articulated in this report to you.

Coming out of the provider world, I know the benefit of what you can do with patient education...

SENATOR CRAWFORD: Um-hum.

MATTHEW VAN PATTON: ...and performance at the point of care. And so pushing those strategies that do put more care management in collaboration with the MCOs, in that venue, is part of our ongoing strategic vision. Now you also got into what I would consider broader marketplace issues. Some things that I can use are our abilities at MLTC to begin to align, some things are...frankly, they will be beyond my control, in terms of the broader market. I can continue to talk about them...

SENATOR CRAWFORD: Right.

MATTHEW VAN PATTON: ...and educate and hope for better alignment, but I'll go to NeHII, for example, which is the health exchange. So when you're looking at those, when you're looking at data and the availability of data in the marketplace, I have my data wells at MLTC. NeHII has its data wells. It's the overlay of those data wells that that data becomes richer and deeper, and the ability to use it more constructively is enhanced for the betterment of the program. So that engagement with NeHII has been a very top priority for me, and I think, going to greater care management, going to greater and more informed decisions, you know, building an enterprise that pulls that data in., In the broader marketplace, I think I've spoken to the Hospital Association and I've spoken to NeHII about this. And so I think currently, the last statistic that was reported to me, about 68 percent of our hospitals were participating in NeHII, and only eight of our post-acute skilled nursing facilities were in NeHII. So there's a disparity in the marketplace, and it's in that space that I think we need to begin to have dialogues around how we work and where we work, those admissions, discharge, and transfer data is all in NeHII; it's there. And I think, if we can get that, that helps us give greater care coordination, long-term, as we do, again, manage the patient as they float up and down the continuum of care. And I think, Senator, you did ask me about the continuum of care and its various components during my confirmation hearing.

SENATOR CRAWFORD: Hmm.

MATTHEW VAN PATTON: And so included in the appendix is also an image that...

SENATOR CRAWFORD: Good.

MATTHEW VAN PATTON: ...defines the continuum of care as I have discovered it to be here within the state of Nebraska.

SENATOR CRAWFORD: So could you give us an update on the percent of value-based contracts that you think you're at now?

MATTHEW VAN PATTON: Off the top of my head, no.

SENATOR CRAWFORD: No, okay.

MATTHEW VAN PATTON: But I can go back and...

SENATOR CRAWFORD: If you could get that, I'd appreciate that.

MATTHEW VAN PATTON: ...get that and get you a report.

SENATOR CRAWFORD: So I appreciate the...where we are in terms of value-based contracts now, and the location of those,...

MATTHEW VAN PATTON: Um-hum.

SENATOR CRAWFORD: ...so whether or not they're all in Douglas and Lancaster County or not. And then a final data question...I think we've talked earlier about the plans for a beneficiary survey, and maybe the chair alluded to that, too. We have some results from back in March, I think, on the provider surveys, and the MCOs do the provider surveys. But I think we were supposed to be getting beneficiary surveys at some point. Has that...is there a time line for that?

MATTHEW VAN PATTON: We do member surveys, but I'm not sure when they're in cycle to come back to you. I'll find out, and we'll report.

SENATOR CRAWFORD: Okay. And is that done by the MCOs or by you?

MATTHEW VAN PATTON: It is conducted, as I...you know what, I believe...

SENATOR CRAWFORD: Okay.

MATTHEW VAN PATTON: I'm going to just say I believe process is that it goes through MCOs, but it is defined, so there are...

SENATOR CRAWFORD: Okay.

MATTHEW VAN PATTON: ...data sets that are measured to, that are specific, defined, and equal across all three. But we can follow up on the specifics of that.

SENATOR CRAWFORD: I would appreciate that. Thank you, thank you.

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

SENATOR LINEHAN: Thank you, Mr. Chairman. You just said something; I want to make sure I heard it right. On NeHII, 68 percent of the hospitals are participating, but only 8 percent of the nursing homes?

MATTHEW VAN PATTON: Not 8 percent, just eight facilities were currently enrolled as participant in NeHII.

SENATOR LINEHAN: Is that because...well, no. I won't ask the question that way.

MATTHEW VAN PATTON: I can tell you why (laughter).

SENATOR LINEHAN: Yeah, why is that?

MATTHEW VAN PATTON: So when you look, when you look at the entirety of the continuum of care, and I'll just go back into, and contextualize, this across my 20 years in healthcare. When I started, Senator Linehan, in a hospital in the mid-'90s, we were paper charting. There was no such thing a an EMR or a computerized physician order entry. Those things were conceptually out there, but not broadly implemented in the marketplace. So you saw, I would say, from the late '90s up until now, a mass movement towards building informatics infrastructure within the marketplace, primarily along the lines of data collections. We're just now entering the phase of understanding the power of that data and how we can begin to effectively use it, hence our juncture here with creating a health management program and pulling those data sets. So if you look, and you look at what was incentivized in the marketplace, through our federal partners, to build informatics infrastructure, it was primarily focused on the acute-care side of the equation. So you have, in large part throughout most of the market, built large and productive informatics systems. On the post acute-care side, there haven't been those incentives there, nor do those providers have the same, frankly, budgetary capabilities of building very large informatics systems. So in some cases, you may have, you know, larger providers who work in a market, who have implemented EMRs within their enterprises, and then you may have some who are two and three facilities, that may not have an EMR; they may still be paper charting. So there is...there's still broader disparities in the marketplace, in terms of informatics systems capabilities, and that's something I think that, in the years to come, you'll see greater focus on building the informatics capabilities of the post acute-care environment as it increasingly becomes more important in the delivery of care and the discharge of patients out of the acute-care environment into lesser-cost environments where you still get a certain community of care, as needed.

SENATOR LINEHAN: A followup question...so what is the percentage of, or maybe they all go through the hospitals, but what about providers like physicians or other healthcare providers? Are they part of NeHII?

MATTHEW VAN PATTON: Some are. I believe that it depends, so it depends on how the facility is contracted. So some physicians may be employed by their hospital and, if they are, then they have access to their EMR and whatever they are contractually held to.

SENATOR LINEHAN: But if they're probably independent, they probably don't.

MATTHEW VAN PATTON: Probably not, but there are some. As I understand it, and I will follow up with clarity on this, there are ways that providers can access (inaudible) data. It's (inaudible) being physicians.

SENATOR LINEHAN: Okay.

MATTHEW VAN PATTON: But Dr. White maybe can follow up with you, after this, to address that, because she's on their board, and she's also been engaged in that part of the conversation.

SENATOR LINEHAN: Okay. Thank you very much.

MATTHEW VAN PATTON: Yes, ma'am.

SENATOR RIEPE: Okay. I had a doctor friend who told me...one time he said that doctors...don't let the...don't let doctors do it EMR. You know it's like driving and drinking; don't do it. Just...that was kind of an initial pushback. And I think we're still at a stage of trying to resolve and sophisticate--integrate--connect all this information technology that we have in front of us.

MATTHEW VAN PATTON: Yeah.

SENATOR RIEPE: Senator Kolterman had a question over here.

SENATOR KOLTERMAN: It's already been answered; thank you.

SENATOR RIEPE: Oh, okay. Are...Senator Williams?

SENATOR WILLIAMS: Thank you, Chairman Riepe. And just one comment back to the concept of resolution and moving that direction, I would like to applaud the willingness of the three MCOs to react quickly in situations that we've had. I received a call on a Friday afternoon last spring, about 4:30 in the afternoon, from a medical service provider in my district. I initiated immediately three calls, one to each of the MCOs, to a contact person. Each one of those MCOs, one of the top people that's sitting in one of these front-row seats right now, called me directly, and by the following Monday everything was resolved with the three MCOs. So I was really pleased with how willing they were to accept the challenge of doing those kind of things quickly.

MATTHEW VAN PATTON: Thank you for that.

SENATOR RIEPE: Okay. Do we have further questions from the committee? Seeing none, we're going to move to the open hearing. How many here--I know there's going to more than two--intend to testify, a show of hands? Okay, thank you very much. Thank you, Director Van Patton.

MATTHEW VAN PATTON: Thank you, sir.

SENATOR RIEPE: We will now move into the hearing of...we are going to...we do have some time in the interest there, I want to limit the clock to, not the three minutes, but I want to try for the five minutes, so that we don't feel like we're trying to cut people off. I would ask you to, and there aren't seats at the front but, as you get ready, if you will, to try to help us continue to move through the hearing. And we don't have any particular order, in terms of the subject matter, so we're just going to open this up, and one of you who would like to testify, please step forward. What you're saying here is that we do have forms that will need to be filled out, or have filled out, you know, for the transcripts. And also if you have any handouts, we'll need, I think, probably ten copies of that to be able to hand out for the committee members. So with that, if you'd be kind enough to introduce yourself, spell your name, and then proceed on, please.

MELANIE STANDIFER: (Exhibit 1) Good morning, Senators. My name is Melanie Standifer, M-e-l-a-n-i-e S-t-a-n-d-i-f-e-r. I'm the revenue manager for CenterPointe, a behavioral health provider that operates both here in Lincoln and in Omaha. I appreciate the opportunity to share with you our ongoing experience with the Heritage Health implementation. Today actually

marks the third time that I've had the pleasure to share not only our experience but a number of other behavioral health providers that could not be here today. It has been 541 days since Heritage Health was implemented on January 1, 2017. During that time, you're obviously quite aware, the provider community experienced a great number of challenges and successes. I'm happy to report that payments are not delayed to the extent that they were this time last year. However, I still believe we're at the benchmark that both the Division of Medicaid and Long-Term Care and this committee would be satisfied with. The ongoing challenges faced by both Medicaid recipients and the provider community are still at an unacceptable level. One of the main concerns that providers face is false claim denials. This is an issue that occurs across all three plans. These are denials of payment for services that were rendered and billed appropriately but were denied incorrectly. Of all the claim denials CenterPointe receives, nearly 70 percent are for invalid reasons. The top denial is "no authorization." In the vast majority of these denials, not only did we obtain prior authorization, but we include the authorization number on the claim when it is billed. The second leading denial is related to credentialing. Despite the fact that we initiated contracting with all three plans nearly two years ago, we still experience problems with claims payment due to the plans not recognizing our network participation status--again, an issue shared by all three plans. The process to rectify these denials is relatively straightforward. You simply contact each plan's customer service, provide the necessary information, and in an additional 10 to 20 business days they will reprocess the claim. However, each one of these calls averages approximately 20 minutes. Currently, just CenterPointe has approximately 150 denials of this nature. It would require 50 hours for me to resolve these denials that way. While I can work through our designated provider representatives to resolve these issues, there is still an unacceptable amount of administrative burden put on providers to simply get reimbursed for the services we have provided and correctly billed. You can see on the attachment that I've provided with my testimony an example of one. This is one individual claim that was rendered back in February of last year, and you can see the number of times that the claim was paid, taken back, repaid, taken back again, just to show/demonstrate the administrative burden that it has taken for us to receive payment on a $38 claim of which $17.42 is still outstanding. Obviously, we are quite in the hole on this claim at that rate. In addition to the administrative strain that these denials place on our organization, there's another side of the issue that I'd like to bring to light today. Today I have a stack of papers and because, obviously, there's HIPAA information in here I didn't include this in my attachment. But this stack right

here is false denials that we've received from one plan, WellCare, in the past 90 days. While this stack represents a significant amount of my time to follow up, it also represents a burden to Medicaid recipients. For nearly every denial and rejection that the provider receives, the Medicaid recipient also receives notice of this denial. CenterPointe specializes in treating Medicaid recipients with severe and persistent mental illness. Receiving these types of notifications create undue stress and concern to our consumers who are already struggling with mental health issues. Once the denial is resolved with the managed care plan, there is no follow-up communication to the provide...to the member notifying them that the issue has been resolved. Again, the burden falls on the provider to communicate that resolution to them. I know that this committee and the Division of Medicaid are invested in the success of the Heritage Health plan. I will say I feel a particular invested interest as I was a member of the team of Medicaid and Long-Term Care when we wrote the RFP for Heritage Health. I sat in countless number of meetings in bringing this plan to fruition. And so I am, you know, here not to sound complaining of the issues we've received, but we want this to be a success. And to that end, we strongly encourage the continued oversight and accountability of this program. I thank you for your continued commitment to improving the quality of Medicaid program.

SENATOR RIEPE: Thank you very much. I'd like to look to questions from the committee. Senator Linehan.

SENATOR LINEHAN: Thank you, Mr. Chairman. Thank you very much for being here. I don't know what to call your model. I know you provide services. Many of your patients are Medicaid.

MELANIE STANDIFER: Um-hum.

SENATOR LINEHAN: Do you have a breakdown of how many are Medicaid, private pay, whether it be insurance or...?

MELANIE STANDIFER: Approximately 30 percent of our population are Medicaid recipients. We obviously serve a largely indigent population, so most of them are uninsured. Our smallest population would fall under Medicare and/or the commercial market.

SENATOR LINEHAN: So what is...do you know what that is, the Medicare/commercial market?

MELANIE STANDIFER: I would say--and this is off the top of my head--between 10 to 15 percent.

SENATOR LINEHAN: So then how do you pay for the 40...50 percent that are...?

MELANIE STANDIFER: So the vast majority falls from the Division of Behavioral Health.

SENATOR LINEHAN: So you get additional funding from the Division of Behavioral Health over and above Medicaid?

MELANIE STANDIFER: Correct.

SENATOR LINEHAN: And how do what your services interact with the regions?

MELANIE STANDIFER: And that's the Division of Behavioral Health. It's...the money is funneled through the regions.

SENATOR LINEHAN: Okay. Okay. Thank you very much. Appreciate that.

SENATOR RIEPE: I had a question. Without naming the managed care organization, is it one or all of the managed care organizations that you have a challenge with, with the false claim denials?

MELANIE STANDIFER: All of them experience it to some extent. The vast majority I would say happens with both WellCare and UnitedHealthcare. Again, that's not representative of our consumer mix. If we had a larger population that had WellCare, we might be financially insolvent. However, thankfully, I think partly due to the efforts of this committee, Nebraska Total Care originally was...struggled quite a bit, and because of the performance improvement plans put in place their performance has definitely improved significantly. And they represent the vast majority of our Medicaid recipients.

SENATOR RIEPE: Senator Crawford.

SENATOR CRAWFORD: Thank you, Chairman Riepe. And thank you, Ms. Standifer, for being here, for sharing this information. This is very helpful. And just so I understand where this is happening in the process, these denials...when the director was up here he talked about the difference between a rejection and a denial.

MELANIE STANDIFER: Um-hum.

SENATOR CRAWFORD: So when you're talking about them being not accepted because of "no prior authorization," is that a rejection that happens before it goes through adjudication, or is it through adjudication and this is a denial that you receive that's part of our denial statistics?

MELANIE STANDIFER: The vast majority of them are accepted for adjudication...

SENATOR CRAWFORD: Okay.

MELANIE STANDIFER: ...and then denied.

SENATOR CRAWFORD: Okay. So they're in those denial percentages...

MELANIE STANDIFER: Right.

SENATOR CRAWFORD: ...that we're talking about. Okay. And now you were talking about the percent that are denied for invalid reasons. And I apologize if you told us this and I just missed it. Do you have a sense of the percent for your practice that get denied for these invalid reasons--no, that's not what I meant--of all your claims, the percent that are getting denied?

MELANIE STANDIFER: So obviously the 70 percent mentioned in my testimony is not, certainly not the percentage of claims that are being denied.

SENATOR CRAWFORD: Right. Right, that's (inaudible).

MELANIE STANDIFER: But of the claims that are being denied, 70 percent represent invalid reasons that then later on the MCO rectifies. But again, that adds time to our accounts receivable.

SENATOR CRAWFORD: Absolutely.

MELANIE STANDIFER: It adds administrative burden on us to follow up on those. But I would say, you know, this time last year I probably would have said it felt like 70 percent...

SENATOR CRAWFORD: Right.

MELANIE STANDIFER: ...of our claims were being denied. I would say it's probably under 25 percent.

SENATOR CRAWFORD: Okay.

MELANIE STANDIFER: So it's certainly not, you know, as the Medicaid director mentioned, I realize that in the scope of the claims processed. But 70 percent of an invalid denial rate,...

SENATOR CRAWFORD: Yes.

MELANIE STANDIFER: ...if I had an employee...

SENATOR CRAWFORD: Right.

MELANIE STANDIFER: ...that made 70 percent errors, I'd fire them.

SENATOR CRAWFORD: Yeah. I hear what you're saying. Yeah, absolutely. Thank you.

SENATOR RIEPE: Okay. Thank you. Senator Williams.

SENATOR WILLIAMS: Thank you, Chairman Riepe. And thank you, Ms. Standifer. And you mentioned there, you clearly identified an issue that you are experiencing. What's the solution to that? What's a resolution?

MELANIE STANDIFER: You know, unfortunately, you know this time last year the issues we were experiencing were widespread and very systematic. They're not so this time this year, which absolutely makes it more difficult because there's these pockets of issues that have cropped up and it really makes it more time-consuming to resolve. What may appear as a single claim denial, we take the time to investigate it, start resolution on that, then two days later we get another one and then another one, and that there may end up being five or six claims for that issue. So it's...at this point it's a little more difficult to pinpoint a resolution. I do have standing calls with two of the three MCOs to regularly address issues as they arise. But again, even preparing for those meetings and having those meetings takes away from the work that I really should be doing. That's added this layer of administrative burden just to get resolution on services that we appropriately rendered and then correctly billed. And it doesn't...it isn't just limited to claims payment. You know, it follows even obtaining authorizations.

SENATOR CRAWFORD: Um-hum.

MELANIE STANDIFER: One of our biggest challenges is for members that get retroactive Medicaid eligibility. And I understand that's a little difficult and more challenging for the MCOs to handle, but it's certainly more difficult and challenging as a provider who's rendered services, has likely asked the region for reimbursement, that we then turn around, have to reimburse the region for those funds, obtain a new authorization for a new payer and then rebill those claims. And while we certainly appreciate, you know, trying to judiciously allocate the state's funds, it's, again, another administrative burden that's passed on to providers.

SENATOR WILLIAMS: In looking at that and your business model...and I'm sure you heard the question that I asked Director Van Patton about the outstanding dollar number.

MELANIE STANDIFER: Um-hum.

SENATOR WILLIAMS: In your particular business model and your particular business, what has that dollar amount, the receivable from Medicaid, what has that done over this period of time?

MELANIE STANDIFER: I can say currently, the current receivable is in the ballpark of $300,000, and that's between the three MCOs and straight Medicaid. About $265,000 of that belongs to the MCOs and we do have about $25,000 to $30,000 that is owed by straight Medicaid. Obviously, a significant portion of that is within the 30- to 60-day range. But we do, I would say, and I'm...I ran some reports and it's a...so it's a little bit off the top of my head, but there's still about $20,000 to $30,000 that's still in the 90-day range of issues to be resolved. And you can see on this attachment that I provided, again, this was a service rendered in February of '17. The most recent interaction that I've had was June, so this month, that this claim is still in the adjudication process. So obviously this claim has aged over a year.

SENATOR WILLIAMS: So would that show then in your 90-day number or would that show...

MELANIE STANDIFER: Yes.

SENATOR WILLIAMS: ...because...okay. It still shows in your 90-day number.

MELANIE STANDIFER: Yeah, because now at this point it's...

SENATOR WILLIAMS: Okay. That number then of $300,000, give or take whatever...

MELANIE STANDIFER: Um-hum.

SENATOR WILLIAMS: ...the number is, is that number larger today than it was a few years ago?

MELANIE STANDIFER: Absolutely.

SENATOR WILLIAMS: And again, your testimony, as it has been before, you are spending more administrative time collecting those dollars.

MELANIE STANDIFER: Right.

SENATOR WILLIAMS: Thank you.

SENATOR RIEPE: Okay. Are there any other questions? If not, we'll move forward. Thank you very much for being here. Thank you for your testimony. Thank you for being here. If you'd be kind enough to state your name, spell it for the record, please, and the organization that you represent.

STACY LERNER: (Exhibits 2 and 3) My name is Stacey Lerner, it's S-t-a-c-y L-e-r-n-e-r, and I'm a pediatric physical therapist at Children's Hospital in Omaha. Good morning, Chairman and committee members. Thank you for the opportunity to speak today on behalf of children with special needs. As I said, I am a pediatric physical therapist at Children's Hospital in Omaha and have been a PT for 25 years. Today I would like to speak to you about concerns with the reimbursement rates and denial rates for durable medical equipment for children with a variety of physical, cognitive, and mobility impairments. At Children's, I am one of the primary evaluators of children in need of various types of durable medical equipment, which include walkers, wheelchairs, standers, gait trainers, bath chairs, and car seats. I have extensive experience assessing for and managing equipment for children. The children I see present with a variety of ages, functional ability levels, and diagnoses. At Children's, we strive to always provide the best for our patients while also weighing the wise use of their insurance and financial resources, knowing these resources are not endless and that equipment must not only suit a patient's needs now but also well into the future. I fully accept that the burden of proof of need for durable medical equipment falls on my shoulders as the provider, working directly with the child's family and caregivers and the equipment vendor in order to make the most appropriate and cost-effective decisions. I take this responsibility very seriously, not only as a provider of durable medical equipment but also as a Nebraska resident and taxpayer. The goal of a durable equipment evaluation in all instances is to maximize the child's functional independence and provide for participation in the child's community, in their family, and with their peers, while

balancing the fiscal responsibilities we have as providers toward the child's insurance or insurances. This maximization of functional independence is vital to the health and well-being of children, as it provides endless benefits to their self-esteem and self-image as well as in their ability to be active participants in their world. Participation, engagement, and mobility aren't simply luxuries; rather, they are basic human and civil rights. Disability and medical issues and mobility impairments aren't something that families choose for their children. Rather, they are thrust into a challenging world of medical appointments, therapies, and durable medical equipment, having to learn a new language and often having to set aside their own grief to make decisions about a device they never thought their child would need. I take my role as an evaluator very seriously for all these reasons. With the upcoming changes to the fee schedule beginning on July 1, there will be significant restrictions to the provision of appropriate and necessary mobility and positioning equipment for the children in the state of Nebraska. One example of this would be a child who still requires a supportive car seat for safe transportation in the family vehicle due to complex medical and neurological needs but who no longer fits into a commercially purchasable car seat, such as one that can be bought at Toys R Us or Target. This child will require a car seat that will cost a vendor approximately $900 to purchase. Based on the new fee schedule, the reimbursement rate would only be $150 for that car seat. This will then leave the vendor to be unable to vend that car seat to the child in need, and as a result that child will not safely and properly positioned in a vehicle for transport to and from medical appointments or throughout the community, rendering them essentially homebound. The changes in this fee schedule will simply eliminate our ability to vend appropriate equipment to children in need. I understand that I need to rule out lesser supportive and expensive items for each and every child, but the changes in the fee schedule will cause our vendors to eliminate the provision of equipment as they will not be able to cover the costs of the items being requested. This is unfair, first, to the patient and family but also to the vendor who is trying to cover the costs of the items they are purchasing for their patients, based upon approvals received from you. The costs of durable medical equipment are high, as we all know, but to undercut on the payment then simply ties the hands of all parties involved and many, if not nearly all, of my families do not have the resources to pay out of pocket for these items. The second issue at hand is the ever-changing expectations and inconsistent rulings by reviewers for durable medical equipment over the past 18 months. There's a much higher denial rate, leaving me and many other therapists to spend much more time completing additional paperwork for appeals and denials, despite our

attempts at providing what is being requested on us based on the criterion laid out by the Medicaid program. Recently, I received a call from Nebraska Total Care regarding a patient for whom I was requesting a manual wheelchair. The patient is a six-year-old boy with a diagnosis of achondroplasia, which is a form of dwarfism. He is the size of a two-year-old. The reviewer called, asking why a basic manual wheelchair she found on the Internet for less than $150 would not work for this patient. I explained to the reviewer that this child, due to the diagnosis, required a custom, much lower than normal seat-to-floor height wheelchair so that he could climb in and out of the wheelchair independently--a skill in which he was capable of doing, a transfer he wouldn't be able to do in the less-expensive pediatric transport chair. The wheelchair reviewer...or the reviewer then asked, well, why can't Mom just carry a footstool around so we don't have to buy a more-expensive chair? These are the reasons that I'm asking for your assistance to continue to demand that children be provided services that are appropriate and necessary for them, including the durable medical equipment. Thank you very much.

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

SENATOR WILLIAMS: Thank you, Chairman Riepe. And just a quick question so that I can understand this. You talked about an evaluation process.

STACY LERNER: Um-hum.

SENATOR WILLIAMS: And then you talked about the reimbursement rate itself.

STACY LERNER: Um-hum.

SENATOR WILLIAMS: On the evaluation process, you're struggling with that one, too, with some of your situations. But is the real problem the reimbursement rate itself?

STACY LERNER: Yes. So I work...I...

SENATOR WILLIAMS: And who sets the reimbursement rate itself?

STACY LERNER: My understanding is that Medicaid has standard...let me back up. I work for Children's. I evaluate patients for equipment with the family, the child, and a durable medical equipment vendor. We do that at Children's Hospital. My time for that evaluation is billed through our electronic medical record to their insurance, whether...whatever it may be, and my time is typically reimbursed for that evaluation process. After that evaluation occurs, my vendor then gives me a quote for all of the items necessary for the item of equipment we're requesting, and I am responsible for writing the letter of medical necessity that would then go on to the insurance company for approval. We then get an approval...we get one of three responses from the insurance company. We get an approval. If that's the case, then that equipment gets ordered and we deliver that equipment. We get a "maybe, we have more questions." Those come to me. We get a denial. We are at Children's, for example, as a therapist, I am not the one billing the insurance company for the equipment. That is on the vendor's side. I am the one who's...

SENATOR WILLIAMS: Right.

STACY LERNER: ...kind of the medical side of things. But my understanding of how the reimbursement...and I know there's...one of my vendors is here today so hopefully they can speak on this better than I can. But my understanding is that there's a set fee schedule. And our understanding is that as of July 1 that fee schedule is changing dramatically that's going to make the ability to vend equipment to children nearly impossible because they're not even going to cover the costs of the items that are being requested. So that's the real issue here. The example I gave on the car seat, that is the dollar amount that our...and you can't vend a $900 car seat and expect to be reimbursed $150 and do that.

SENATOR WILLIAMS: But whoever is setting that $150, it's not the MCO that's setting that number.

STACY LERNER: My understanding is it's the state Medicaid program.

SENATOR WILLIAMS: That's what I wanted to hear.

SENATOR CRAWFORD: Yeah.

STACY LERNER: That's my understanding.

SENATOR WILLIAMS: Thank you.

STACY LERNER: Yeah.

SENATOR RIEPE: I have a general question...

STACY LERNER: Yeah.

SENATOR RIEPE: ...and that is, is there any repurposing of any of the durable medical equipment that particularly with children they outgrow it hopefully?

STACY LERNER: So there is. What we try to do when we're evaluating perhaps an 18-month-old for a mobility device, we know that 18-month-old is not going to stay the same size at 5 that they are at that time. We are able to build in growth into equipment. Let's say they're nine inches wide. We'll build in perhaps up to 13 inches wide but then we'll customize the seating to make it more narrow for them. But then over time we get greater growth out of that chair and we get a maximized number of years to use that chair. What typically happens, at least at Children's, is when a child, for example, I did a delivery yesterday to a teenager. Her old chair she no longer needs. Her family wanted to donate it back to another family. So what we try to do is either within our Children's family, our Children's therapy families, we try to either redeliver that chair to someone else who's struggling to get a chair through insurance or doesn't have insurance. But there's also, for example, in Omaha a physical therapist who has kind of a closet, and I believe there is also one here in Lincoln, where she keeps equipment. And she works in the school system. So as kids need things, she brings it out and then repurposes it that way. So there are attempts to do that. Certainly, you know, one chair built for one child may not exactly fit the next. But we try to work with our vendors and other therapists to do those things.

SENATOR RIEPE: Um-hum. Okay. Thank you. Are there additional questions? Seeing none,...

STACY LERNER: Thank you.

SENATOR RIEPE: ...thank you very much for being with us. Good morning, Doctor. If you would state your name, spell it for the record, and tell us who you're with now.

BOB RAUNER: All right. My name is Bob, B-o-b, Rauner, R-a-u-n-e-r. I'm chief medical officer, OneHealth Nebraska. We're one of the ACOs that has patients centered in Lincoln and Grand island. And so...appreciate the testimony today. I just want to add a few caveats. I'll try to keep it pretty brief. One is that if I had one request it would be that the MCOs have value-based purchasing contracts outside of Omaha by January. I've been working across the state with my current job and my prior job with SERPA-ACO back five years. Medicare has had value-based purchasing for more than five years, Blue Cross more than three. Both of the prior outstate medical Medicaid MCOs, Aetna and Arbor, had in place value-based contracts three and four years ago. And those of us outside of Omaha have still been waiting, and so we would like to put some pressure there. Right now I've been trying to meet with them on multiple times. Only one MCO do we have anything actively even talking about a potential contract. And so I think they put all their time in Omaha essentially and kind of stop working there and fixing their other issues. But those of us trying to do this outside of Omaha, it's hard to sustain these programs for half of your provide...half your patients with nothing for the other half. And if there's only so much longer that we can do this before eventually we're just going to have to start dropping out various Medicaid MCOs, UnitedHealthcare, if they're not going to work with the rest of the state. We know they've got contracts like this in Missouri, for example. I know UnitedHealthcare has things like this. So it's not that they can't. I think it's a question of will. Second thing I'd like to mention, just to take some of the data with skepticism. I think CenterPointe just mentioned there's that clean claim payment rate can be gamed a little few ways by what are...what is an actual denial versus a real denial, and I think she had a good example of that. Another example where things get messed up or delayed, credentialing of a provider. And so I can't submit a bill if the MCO doesn't recognize that I exist. And so if you have a new person, say, moves out to Gothenburg that's a new resident graduated and he's starting July 1 and he can't get credentialed for six months, they can't bill for Medicaid for six months. And so we had a lot of problems this last year with delays in credentialing. With delegated credentialing, you can have these things turned around in 10 to 14 days, and so some of the MCOs have very long times to recognize that you actually exist, even though you've worked your whole career and gone to the University of Nebraska and everything. The third thing I'd say is if we could look to the value-based

purchasing programs that are already out there and been out for, you know, five, six years now. Medicare, Blue Cross Blue Shield, they've got broad measures, everything from customer satisfaction, which is what we...the Medicaid director talked about with the Triple Aim utilization. Both of our Medicare and Blue Cross judge us on hospitalization rates, ER rates, things like, you know, how many heart care patients end up in the hospital, and then broad-based population things like percentage of patients who are screened for cancer, vaccination rates, diabetics under control, blood pressure under control. These are all out there. They've been existing. We shouldn't have to reinvent the wheel. We had this in place, like some of you mentioned, three years ago with the prior MCOs and so let's get there. We could get there already. It's already out there. Last thing I'd say is if you're going to have...do beneficiary surveys, the MCOs should not be doing the beneficiary surveys. Should be an independent third party. So when Medicare does out patient satisfaction survey, we have to contract with an independent third party that's certified so they're getting accurate results and we can't, you know, internally game the numbers. We use EuroPulse CSS, so they actually do a random sample. It's very valid. And so if somebody is going to be surveying the beneficiaries, it shouldn't be the MCO. It should be some independent third party to make sure it's accurate. And with that, I'll stop and answer any questions you might have.

SENATOR RIEPE: Thank you very much. You talked about the satisfaction survey. In that process, is that a paper process or a telephone process?

BOB RAUNER: With Medicare it's both. They'll do both paper and follow-up phone surveys, and they can even opt for multiple languages if you want to.

SENATOR RIEPE: Okay.

BOB RAUNER: So they're both done both ways.

SENATOR RIEPE: My sense is with paper, people that are happy just kind of, I'm too busy, and put it aside.

BOB RAUNER: Um-hum.

SENATOR RIEPE: People that are unhappy certainly will respond...

BOB RAUNER: Yeah.

SENATOR RIEPE: ...in an angry mode. People on the telephone will usually respond,...

BOB RAUNER: Yeah.

SENATOR RIEPE: ...personal experience. Also, on credentialing, historically over the years, and it's been a while since I've been in the hospital business, but Medicaid was the quickest to respond. Has that changed?

BOB RAUNER: Well, I think in the past maybe they wanted people to take care of their patients.

SENATOR RIEPE: Oh, absolutely.

BOB RAUNER: I can speculate on various reasons why. I mean unfortunately, as an insurance company, you pay them. The longer it takes them to pay us, that's money they're making on the float so sometimes the incentive may not be there. It could be just new systems. I think a lot of it was, frankly, they had new systems they couldn't fix. And we had one MCO in particular that was six months, nine months to get people recognized. And so...

SENATOR RIEPE: Have you been in practice long enough to see both sides of this? And did you see it when it was fairly quick because,...

BOB RAUNER: Um-hum.

SENATOR RIEPE: ...as you said, we were eager to get somebody, they were eager to get somebody.

BOB RAUNER: Yeah.

SENATOR RIEPE: Medicaid was eager to get somebody that would provide services to their beneficiaries. But if they've now gone to managed care, maybe that slowed down some.

BOB RAUNER: Yeah. In 20 years, my wife and I did not have this problem. We went to Sidney for my first practice. We got credentialed on time. When we moved back to Lincoln it was surprising to me that even though we did our residency training and we had everything here, one of the hospitals was...it took Lisa a month or two late but...so there was just one month that she couldn't do hospital rounding. But it didn't delay our entering the practice either when we were in Sidney or when we came back to Lincoln. So this three- and six-months' worth has not happened to my knowledge.

SENATOR RIEPE: Okay. Other questions from the committee members? Senator Crawford.

SENATOR CRAWFORD: Thank you. And thank you for being here. So just to clarify, you mentioned that we...the MCOs should look at purchasing programs already out there, value-based contracts already out there.

BOB RAUNER: Um-hum.

SENATOR CRAWFORD: You are currently, I think you said, using a value-based contract with Blue Cross or a couple of entities, correct?

BOB RAUNER: Yes.

SENATOR CRAWFORD: Right. And are those kind of similar to the value-based contracts that were developed out of that managed, patient-centered, managed-based care initiative that we had at the state previously?

BOB RAUNER: Yes. There are actually national efforts to have consistent measures across plans and Medicare actually has had one ongoing for years. There's actually an ongoing group that includes both Medicare and the various medical specialized that have a consensus to set up core measures that can be drawn from. Both those plans essentially use those set of measures so that

we're all doing breast cancer screening, we're all doing, for example, HPV vaccination at the same time. That type alignment, you can change the health of an entire community. You also--I think one other thing I forgot to mention--you also make sure of the validity of your data. On, for example, I mentioned Tdap rates, I would question how close those numbers are to reality. So as you've mentioned that claims data often is very incomplete, especially with the high turn rate Medicaid, I can tell you that Lincoln Public Schools tracks this very tightly because it's required before a kid enters a school. They're at 99 percent here in Lincoln. So I would question anything much below 90 percent as being accurate. Now maybe some outside of...maybe other school systems aren't tracking that well, but you could call Bellevue or Gothenburg, the school nurse, and ask what's the Tdap rate. They'll tell you what the 7th grade Tdap rate is and most of the time it's 99 "percentish," unless they're not tracking. So I don't...I'd question the validity of that data. Both Medicare and Blue Cross contracts, they do a prelook with claims data, then they send to us and then we report based on our clinic, what we have in our charts to basically get the real number. So it's a two-step process because, unfortunately, most of the information you need is often not in claims. It's in the doctors' charts.

SENATOR CRAWFORD: So to get to a value-based contract, one, you need some agreement on the measures that you're sharing, and you say there's already a shared national set of those that could be used.

BOB RAUNER: Yes.

SENATOR CRAWFORD: The second piece, I think from our earlier conversation, is that there's some attention to paying providers for management.

BOB RAUNER: Yes.

SENATOR CRAWFORD: So it goes beyond...

BOB RAUNER: Um-hum.

SENATOR CRAWFORD: ...just looking at outcomes or just paying for care but also paying for some of that management. Is there any shared national standard or assessment of what that is that can just be picked up and pulled right into a contract, or maybe it's that you have that with some of these other contracts so there's a good sort of state standard for that?

BOB RAUNER: Yeah. Most people have their payment in three buckets. Fee-for-service has been the way it has been forever essentially. Most of them add a per-member-per-month type payment. And then if you're an ACO contract with at least 5,000 they'll sometimes do a shared savings, meaning if I lower the cost for everybody we split the savings, for example. There's published things on per member per month. You can actually Google like New York Medicaid, for example, has a published list of rates of what it recommends for its different layers of levels of medical home. There's public reports on what it actually costs the doctor's office to do those types of things. So, you know, if it costs you $4 and they're paying you $2, obviously that's not going to work. So you have to kind of sense it, to some extent, to what your costs are. Medicare nationally, it has a CPC-Plus program, which is active in Nebraska, where they pay risk-adjustment per month. That's the way Blue Cross works. That's the way both Aetna and Arbor worked previously, that there was a per-member-per-month payment, and that's what you use to hire your care coordinators, your diabetes educators, your social workers to do all the outreach.

SENATOR CRAWFORD: Thank you. I appreciate that.

SENATOR RIEPE: Okay. Other questions? Seeing none, Dr. Rauner, thank you very much for being here. Welcome. If you'd be kind enough to state your name and spell it, please, and then share with us the organization you represent.

CAROLYNNE NOFFSINGER: Sure. Morning, Senator Riepe and the members of the Health and Human Services Committee. I appreciate you allowing me to speak this morning. My name is Carolynne Noffsinger. It's spelled C-a-r-o-l-y-n-n-e, last name is N-o-f-f-s-i-n-g-e-r. I'm the CEO of Acute Practice Solutions, LLC, a consulting firm for medical practices here in Nebraska. I'm also the COO of Fallbrook Family Medicine here in Lincoln. In support of Senator Crawford's efforts to support managed-care programs and Medicaid for the state of Nebraska, that's why I'm here today. I like to provide proactive solutions for healthcare. My background

includes more than 25 years in healthcare, 12 of which I supported 48 ACOs across over 100 private practices. And I served most recently as a senior vice president at a large healthcare system for population health and care management. As of late, within the last couple years, I've been working with several practices within the Lincoln area and I notice that the current on-boarding process for managed-care programs, such as WellCare, are very ineffective. While consulting for these practices in Lincoln, it was brought to my attention that WellCare was sending out care management requirements for these groups with HEDIS measures. And being directly involved with these practices and their population health strategies, I investigated this, found that most of the patients who were being sent to the practices aren't even patients of these physicians. For example, during the month of February this year, when I first was made aware of this issue, I saw that one of my current family practices received multiple letters which have included over 1,000 patients who had never been seen in their offices. The patient information included to them was patient name, date of birth, their WellCare ID, Medicaid ID, patient address, patient phone number, effective date of the patient's insurance policy, and the medical conditions of these patients. So initially I contacted WellCare to notify them because I thought it was a HIPAA violation, and I reported it to their customer service representative, who then transferred me to someone in the provider escalation department. They appeared to be very concerned that this had happened. And since reporting this issue via phone, e-mail, and then I met with WellCare directly, I was made aware of verbiage, from Senator Crawford, as given to her from the Department of Health and Human Services Medicaid Director Matthew Van Patton, within the WellCare contract that allows this type of referral; thus, not violating HIPAA. Though the verbiage in the contract protects WellCare from a direct HIPAA violation, sending patient-protected health information to providers who don't even see these patients is a waste of money and resources. WellCare has specific protocol to align patients with providers but this doesn't appear to be followed. I have seen in the three practices I've worked with within the last year and most recently, which has been Fallbrook Family Practice; Women's Health Care, Williamsburg; and Lincoln Internal Medicine Associates, that WellCare sends patient personal information to medical providers who've never seen the patient. To comply with the quality HEDIS measures, care managers and billing staff in these practices, at first they started to try to contact these patients and initially found the patients had never even heard of their providers. Additionally, WellCare expects these medical providers to see these patients to complete the quality HEDIS measures even when they're not accepting new Medicaid patients, nor have they even seen the

patients there in any capacity. In addition to Medicaid patients not receiving the preventative screenings and care from the care management program, it also bothers me that WellCare receives money from the state of Nebraska for their ineffective care management population health strategy. Upon meeting with a WellCare representative to express my concerns, I was told that they just don't have a better way of connecting their patients with providers. I did some research and learned that WellCare is a multimillion dollar company who is to serve the underserved, and there's a more effective way to "restratify" patients through claims. And it was interesting that Dr. Rauner spoke before me because I work closely with him in OneHealth. I am greatly concerned how ineffective and broken the population healthcare management strategy is for the state of Nebraska. Population health is my passion. That's what my focus has been for the last ten years of healthcare. Our Medicaid patients deserve a more efficient way to get their care management resources they deserve. I do believe that what Dr. Rauner said was accurate. Using a ASO strategy, such as Blue Cross Blue Shield and Medicare have already put in place, is very, very effective. And they go through claims to identify the providers, to identify the providers that are associated with the patients. I'm not quite sure really on how WellCare is doing it because the current processes in place doesn't make sense to me that it actually is being done that way. I work directly in this field in a very successful program with various ACOs, several hospitals, and private practice settings through Medicare and Blue Cross Blue Shield strategies, and I'm offering to help solve this problem because of the waste it is to the state of Nebraska, the burden it places on medical providers and a lot of administrative issues and then in our communities, and the better service to the Medicaid patients in our state. And that's all I have.

SENATOR RIEPE: Okay.

CAROLYNNE NOFFSINGER: Thank you.

SENATOR RIEPE: Thank you very much. Are there questions? I would like to say this. Heritage Health is a managed care...

CAROLYNNE NOFFSINGER: Correct.

SENATOR RIEPE: ...based, not a population-based health delivery model.

CAROLYNNE NOFFSINGER: I think they're pretty closely linked in the strategy.

SENATOR RIEPE: Well, I'm a fan of population-based healthcare, but this is not population-based health. They may be close but we have to stay on track in terms of where we are today,...

CAROLYNNE NOFFSINGER: Okay.

SENATOR RIEPE: ...which in managed care (inaudible).

CAROLYNNE NOFFSINGER: And managed care is value-based medicine instead of being fee-for-service, so the way that I define population health is probably pretty closely aligned with what managed care is. So I use that term "population health" broadly. The way that I see population health through managed care is pretty much how they're doing it now with the quality measures, the HEDIS measures, making sure that patients get the preventative services that they deserve. So my definition of population health is pretty much in alignment with the managed care strategy that Medicaid, the three different MCOs are trying to achieve, sir.

SENATOR RIEPE: And I don't want to get into a discussion back and forth about what I see as population-based healthcare.

CAROLYNNE NOFFSINGER: Sure. Sure, I just wanted to clarify that. I understand.

SENATOR RIEPE: We could be here quite some time. Are there...Senator Crawford, please.

SENATOR CRAWFORD: Thank you, Chairman Riepe. And thank you so much for being here and I appreciate your experience with the clinics, that since you are a service consultant you see multiple clinics and see what's happening. And I appreciate your offer to be of help, so I appreciate that too. Have you been invited to attend any of the administrative simplification meetings?

CAROLYNNE NOFFSINGER: I did. They just invited me. I was out of the country, just got back in the country.

SENATOR CRAWFORD: Okay.

CAROLYNNE NOFFSINGER: So, yes, and I plan on attending the next one.

SENATOR CRAWFORD: Excellent. So if I understand your concerns, one is that the managed care organization may be getting credit for linking a patient to a primary care provider, which is really an essential function we want them to do.

CAROLYNNE NOFFSINGER: Right. I...

SENATOR CRAWFORD: And they are sending information back to Medicaid to say, check, we linked them up. But you're saying from the clinic side you're getting these letters, like this is your new patient, and it's not someone that you have accepted.

CAROLYNNE NOFFSINGER: Correct.

SENATOR CRAWFORD: And so...

CAROLYNNE NOFFSINGER: Most of these get put in the shred bin.

SENATOR CRAWFORD: ...that disconnect. They get put in the shredder bin.

CAROLYNNE NOFFSINGER: Um-hum.

SENATOR CRAWFORD: So this "we have connected them to a primary care provider" may not be accurate.

CAROLYNNE NOFFSINGER: Correct.

SENATOR CRAWFORD: It's not accurate in the case of many of the situations of those letters that you received from WellCare. Have you seen that from either of the other two managed care...?

CAROLYNNE NOFFSINGER: No.

SENATOR CRAWFORD: Okay. And so you get asked ahead of time. The clinics get asked ahead of time...

CAROLYNNE NOFFSINGER: Um-hum.

SENATOR CRAWFORD: ...on the other two plans or something like that. Yeah.

CAROLYNNE NOFFSINGER: They do. I mean the way that they get referred, like one of them in particular, one of the groups I work with do not take any new Medicaid patients. The only way they take any kind of Medicaid patients is if it defaults that they were previously in our commercial plan or, you know, they lost their job and they newly were on Medicaid. They don't abandon their patients but they don't take any new Medicaid patients. And all of a sudden these names are popping up so it doesn't make sense with the providers at all.

SENATOR CRAWFORD: Great. Well, I appreciate you bringing this to our attention.

CAROLYNNE NOFFSINGER: Thank you.

SENATOR CRAWFORD: And I appreciate your offer to help and your offer to be a part of the administrative simplification group.

CAROLYNNE NOFFSINGER: Thank you.

SENATOR CRAWFORD: And thank you so much.

CAROLYNNE NOFFSINGER: Thank you. Appreciate it.

SENATOR RIEPE: Can you tell us a little bit about...more about your company?

CAROLYNNE NOFFSINGER: Well, it's...I've been doing this for about 12 years. I started doing that because I found that a lot of providers, they go to school to be doctors. They don't go to school for business. And actually Senator Crawford was one of my professors years ago. And I've been in business for about 12 years and in-between consulting started just to try to do checks and balances for practice, make sure they have the right. I do an overtop analysis of every practice I go to. Each individual practice has different needs. And in the last ten years I've moved into more of a managed care population health strategy to try to help them make sure that what their services they're providing they're getting paid for. So I focus on revenue cycle. I focus on care management. I focus on their staffing ratios and make sure there's no fraud, waste, and abuse. I used to serve in the military so it's very important to me.

SENATOR RIEPE: Okay. Thank you very much.

CAROLYNNE NOFFSINGER: Thank you.

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

CAROLYNNE NOFFSINGER: Thank you. Appreciate it.

SENATOR RIEPE: Thank you for being here. Our next testifier, please. Thank you for being here. If you'd be kind enough to state your name, spell it, please, and then...

LEISHA EITEN: Yes.

SENATOR RIEPE: ...the organization you represent.

LEISHA EITEN: (Exhibit 4) My name is Leisha Eiten. It's spelled L-e-i-s-h-a, my last name is spelled E-i-t-e-n, and I'm representing the Nebraska Speech-Language-Hearing Association. So thank you for this opportunity to come and talk to you. At the, I believe it was, the March meeting I had spoken with you, Senator Riepe and Senator Williams at that time, so I felt like it would be good to provide some updated information to you. I am the cochair of Nebraska Speech-Language-Hearing Association's insurance and reimbursement committee. We primarily

work on issues related to Medicaid. We've kind of been much more focused on Medicaid with the change to Heritage Health. I had previously reported to you that we were audiologists. Particularly ones who are working with hearing aids and hearing aid patients had significant concerns due to the inconsistencies between the MCOs related to the "preauth" process, "preauth" information, and then claim submission. So it was creating a high administrative burden and people were reporting just problems with reimbursement. Since the last hearing where I reported to you, I was also able to attend the Administrative Simplification Committee and kind of reviewed some of those same issues. And I wanted to personally thank Heather Leschinsky of DHHS because she requested that a meeting be held between Medicaid and audio...you know, our association, and all three of the MCOs. We have been able to present our issues directly; however, that group doesn't necessarily have all the answers because some of them are much more process related. We wait to hear back on any proposed solution. So we met the first part of May. I'm not really sure what happens from here so the ball is a little bit in the MCOs' court to figure out how to come up with a simplified way of doing the preauthorization process. The other issue I had reported previously was concerns about patient access to audiology services, specifically hearing aid services across the state. And since that hearing we actually, our association, reached out to all of the audiologists that we knew across the state, not necessarily even if...we contacted them even if they weren't members of our association but those we knew who were dispensing hearing aids got a little bit more specific information. So our feedback from audiologists indicates that in the rural areas, particularly around West Point, Hastings, O'Neill, Columbus, these all have audiologists that are in small private practices and in all those cases they have stopped taking either any new Medicaid patients or any at all. So they may be maintaining some services for Medicaid patients with hearing aids, but they're not taking anyone new. Some of them have just refused to take Medicaid at all for any reason. What they reported was the reimbursement and the administrative load was just too high. They couldn't absorb it into their practice. Not a problem in Omaha because there are enough providers to sort of absorb the load. However, when you think about outstate, a lot of times people's next step would be to come into Lincoln. And so in Lincoln we know that there are two practices that have limited their patients to only UnitedHealthcare, will not take the other two MCO insurances. And then there are at least two more that have either severely restricted the number they will see or they have, once again, only limited it to patients that were already in the practice and won't take new. So that has created more pressure in the Lincoln area for patients finding an audiologist

who can provide the services that they need for hearing aids. So that's communication, that's working, that's living, that's a really critical thing. So it continues to put a burden on patients who are covered under Medicaid to find a service provider, particularly rural and outstate; that it also puts a burden on the providers who still are wanting to maintain Medicaid services. So I'm in a bigger hospital system. I work at Boys Town. At one of our clinic locations, we're at about 50 percent of our hearing aid patients are Medicaid. We can absorb it. If you're in a private practice you cannot absorb that number. And if everything gets sort of pushed into the training program at UNL, they also cannot absorb that load of Medicaid patients needing services. So just wanted to give you a little bit more specific information. We felt we needed to sort of gather that and share that with you.

SENATOR RIEPE: Okay.

LEISHA EITEN: This was also shared with the Administrative Simplification Committee when we met with them. And I just...thanks for the opportunity to bring the concerns.

SENATOR RIEPE: Thank you. Senator Linehan, (inaudible).

SENATOR LINEHAN: Thank you, Mr. Chairman. So Boys Town is absorbing the cost but then you said something about the training program at UNL. So that's a training program. Could you just...

LEISHA EITEN: The audiology, the audiology Au.D. program at UNL is the only audiology training program in the state and so they can't refuse Medicaid patients because that clinic sort of runs as a nonprofit clinic. So they don't have the ability to say no. So if you have two, three clinics in Lincoln that can say no or are saying no, there's not a lot of other choices for some patients.

SENATOR LINEHAN: So they're going to UNL. Are these...

LEISHA EITEN: They're trying.

SENATOR LINEHAN: ...other people who are saying no...okay, that's what I don't understand. Is UNL taking care of them or not taking care of them?

LEISHA EITEN: Well, it creates a big backlog so that patient access becomes, well, we can't get you in for this many weeks or months because...

SENATOR LINEHAN: Okay.

LEISHA EITEN: ...the clinic is full. It's not a huge serve...I mean it's not a very large service provision, doesn't have that much capacity.

SENATOR LINEHAN: Okay. Okay.

SENATOR RIEPE: Okay.

SENATOR LINEHAN: Are there other...you said in Omaha people, so besides Boys Town it's Children's?

LEISHA EITEN: Children's provide services. There is a few other clinics that may be the diagnostics but will not handle the hearing aids, but will do the hearing aid fittings. There are some small practices that traditionally have just done Medicaid and they have continued to commit themselves to provide Medicaid services.

SENATOR LINEHAN: Okay. Thank you very much.

LEISHA EITEN: Yep.

SENATOR RIEPE: Senator Williams.

SENATOR WILLIAMS: Quick question. Thank you, Senator Riepe. So in the numbers, when we talk about where providers are in all of this,...

LEISHA EITEN: Um-hum.

SENATOR WILLIAMS: ...if we have a provider that's sitting in a rural area that has a very limited, okay, I will do one at a time and then when I get that hearing aid paid for I'll do it. But they would still be listed as a provider...

LEISHA EITEN: Yes, they would. Yeah.

SENATOR WILLIAMS: ...even though the reality is it's so limited it's...

LEISHA EITEN: And we did share that information with the MCOs at our meeting because they...their information says they have adequate networks.

SENATOR WILLIAMS: Right, that was my point.

LEISHA EITEN: And my response was it depends on the question.

SENATOR WILLIAMS: And that's being shared and so that the...

LEISHA EITEN: Yeah.

SENATOR WILLIAMS: ...MCOs know that.

LEISHA EITEN: Yeah. It depends on the question that you ask. I could say I'm a provider and then say, well, I'll do your hearing test but I will not fit your hearing aid. I'm still listed as a provider in the network.

SENATOR CRAWFORD: Oh.

SENATOR WILLIAMS: Thank you.

LEISHA EITEN: Yep.

SENATOR RIEPE: And it's the cost of the hearing aid itself that's a real deterrent?

LEISHA EITEN: No, it's not.

SENATOR RIEPE: It's not a pass-through cost?

LEISHA EITEN: It's the entire process and the administrative burden to get the authorization and then make sure that you are actually paid, because we do work with our insurance, our hearing aid manufacturers do provide us Medicaid...a Medicaid-contracted rate. But the process is so unclear from MCO to MCO that sometimes what happens with the contract you may have is you're not even reimbursed the full amount of the cost you owe the manufacturer. So as you were hearing from the pediatric physical therapist, why would you do that, if I can't even recoup the cost I must pay? It's difficult to justify.

SENATOR RIEPE: Understand. Senator Linehan.

SENATOR LINEHAN: Thank you, Mr. Chairman. So in the...so they're refusing to reimburse because they don't think it's necessary? Why would they say...

LEISHA EITEN: No, it's a very...it's an inconsistent preauthorization process that then ends up resulting in you may think you can proceed and you may then proceed and fit the hearing aid and bill it to the...in to the MCO. And sometimes then on the other end you get the feedback that says, well, no, we didn't, that authorization is not proper. So there are some inconsistencies in how they...how the preauthorization approval goes through.

SENATOR LINEHAN: Okay.

LEISHA EITEN: And it's kind of complicated. I can give you more details. Then on the other end, depending on the contract that you have with particular MCOs, there might be variable reimbursement that you get from the amount that you've billed to them.

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

SENATOR RIEPE: Okay. Senator Crawford.

SENATOR CRAWFORD: Thank you, Chairman Riepe. So I'm just trying to understand. You get a preauthorization.

LEISHA EITEN: Always.

SENATOR CRAWFORD: And then you submit the claim...

LEISHA EITEN: Yep.

SENATOR CRAWFORD: ...and with the preauthorization information. And then you're told that was wrong or you didn't do what we preauthorized or...I mean how do you deny that?

LEISHA EITEN: I'll give you one very interesting example. UnitedHealthcare, we always send a preauthorization request. UnitedHealthcare, as a general rule, will come back and say, there is no "preauth" required so please proceed. Then you bill it and the first time the billing goes through you may get feedback that says we don't have a preauthorization in place. So then that's one additional administrative step. So that doesn't hit the problems list. That's just an administrative burden of having to submit everything twice in order to get paid for what you had billed the first time. So if you have a very small practice where you're regularly having to do that, I mean, it doubles your administrative burden over the number of people; they stop doing it.

SENATOR CRAWFORD: So but why wouldn't you report that as a problem? Why wouldn't that show up on the list?

LEISHA EITEN: Because you have to report that, that particular case, that particular number, that one patient has to hit it as a problem.

SENATOR CRAWFORD: You mean in order to report it to Medicaid.

LEISHA EITEN: Yeah. I mean I...we could tell our...

SENATOR CRAWFORD: You could.

LEISHA EITEN: We could tell all our providers every time this happens...

SENATOR CRAWFORD: Hit that.

LEISHA EITEN: ...call the...

SENATOR CRAWFORD: Yes.

LEISHA EITEN: Yes, and that's another administrative burden still (laughter).

SENATOR CRAWFORD: I know, it's another administrative burden. I appreciate that (laughter). You shouldn't have to do that. It's an administrative burden. But, yeah, we need some way of knowing when it's happening and how much it's happening. It sounds like it's...yeah.

LEISHA EITEN: So what happens in a small practice is they say, I'm out.

SENATOR CRAWFORD: Exactly. I understand. Right. It's a burden to have to do that. So from a solutions perspective, is it possible that one could know what I guess an earlier testifier talked about as a false denial, that you could know that if you had data that it was denied and then later accepted? She was...I'm just trying to think, is there any way for us--and maybe...you don't have to answer now--but if there's a way for us or someone to identify or see the rates of these false denials in a way that we can certify or verify?

LEISHA EITEN: It is difficult to get the data. It's tough to get the data.

SENATOR CRAWFORD: Yeah. It is. It is. And that's another administrative burden. But...so I appreciate you letting us know what is happening and that it's happening at a rate that is, regardless of the rate, if the rate is one that's having people not provide Medicaid services, it's an unacceptable sort of mess, I think...

LEISHA EITEN: Yes. Right.

SENATOR CRAWFORD: ...what you're conveying and I appreciate that. So thank you for sharing that and explaining what that looks like from your perspective. Thanks.

LEISHA EITEN: Thank you.

SENATOR RIEPE: Okay. Thank you very much. Thanks for being here. Our next testifier. If you'd be kind enough to state your name, spell it, and the organization you represent, please.

LAURA WAGNER: (Exhibit 5) Yes. My name is Laura Wagner, L-a-u-r-a W-a-g-n-e-r. I am a constituent, taxpayer, parent. I do not represent an organization. I am here today to talk a little bit about what Stacy Lerner talked about with durable medical equipment reimbursement for Medicaid recipients. I am here with my husband Gabriel and my daughter Harmony, who they stepped out. She was a little bit too excitable for this. Harmony will be nine years old on Thursday. She is a 4th grader this fall. She was born with a brain injury and has cerebral palsy, or CP, and dystonia. Harmony requires 24/7 care for all activities of daily living. Most of you are probably familiar with CP. In a nutshell, it means that her brain has trouble telling her body what to do. For Harmony, she has very low tone. It means she can't stand, sit, or even hold her head up without support. She can't swallow well so we have to suction her mouth so she doesn't choke, and she eats through her feeding tube. You may be less familiar with dystonia, which is a movement disorder. That means when Harmony does try to do...make her body do things, her muscles do something else. She'll try to reach for something, her arm pulls back instead, or she'll get excited and her whole body tenses up and goes straight as a board. This can also make her muscles cramp up, she can get stuck in a position, like a charlie horse, but anywhere in her body. This happens particularly when she is not fully supported and her body is trying to compensate to hold herself up. This combination of very low tone, very high tone, and muscle contractions present a lot of challenges for Harmony's care and particular for the challenges for the equipment that we rely upon to care for her. As you may have seen when she was in here, she requires a lot of support in her wheelchair. It's been very difficult to find a seating system for her that is supportive enough for her entire body and comfortable enough for Harmony to be able to sit in for any length of time. She currently has a custom-molded seat back and cushion, which she's

had for about a year. She is growing slowly, which is actually a good thing, and with some creative modifications she hasn't outgrown it yet. But the expectation is she will likely need a new molded by the end of this year. Prior to this, she was only comfortable laying on the floor or sitting in our laps, which has gotten a lot more difficult as she's gotten bigger. We've had to minimize...in the past we had to minimize time in her chair and would only put her in it if we really had to, like to leave home for a doctor's appointment or something. She used to get bruises, sores, and skin breakdown from twisting in and fighting against her chair. Many of her doctors...and to clarify, that is prior to the custom-molded seating that she currently has. Many of her doctors are in Omaha and she would...we live here in Lincoln, and she would cry the entire drive, all the way up to Omaha because her chair was causing her pain. She would end up with pressure sores or bruises and it was really terrible to put her through that. It was a very long drive. Thankfully, that is no longer the case. The seat has made such a huge difference for Harmony to be able to tolerate her wheelchair. There are health benefits to having a chair which is properly supporting her, including being able to safely go to doctor's appointments in Omaha, as most notably she is not hurting herself in her chair. Being properly supported decreases the effects of dystonia for her so that her muscles aren't cramping or making her body twist into terrible and uncomfortable positions. Additionally, when you sit upright, your lungs function better. Harmony is able to breathe better. She can cough effectively to clear herself out. The custom seating is helping to keep her spine supported and as straight as possible, hoping to greatly reduce the need for future spinal fusion surgery that so many kids like her have to endure. Her overall health has just really improved over this year and I do think that finally having found a good seating system has contributed to that. Another piece of equipment that has been so important for Harmony is her bath chair. Because of her CP, she can't stand in the shower or even sit in a tub. As soon as Harmony outgrew the little infant bath that sits on the counter with the sling in it, we had to get a bath chair to be able to bathe her. It's not safe for somebody to just hold a wet, slippery kid that can't control her body in the bathtub. We would all end up getting hurt. And it's not hygienic to only be able to take a sponge bath, especially for a nine-year-old girl who wears...little girl who wears diapers. I don't love sharing that in public but that is the reality of her life. And there is just simply not a way to bathe her without a bath chair. Having appropriate equipment to care for Harmony is essential for us to keep her healthy, which clearly keeps her medical costs low. Having appropriate equipment to care for her has allowed her to live at home with us rather than in an institution. It is not an option to have lower quality or more

standard seating for Harmony. We tried that. It had a negative impact on her health and her ability to interact with the world and enjoy life. It's not an option to not have a way to bathe her. It's not an option for us to even just pay out of pocket for equipment like this. We are a single-income family. We do not have in-home nursing. We have chosen to not use in-home nursing for Medicaid. We tried that for nine months and it wasn't working well for us as individuals. So I work full time and my husband Gabe stays home and cares for Harmony. But that's...a single-income family has challenges, obviously. So in order to keep her at home, have us care for her, we just have to have the right tools to be able to do that.

SENATOR RIEPE: Okay. Thank you.

LAURA WAGNER: I appreciate your time.

SENATOR RIEPE: Thank you. Are you enrolled...is it Harmony?

LAURA WAGNER: Harmony, yes.

SENATOR RIEPE: Is she enrolled in one of the managed care organizations?

LAURA WAGNER: She is, yes.

SENATOR RIEPE: Okay.

LAURA WAGNER: So we...I'm actually lucky enough that we have primary insurance through my workplace and Medicaid for her as secondary, and we use UnitedHealthcare for her managed care program for secondary.

SENATOR RIEPE: Okay. Are there other questions from the committee members? Senator Williams, please.

SENATOR WILLIAMS: Thank you, Senator Riepe. And thank you for being here. So the question that you're concerned with most is the ability to continue to get the upgrades with the durable medical equipment...

LAURA WAGNER: Um-hum. Yes.

SENATOR WILLIAMS: ...that you need. Do you have any inclination or insight into whether that is a real concern or is it going to happen?

LAURA WAGNER: So my understanding is that things like Harmony's custom seating system are not going to continue to be reimbursed at the same--and this is my nonmedical person understanding--are not going to be continued to be reimbursed at the same rate, meaning we aren't going to have access to, when she outgrows her seating system, we aren't going to be able to get a new one and will either have to go back to what we had before, which wasn't working, or continue to make this work even though she's growing bigger or I'm not really sure what.

SENATOR RIEPE: Do you know what as fact or is that simply...

LAURA WAGNER: That is the information that I have been told and was why I was...it was suggested that if I had concerns about that, that this would be the forum that I could share that information.

SENATOR RIEPE: You were told that by a navigator or the durable medical equipment company?

LAURA WAGNER: I'm not sure what a navigator is. I was told that by our...

SENATOR RIEPE: So within UnitedHealthcare would be a coach...

LAURA WAGNER: Oh, I'm sorry.

SENATOR RIEPE: ...or something like that or...

LAURA WAGNER: No, by our physical therapist shared that information with me,...

SENATOR RIEPE: Okay.

LAURA WAGNER: ...the one that helps us with her medical equipment. Because we recently had an appointment within the last few weeks to adjust for growth on her chair and we were talking about the need moving forward of when she would probably be outgrowing it and what our next steps would be, and it led to the conversation of we may need to get creative in the future if this is not an option.

SENATOR RIEPE: Speculation is always interesting. Senator Crawford.

SENATOR CRAWFORD: Thank you, Chairman Riepe. And thank you so much, Ms. Wagner, for being here today and talking about what that looks like for a child, so that we can really see that impact on the child. Is Harmony, is she on a waiver or...?

LAURA WAGNER: She is. She's on the aged and disabled waiver.

SENATOR CRAWFORD: Okay. Okay. And so your concern is just to make sure that our reimbursement for durable goods and how we treat those waivers are ones that still take into account concerns for our kids like Harmony,...

LAURA WAGNER: Yes.

SENATOR CRAWFORD: ...that have these very special complex needs...

LAURA WAGNER: Yes.

SENATOR CRAWFORD: ...that are hard to understand without someone like you coming to tell us what those details of their day looks like. So I appreciate you coming to do that. And I also had one of my constituents come talk to me recently, you know, about complex care for her child.

LAURA WAGNER: Right.

SENATOR CRAWFORD: And sometimes it's just hard to see what that complexity looks like without people like you being...and her being willing to take that time to share that. So thank you for coming to share that. I appreciate that very much.

LAURA WAGNER: Thank you.

SENATOR CRAWFORD: Thank you.

SENATOR RIEPE: Okay. Senator Linehan, please.

SENATOR LINEHAN: Thank you, Mr. Chairman. This may be knowledge the rest of the committee understands, but I'm going to ask you because...so Medicaid is secondary to your primary insurance. So you submit everything to primary insurance before and what they don't pay you turn to Medicaid? Is that how...how does that work?

LAURA WAGNER: I don't personally do that but, yes, they, the provider, submits. It first has to go through primary and then I believe they submit it to Medicaid. I don't...

SENATOR LINEHAN: Okay. That makes sense.

LAURA WAGNER: ...deal with that. But, yeah. And the only bit of it that I know is four things that my primary insurance doesn't cover, like the bath chair as an example. Primary insurance says that's not medically necessary, we don't pay for that. So they deny it. As soon as there's a denial then it can get turned over to Medicaid for Medicaid to cover.

SENATOR LINEHAN: Okay. All right. That's very helpful. Thank you very much.

SENATOR RIEPE: Okay. Thank you very much for...

LAURA WAGNER: Thank you so much.

SENATOR RIEPE: ...coming all the way down here to testify.

LISA LANNIN-CLARKE: Thank you, Senators, for allowing me to speak. My name is Lisa Lannin-Clarke, it's L-i-s-a L-a-n-n-i-n-hyphen-C-l-a-r-k-e, and I'm also a parent of a child who has disabilities. However, my child is now an adult and so I have recently transitioned from the pediatric world to the adult world. And I just wanted to share with you a little bit about my experiences as being a Medicaid recipient with what occurred with that transition. I, first of all, had my pediatrician search for several years for me to find a primary care physician that I could have. She was unsuccessful. So when she turned 21, I went ahead and received my card from UnitedHealthcare telling me, assigning me a provider. And so when I contacted that provider I was told, you can't use this, we don't know why UnitedHealthcare assigned you this person, she's a nurse practitioner, you can't even do that. So I said, well, okay, I wasn't aware of that. And then she goes, and besides that, we're not taking Medicaid patients. And I explained to her that I have Medicare, I have my insurance as well, my primary insurance, so Medicaid would be third. They said, we don't take Medicaid patients. I went then into a very combative conversation with her about that, seeing as I didn't feel like that that would be relevant. She said, we only take an allotment, and she went on to describe to me how many additional administrative people that they would need in their particular office to manage any more Medicaid patients. I was obviously upset by this so I went ahead and I started looking through my phone book, trying to find someone, realizing that here she's going to need a primary care physician. And I finally contacted LMEF (phonetic) and they gave me a list of people for me to start going through that I could, you know...because I called the, I guess I should say the Lancaster County Health Department to try to see if they could give me some kind of direction on who would be taking Medicaid patients and what would be available in my community. By the time I called the third person they said, you know what, I think you could call this office and I think they're taking Medicaid patients. And so thankfully, I mean I spent a better half of half a day trying to find a provider. And so I just wanted to let you all know that it's real. It's not speculation. I mean Medicaid to me, I almost was like do I need to have Medicaid here because it's keeping her from providers? And I just wanted, too, when you were talking a little bit about what that translates to, we have now been on a year wait list to get in to see an endocrinologist. I mean because they only take a certain allotment. Now, realistically, nobody can wait a year to see their endocrinologist. So thankfully, her pediatrician has like bridged the gap when I told him, you

know, I'm on a year wait list. So I just wanted you all to know, just from the parent perspective, that it's real. Things are coming down and it's not looking any brighter. I mean I'm concerned. I feel like I'm covered right now but I also had the opportunity to participate in the random survey, a family survey, so I did share again this insight that...our experiences is that we had here. But I believe that they're probably not any different than what other people are already experiencing.

SENATOR RIEPE: Okay. Thank you, ma'am. Let's see if we have any questions from the committee. Thank you so much for sharing your story. We appreciate it; it's helpful. Additional? Okay. If you'd be kind enough to state your name and spell your name...

FRANNIE GREEN: Yes, my name is...

SENATOR RIEPE: ...and tell us the organization you're with, please.

FRANNIE GREEN: Yes. My name is Frannie Green, F-r-a-n-n-i-e G-r-e-e-n, and I'm representing the Midwest Association of Medical Equipment Services. And I am the Nebraska chairperson for the association. We represent nine states in the Midwest that provide medical equipment. So the information that I'm providing today is a combination from many different providers within Nebraska itself and concerns that I have been questioned about recently as being the chairman and kind of their go-to person for these kinds of things. We received a letter from Nebraska Total Care around June 8. The letter was dated June 1, and it was indicating their new fee schedule to go into effect July 1. There were some drastic changes to that fee schedule. We, at that point, had less than a 30-day notice due to the timing of when we received the letter and when it was to take effect. Some providers did not even get a letter. I spoke to two in the past week to two weeks that one heard it through the grapevine and another one happened to have an on-site visit and their provider rep had just casually mentioned it to discuss it, but they had never received a letter. What had happened is they took many of the existing rates, and there were some decreases in rates. There are some issues with those. The biggest concern we have is the "rate not established" items. These are items that have such a complex variety of different pieces of equipment that there's such a wide range of pricing. This is why there's never been an established allowable. I was on a Medicaid committee probably seven to ten years ago that worked in trying to see if there was a way to come up with a set allowable once on these items.

No matter how anyone tried, it had failed because of that wide variety. What Nebraska Total Care has done is they have established a rate for these codes now. For example, a piece of bath equipment, the complex rehab type bath equipment that may cost us, starting at $1,000, up to $4,000. We're going to be getting reimbursed $103.99. Okay? And the shipping of a piece of equipment like that can be anywhere from $25 to $150. So as you can see, that reimbursement barely covers the shipping in some cases. That's not sustainable. We can't provide that equipment. Because of the notice that we were provided with, some of this equipment has already been ordered for the patient through approval. So now we're going to be stuck with equipment and not be able to provide it to the patient because when we submit that claim it's nowhere near going to cover our cost. And I think something that's often forgotten in the DMA world is that there's a service component. We don't get billed an office visit. We are unable to bill for an office visit. All the assembly, the fittings, the adjustments, those kinds of things, at the time of that initial equipment, that's not separately billable. We only bill for the actual equipment that we're providing. We have to have accredited personnel that are evaluating these patients. Our facilities have to be accredited. There is a lot of cost that goes into just the service component alone, let alone the actual equipment itself. Some of the custom-molded seating systems that someone else had kind of testified about, a custom-molded seat cushion that costs us anywhere from $500 up to $2,200, we're going to get reimbursed $450. Again, that's not taking into consideration any of the other components of the service-based part of that. Something else they had indicated is those items that a fee was not established for, they're going to pay us 10 percent above our actual cost. I don't know what kind of business can take 10 percent above their cost, providing the kind of care and service that we do, and be able to keep their doors open. And Nebraska Medicaid used to pay 30 percent above our cost. That wasn't great, but it was doable. The biggest frustration was the lack of communication that Nebraska Total Care had with the providers. Although the letter indicated there were some provider feedback that initiated this or made them look at it, I have not found one provider, when questioned, that knew anything about it or had any kind of discussion. So what we would ask is that there's a delay in that fee schedule, pushing that back until the first of the year, and allowing providers some input and to work together and collaborate on what would be acceptable from all sides. We understand it's a Medicaid funding program. We're not asking for the world. We're asking to be able to keep our doors open and be able to provide the service that these clients need. Thank you.

SENATOR RIEPE: Okay. How many durable medical organizations that then provide services to Medicaid recipients are there in the state? Do you know offhand?

FRANNIE GREEN: There have been several either mergers and several small businesses that have joined with, either closed or have gone ahead and joined with larger. I'm aware, off the top of my head, of maybe 15.

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

FRANNIE GREEN: Thank you.

SENATOR RIEPE: We appreciate it. Other testifiers? Do we need another chair for the young gentleman there? No? You're willing to stand, are you? Okay, you can stand over there by your mom or...

QUINN OTTE: Hello, I am Quinn Otte. I am 11 years old and I am a student from Moore Middle School. I love to read, spend time with my family, explore new places, and dance. In fact, I have been on my dance team, Dancing Beyond Limits, for over six years. I am here to share my views on complex rehab technology and durable medical equipment, and the impact of not having mobility or things like bath equipment reimbursement would have on my life and other wonderful people like me. I have a shower with a roll-in chair. Ironically, the handle for the shower was not working last week and so I could not take a shower that day. It was frustrating. I cannot lay on the shower floor. I have a "trach" and would choke from the water getting in my "trach", along with the fact that it would be dangerous to pick me up wet, as I would be slick and I could fall, or the person picking me up could hurt themselves. The other option we have been told there's a bed bath. Hello. I am Quinn Otte. I am 11 years old...

MS. OTTE: Sorry.

QUINN OTTE: ...and I am a student from Moore Middle School. I love to read, spend time with my family, explore new places, and dance. In fact, I have been on my dance team, Dancing

Beyond Limits, for over six years. I am here to share my views on complex rehab technology and durable medical equipment, and the impact of not having mobility or things like bath equipment reimbursement would have on my life and other wonderful people like me. I have a shower with a roll-in chair. Ironically, the handle for the shower was not working last week and so I could not take a shower that day. It was frustrating. I cannot lay on the shower floor. I have a "trach" and would choke from the water getting in my "trach", along with the fact that it would be dangerous to pick me up wet, as I would be slick and I could fall, or the person picking me up could hurt themselves. The other option, we have been told there's a bed bath. Have you had one? For the one day our shower knob was broken, I had to have a bed bath. It was a mess. My hair was still dirty. My bed was soaking wet afterwards and I was not really very clean. I deserve to feel clean along with going to school smelling clean and feeling clean instead of being stinky and itchy. I also want to talk about my complex rehab technology. I have to rely on caregivers to feed me, cloth (sic--clothe) me, shower me, care for me in so many ways. My chair and my computer help me help myself. This is how I can communicate. This is where I have freedom. This is how I can be me. I can share my voice. I can do my homework. I can move myself from one place to another. I deserve to move myself just like you. I deserve to share my opinions and contribute to society. I have to have this complex rehab technology and my chair and my computer to do this. I have many friends who are on chairs like mine and have technology that helps them communicate. They have jobs. They are working hard in school and they are making the world a better place. Please don't take away our movement and our voice. Being stuck in bed or in feeling (inaudible) will close off our world. It is not okay for us to be shunned and hidden away. We have so much to share with the world and deserve to have our medical needs met. We did not ask to be in our chairs, but we now need them to manage our world. I am so thankful for my doctors and therapists. They help me continue to make my body work. They help me use my muscles correctly and they help me make my body work its best. They help me gain strength, instead of my body not always doing what I want it to. I am thankful for them helping me get the complex rehab technology essential for my health and my life. Please continue to take action to protect us, not compromise access to the complex rehab technology for many of the people with disabilities who rely on it. Thank you, and let's keep Nebraska nice.

SENATOR RIEPE: Thank you very much. And is that your big brother with you?

ISAIAH OTTE: Yeah.

SENATOR RIEPE: You're a good brother. Do you have something to add too?

ISAIAH OTTE: Um-hum.

SENATOR RIEPE: Would you tell us your name, please.

ISAIAH OTTE: Isaiah, I-s-a-i-a-h.

SENATOR RIEPE: Thank you.

ISAIAH OTTE: And then my last name is O-t-t-e.

SENATOR RIEPE: Thank you, Isaiah.

ISAIAH OTTE: I'm here to talk about why people should have wheelchairs and shower chairs. Imagine if you were in their shoes and you could not get out of your bed. Then people have to give you a shower in bed. Then your bed would be stinky and all wet. We were just fostering a child. When we gave him a shower in bed because he had a cast on his legs. After the shower, he was...he still stink. Then if you had a bad wheelchair, it would be hard to get around. Imagine if you got constant bad cramps. That's what it would be like. And thank you for listening.

SENATOR RIEPE: Thank you.

SENATOR CRAWFORD: Thank you.

SENATOR RIEPE: How old are you, Isaiah?

ISAIAH OTTE: Twelve.

SENATOR RIEPE: We think you're a hero. Are there questions of Isaiah? Okay.

SENATOR CRAWFORD: Thank you.

SENATOR RIEPE: Thank you all so much for coming. We appreciate it.

JENNIFER STUHMER: I can't go yet, sorry. She's--got to say--powerful. Well done, Quinn.

SENATOR RIEPE: Okay, our next witness or testifier, please. It's going to be hard to beat that one.

JON NOVAK: Yeah, I got to follow that (laughter).

SENATOR RIEPE: Good to see you again.

JON NOVAK: Good to see you, Chairman and members of the committee. You have an awesome responsibility.

SENATOR RIEPE: Would you state your name and spell it, please, for us?

JON NOVAK: Yeah, sorry, I should have this down. My name is Jon Novak. I represent Total Respiratory and Rehab. Spelling is J-o-n, last name is N-o-v-a-k.

SENATOR RIEPE: Thank you, Jon.

JON NOVAK: I can solve a lot of the problems that...as far as clearing up what has happened here and actually I want to know...want you to know I did not orchestrate this. I was actually asked or notified that this was going on today and had to move my calendar around. But it was important enough that I felt like people might have right intentions but not all the facts, and that's where I'm trying to hopefully gain and help you with this. As Frannie Green with MAMES stated, we as a company, Total Respiratory and Rehab, received a letter from Nebraska Total Care. There was a question earlier, asking if this was Medicaid reimbursement rates. It is not. This is Total Care reimbursement rates changing for this type of equipment. The letter was dated June 1st. It came to our office, we received it on the 8th, And the part that I thought was most

interesting was: In response to feedback we have received from our network providers--well, that would be us, which we were never consulted, nobody ever asked us--that they were going to provide more efficient claims processing. Well, here's what they've done. The back and cushion that is custom-made that we heard about earlier and all that did for Harmony, our reimbursement rates will be changing on those, and these are the "rate not established" codes. Basically, what they were is they were a percentage of billed. Now what they're going to is an actual fee schedule, a fee schedule for a custom back, we will be reimbursed $789.58. Our cost before any of administrative fees, evaluation fees, driving to appointments, delivering of equipment, adjusting, anything, billing, prior authorization, the building, the accreditation, $1,546. That means that we'll lose about $800 on that back. That cannot happen. On a custom cushion that they were just seated on, and that is an E2609. That reimbursement rate will be changing. There again, it was a percentage of billed. Now they're going to a fee schedule. That is going to $450. My cost on that before freight, before evaluation, before I pay my person for evaluation, drive time, equipment, billing, prior authorization, coordination, $954. I get to lose $500 on that cushion. The bath chair that they were referring to, I get paid $103.99. I get to pay--these are right off manufacturer invoices. And just so everybody knows, when we looked at this, we looked at least two different manufacturers of the same type of equipment. We're not going with the Rolls-Royce. We're not going with the Cadillac. We're going with the basic stuff. There's not a lot of manufacturers on a lot of this stuff. When it comes to custom backs cushions there's not a lot of choices. There's not that big of a market so you have limited suppliers, same thing with the custom shower chairs: $2,196 is what that unit cost me that I'll get paid $103.99. How long am I going to stay in business doing this and why is it my responsibility to pay when they have benefits and should have benefits that the state is paying? A...I mean, I could go on and on, on all this reimbursement stuff. All I can tell you is that there is...for somebody to be able to take a bath, to get down, for a lift to drop them down in their bathtub, I get paid $103.99. It costs me $2,190. These are real problems. These are real issues. I would tell you, as a provider with Nebraska Total Care, I'm asking the Oversight Committee not just to hear these stories of what's going on; understand that they're real; understand the Oversight Committee needs to take action and take action now. Frannie was speaking on behalf of MAMES. I'm speaking on the behalf of Total Respiratory and Rehab. I will not continue this contract with Nebraska Total Care. I will give my notice, no questions asked, and never look back. If this is the way they want to try to strong-arm vendors instead of partnering for care, I don't want anything to do with it, and I can't.

There's too much work on the front end and the back end. And coordinating with these families and telling them no and telling them that I'm going to lose, this is not speculation, Chairman. This is real. These are real problems. So they were not speculating, therapists that told them that. Does it make sense for me to provide that? Absolutely not. So what I am asking for is for the Oversight Committee to get involved, get with Nebraska Total Care, ask them to suspend, give some time to reevaluate what they are about to do, because it's just not me that won't be able to sustain. Many other companies have gone out of business or had to sell. This is not smart business. This does not make any sense. I will tell you that we need to sit back, somebody needs to get a hold of Nebraska Total Care, and they need to revisit this immediately. They need to say we're going to take six months, we're going to evaluate, we're going to collaborate with vendors like they said that they did, which they did not. Frannie just testified that nobody reached out to her or any of the members, and nobody reached out to me. I don't know who they talked to. I don't think they talked to anybody. And it's funny, all these reimbursement rates went in their favor, every single one. And so with that, I will also tell you the second problem is the NAC. The Nebraska Administrative Code is a mess. It is denying access to individuals who desperately need equipment. One flaw with the NAC, even though there's medical necessity, one flaw with the NAC is it says "least costly option available." We have been asked to, instead of a tilt-in-space manual wheelchair, which for some reason...and every one of these, that's a manual tilt-in-space wheelchair right there. Dr. White has called that dangerous. How that's dangerous I have no idea, but says it's dangerous in some cases. I don't want to take words out of her mouth but she put it in writing. That is a custom back...

JENNIFER STUHMER: It is; it's a custom seat, as well.

JON NOVAK: ...and a custom seat. These items are necessary. These items are required. The NAC states that a least costly option be available. Right now in skilled nursing facilities, the least costly option is making people bed bath. What we are doing is we are getting equipment denied based on the least costly option because the administrative law judges have to follow law. Law is the NAC right now. Law says least costly option. Least costly option of pressure relief is putting somebody in bed. I don't know how you guys would feel but I do not feel good about that as a Nebraskan and a taxpayer. I can tell you when my dad was alive with Parkinson's, as he had his debilitating disease, when I walked in and he was in bed instead of the ability for me to take him

down and get ice cream or whatever we wanted to do, the quality of life has to be there. Being put in bed as an alternative pressure relief, somebody should be pressure relieving approximately every 15 minutes. How often do you expect a facility--we've all been in facilities--to transfer somebody in and out of their chair to bed, bed to chair, all day? That's not feasible. Pressure ulcers cost thousands of dollars, but yet and still we do this. I will also tell you there's two other...there's some other issues going on. The diagnosis code requirement that Nebraska Total Care has put on children 18 years and younger is a disgrace. They are requiring a diagnosis code to qualify for certain types of equipment. That is fine in the adult stages, once an individual has been properly diagnosed. Most of the doctors/therapists do now want to diagnose kids until they have had an opportunity to develop because, once they put that label on them, they're there. And so they don't want to diagnose these kids, but the kids need the equipment. So before the way it was done is 18 and younger you could get equipment that was needed as long as it was medically justified. Now Nebraska Total Care--the only MCO that is doing this, I will tell you--is requiring a certain diagnosis code. So if you have muscular dystrophy, you have to have the type of muscular dystrophy that they state. But if the doctor specifies and has specified on their diagnosis a more specific diagnosis, a version of the muscular dystrophy, they don't get the equipment. This is a letter...this is a part of semantics and it's disgusting. The other thing I will tell you is for some reason Nebraska Total Care--I'm not sure about UnitedHealthcare so I do not want to say--is now arbitrarily, even though Nebraska Medicaid states that it has to provide K6 and K7 manual wheelchairs, is stating that they're part of the per diem now. Now, how that shifted from what it was to what it is I do not know. That's a heavy-duty manual wheelchair and then an extra-heavy-duty wheelchair. The facilities shouldn't be burdened with that huge expense. And the patient or the member should not be able to get around within the facility safely and not have the appropriate chair that is for their weight. I will tell you also the prior authorization process, we get prior authorization on very many items. I've said this before; I will say it again. Our denial and approval rate with Nebraska Total Care is about 95 percent denial rate. And then you take that same documentation anywhere else, whole different ball game. I will tell you, UnitedHealthcare is getting much better, WellCare, and they all have their strengths and weaknesses. I've heard that today and I understand that. They're each going to have things that they're good at and things that they're not so good at. That's no different than me. We all have our strengths and weaknesses. But I can tell you that when we are looking at the least costly option and that's it, I have had a child needing a floor sitter that was told to use a beanbag. I have

had a child that needed to be sat up completely and then also, as a safety concern as far as getting up, they said to cut off the legs on a standard hospital bed, the legs at the feet, cut those legs off and then use cinder blocks to raise the head of the bed instead of the actual proper equipment. They are going outside the realm of what is considered normal or conventional thinking for medical equipment and they are utilizing beanbags. They're using pillows. They're using the craziest things I've ever seen. Cutting off legs of equipment? We can't even do that as a provider. If we cut the legs off of that, all of a sudden we've become a remanufacturer. We're not insured for something like that. And, boy, tell me what happens if my insurance company finds out that I've put a bed up on some cinder blocks? They...I'll never get insured again if there's an accident, and mostly likely there will be. A wheelchair could hit those as they're pulling the chair up for transfer. There are so many things that are so unconventional anymore and now all we care about is cost. We have to keep costs in mind, I understand. This is managed care, but it's also care. And right now, we're not.

SENATOR RIEPE: Okay.

JON NOVAK: Thank you. If there's any questions, I'd be happy to answer them. I appreciate you letting me be frank. This is frustrating. I will reiterate that car seat issue, my cost is $900, reimbursement $950...or, I'm sorry, $150. My cost is $900.

SENATOR RIEPE: Okay.

JON NOVAK: This, I could go on and on. I've got examples.

SENATOR RIEPE: When is the new fee schedule set? Is that...we heard sometime July 1.

JON NOVAK: It's going into effect. I have: Effective July 1, we will update our payer Medicaid fee schedule. And this is from Nebraska Total Care. It's from Adam Peters, senior vice president of operations. This needs to stop.

SENATOR RIEPE: Um-hum.

JON NOVAK: Otherwise, I will definitely, and as a business owner, I will definitely cancel and give notice on my contract.

SENATOR RIEPE: Have you had ongoing conversations? I mean this was not just...I mean this isn't just today, a few days in front. Have you been at this for three months or six months...

JON NOVAK: We were only notified...

SENATOR RIEPE: ...in the negotiation process?

JON NOVAK: We were only notified of this on July...June 8. Today is the 26th, I believe.

SENATOR RIEPE: Yes, it is.

JON NOVAK: And so I mean I've had 18 days. I have talked to the state on this. Nebraska Total Care has had many of the members of MAMES reach out. This is...they're saying this is what it is and they did this for us. Just so you know, they did this to accommodate the providers.

SENATOR RIEPE: Do you normally have, with all the managed care organizations, have like a 12-month contract or is it sort of month to month or what's that relationship?

JON NOVAK: I believe ours was a three-year but they have the right in the contract to change reimbursement. So obviously they're doing that.

SENATOR RIEPE: So it then makes it really not a contract if...

JON NOVAK: And this would be at...yeah, this would be. So this is what they're doing. And so they appear to have...they're all within their right of the contract, but me, as a business person, does not have to. I can go ahead and give my notice and that's what I absolutely intend to do. I will also tell you that as far as throughout the state we are one of the largest providers and access will be dropped dramatically. And I have...and Frannie just told me that she talked to four other members who will drop as well. Now, she did state that there are 15 other providers in the state,

but I will tell you that provide this type of complex equipment there are about 4 or 5. And if me and four others go, I think that's what's causing the uproar here today because I can't do this. I hope you understand. If anybody has ever been in business and you need to make payroll, you need to pay rent, you need to pay your insurance, with us it's so many more layers. It's accreditation. It's getting the prior authorization. It's getting the billing. It's managing your accounts receivable and doing the right thing day to day. And with this, I can't even come close to any of it. It is not sustainable.

SENATOR RIEPE: Okay.

JON NOVAK: And so I need you guys to take action, please, on all the things I talked about. The NAC, the K6, the K7s, the least costly option is a disaster. I mean it is clear that the administrative law judges want to approve this equipment because they see that it's medically necessary, but it's not the least costly option. Least costly option is laying in bed.

SENATOR RIEPE: Okay.

SENATOR CRAWFORD: Thank you.

SENATOR RIEPE: Are there additional questions? We hear your concern but are there other questions? Seeing none, thank you. Thank you very much.

JON NOVAK: Thank you.

SENATOR RIEPE: I know we kind of went beyond the red light because you had some strong points to make.

JON NOVAK: I appreciate it. Thank you.

SENATOR RIEPE: We appreciate that. Thank you.

JENNIFER STUHMER: I know you're thinking of lunch. Can I go? You'll find that these are some photos--on the back is my personal information--of exactly the things that he just talked about.

SENATOR RIEPE: Okay. If you would, please, your name, spell your name, too, please, so we know. And who you represent, if that's yourself or your child then that's fine too.

JENNIFER STUHMER: (Exhibit 6) Absolutely. My name is Jennifer Stuhmer, J-e-n-n-i-f-e-r S-t-u-h-m-e-r. I am Damon's mom. This is Damon. His device has gone to sleep, otherwise I'd say he may talk, and he still may and I'll let him when he gets a chance if he chooses. Dear Health and Human Services Committee, thank you for your time today. I do know it's valuable. Damon and I are here today advocating for appropriate reimbursement rates for complex rehab technology and durable medical equipment. I have had to advocate for his medical needs his entire life. This is something no mom should have to worry about. Insurance companies seem to think that since the needs like Damon are so rare that it's not necessary sometimes. This new fee schedule for one of the managed care healthcare plans, which is the one we happen to be on, Total Health Care, Nebraska Total, will limit funding for equipment medically necessary for Damon's livelihood. This is irresponsible and a disgusting precedence that must not be allowed. Damon turns 14 on Thursday. Time flies. He was born with a rare genetic chromosome deletion called Kleefstra syndrome. He is one of 300 diagnosed in the world. The characteristics of his deletion are heart disease, which was repaired at age four; learning delays; hypotonia, seizures, and hearing loss. When Damon was born, he was immediately admitted into the NICU at Children's Hospital and stayed there for seven and a half months. Then he went to the Ambassador in Omaha, which is a nursing home, but they had a pediatric wing, just a small wing then. And once he successfully transitioned to a home ventilator, we arrived to our home in Lincoln. He was 15 months old. He underwent over 100 hospital stays to date, over six major surgeries, including a "trach" put in a five months old, and many trips to the OR and clinics for annual cares and checkups. He still requires nursing cares while parents sleep and work, and his medications have ranged from $500 to $5,000 a month, depending on what issues we're dealing with at the time. Damon is on complete Medicaid. Due to reaching his million-dollar cap at age...at three months old, back in 2004, we were lucky enough that Children's Hospital was very diligent about getting us set up with Medicaid at that point and have thanked God ever since.

And everyone who pays taxes, thank you. But by you all paying your taxes, you have saved my son's life many times over. In 2010 Damon was in kindergarten. He was walking and running with a walker pulled behind him. He was kicking balls, spelling his name and eating and he was beginning to self-propel his own little, teeny-tiny, orange wheelchair that he chose out himself. Life was easy and life was happy. I was fine. Based on those circumstances, we wouldn't even be here today, except for on February 23, 2010, Damon spiked a fever of 106.3, no etiology, which caused a seizure that lasted an hour and a half long that fried a quarter in circumference of brain matter around his brain. Three shots of Valium didn't stop the seizing, didn't stop the seizing. So he went comatose and later the doctors decided that he's brain dead, we need to talk about end-of-life discussion. Yeah, I wasn't having that (laughter). I told Damon before we left that night to take care of adult needs, if you will, that this is not okay. Mommy knows you're there; you need to tell the world. So Damon surprisingly tracked me across the room twice the next morning. The nurse witnessed it. We then took the end-of-life discussion off the table and began rehab and healing from this traumatic ordeal. And this episode did leave Damon, though, with a newborn status. He was weighing 50 pounds. He had lost all mobility, fine and gross, and we basically had this newborn six-year-old, and it meant that we needed a bigger home, we needed to provide space for all his new ICU bedroom, complete with a hospital bed, the ventilator you see in there, suction machines, cares cart, oxygen, respiratory machines, a bath chair. We had no longer walk...he no longer could walk so we needed a new wheelchair. And he couldn't sit up so we needed a new bath chair to bathe him in. Keep in mind, he spends most of his waking hours in his chair. It is his way of life and communicating with the world on its level. It is necessary. Fast forward eight years, now we needed a new wheelchair. He (sic) was literally falling apart. His old one was literally requiring repairs monthly. Damon also developed some serious scoliosis, using the old wheelchair, of his spine due to very low tone that worsened due to the 2010 event. Ortho mentioned surgery, but this would need to be done many times as he's only 13 and he's surely to grow some more. And they suggested, along with the PT, to fit him into a custom wheelchair that will support his spine curve and prevent it from getting worse. And this meant a custom seat to offer appropriate support to his "booty" and his hips to prevent him from leaning to one side. Thank you.

SENATOR RIEPE: Can you kind of pull it together best you can?

JENNIFER STUHMER: Oh, I went red. So really, Damon needs what you see in front of him. That's his daily life. He needs those things. And this low reimbursement status, we use Total...Nebraska Total. We use Total Rehab. If that, what are you calling it, EMO or...what's the...I'm sorry. If that insurance company chooses not to provide what my son needs, what am I supposed to do now? That's my question. Because if the company that provides what we need isn't going to provide it and the insurance isn't going to pay for it, my son now is left with this. But he's surely to grow. The wheelchair will deteriorate. The seating, it will deteriorate. So please stop what they're doing as of July 1. Help us find a solution.

SENATOR RIEPE: Is one of your choices one of the other two managed care organizations?

JENNIFER STUHMER: It's not. I can't just switch my...I can't just go from my company and say, hey, I want UnitedHealthcare. One of the reasons who we chose Nebraska Total is for nursing. So you've heard that each one has their specialty. Nebraska Total is paying very well for our nursing. We use that for every night so that we have a nurse that watches Damon and has to be there watching him pretty much while my husband I sleep so we both can work, for respite, for when we're both working but Damon can't go to school. They're providing those nursing. So I'm sure, but I don't think I am allowed through Heritage Health just to say as of July 1st I need to go to another company. I don't think I can do that. It's a great question. I would love the answer. Please help.

SENATOR RIEPE: Okay. Are there other comments or questions from the committee? Seeing none...oh, you have some. Senator Crawford.

SENATOR CRAWFORD: Well, thank you, Chairman Riepe. And I'm not saying this solves the problem, but we, thanks with our legal counsel, we definitely can get back to you with the answer of what it does mean to change. Obviously, that does have a delay in other issues as well.

JENNIFER STUHMER: Right.

SENATOR CRAWFORD: I appreciate you coming to share your story.

JENNIFER STUHMER: Yes.

SENATOR CRAWFORD: And appreciate your call to action. Thank you.

JENNIFER STUHMER: I thank you. Thank you all for your...

SENATOR RIEPE: My legal counsel tells us...or the committee's legal counsel says that you eligible to switch, so I don't know.

MAN FROM AUDIENCE: Is there open enrollment?

JENNIFER STUHMER: Thank you. It's not open enrollment right now.

AUDIENCE: For cause.

SENATOR CRAWFORD: For cause.

JENNIFER STUHMER: Okay.

SENATOR RIEPE: Okay. Good enough. Okay. Very good. Thank you very much. Thank you for being here. Damon, thank you for being with us too.

JENNIFER STUHMER: Thank you, sir.

SENATOR RIEPE: Okay. Thank you. Additional testifiers?

CHRISTINA SCHEER: Yes.

SENATOR RIEPE: Please come forward.

CHRISTINA SCHEER: Thank you.

SENATOR RIEPE: If you'd be kind enough...

CHRISTINA SCHEER: I feel short in this chair.

SENATOR RIEPE: ...please state your name. We don't have a telephone book.

CHRISTINA SCHEER: That's okay.

SENATOR RIEPE: I'm sure we have some bureaucratic things we could have you sit on...

CHRISTINA SCHEER: Exactly, but it's okay.

SENATOR RIEPE: ...but it might raise you too much.

CHRISTINA SCHEER: I'll just sit tall.

SENATOR RIEPE: If you'd spell your name as well and then tell us who you represent.

CHRISTINA SCHEER: Yes. I'm Christina Scheer, C-h-r-i-s-t-i-n-a, Scheer is S-c-h-e-e-r, and I do go by Chrissy, so I don't know if that matters. But I am a pediatric physical therapist, much like Stacy Lerner who actually testified early on today. I work for Handprints and Footsteps. It's a small pediatric occupational therapy, physical therapy, and speech therapy clinic here in Lincoln, and my role for the last eight years has been doing adaptive equipment assessments and delivery for kids with physical disabilities. Before that, I did that as well as regular ongoing therapy treatment, but my focus has been equipment. My concerns are the fee schedule that's been discussed with Nebraska Total Care going into effect July 1. It effectively eliminates options that myself, as a therapist, would need to choose for a child with needs. As it's already been talked about so I'm not going to go into all the details on that we have to choose the least costly option and that burden is on us as therapists. That is our job. I write 12- to 20-page letters for pieces of equipment. This is...if we're going to talk administrative time,...

SENATOR CRAWFORD: Yeah.

CHRISTINA SCHEER: ...it's a lot of time I spend writing letters. And I need to be able to justify the appropriate equipment and that burden of proof is on me. But if the vendors are not going to be able to supply the equipment, then you are putting me in an ethical dilemma because you're asking me to choose equipment that I know is not appropriate, is not...mean, the least costly option is bed but we also have school regulations in Nebraska so kids should have the right to go to school. They're not going to go to school in bed so we need some sort of mobility device or a wheelchair. But if I put them in something that's not appropriate, then I'm putting them at risk for sores, for respiratory issues, GI issues. I have a lot of kids who have really bad reflux and so you can't change the angle of their chair. They're going to reflux, vomit, and aspirate. Like there are real medical concerns here. And I...the burden of proof of that is in my letters. I have to talk about all of that. But if I'm limited to what I can talk about or what we could get, then you're putting me in a really hard position. I would have to choose, do I pick something that's going to meet the fee schedule requirements but I know is going to cause other problems, especially for a child that maybe we already know this was a known issue. And so I just challenge you guys to come up...I liked what Jon Novak said about can we stop and kind of delay the implementation of this fee schedule so we can relook at it. I honestly, as a physical therapist and provider, I heard about this I think June 9, the day after Total Respiratory got their letter. They told me because I am a therapist that writes a lot of letters and they're one of the vendors I use a lot. In Lincoln specifically, which is where I'm based out of, really they are about the only vendor who does very complex rehab equipment. And that's kind of...I think there's also a misunderstanding sometimes. Durable medical equipment and complex rehab technology, it all, on the NAC code, falls under durable medical equipment. But the reality is durable medical equipment, by definition, is equipment that most people, you and I, could maybe need to use some time in our life, like we have a surgery or we have an injury or an illness: your basic walker, your cane, your bedside commode, those kind of things that you, the general population knows what they are. And that makes sense to have a set fee schedule for those items. They should not be that costly. However, complex rehab technology is very specialized. It's very individualized. As you saw the kids who came up here, you know, that would not be useful to you or I unless we had an injury or an illness that precipitated a need for that. But the general population doesn't need complex rehab technology. And that's where, if you're setting a fee schedule on it, it's very difficult to supply that because it's such a small supply and small demand in the marketplace for these individuals that need complex rehab technology. I think that makes sense. Sorry. So I guess I just

would ask that we move forward with seeing if there's a way to stop this from going into effect and to really reevaluate what our options are. Otherwise, I'm going to be stuck in a very ethical dilemma on what I should supply kids. Thank you.

SENATOR RIEPE: Okay. Thank you. Are there...Senator Crawford.

SENATOR CRAWFORD: Thank you, Chairman Riepe. And thank you so much for being here today and sharing your perspectives and your experiences. I wonder if, from your professional opinion, you have an alternative standard that you would recommend, if it's least costly option is the standard that you're...that now is causing the problem.

CHRISTINA SCHEER: Um-hum.

SENATOR CRAWFORD: So I think I'm hearing it's the standard if one issue and then the Total Care change in reimbursement is another issues. But let's focus on the standard issue right now.

CHRISTINA SCHEER: Um-hum.

SENATOR CRAWFORD: Do you have a recommendation of a different standard?

CHRISTINA SCHEER: I don't know that I know, I have the solutions to those issues.

SENATOR CRAWFORD: Okay, okay.

CHRISTINA SCHEER: I've been, like I said, I've been doing exclusively equipment for eight year. The NAC code hasn't changed since 2014. So we've had to work...learn to work within it, I guess. But I am getting more and more denials stating things from the code that doesn't even make sense. And so then I have to rebuttal, basically, and say, well, we are meeting these requirements. And that's a lot of time on my part, too, to argue something that's already there.

SENATOR CRAWFORD: So the code itself has not changed.

CHRISTINA SCHEER: Correct.

SENATOR CRAWFORD: But the way you're seeing the code implemented...

CHRISTINA SCHEER: Correct.

SENATOR CRAWFORD: ...has changed.

CHRISTINA SCHEER: The interpretation has changed. I actually did...

SENATOR CRAWFORD: Okay. And who from your...who do you think is doing the interpretation?

CHRISTINA SCHEER: I would say my biggest issue would be Nebraska Total Care.

SENATOR CRAWFORD: Okay, the managed care organizations are doing the interpretation,...

CHRISTINA SCHEER: Interpretations themselves.

SENATOR CRAWFORD: ...as far as you see.

CHRISTINA SCHEER: Yes.

SENATOR CRAWFORD: And the way they're interpreting that code has changed.

CHRISTINA SCHEER: Correct. Yeah, I was on a peer-to-peer review with the physical therapists at Nebraska Total Care over an item and she said, well, these are new regulations. I said, no, these have not changed since 2014. You look them up on-line; they have the date stamped on them. And she said, well, they're new interpretations. I said I would agree with that but I'm not sure I agree with how it's being interpreted.

SENATOR CRAWFORD: And just for our sake and the record's sake, could you tell us what NAC stands for? What that is?

CHRISTINA SCHEER: Ooh, I can. Sorry. Oh, it's right here.

SENATOR CRAWFORD: Nebraska Administrative Code?

CHRISTINA SCHEER: Administrative Code, yes.

SENATOR CRAWFORD: Okay. So you're talking about the regulations in place. Yes. All right.

CHRISTINA SCHEER: Yeah, the Title 471.

SENATOR CRAWFORD: Okay. And the actual formal regulations are...have not changed but you are seeing the interpretation or application of the standards being changed.

CHRISTINA SCHEER: Correct.

SENATOR CRAWFORD: Correct, all right. All right. Thank you for that. I appreciate that clarification.

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

CHRISTINA SCHEER: Thank you.

SENATOR RIEPE: Do we have other testifiers?

RENEE KAMP: Hello. My name is Renee Kamp, R-e-n-e-e K-a-m-p, and I too am a pediatric physical therapist in Omaha. And I am not going to beleaguer anything that we have previously heard because we're all faced with the same challenges in our profession. One thing that I would like to say is that the company that I contract with in Omaha has recently been having a lot of problems with the reimbursements from these various MCOs. This is a problem that has

basically begun since the privatization of Medicaid, so effective like January 7 of '17. And I am seeing a little boy, and I have seen him weekly, and they have not received any payment or reimbursement for my services since January. It is going on July.

SENATOR WILLIAMS: January of '17?

RENEE KAMP: January, I'm sorry, January of '18.

SENATOR WILLIAMS: Okay.

RENEE KAMP: So six, going on seven months. Thank you for your clarification. They cannot afford to continue in this manner. They also have problems with preauthorizations, as had been spoken about before, in that they think that they have the preauthorization received. They receive a code. And then when they go to bill for said services then all of a sudden they weren't preauthorized so, sorry, you cannot receive payment for those services. All of this, of course, puts everything on hold. And most importantly, and I think what we're losing sight of in this entire process, is the families and the children are the thing, are the people that are being put on hold, the important things that we work with everyday. It's why I chose this profession. I love working with disabled children and their families. And they are constantly put on hold due to insurance issues, equipment issues, whatever it may be. And we have just witnessed what these families go through on a daily basis, the challenges that they are already faced with, and we add to that stress and those challenges when they don't deserve it. And so it's a broken system. It has been for a long time. And it needs to be fixed and it needs to be addressed. And you can have all of your neat little reports that have all of the statistics, the data, everything else that we heard about at the very beginning of this meeting, and they don't mean anything when it comes down to the families and the people that we serve. It's a real source of frustration for me, and I guess I just can't put into words how I feel for these families and what a travesty it actually is. So thank you for your time.

SENATOR RIEPE: Okay. Let's see if we have any questions. Any from the committee? Senator Crawford.

SENATOR CRAWFORD: Thank you, Chairman. And thank you for sharing your professional experience. Most of the testimony that we've heard has been about Nebraska Total Care and changes there.

RENEE KAMP: Um-hum.

SENATOR CRAWFORD: Are your comments...are your experiences with other providers similar? Are your comment...let me back up, ask a cleaner question.

RENEE KAMP: (Inaudible).

SENATOR CRAWFORD: Are your comments (laughter) about your experience with Nebraska Total Care or are they comments that are more broadly applied to other MCOs as well?

RENEE KAMP: I would say at this point they all kind of fluctuate, okay?

SENATOR CRAWFORD: Okay.

RENEE KAMP: As was said before, each one has their strengths and their weaknesses. Some pay for certain things and don't pay for others. So a family needs to really look at each individual plan to see what best suits their family.

SENATOR CRAWFORD: Um-hum.

RENEE KAMP: And not one plan, of course, is going to suit and be appropriate for each family. That said, on my way down here, when one of my coworkers heard that I was going to come to this meeting, she received a fax last night from Nebraska Total Care denying a preauthorization for a little boy that we just received a referral on who was in a...he had been hit by a car, has a severely fractured leg, is immobile, lives on the third floor of his apartment building, cannot walk, cannot transfer, needs to be taught all of these things, as does the family to be taught these things. And then they determined that it was not medically necessary so they denied us visit, like any type of a referral. We cannot see that child because it's not medically necessary. Now I don't

know, but most therapists that I know would probably say that that's medically necessary for the family to continue on for the next 8 weeks, 12 weeks, whatever it is for this fracture to heal. And typically, you know, we don't abuse whatever, like, time frame that we have. Most of us do not, like, exceed...like just keep seeing children over and over and over and over again because we can. You know, that is something that you would be in, do your training with the family, show them, you know, problem solve with them, and then probably discharge. We're in and out of people's lives a lot. You know, if they need help down in the future, then we would be part of their life again. And then as far as like with WellCare, they are fairly noted for...with the whole preauthorization. You think that you have a "preauth" to see a child and you really don't. When it comes time to submit your claims then, no, we did not preauthorize you for that. Well, yes, actually you did. And so then you have to fight that battle. And then it just takes...the battles that are fought on a daily basis by people who do billing and who provide services is real. And, yeah, and like I say, each one is different. I have even heard...I won't go there.

SENATOR CRAWFORD: Yeah.

SENATOR RIEPE: Okay. Thank you. Are there other questions? Seeing none, thank you very much. How many more people do we have that are here to testify? Do we have any more? Okay. Seeing none, on behalf of the committee we thank you very much for all of your time and effort. Do we have some letters too?

TYLER MAHOOD: (Exhibits 7, 8, and 9) Yes. I have a letter signed by Heather Bird, representing Heartland Family Service; Andy Hale, representing the Nebraska Hospital Association; and Deborah Wegehoft, representing the Box Butte General Hospital.

SENATOR RIEPE: All expressing concerns. Okay, we will take a look at those as well. We appreciate the letters and, obviously, the engagement. Do you have a question? That said, that concludes this hearing of Heritage Health. We will be meeting again, I think in September, and we will be addressing issues that were brought up today with the people that execute the program and that's with the administration in the department of Medicaid and Long-Term Care. So again, thank you all for being here; we appreciate it. And thanks to the committee.