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The Committee on Health and Human Services met at 9:00 a.m. on Friday, September 7, 2018, in Room 1507 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public hearing on Heritage Health quarterly briefing. Senators present: Merv Riepe, Chairperson; Steve Erdman, Vice Chairperson; Sue Crawford; Sara Howard; Mark Kolterman; and Lou Ann Linehan. Senators absent: Matt Williams.

SENATOR RIEPE: Welcome to the Health and Human Services Heritage Health oversight committee hearing. This is our actual sixth hearing and we appreciate the fact that you all have an interest and that you're here. My name is Merv Riepe. I serve as the Chairman of the Health and Human Services Committee. I represent Legislative District 12, which is the Millard and Ralston area, if you will. Today is your public part of the legislative process and this is your opportunity to express your position before us today. The committee members may come and go during this particular meeting. It is not indicative of their lack of interest, it is simply a matter of conflicting schedules, if you will. I ask that you abide by the following procedures. One is to, please, like I have done, is silence my cell phone, and to move to reserve chairs if you do intend to speak. Today we will have a set order of testimonies, first kind of a...we will not have...it's a first come, first served. And we ask you to sign in so that we have an idea as to who is testifying. We will also, if you do come in front of the mike, we're going to ask you to state your name, spell your name, and indicate to us who you represent so that we can get all of this captured. We'll also...as usual, I ask you to be concise and to go into specifics so that we don't end up going over time. Well, I don't think today we're going to use a clock but we will see. I don't think we'll have to. If you do have written materials we would ask that you distribute those to the committee members prior to coming up here. We normally have a requirement for ten so that all the members can have those here. And the committee members with us today, I will ask them to introduce themselves. And I would start with Senator Howard, please.

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

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

KRISTEN STIFFLER: Kristen Stiffler, legal counsel.

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

TYLER MAHOOD: Tyler Mahood, committee clerk.

SENATOR RIEPE: We also have Senator Linehan, who is a committee member, and she will be here I think in short order. And Senator Kolterman is planning on attending. He's been a little bit under the weather. Also, I wanted to introduce...peeking around the corner here is Alyssa and she's the page. And if you do happen to need copies of something that you want distributed, Alyssa will be like lightning and zoom out of here with it and come back with it and give it to you. With that, I would like to move on into just a few remarks as we go into the hearing or the meeting. Today, September 7, as I said, is our sixth Heritage Health oversight committee hearing. An agenda for today's meeting has been provided. While issues remain, progress has also been made in outcomes and processes. Due to the testimony that was received during the last hearing, Dr. Van Patton requested he have the opportunity to further explain medical necessity and how medical necessity is determined. So we will be...that will be a main focus of his remarks in the briefing. So that said, Director Van Patton, I would invite you to come forward and to make your presentation.

MATTHEW VAN PATTON: (Exhibits 1-4) Good morning everybody. Hope all are well. Chairman Riepe and members of the Health and Human Services Committee, my name is Matthew, that's M-a-t-t-h-e-w, Van Patton, 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, submit for your review the calendar year 2018 second quarter report on Heritage Health, Nebraska's Medicaid managed care Program. This report is organized into five sections, some of which are familiar to the committee: business performance; stakeholder engagement; quality management

and performance improvement; a focus on medical necessity; and the future, a discussion on recent and upcoming changes in the division. Few programmatic changes have occurred since our last briefing in June. As such, there is very little change in the data and performance metrics found in the first three sections of this report. I would encourage the committee to review the first three sections at your leisure and follow up with any questions you may have. I ask the committee to now please join me at the beginning of part IV on page 26 of the report. Where I would like to focus my testimony today, this section of the report focuses on the role of medical necessity in the Heritage Health program. Historically, all Nebraska Medicaid programs have used the state's medical necessity requirements with prior authorization services. In consideration of balancing the interests of stakeholders in all Nebraska Medicaid programs--including the Heritage Health program--all healthcare services that are covered under the program must be medically necessary. The general guidelines for medical necessity are outlined in Title 471 of the Nebraska Administrative Code. There are eight criteria that guide all services provided under Nebraska Medicaid which are listed in this report. They are: 1. Necessary to meet the basic health needs of the client; 2. Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the covered service; 3. Consistent in type, frequency, duration of treatment with scientifically based guidelines of national medical, research, or healthcare coverage organizations or governmental agencies; 4. Consistent with the diagnosis of the condition; 5. Required for means other than the convenience of the client or his or her physician; 6. No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency; 7. Of demonstrated value; and 8. No more intensive level of service than can be safely provided. Current medical necessity regulations require the Medicaid member's individual circumstances are taken into account. For example, a member's available community support and living arrangement may disqualify them for the same service that someone with the same diagnosis may receive through Medicaid living in a community where supports are different. The Heritage Health program allows for a more accurate evaluation and appropriate application of services than was possible prior to 2017. All of the MCOs in the Heritage Health program are required to follow the state's medical necessity definition. The MCOs' contract requirements also specify the decision-making time frames for service authorizations and appeals. For the MCOs, medical necessity is determined by a licensed clinician. A clinician, being a physician, nurse, or therapist, is able to use professional judgment, i.e., the clinical practice guideline, in determining whether the service being requested meets

medical necessity criteria. All denials or limitations of requested coverage for services are determined by a licensed healthcare professional. Peer-to-peer clinician review is brought into the process in the event of disagreement by the requesting practitioner when an adverse determination is rendered. Peer-to-peer reviews are performed with a clinician in a similar specialty during an appeal. Applying medical necessity is a tool by which utilization is monitored, ultimately to optimize care in the appropriate setting and at the appropriate cost. Turning to page 27, Figure 25 details how the MCOs utilize medical necessity when preauthorizing services. Beginning at the top of the graphic, a prior authorization request is entered into an MCO's system. If all requirements are met, including medical necessity guidelines, the service is authorized. However, the request may be denied in the event there is insufficient information. In this case, the MCO may request additional information. When all of the necessary information is received, it is then reviewed for medical necessity. If the necessity of the service is confirmed, the service is authorized. If necessity of the service is not confirmed, the MCO will deny the prior authorization. However, the MCO may require more information in peer-to-peer review to confirm this decision. Included with this report are three attachments with the types of services for which each of the MCOs require prior authorizations. Of all claims processed by the MCOs year-to-date, claims paid for services requiring prior authorizations represent only a small percentage of the total claims paid. For example, within this current year, year-to-date, Nebraska Total Care, just for example, has processed 1.5 million claims thus far. Of that, 22,127 prior authorizations were entered. That constitutes a percentage of about 1.475 percent of all claims processed by Nebraska Total Care. Turning to page 28, we begin the section on service decision types. Although the last section focused on prior authorizations, medical necessity is a component of the authorization process for all service types. The time frame of a decision depends on the service type. Noted on this page are three of the most common utilization management decision types that each of the Heritage Health MCOs make. Nonurgent preservice decisions are the first decision type noted on this page. They must be made within 14 days of the MCO receiving the request from the provider. The MCO can extend this time frame for an additional 14 days if it is unable to make a decision due to factors it cannot control, such as incomplete information. When the MCO makes its decision, it must be communicated to the provider within one business day. This day must be within the time frame of the 14-day period. An example of this type of decision would be an authorization for in-home skilled nursing visits. Next are urgent preservice decisions. This decision type is similar to the previous type but on an

expedited time frame. The MCOs must make these decisions within 72 hours. An extension of 48 hours is allowed if needed but it must be requested within 24 hours of receiving the request. When a decision is made, it must be relayed to the provider within one business day inside of the MCO's decision time line. And example of this type of decision would be when a member leaves the hospital and is discharged to their home and requires a ventilator. The final decision type noted on this page are urgent concurrent decisions. Urgent concurrent decisions are needed when a member is currently receiving ongoing care, such as inpatient hospital care, and the care provider determines that the member needs care in addition to what was originally authorized by the MCO. When a provider submits an urgent concurrent request to the member's MCO, the MCO has 24 hours to make a decision and communicate the decision back to the provider. There are a few situations in which this time frame may change. One such case would be if the provider requests an extension more than a day before the initially authorized period would end; another would be if the provider is requesting an additional authorization for care unrelated to the initial approval. In both of these cases, the MCO will have 72 hours to make a decision. An example of this decision type would be if a member was admitted to the hospital for two days for total knee replacement. If the member was experiencing uncontrolled pain at the end of two days, the member's physician may request the member's inpatient stay be extended. Turning to page 29, we begin our section on member appeals. All Heritage Health members have the right to appeal their MCO's adverse decision. This encourages members to be engaged in their own healthcare. Per federal regulations, members must appeal decisions to their MCO before the appeal is escalated to the state. On this page we have included a list of instances in which a member may file an appeal with his or her MCO. Figure 26 illustrates the member appeal process. Following an adverse decision the member must contact their MCO according to the instructions in their member handbook to initiate the appeals process. It is important to note that members cannot appeal an adverse decision more than 60 days following the decision. At this point, the health plan evaluates the appeal and makes a decision. They will either overturn their initial decision or uphold the original decision. Members can file for a state fair hearing after completing the appeals process with their MCO if they still disagree with the MCO's decision. Turning to page 30, Figure 27 illustrates the state fair hearing process. Within 120 days of an MCO upholding an adverse decision, a member can contact DHHS to request a state fair hearing. The process for contacting DHHS to request a state fair hearing is available in the MCO member handbook, as well as in the adverse decision letter sent to the member. In the event that the appellant member

is not satisfied with the state fair hearing outcome, the appellant has the right to take the case to state district court. The court will then decide if the law was accurately interpreted in the state fair hearing. "Future Roadmap" section, beginning on page 32 is our section on recent and upcoming changes in MLTC. The first topic I would like to share with the committees...with the committee is MLTC's plan to carve in non-emergency medical transportation, or NEMT, in the Heritage Health benefits package. MLTC's plan to carve in NEMT into Heritage Health's benefits package was first addressed in DHHS's July 2018-June 2019 business plan. An example of this service would be transportation to routine doctor's appointments. Including NEMT in the Heritage Health benefits package contributes DHHS's division-wide goal of integrating services and partnerships and will help MLTC realize the advantages of managed care. NEMT is currently provided via a fee-for-service broker contract with IntelliRide. These fee-for-service claims are currently paid in the state's aging MMIS system. The state of Nebraska's current contract with IntelliRide will expire at the end of June 2019. With the goal of sunsetting the claims broker function of the MMIS, combined with an increased focus on our health plans to deliver cost-effective, whole-person care, MLTC sought alternative ways to administer this service. After assessing options in light of the Triple Aim--better quality, cost containment, and an improved experience for both providers and members--MLTC decided the best way to administer the NEMT service was to carve it into the Heritage Health benefit package. The Heritage Health MCOs are both contractually bound and financially incentivized to ensure their members access the health services they need, especially in regards to preventative and primary care. Thus, the MCOs have a vested interest in providing transportation to members who would otherwise have difficulty in keeping their healthcare appointments. Carving NEMT into Heritage Health bridges a gap in the continuum of care for all members and enhances Heritage Health's ability to provide person-centered care management. Additionally, DHHS will be able to set performance standards for NEMT, similar to other performance standards in Heritage Health. These standards can be tied to financial withholds to promote quality service for Heritage Health members. MLTC will engage stakeholders, including both members and NEMT providers. NEMT providers will be advised of MLTC's targeted launch date of July 1, 2019. Figure 28 on page 33 provides a projected time line for the NEMT carve-in project. Another upcoming Heritage Health project is the redevelopment of the Heritage Health on-line public dashboard. The Web address for this dashboard is available in this report. A team including members of MLTC communications, plan management, and data and analytics are developing a new

dashboard that is more concise and useful to all stakeholders. This dashboard will be updated on a quarterly basis. The team aims to launch the dashboard at the beginning of October 2018. When the new DHHS Web site launches in 2019, MLTC communications will begin exploring ways to continue improving the public dashboard function. I would also like to share with the committee updates on recent Heritage Health administrative simplification projects. The Heritage Health Administrative Simplification Committee has recently completed two projects at the advice of stakeholders from across the state. The Nebraska Home Health prior authorization request form, a project that began with a suggestion from the Nebraska Home Care Association, is nearing completion and is currently with the NHCA for the association's review. This form is a common prior authorization form for all home health services, including nursing and therapy services. Additionally, a common prior authorization form for hearing aids is nearing completion. This project began with an idea from the Nebraska Speech-Language hearing Association to streamline the process by having a universal form that is accepted by all three Heritage Health MCOs. The draft form was formally reviewed by the NSLHA earlier this week and will soon be finalized by MLTC. Finally, I'm excited to share with the committee that Dr. Larra Petersen joined the staff last month as the new deputy director of healthcare informatics and business integration. Dr. Petersen previously oversaw population health, episode payment models, post-acute care, and analytics at the Methodist Health System in Omaha. Recently, she developed and oversaw the Nebraska Health Network's strategic plan on clinical and organization priorities for accountable care. She also oversaw the development and implementation of strategies, policies, and procedures facilitating clinical integration and population health across a multidisciplinary network of physicians and clinical staff from separate institutions. Her background and skills will help her fit well into her new role, which began on August 20, 2018. The division thanks Kris Azimi for serving as deputy director in the interim. Thank you, Mr. Chairman and members of the committee, for your time here today. This now concludes my report.

SENATOR RIEPE: Thank you, Dr. Van Patton. Before we go further, I did want introduce Senator Mark Kolterman, who has joined us, a long-standing member of this committee, so we're glad to have you here. Dr. Van Patton, I know I want to express an appreciation. I know that you're in the middle of budget work right now, too, so that...but we needed to stay on track with

our hearing. And so you did double duty and we appreciate that. I'd like to at this time open it to any of the committee members who might have a question of you. Do we see any as such?

KRISTIN STIFFLER: Senator Howard (inaudible).

SENATOR RIEPE: I'm sorry? Oh. Oh, sorry. Dr. Howard (sic).

SENATOR HOWARD: Oh, upgrade.

SENATOR RIEPE: Well, I don't know on a given day--maybe not.

SENATOR HOWARD: Thank you for visiting with us today. Can you give me an update on the MMIS system upgrades?

MATTHEW VAN PATTON: Sure thing. So since my arrival, Senator Howard, and it was reported at last committee hearing update, we have effectively engaged our team to create a sunset plan for the MMIS system.

SENATOR HOWARD: Okay.

MATTHEW VAN PATTON: As you know, its multicomponents are aging. It's 44-plus-years-old COBALT system. Attracting staff who still have an understanding of how to use that system, they're limited in the marketplace, they're aging out and retiring. So that is a problem, as well as the ongoing maintenance of that system, which costs the state about $4 million a year just to keep that old enterprise up and running. So we have taken an approach of a modular development and movement of different components out of that system so that the...probably the one at the forefront of everybody's mind, certainly mine, and to the credit of the agency now having the skills of Dr. Petersen on our staff, is the data management and analytics component which will move our Encounter data into our new DMA platform that Deloitte is building. And we're on a production time line to have the MVP product open by June 2019. So it's a modular removal. And as I said in my testimony, there are components that are still in there that are at the forefront of my mind such as our claims processing system for those remnant populations,

NEMT being one of those claims that process through there. And I think to on a year's basis we process about 4.5...excuse me, 450,000 claims in NEMT through that enterprise. So moving those things into Heritage Health, where we already have a ready, accessible network...excuse me, ready and accessible claims processing enterprise within our MCOs makes a lot of sense as we're moving things through the sunset process.

SENATOR HOWARD: So when you say the sunset process, the first step would be June 2019 for the data management?

MATTHEW VAN PATTON: That's the DMA, and there are other components to it.

SENATOR HOWARD: Do you have sort of a time line or a plan that you could share with us?

MATTHEW VAN PATTON: It's being created by the agency now and there are components of the time line, so you would see the NEMT being one of those time lines as tied to it as we give consideration to what's still being fully managed by that enterprise. But in terms of the full construct of that plan, it's not ready yet, and the agency is still working on that, Senator.

SENATOR HOWARD: Okay. And then I did want to ask about the transition for NEMT because we've had a lot of problems with IntelliRide. I get reports from the PSC about how many problems we've had with IntelliRide. And so for your functionality you're shifting NEMT into the Heritage Health because it's probably easier to manage. But is it your expectation that we'll see better services from that as well?

MATTHEW VAN PATTON: Easier to manage from my perspective, yes, because we do have the aging enterprise and we need to figure out how we mitigate those claims processing services that are still there, yes. It's more of a philosophical engagement for me at a very high level. When you are engaged in managed care, the benefit of managed care is care management. And so you have individuals who miss primary care appointments or they simply don't attend. When you have the ability to effectively manage the care within a contained enterprise, such as what the MCOs provide for us, you have greater engagement. So at the same time you're setting up the appointment for the physician office visit, you're aligning that appointment for the ride services

to be made available as well. And so what the MCOs do, in terms of who they contract with, just as we would be in the same position with our expiring contract with IntelliRide, we'd have to go out to procure a new contract. That would be up to the MCOs to acquire contracts with providers that could fill that service within the marketplace. And that would be in their professional judgment which ones best fit their enterprise, best fits their needs, and would able to deliver the product at the highest quality component in the marketplace.

SENATOR HOWARD: What type of guidance have we given them in regards to NEMT and their contracts?

MATTHEW VAN PATTON: So this is a carve-in process again, as we said, so we're just beginning the process of discussion as to how this would be fully folded in. That's why there's a 2019 movement towards this. It will take time for us to properly account to all the components that will have to be considered and let them have the time to build that enterprise.

SENATOR HOWARD: But as a state, what are we telling them exactly that we want them to do?

MATTHEW VAN PATTON: I'll tell you at this point, Senator Howard, I would rather follow up in questions...take that question and then go back to the staff and look at what we've done in terms of communication, and then communicate that back with you before I say something that's not factually correct here.

SENATOR HOWARD: Okay, thank you.

SENATOR RIEPE: Thank you, Senator. I have a question. You talked a little bit about the information technology. I think in there I picked up on the word "build." I'm curious how much of it is off the shelf and how much of it is customized specifically for your division?

MATTHEW VAN PATTON: Within...well, there are multiple enterprises that are underway at this point. We have engagement on enrollment and eligibility systems, we have engagement with Deloitte and the DMA. So some of those enterprises are coming in where there is existing architecture. So you buy the architecture, or it's like buying a prebuilt house, and then you...the

programmers go into the existing architecture and they begin to build the modules inside of it. And that's really where the expertise of both our staff at understanding policy and eligibility and requirements that would be relayed back to the programmers as they build where this becomes time consuming and labor intensive. But I think in today's marketplace with technology companies you have ready-built infrastructure that you can acquire and you just build and you create a system that's specific to you and your needs by tweaking what's inside of that existing architecture. And I would say the same thing holds true with the platform we're building with Deloitte. Deloitte has built DMA platforms for many entities, so we are able to capitalize on that market knowledge but then just modify the system to accommodate Nebraska-specific needs.

SENATOR RIEPE: I assume that that's the reason Deloitte was selected, given their experience with similar operations?

MATTHEW VAN PATTON: I would say that's probably a factual statement, Senator. That selection occurred before I arrived but I would say that would be a true statement, yes.

SENATOR RIEPE: Okay. Another question I have is, do we have any data on how many appeals have been gone through the managed care organizations? Is there both maybe an absolute number and a percentage?

MATTHEW VAN PATTON: I'm sorry, Senator, I didn't hear the...

SENATOR RIEPE: The appeals, how many appeals do we...have we had in X period of time?

MATTHEW VAN PATTON: Appeals? I think when I checked with our state fair hearing office...if you'll bear with me one second I'll make sure I'm...total appeals for year to date going through state fair hearing related to Heritage Health: 56. These are appeals where a hearing was held and an order was written. It does not include cases where there was a summary dismissal, so 56.

SENATOR RIEPE: Okay. Under the issue of medical necessity, in your presentation it appears that it's mostly either, which makes it sound pretty simple, it's either up or down, yes or no, and

yet has discretion go and fall in favor of the individual making the decision that they're able to use that discretion when it's a, quote unquote, gray area?

MATTHEW VAN PATTON: Well, I think that's the benefit of the peer-to-peer review. That also why you want clinicians at the helm making those decisions. I also again want to reiterate the vast majority of claims go through...there's consideration of medical necessity with every claim. It's just really the volume that really ramps up is around the prior authorization request. And so there's a reason why the plans managing their populations have a certain number of procedures that they--or services--that they require prior authorization for. And in that process, you know, when you look at it in terms of how it works, the vast majority of those things are straight up and down, it's just pretty black and white. It's really when you begin to get into questions about what this provider thinks is necessary versus what is prescribed by those boundaries I read forth for you that are prescribed in our law that we have to follow. And then there also comes into account professional judgment, as well as evidence-based practices in the marketplace coming from various trade associations that have created new practice provisions or medical science or direction and guidance from other governmental entities, as I said. So that's also the benefit of having the physicians at the helm and other clinicians at the helm. But when it comes down to it, it's a sharing and a meeting of the minds within that process. And so that's, I think, a very equitable balance that we've created within the construct of medical necessity is that it's at a level where individuals who have the professional competencies and skills, as well as the training, are in a dialogue to really reach a point and a course and direction on determination.

SENATOR RIEPE: In your opinion, is it more complicated on the behavioral side than it is maybe the physical side in terms of making those medical necessity judgments?

MATTHEW VAN PATTON: I don't know that I would say either one. I think every case, every situation is unique. And I think that's also a point that needs to be made is we have an integrated care plan, which has physical, mental, and pharmacy completely integrated. You're looking at the total construct of need around that patient. And so Senator Crawford had asked some follow-up questions about data and if we could break it out. Well, you can't really break it out where it's statistically valid to know what's going on in a care exchange. You may have an OB/GYN who's talking to a mom who has just delivered and they're addressing issues, you know, related to

postpartum depression. That's a mental health, that's a behavioral health issue, it's going on in that care exchange, so you don't always know that without having to go through a full chart review as to whether or not that occurred within that care venue. So that's why it's pretty hard to break that out. So going back to your question, I don't know that I would say it's either one is more difficult than the other because it is truly situational and it's based on, again, the variables around that patient and around that patient's needs.

SENATOR RIEPE: I bring that up only because at times we've had concerns expressed about whether something was authorized or not authorized. And it seemed to me on an empirical study I guess of one that it functioned...more concerns came from the behavioral health side than they did from the physical side. And maybe that was the difference between smaller providers and larger providers on the physical side with even physician group practices, hospitals, etcetera. Just kind of a point of curiosity. Senator Kolterman, please.

SENATOR KOLTERMAN: Thank you, Senator Riepe. Sorry I was late. I had another meeting before this one. When you start talking about pharmacy as part of the managed care organization and you start looking at, you know, obviously we encourage generics, we have a preferred drug list.

MATTHEW VAN PATTON: Correct.

SENATOR KOLTERMAN: And according to what I read here that because of the rebates it allows those preferred drugs in many cases to become just as competitive as generics. There's some talk in Washington to eliminate rebates completely. How would that affect our plan and how...in other words, do we have provisions with pharma to take care of those, to lower their prices so that we don't have to rely on rebates?

MATTHEW VAN PATTON: Let's just say in broad constructs, if the rebates were to be eliminated I think you have a very natural fall-back position in that you already have the entities' and our MCO's capability to manage the pharmacy benefit as it currently stands. So let's just say in theory that that was completely eliminated; you then have the pharmacy management service already integrated into the MCOs and Heritage Health. So there would probably be a financial

impact on the state to a certain degree. If I could quantify that at this moment? No, I couldn't, Senator, but...

SENATOR KOLTERMAN: But that's what I was getting at. If that would happen, there would be a potential cost to the state.

MATTHEW VAN PATTON: Yes, potentially.

SENATOR KOLTERMAN: The other question I have around that, do we...who manages the benefits? Do we manage the benefits or do we help pick the preferred drugs or do we let each of the three managed care organizations handle that?

MATTHEW VAN PATTON: That's a fair question. So the construct of the state's pharmacy administrative services is broken into a couple of levels. You may be familiar with the construct of the pharmacy and therapeutics committee, you may have heard it referred to as the P&T committee. That committee, as I understand it, there's members, and I have not had the opportunity to make any appointments but I understand those appointments are made by the division's Medicaid Director. The P&T committee's function is to review the formulary that the state has set forth, those drugs that are on our preferred drug list, and to make decisions as to what actually makes it onto the PDL and what doesn't. A second function of pharmacy services is drug utilization review. Now, each of our MCOs do drug utilization review according to their own health plans, so there's some degree of duplicative infrastructure there. Our drug utilization review service is contracted currently through the Nebraska Pharmacy Association and they provide drug utilization review for the state for that service. But when it comes to deciding again what happens, what goes on the PDL, that is determined by the P&T committee. They meet at regularly scheduled intervals and it's a form much like this, as I understand it, where entities can come and make their petitions known and decisions are then made at that juncture.

SENATOR KOLTERMAN: And once that happens, let's say that one of the organizations decides they don't want to use this preferred drug any longer, take it off the formulary list. How is that information sent out to the patient that's been using that particular drug for so long?

MATTHEW VAN PATTON: Senator, to my knowledge we haven't made any edits to take drugs off the preferred drug list. And I think it's also important to note that if the FDA has an approved drug then Medicaid is required to cover that drug. Now, that doesn't mean that it necessarily makes it onto our PDL, it just means that it can be covered, it just has to go through prior authorization and the normal running of the gauntlet for medical necessity, if you will. But in terms of migration on and off, if something were to theoretically come off the PDL list, that would then be a provider bulletin that would be sent out in an update to both prescribers as well as the pharmacies letting them know that that happened. And then if individuals I guess were on that particular medication that was on the PDL, there may be some communication that would come out from the plan to them to let them know. But really, I don't see how that would really affect them, other than it would have to go through a prior authorization process possibly. But there are mechanisms within our administrative infrastructure to communicate with the provider community I guess is the quick and easy answer to your question.

SENATOR KOLTERMAN: Okay. One last question?

SENATOR RIEPE: Absolutely.

SENATOR KOLTERMAN: On the rebates, does the state get the rebate or does that managed care organization get the rebate?

MATTHEW VAN PATTON: The rebates come back to the state.

SENATOR KOLTERMAN: Okay, thank you.

MATTHEW VAN PATTON: Yes, sir.

SENATOR RIEPE: Senator Crawford.

SENATOR CRAWFORD: Thank you, Chairman Riepe. And thank you for being here today.

MATTHEW VAN PATTON: Yes, ma'am.

SENATOR CRAWFORD: I wonder if we could just talk a little bit about some of the numbers that are on page 6 and 7. So just understanding this claims process and how medical necessity enters into that, so if I understand, on the bottom of page 6 these would be...this is the percentage of claims rejected, so these would be the claims that would be considered unclean claims, is that correct? I mean...

MATTHEW VAN PATTON: I have...

SENATOR CRAWFORD: I mean the claims that just get sent back, that there's something wrong with it?

MATTHEW VAN PATTON: If I could, Senator, I have a handout that might be helpful, again, explaining this process.

SENATOR CRAWFORD: Okay.

SENATOR RIEPE: Okay.

SENATOR CRAWFORD: Okay. And I...all right.

MATTHEW VAN PATTON: So...

SENATOR CRAWFORD: So the next table that we have would be the percent of claims, and I'll look and see at the figure. The next table, the figure 6, claim rejected, all right. So the next figure, figure 6, would be of those claims that don't get kicked out because they're rejected, the ones that get denied for some reason. And that might be medical necessity, that might be duplicate claims, you have the other reasons that might be. So one...my main question is, as we look at those numbers in figure 6, right now it looks like they're close to 20 percent for 2 of the providers. So about 20 percent of those claims are getting denied. Is that a cause of alarm or what would that figure need to get to before we felt like we have a concern with claims being denied or providers not being informed about medical necessity? In other words, as you look at...as you see these numbers that come in for the providers on claims denied, what are you

looking for and what would be a figure that would cause you to say, oh, something is going on that we need to do something about?

MATTHEW VAN PATTON: If you will permit me, Senator, I think to properly unpack all that was just brought into the conversation there, let's go back to the document that I just passed out, if you would, because there's a term of art that's being used that's really not part of the industry's nomenclature, and that is "clean claim." And what I want to reiterate is that it is simply a claim.

SENATOR CRAWFORD: Claim, right, okay.

MATTHEW VAN PATTON: So when you look at the adjudication process, this graph and very simple construct, the claim is submitted, the claim is rejected upfront, meaning it doesn't enter the system because it's data in. If the data that comes into the system doesn't have the basic components for adjudication, it's going to get kicked back out. So that can mean it's incomplete information, wrong provider number, incomplete documentation. If it's not there, it's not going to go through because it simply can't be processed because it doesn't have the proper information for adjudication. That is a rejected claim. So the percentage of claims rejected is what's represented in figure 5, okay? If you go over to claims denied, on figure 6, so claims going through the adjudication process are either paid, again, or they're denied. And so the vast majority percentagewise of the claims that come through every day are claims that they simply go through run-of-the-mill business, they're paid, they're denied, and in that box you see the top reasons for denial. Maybe it's a duplicate claim; they've billed Medicaid when there's a primary provider...another coverage that should that billed primary; the time limit for filing the claim has expired, which is something that happens in the marketplace, providers don't submit times within the time frame required for a submission and, therefore, it doesn't get adjudicated...or it doesn't get paid, excuse me; and then the service may not be covered by Medicaid. And so when I look at these percentage rates and I look at the list of the reasons why, do I think that there's cause for concern within these numbers as I see them at this point? No, ma'am, I don't. I think this is normal course of business and I think this is in line as best we can tell at this point with what's happening in neighbor states as well as at the national level.

SENATOR CRAWFORD: Okay. I was just going to ask if it's in line with what we see in our neighboring states. And you believe that it is?

MATTHEW VAN PATTON: Yes, I think that this...

SENATOR CRAWFORD: All right.

MATTHEW VAN PATTON: I think Nebraska is performing incredibly well at this point within these processes...

SENATOR CRAWFORD: Thank you.

MATTHEW VAN PATTON: ...considering the volume of claims in total that we run through every single day.

SENATOR RIEPE: Senator Howard.

SENATOR HOWARD: Thank you, Senator Riepe. I wanted to ask you about long-term care because we've had conversations in the past about rolling long-term care services into our managed care plans. Do you still have plans for that?

MATTHEW VAN PATTON: We've got another handout if you are interested in it.

SENATOR HOWARD: I am interested in those handouts.

SENATOR RIEPE: Okay.

MATTHEW VAN PATTON: There are two here, and I'm going to...I'll circulate this one first because this is 2017 and this is 2018. So that's the top and that's the bottom there.

SENATOR HOWARD: Sure.

MATTHEW VAN PATTON: Thank you. And if you would leave one of those for me. Sorry, I'm getting ahead of myself, thank you. All right, so the first pie chart that you see there, the one that has "No Rating" at 7 percent in the green slice, this is 2017...representative of 2017 data. Let me tell you what this is and why this is an important piece of this conversation, Senator Howard. When I first came and was on-boarded into Medicaid and its full functionality, of course, I think there's also a notation here, long-term care services, the per diem day rates are not part of Heritage Health at all. They are still paid through that aging MMIS claims brokerage system. And again, it's another problem down the road for me. As I'm losing that processing ability through that MMIS system and the claims that go through for these services, we have to buy an aging...or we have to either replace that or be on a path to carving it in. And we already know the cost of replacing the claims brokerage system is about $24 million. So we already have an enterprise that can process those long-term care claims through what we require within Heritage Health and the MCOs at this juncture. So what I would tell you is that there is a march towards carving in long-term care services into managed care. That being said, what's of more concern to me right now in the marketplace, and as we currently have a methodology for calculating per diem rates, that's done under what it known as a cost-based reimbursement model which is something that, as I've said on a couple of occasions to many individuals, both who are probably in the audience behind me and then to you separately as we've talked about long-term care services, cost-based reimbursement modeling is not an effective way of setting rates for the state in part because it actually has a built-in mechanism to incentivizing those to perform poorly or perform less, have less administrative efficiency within their enterprises. And you actually end up rewarding those who operate less efficiently, and those who perform better end up having lower costs so their reimbursement is lower. And you can see that to a certain degree played out in this pie chart. What's more interesting to me, and what should be of primary concern to you, is the value of the buy that Medicaid makes in the marketplace related to the quality of services returned against that buy. When you look at this pie chart and you see the per diem rates, what we...what our staff did is they went through and they took all the skilled nursing facilities in the state, they went through and organized them by their per diem rate, and then cross-referenced those facilities with their CMS--Centers for Medicare and Medicaid Services--star-rating system, which is assessing their quality of performance both in terms of staffing, safety, facility services. It's a pretty comprehensive metric. We can share that with you after the fact if you're interested in learning. Or it's available, readily available on CMS's Web site. We cross-referenced each facility

with their star rating and then we went through and we broke them down and created this representation. What is most pointed about this, and where you should be focused, is that there is a quality chasm in the marketplace in this state related to the delivery of services. We have facilities who are performing at five and four star, roughly 50 percent of the market. We have the rest of the market at three, two, and one star, and that set, that "No Rating" means that they were not in the market long enough to actually have data reported for them within the CMS system. So that's 2017. What's also very interesting about this is when you look at the one-star performers in the marketplace and you look at the five stars on average, the average per diem rate for those, there's a delta of $20.20 difference between what we're paying our lowest performers in terms of the quality that they're delivering in the marketplace and those that are performing at the highest. And to me that's problematic because you have folks who are doing an outstanding job in their facilities, they're really focused on the things that create a good, safe environment and a quality care experience for the patients--and the providers, frankly--within those environments, and then you have that small delta between. So if you flip to the next one, this is the 2018, where we recently did our statutory re-basing, same allocation. What's more interesting about this is the delta between the top performers and the delta between the bottom performers is $13.48. So it's narrowed. In 2015...excuse me, 2017 data, we were actually paying two-star performers less than we were paying three-star performers on average with the average per diem rate. So for me, the march towards full-on managed care, the first stop in the progression there is to address quality in the marketplace. And I highly recommend a new formulary that takes into account, that ties rate setting, rate reimbursement...or excuse me, rate setting and reimbursement to quality scores so that we then begin to create a natural incentive in the marketplace for performance to come up. That, again, goes to the value of the buy that Medicaid is making and it goes to what I would consider fulfilling the broader objectives, which are pointed and part of Medicaid's direction of fulfilling the Triple Aim: focusing on quality, focusing on cost, but focusing on the experience for both the provider and the beneficiary. So as you're moving towards, I think your intermediate stop should be somewhere in the space of tying rates to quality performance in the marketplace. This quality chasm is of very pointed concern to me.

SENATOR HOWARD: Are you not able to do that administratively, or do you need an act of law?

MATTHEW VAN PATTON: At this point I think, Senator, I would have to go back into the statute to see where that is. Currently, rates, I can tell you, are in regulation. So regulation...the cost-based reimbursement model is codified in regulation, so that would have to be modified. And so in terms of the process that would have to be undertaken to change it, I know we would have to go through some regulatory reform process at a minimum. There may be...

SENATOR HOWARD: So then are you still intending to roll long-term care into managed care?

MATTHEW VAN PATTON: That would be the best course in direction, ultimately, yes, ma'am. I think that's where it's best suited because, again, I think you have to talk about the broader interest of the marketplace and the experience of the consumer. And I'm fully well aware, too--I think I want to make it very clear--I understand when you talk about long-term care services you're talking about different populations. They just have been folded into this broader term. And I understand the management of certain populations. There's developmentally disabled adults being folded in versus those who are aged and disabled in skilled nursing. That's a different population, it's different management. I completely acknowledge that is a reality of the march towards and I think that's why, first and foremost, as we look at long-term care reform, this is the first stop in the march towards, if you will.

SENATOR HOWARD: Value-based billing is the first stop. Or value-based payment systems?

MATTHEW VAN PATTON: Pay for performance I think...

SENATOR HOWARD: Pay for performance.

MATTHEW VAN PATTON: ...would be more appropriate term of art to apply to it, yes, ma'am.

SENATOR HOWARD: So then what would your time line be for rolling long-term care into managed care?

MATTHEW VAN PATTON: I don't have that in my mind at this point. And I think there's still additional stakeholder engagement. I think it's very fair to say we know the marketplace

dynamics, we know what's happened with facilities in the marketplace, have certainly caused us to look at how we're currently reimbursing within this cost-based model. And I think that we have to have additional stakeholder engagement, and that certainly has time line associated with it. But I don't want to put a mark in the sand that I can't hold myself to without proper study and due diligence.

SENATOR HOWARD: So, and I apologize, this is the last one. So what's your time line for pay for performance?

MATTHEW VAN PATTON: I'd like to see us move sooner towards that than later. I think that we have to address the quality chasm. We owe ourselves that, our beneficiaries that. And so I would really like to see the agency begin to lay tread on moving into that payment methodology within the next couple of years.

SENATOR HOWARD: Okay, thank you.

MATTHEW VAN PATTON: Yes, ma'am.

SENATOR RIEPE: Senator Kolterman.

SENATOR KOLTERMAN: Thank you, Senator Riepe. I have some questions, Doctor, about with the major...you know, it doesn't sound like a lot. So you've got a one-star versus a five-star, and I appreciate the fact that that's come down, the delta, the difference between those has come down considerably, but it's still almost $5,000 a year per bed. So that's a lot of money to these homes. And we've already seen closures of about four of them in the state, maybe five. We've taken some of those over. Are we managing those homes now?

MATTHEW VAN PATTON: I would have to say, Senator, Medicaid is simply the payer in that, in terms of what's happening on the day-to-day administration of those facilities. And what's happening with the receivership with those facilities, that is a matter of public health and the receiver. And so I don't always keep line of sight into what's happening with day-to-day management. In terms of payment, I can tell you that our team is monitoring and we stay on top

of making sure payments are processed in a timely manner, of course, back to those facilities so that they do maintain solid revenue lines coming out of Medicaid as it's applicable.

SENATOR KOLTERMAN: So when an organization goes under, and we've seen that because of...many times because of such low Medicaid reimbursement rates, along with other things, of course. When the state takes it over, they take it into receivership and have somebody manage that for them.

MATTHEW VAN PATTON: Correct.

SENATOR KOLTERMAN: Do they stay at the same level of reimbursement that they were at or do we give them a little bit more because the state's managing it and they're supposed to be better?

MATTHEW VAN PATTON: They...as I understand it, the facilities coming into the receivership were at a rate and then they go through annual re-basing every year. And then those rates are re-based and whatever their performance level is at that point dictates that rate, which, again, the facilities, if you're talking about that have entered into receivership, just got their 2018 rate re-basing. So that happened I believe at the end of June or July. So those facilities have, just like every other facility in the state, received their rate notification. I want to go...I want to dive deeper into the subject area that you've taken us into with facilities. Medicaid, in the grand construct of the management of these facilities, is but one payer within the marketplace. So facilities operating in the marketplace, if they are maintaining healthy payer mixes, they're going to have both commercial, if their service is in the marketplace for long-term care, they're going to have Medicaid, they're going to have Medicare, they're going to have private pay. When you begin to look at those facilities as well, you have to look at their census rates. Do those facilities have enough bed stays to justify their administrative overhead and their existence in the market, are they getting enough people in those beds? So there are a lot of factors that go into what I would call the overall management construct of those facilities. And again, I want to say Medicaid is only one portion of the overall management paradigm in that management consideration.

SENATOR KOLTERMAN: Doctor, I understand that. But the reality is in the state of Nebraska over 50 percent of our long-term care population is Medicaid. And in some instances we've got facilities that are 90-some percent Medicaid or 85 percent Medicaid. That, if we base it on a model that it really kind of penalizes the higher number of beds that you have on Medicaid, the people that are in those homes, aren't we really...because we have a lot of homes that will take a handful of Medicaid but that's not their goal. Their goal is to make a lot more money, so they'll take mostly private pay. Now, some of them get there and end up on Medicaid and they won't kick them out. Somebody would kick them out. So somewhere that's flawed. And I happen to have a couple of them in my district, three at least, that are...they take a lot of Medicaid and they don't get a lot of private pay. So we're really penalizing them because when you look at the dollar, the difference, if you were to give them $5,000 a bed more per calendar year, they might be able to at least break even. Right now they're bleeding. So how do we address that issue? That's a key issue in my opinion.

MATTHEW VAN PATTON: I think that should be part of the conversation. And I would say, where are those facilities are also falling on the quality scale? Are they four, are they five, are they three, are they two, are they one?

SENATOR KOLTERMAN: Right.

MATTHEW VAN PATTON: Under a pay-for-performance model you begin to reward those that are performing better in the marketplace, delivering better services, operating more efficiently. So I think it all washes out when you go into a model like that because if they're doing a good job in the marketplace and we build a system that rewards that performance, you begin to move their pay up. If they're not performing at the level, it sets the level at the bottom, then you give incentives for them to move up and increase their performance.

SENATOR KOLTERMAN: But there's nothing in our statutes I don't believe that says we have to take, a home has to take, a licensed facility has to take a certain amount of Medicaid.

MATTHEW VAN PATTON: Senator, I don't know that.

SENATOR KOLTERMAN: I don't think there is.

MATTHEW VAN PATTON: I couldn't comment as to whether that was true or false.

SENATOR KOLTERMAN: I just don't want to see the people penalized that are on the lower end of the spectrum because they can't pay for themselves and there's not enough other people in the facility to shift that cost.

SENATOR RIEPE: Thank you.

SENATOR KOLTERMAN: Thank you.

SENATOR RIEPE: Senator Erdman, please.

SENATOR ERDMAN: Thank you, Senator Riepe. Thank you, Dr. Van Patton, for being here. Senator Riepe had asked the question about how many appeals you had and you had stated 70...56. Can you share, do you have the information to tell us how many of those went to the state fair hearing from that process?

MATTHEW VAN PATTON: Those would be the state fair hearings.

SENATOR ERDMAN: Okay.

MATTHEW VAN PATTON: Those would be the ones that came to my desk.

SENATOR ERDMAN: Okay. So what is a state fair hearing? Can you describe that for me?

MATTHEW VAN PATTON: So that's the process after you've gone through those processes that we walked through in the presentation. And the beneficiary disagrees with the outcome of the MCOs, they then say we want a state fair hearing at that point. And then they meet with the hearing office, the hearing office does their process, and then ultimately it comes back to my desk and then I enter the ruling. And then if the ruling goes back, again, if they don't like what

the agency has determined, then it can then go on into the court, and that's their right to take it there.

SENATOR ERDMAN: Okay. I was listening to the conversation that you had with Senator Kolterman. I'm not by any means an expert on nursing homes but I have several in my community and in my district. And one of the cities was managing a nursing home and they weren't making it, so they contracted with somebody to do that. And what I have discovered, like in real estate, there are three very important things, they're: location, location, location. And in nursing homes, there's three important things: management, management, management. And that management firm took over that nursing home. In the first month that they were there they made $39,000, and they've made more money since. So the point was the city was trying to run it, didn't have the correct management to make the current decision...correct decisions. The management people came in and did it according to what needed to be done to be efficient, and they're making money and they're expanding. And so, Senator Kolterman, maybe in some of those cases it's a different management style or a different attitude towards what service is being rendered or done. How they're done makes a huge difference. And so it's interesting to see how that works. Some work and some don't.

MATTHEW VAN PATTON: Yes. Yes, sir. I'd also like to share with the committee another perspective. If you look at initiative with AARP, which is aging in place, we have the opportunity now...and to your point, Senator Howard, how soon do you get there? Well, part of the infrastructure within our constructs of managed care, again, you're managing the physical, behavioral, and the pharmacy component. When you're managing that comprehensively, you can begin to wrap services around that prevent overutilization of institutionalizations in the state. And if you really begin to ask people, where would you rather go, would you rather recuperate in home, would you rather stay in your home longer with services more appropriately wrapped around you to support the constructs of a stay at home, most people would say yes. And in most situations you can deliver the same level of care and get the same outcomes, if not better outcomes, by wrapping their services around the individual and letting them stay home, where you prolong the need to institutionalize them. That's not to say you won't always have a need for institutionalized care, you will, but at least when you have managed care you can really get in and engage with that patient, with their family, determine what the constructs and the resources

are that could be wrapped around to keep them in that place. And I think that should, as much as we look at reforming and tying pay for performance to how we pay our nursing home facilities in the marketplace, we should also look at the constructs of how we apply our managed care portion to keeping those individuals and the resources that are available to them within their home and wrapping those services around. It's a dual conversation, it's also one of the key benefits of managed care, and I think that again goes back to the Triple Aim of cost, of quality, and experience, and improving that across those three lines. And I think that's a major experience improvement for most families. We recently experienced it in our own family, where we decided to keep my wife's grandfather at home and bring in home health and hospice services into the home versus putting him into a skilled nursing. It worked better for the family and everybody was at greater peace with that. So I've seen it work and I know how it can work very effectively in the marketplace.

SENATOR RIEPE: Well, I think the issue of aging Americans and aging Nebraskans is a major issue and runs...ranges from forever homes all the way to occupancy and payer mix and resources that the individual may have and just the absolute cost of going. And you can take a small fortune and turn it into nothing in a matter of years--very complicated and not going to go away anytime soon. Are there other questions? Senator Howard.

SENATOR HOWARD: Thank you, Senator Riepe. I wanted to ask you, because Medicaid expansion has been certified on the ballot and you're our Medicaid Director, I wanted to ask for your thoughts and feedback about the time line for the state plan amendment should it pass in November and what your plans would be for that population.

MATTHEW VAN PATTON: Well, I would say at this point, Senator Howard, it would be more appropriate to say let's see what the will of the people are when they go into the ballot box come November. I think they have a lot of things that they have to weigh in making that decision: the cost of what that will be and if that's what they want. What I will say in terms of time line and infrastructure is that I have a very highly functional and professional staff who understand the mechanics of what would have to be done. In terms of an actual time line, I can tell you it would not be an overnight turnaround. There are a lot of things that would have to be considered, all things we deal with on a normal day-to-day routine business basis in Medicaid. But I'm not

going to put myself to a time line simply because I can't work like that in the constructs of an "if-and-but" situation, so.

SENATOR HOWARD: I think it says that you would have to have a state plan amendment by April. Would you be able to do that, would your team be able to do that?

MATTHEW VAN PATTON: You know, at this point, Senator Howard, I would rather not give an answer as to whether or not that could be done or not, simply because there are a lot of variables that I'd have to weight out with them in totality. And we've talked about the construct but in terms of actually being able to hit a time line, again, it's not something that would be turned on overnight.

SENATOR HOWARD: And then would it be your intention that the new population would be rolled into managed care or would the state be managing that for MMIS?

MATTHEW VAN PATTON: Again, before I comment on what could be or could not be, I would rather see what the will of the people is. And we'll make our determination as to what we do after the we see the will of the people.

SENATOR HOWARD: So you've done no planning?

MATTHEW VAN PATTON: No, ma'am, I didn't say I've done no planning.

SENATOR HOWARD: Okay.

MATTHEW VAN PATTON: I said that our staff are well aware of what the construct would be...

SENATOR HOWARD: Okay.

MATTHEW VAN PATTON: ...to implement. But at this point, we are a lean agency. We have a lot of work that goes on every single day. So to begin to lay plans to do something that may or may not happen, we know the components of what the plan would be, we know how to get there.

But in terms of actually mapping out a production time line, which if you...Senator Riepe can tell you, and others who have been in my office, there are multiple project time lines that get mapped out by our staff. If you're asking me if I've gone to that level of detail, no, simply because I don't know the will of the people and what that will be expressed come November.

SENATOR HOWARD: And just out of curiosity, because you said you're a lean agency, how many open positions do you currently have?

MATTHEW VAN PATTON: That number fluctuates daily. I meet with HR every two weeks. I don't keep up with it in terms of an actual metric. They come through in job openings and then we assess the position and then I send back my approval as to whether or not the positions get filled. What I can tell you from my assessment is that I've got a third of my work force is currently at, eligible to, or long since past eligibility to retire. And so for me that's a very pointed concern with my work force and my ability to continue to operate down the road and an ability to attract talent. So I manage my work force very carefully. To that point, we're engaged in several activities, such as member...excuse me, all-staff meetings where I go and I meet with the staff, and then also my deputies have regular one-on-ones with their directors and then it passes down. And so during my deputy director meetings, always on our agenda is topics of HR, so we're keeping a finger on the pulse of what's happening in our agency.

SENATOR HOWARD: Are you able to share how many open positions you have at a point in time with the committee?

MATTHEW VAN PATTON: Sure.

SENATOR HOWARD: Thank you.

MATTHEW VAN PATTON: Sure, we can do that. I just don't have that number off the top of my head.

SENATOR HOWARD: Sure, thank you.

SENATOR RIEPE: What was the percentage that you said that we're in?

MATTHEW VAN PATTON: It's about a third.

SENATOR RIEPE: About a third?

MATTHEW VAN PATTON: At...within two years at or past retirement eligibility.

SENATOR RIEPE: Okay. Other questions from the committee? Thank you. It's been a good presentation, good dialogue. We appreciate that very much.

MATTHEW VAN PATTON: Thank you.

SENATOR RIEPE: Seeing no further questions, we're going to move to the open hearing. I would ask for a show of hands how many people do we have that intend to speak? Okay, one, two, three. Okay, that's great. We would invite in any order, kind of a first come, first serve, no pushing, no shoving. It's very helpful, too, if some of you are going to testify, if you could fill in the front row and that way we'll be able to move along a little quicker. Welcome. Thank you very much for being here. If you would state your name and spell it for us and then share with us who you represent, that would give us (inaudible).

SHEILA AUGUSTINE: (Exhibit 5) Absolutely. Good morning and thank you for the opportunity to address you guys today. Mr. Chair Riepe and members of the committee, I'm Sheila Augustine, S-h-e-i-l-a A-u-g-u-s-t-i-n-e. I'm currently the director of patient financial services at Nebraska Medicine. At Nebraska Medicine I'm responsible for both hospitals' and the providers' billing. I have worked with UnitedHealthcare's provider advocate, Meagan Weese, since 2013. I'm very frank, I'm very open with any questions or issues that I may be experiencing. I will tell you Meagan and her team of provider advocates have the full support of the UnitedHealthcare staff and leadership. Any issue large or small gets immediate action. The UnitedHealthcare provider advocates have resolved some challenges that we have experienced with trauma claims and credentialing issues. Communication is based upon taking action to resolve any of our needs. I take my concerns directly to UnitedHealthcare, not by calling DHHS

to then call UnitedHealthcare. They should hear from me what I'm experiencing so they can understand what they can do to help. UnitedHealthcare's attention to detail and results-oriented attitude allows for my team to complete their processes and feel confident that UHC has demonstrated best efforts to address our needs. There will always be challenges within healthcare but what makes the biggest difference in working through those challenges is having a solid relationship and folks take responsibility to do what they need to do to get the issue resolved. UnitedHealthcare continues to show their willingness to work with providers, they ensure that expectations are met in a timely manner, and continuously give us updates on their progress. This is due to their hard work and dedication.

SENATOR RIEPE: Okay, thank you very much. You've got a whole room just sitting here. Senator Crawford.

SENATOR CRAWFORD: Thank you, Chairman Riepe. And thank you for being here today, Ms. Augustine. I appreciate this review of your relationship with one of the providers. I was just curious if you also work with the other two providers as well.

SHEILA AUGUSTINE: I do. I work with all three of the MCOs.

SENATOR CRAWFORD: Okay, okay. And can you explain why you're primarily sharing your experience with one?

SHEILA AUGUSTINE: I am sharing my experience with UnitedHealthcare, it is a very positive experience, it has been that way since 2013. Two of the other MCOs are very new. I'm sure, as you all know--and I do speak frankly, sorry--as you all know, we went off to a bumpy start...

SENATOR CRAWFORD: Okay.

SHEILA AUGUSTINE: ...in January 1, 2017. I think we are all starting to get back to a good positive but I'm speaking on behalf of UnitedHealthcare simply because I have a very good working relationship with them and they are the first ones to resolve my issues.

SENATOR CRAWFORD: Thank you.

SENATOR RIEPE: Are there other questions? Seeing none, thank you very much for being here.

SHEILA AUGUSTINE: Thank you.

SENATOR RIEPE: Ms. Seelhoff, welcome. If you would be kind enough to state your name, spell it.

JANET SEELHOFF: Sure.

SENATOR RIEPE: You know the drill. Thank you.

JANET SEELHOFF: (Exhibits 6 and 7) Good morning. My name is Janet Seelhoff, J-a-n-e-t S-e-e-l-h-o-f-f, and I am the executive director for the Nebraska Home Care Association, testifying on behalf of our members to give you an update on what's been happening since the last Heritage Health briefing. We had a meeting with the managed care leaders and Department of Health and Human Services staff on June 19. At that time we addressed 14 issues that were related to authorizations, 11 related to appeals or denials of services that were past 90 days: at that point, over $523,000 in outstanding claims that were past the 60-day mark. We also talked about overpayments that have been issued to our home health agencies at that time. We talked about interest payments that were not being made to our providers for claims that were past 60 days. We also talked about, as Director Van Patton mentioned earlier, developing a common prior authorization form. And we also just made a request for ongoing education and training and good communication with our managed care plans. We also talked about contractual requirements and policies. And we do want to thank the HHS staff and particularly Kim McClintick, Lisa Neeman, and Denise Woolman for working with us on developing a common authorization for home health services. We received a draft and sent comments back from our association last week and are anticipating a follow-up communication from DHHS and really feel like that will help streamline the authorization processes going forward. Just to give you an update regarding those 14 authorization issues I mentioned that were addressed at the June 19 meeting, 7 have been resolved and 3 are in the process of being resolved. The seven outstanding

issues are related to authorization of PRN visits, retro-authorization of home care visits for newborn babies. There's...we understand there's a delay in the assignment of their Medicaid numbers but there have been some issues there with retro-authorizations. There are always...there continue to be delays in receiving authorizations. We're aware that one managed care's fax system is not consistently picking up all the authorizations that are being submitted by our members and so that's been an issue that we're continuing to address with them. The ability to bill for hospice service intensity adds is still an issue. About two-thirds of our home health agencies do provide hospice services in Nebraska. And then a clear method of billing for home care-related telehealth services, and we are having conversations about everyone about that. And I've given you an attachment, I said "A" in my written testimony. It's labeled "Attachment 1," just to give you some more specific details about those issues. As I mentioned, communication is so important and we have asked our...the managed care plans to do some specific outreach, especially to home health agencies that have a high volume of Medicaid clients, but ultimately and ideally, all of our agencies. And we understand that the plans have a large number of healthcare providers across the state that they're contracting with but I think that is so important. And I've had some agencies report to me now that they've reached out to the managed care plans and they've been able to sit down and they're really looking at doing monthly meetings to go through claims with them. I listed an example here for you of one agency that, when they sat down with a managed care plan, they found there were 52 claims that the managed care plan did not find in their system, even though they had been submitted correctly and on time to that managed care plan. So I think those conversations are so critical. We don't know why that was the case but certainly that continuous follow-up is so important going forward. I also wanted to thank Dr. Kevin Nohner, I know he is here in the room. He is the medical director for UnitedHealthcare Community Plan and he reached out to our association. And we just had a conference call this week with three home health agencies that provide respite services for children. And there was some overlap, and the reason why is to make sure there's adequate nursing staffing for those clients. And we were able to start working on a plan to really collaborate and work through the scheduling with those agencies, so we really appreciate that. And I would say the managed care plans, if you see other issues like that and your medical directors do, please come to us and let's work together to figure those things out. With regard to reimbursements, right now, as of two weeks ago when I asked our members how many outstanding claims they had past 60 days, I had about 10 members who responded back to me

and estimated about $133,000 in outstanding claims. It is improving but that is still an issue that we see on an ongoing basis. As far as network adequacy goes, I'm glad to hear that none of our agencies have discontinued services for Heritage Health clients at this point. I am aware of an agency here in Lincoln that twice was close to closing their doors because of the amount of outstanding payments, and it's an agency that is primarily Medicaid services. They don't take many Medicare patients. They were owed six figures of claims going back to 2017 and then finally were paid last month for that, so we will certainly continue to watch that closely but are glad to see that they have been given payment for that. As far as ongoing issues, authorization denials, even though the agencies have submitted the claims on time and correctly--I'm sorry, not claims, but requests for authorizations--it seems like there is still systemic issues with that: some inconsistency between eviCore and the WellCare system with authorization of visits, slow responses and inaccurate responses from provider service representatives. One of the managed care plan's Web site has not been working correctly so it has been hard for agencies to get those authorization requests to go through. So they have gone to using that managed care plan's fax system, and sometimes those faxes are being lost. The one thing I hear consistently from all of my members is they will call in to request authorization and one person on the phone will say you're approved, you don't need prior authorization. Well, yes they do, so, and they know they need prior authorization, so they will call back, talk to someone else, and that person will say, oh, yes, you do need prior authorization. So there seems to be somewhere a disconnect in understanding the requirements with that. And then we've had some challenges with nonpayment for dual-eligible clients, agencies being asked to bill primary. In most cases that's Medicare, and in most cases that's unnecessary because that patient is not homebound so they're not eligible for Medicare services. And we'd like to just bypass that and be able to bill directly to Medicaid because that is who is the payer source in those cases. I would say overall things are improving. I mentioned the ongoing issues that our members are dealing with. I also wanted to thank Meagan Weese and Kathy Mallatt from UnitedHealthcare Community Plan for reaching out to us and meeting with us this summer. A couple of things that came out of that conversation is that we're putting together a presentation for their staff that just explains all the home care services and what that entails and what options look like. And we'll be sharing that also with WellCare and Nebraska Total Care. And then UnitedHealthcare offered to schedule quarterly calls with our members and I listed for you a long list of topics that would be included in that. But I think that will be very helpful for all parties, for their teams, the HHS staff if they would like to join those

calls, and our members to really talk about what are some of the common reasons for denials that you're seeing, just to go through a claim and help us better understand what's included in that, because sometimes it's very confusing to read a claim and know did I get full payment for that or was it partial payment, and if they're looking at making a change in coverage or processes, just to talk through that with our members ahead of time so we can really address any concerns that might happen and really resolve those before anything has changed.

SENATOR RIEPE: I don't want to cut you off but we're running without lights today.

JANET SEELHOFF: Sure, sure.

SENATOR RIEPE: And so I'm going to be a little bit invoking, if you will, at times to say, if you can...because we do have some other people.

JANET SEELHOFF: Absolutely.

SENATOR RIEPE: And we have people attending here that probably have to go to a wonderful luncheon.

JANET SEELHOFF: Sure. No, that was actually the final point I had, so I would be happy to answer any questions.

SENATOR RIEPE: Thank you. Are there questions from the committee? That's an important piece. Okay, seeing none, thank you very much. I think you've made some good points and we have them recorded.

JANET SEELHOFF: Thank you.

SENATOR RIEPE: Thank you. Doctor? We know you but...

BOB RAUNER: Okay.

SENATOR RIEPE: ...the record needs your name and spelling, please.

BOB RAUNER: (Exhibit 8) Right. I wrote it down, too, but...so Bob Rauner, R-a-u-n-e-r, here in Lincoln, Nebraska. I'm chief medical officer of OneHealth Nebraska. It's an ACO that has clinics in Lincoln and Grand Island, Nebraska. So I'm coming to follow up on some things. I've kind of just summarized in seven points where we're kind of at in our frustrations working with the Medicaid managed care companies. We have ongoing contracts with Medicare, Blue Cross Blue Shield, soon Aetna, and the Medicaid MCOs are one hole where we can't get things to work. Some of these things, you know, there was a plan for Heritage Health to enter the world of (inaudible) value-based purchasing and we already had that prior to Heritage Health. We had two good contracts with Aetna and Arbor. Our Aetna contract, when I left my prior job we were getting paid $6 per month but we were saving them $16. This works and we've got a lot of evidence that this does work in Nebraska. And I don't know if you know, but last week Medicare released its results on all the ACOs across the country. Eight of them are in here, Nebraska. Four of the eight saved Medicare more than $1 million. And so this has been going on for five, six years in Medicare. Our big frustration is we want Medicaid to get there. We were there two years ago. We don't seem to be there right now. Some of the problems come with they're just basic things. So we talk about billing. Well, what do...what's this whole clean claim thing? And I think you need to look at three different things as part of that number. It's not just simply one number you can look at. Number one, the first struggle is actually enrolling a provider because you can't file a claim if they don't know you exist. And we're still struggling with that. We've had MCOs where we've been working for six months or more to recognize that this doctor exists, even though they've practiced their entire life in Lincoln, Nebraska. That's important because you can't file a claim if they don't recognize you. And when you're in...it's especially a problem when you're a growing practice, you hire a new provider, and they can't bill that insurance company. Well, you're the guy on the call, you can't in theory see these patients but you have to. Well, that...but the Medicaid MCO is basically getting free care when that happens. The other thing, just filing a regular claim, it's one of the problems. We have actually a clinic that has been having trouble filing just well-child checks. That's about as bread-and-butter Medicaid as you can get. They've been seeing this insurance company's patients for years. Why suddenly can't they bill well-child checks, why are they getting kicked out, why are they getting denied? It's "not a clean claim," I guess, but it's a technical problem on the MCO side, not our side. And so that may not

be in those numbers that you're seeing. Twenty percent rejection seems really high to me. I mean, many of these things, someone comes in for an ankle sprain, a sinus infection, a well-child check, a well-woman exam, that's most of primary care. Those numbers shouldn't be that high. So why are there so many technical problems? Because you can't do anything if you don't have clean data to work off of. Enrolling providers is important because you can't figure who is seeing who if you don't know which providers go to which claim. So last week we had to negotiate with one of them, they threw up what they thought were our numbers, they started...I started looking at the list of providers they had and I said, well, wait a second, those people don't even work for us. So they sent us the list. Out of about 150, 50 of those providers were not ours. They were someplace else, other plans. One of them I actually went to residency with 20 years ago and he's been in South Dakota for 20 years. Thirty-two of ours that aren't...weren't on that plan, so there's no way you can run accurate numbers if you don't know which providers belong to which clinic and which system. And because of their enrollment issues, until they figure that out, that won't...they can't really do value-based purchasing like they claim to do. For Medicare, there's a PECOS system. All doctors are registered on that, we have to update it regularly. I can log in on my computer right now and look at Medicare and see who our providers are. I can do the same thing with Blue Cross. When we get a new provider with Blue Cross Blue Shield, I can get them enrolled in 10 to 14 days. Every quarter we update the numbers. We need an accurate way to list who's a doctor and who's not a doctor. It would be great to have one common system that everybody used. Nebraska, Bryan, and us all use the same credentialing system. Not one of them plans refuses to go by that credentialing system. It shouldn't be that hard. And so our struggle is it's these technical things. If we can't even get these technical things fixed, how can we move on to value-based purchasing? And my frustration is that we were there two years ago with Aetna and Arbor. And so the big thing I would say is at some point we need to move on, we need to do something. I think one of the problems is that there's nobody based outside of Omaha for a lot of these plans that we can work with at a system level. At our meeting last week, the three people in the room, one administrative person was from Omaha, the other two drove up from Kansas City, and the person doing most of the talk was actually I think in Indiana. And that's why they don't know what's going on outside of Omaha for the most part. So I think we need some more local representation. Other than when we were negotiating, I thought we finally were getting to the point where we might have an ACO contract with one of the managed care companies, and things start...ground to a halt a few months ago, found out, well, the two people we've talked to

have now resigned so they've got turnover. We're starting over again. So the one thing I would like to point out, Senator Howard, if this Medicaid bill gets passed, or this referendum, what is the plan going forward? I really think we need to find a way to cover people who have no health insurance in the state. So in one sense, I kind of want that to pass because we have to have something to cover those people. You know, family of four making minimum wage, they have to have a way to have health insurance. If Medicaid is the only way to get there, so be it. But right now, Medicaid needs some things fixed. And I think I'm worried that if it passes we'll have a bigger mess than we already have. At the same time, I still want these people covered, and so we need to figure something out. I wish we would look at what some other states have done that are kind of innovative ways. Arkansas is probably one of my favorite examples. They're the Section 1332 and 1115 waivers that allow you to do other creative things outside of a typical Medicaid system. And I think the Arkansas system is a good example we should follow. So if some people are starting to plan if that does pass, I really would hope we look at Arkansas or some of those other states with the waiver processes because there are ways to integrate what you're doing with Medicaid with what the private sector is doing. And so right now we're already there with Medicare...or we're already there with Blue Cross Blue Shield, we'll be there soon with Aetna, we need Medicaid to also be part of this whole thing. It's really hard, the problem with our clinics is you really...what we're trying to do doesn't work with a fee-for-service billing system. And so our doctors basically have one foot on the dock and one foot in the canoe. In the next year, we're just going to have to jump in the canoe; and if Medicaid can't go there, we just can't see Medicaid patients anymore. We have private practice clinics. Every single one of our clinics is willing to take at least some Medicaid. They see it as their civic duty to take Medicaid just like, you know, as a Christian I tithe. We think we should take care of Medicaid but at some point, if they're just not going to pay their bills, you got to move on. And so we're ready to go there if Medicaid would come with us. And so one option is actually contracting directly with the state in some fashion. You know, we're seeing a lot of businesses that are actually going around insurance companies and contracting directly. The latest one, I think Comcast, was in The New York Times, they're going directly to provider systems. Ironically, GM and Ford is contracting with Henry Ford Health System. I know locally you've got Warren Buffett and Jeff Bezos and Jeff (sic--Jamie) Dimon saying we've got to find another way around this. So to provide care--we can provide care, that's what our doctors and nurses do--we need a system that can integrate with what we're trying to do and we've got the numbers to back it up. Now I

could...next time I'll...I can bring in the Medicare numbers of all the eight ACOs. I've shared that with your committee in the past. It just came out Thursday so I'm not finished putting it together. But I'll put that together so you can see how everybody is doing in Medicare. I hope Blue Cross will release its numbers in the next couple months. They've got...they've been going for about four years now and we've got great results on that too. So with that, I'll answer any questions. Thank you.

SENATOR RIEPE: Okay, thank you. One of the questions I have, Doctor, did you contract with UnitedHealthcare on a value-based prior to Heritage Health?

BOB RAUNER: No, we've never been able to get something going with them, so.

SENATOR RIEPE: You...?

BOB RAUNER: Even with SERPA I couldn't get...we didn't have...we had a contract with Aetna and Arbor, but we didn't have anything going with UHC at the time. I don't know if they do now. Here in Omaha that's the meeting we had last week, and it took us six months just to get a meeting with them, so nothing with UHC yet.

SENATOR RIEPE: Okay. Okay. Are there other questions? Seeing none, thank you. Thank you for the information. We'll look forward to getting more information. Welcome.

SARA ELLIS: (Exhibit 9) Good morning. Thank you for the...

SENATOR RIEPE: If you'd be kind enough, state your name and spell it, and then tell us who you represent, please.

SARA ELLIS: You bet. Mr. Riepe, members of the committee, I am Sara Ellis, S-a-r-a E-l-l-i-s. I'm the director of patient accounts for York General Hospital. So at York General I am responsible for all the hospital billing. I worked with UnitedHealthcare provider advocate Jenn Nelson for over two years. And Jenn has worked really hard to establish a great relationship with us. I have great communication with Jenn, I've had outstanding service from her. I know I can go

to Jenn with anything and she can always help me. If I have an issue, Jenn will resolve it in a very timely manner and she'll keep me informed of the progress as it's getting resolved, which I find huge. We have monthly meetings with Jenn and we talk about anything I have to discuss, and she brings us proactive information about changes and provides training and education when needed. I appreciate the way UnitedHealthcare works with York General Hospital and Jenn's proactive approach to supporting our team. She is always informative in bringing awareness to upcoming provider expos, forums, and seminars. Those forums help my facility not only on the level of awareness to UHC requirements but it also allows York General to network on a broader spectrum with other facilities similar in size and build great working relationships, which I feel UnitedHealthcare is very supportive of. And we really appreciate all that they do to keep us going.

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

SARA ELLIS: Thank you.

SENATOR RIEPE: Thank you for being here. If you would be kind enough to state your name, spell it, please, and then tell us who you represent.

MARY WALSH-STERUP: (Exhibit 10) My name is Mary Walsh-Sterup, last name spelled W-a-l-s-h, hyphen, S-t-e-r-u-p, and I'm with Central Nebraska Rehabilitation Services. And we have clinics in multiple cities within the state of Nebraska. So first of all, I would like to thank you for taking the time to allow me to sit and talk to you today and testify before you. One year ago, in September of 2017, I was here and I testified before you about the struggles that we were having as therapy providers providing PT, OT, and speech with WellCare, and mostly with their third-party authorization that they had in place, eviCore. They were denying medically necessary care to the WellCare patients. As a large therapy provider in the state of Nebraska, we were very frustrated with the frequent inappropriate denials and significant increase in the administrative burden, to name just a few of the things that I think I testified about last year. We were at the point that we were considering dropping WellCare from our services. And at that time last September, several of my colleagues across the state were not taking WellCare for their Medicaid patients. WellCare listened. They heard us. Shortly after that testimony in October of 2017, they

put their authorization process on hold. They reached out to myself, as well as several other providers who testified that day and other providers throughout the state, and formed an advisory committee that addressed all of the issues that we were having with eviCore and the authorization process. They streamlined their process, they significantly decreased the administrative burden that we had, and developed a user-friendly product that made it easier for us as providers to use. They worked with us to help establish realistic norms and processes for the authorization requirements based on industry standards and looked at our professional associations for guidance. Once they established the system and put this in place, they had several people from eviCore who came from across the country to Nebraska and met with us on-site in our clinics to run test runs. When they were there and they continued to have struggles with their portal and they saw our frustration firsthand and things did not go as planned, Elsa (phonetic) with WellCare looked me in the eyes and said, we'll fix it and they'll be back. A week later they came back to Nebraska, they met with several providers in the Omaha area. Unfortunately, they couldn't make it out to our office in Grand Island because we had a little snow and they were from like California and Florida and weren't really, you know, happy to be driving on the roads. But I felt good about it because I was able to work with them on-line and on the phone. And I have a great deal of confidence that if I would ask them to come back again they probably would have. What's really important is during this time when they were continuing to...struggling with this, they further delayed the authorization process. They wanted to get it right before they threw it out there to us and made us deal with it. I guess my big message here today is to let you know that a year ago I was here and I testified about WellCare, but I'm very impressed as how well they listened. They reached out to us as providers; they formed an advisory group and worked collaboratively with us as a group to find a solution; they valued our opinions. Today, although it's not a perfect system, we all feel much better about WellCare and feel much better about working with WellCare patients and their clients. The authorization process is streamlined and much easier to use and they're responding in a timely manner about our request. There is a significant decrease in the amount of administrative burden that we experience, and for the most part we are getting paid and paid in a timely manner, which is really important. The bottom line is I think it's a win-win situation for all of us. It's a win for us as therapy providers because we're able to do what we love and provide care to our patients. But more importantly, it's a win to the patient, and it's a win to WellCare patients and the people of Nebraska, that they're able to get the services that they need.

SENATOR RIEPE: Okay, thank you. Let's see if we have any questions. Thank you very much for being here. It takes, yeah, it takes a lot to come back and say we've made...seen some improvements both from WellCare, and in this case we also have UnitedHealthcare. So that bodes well for the maturity of providers. If you would be kind enough to state your name and spell it, please.

DAYLE HARLOW: (Exhibit 11) My name is Dayle Harlow, D-a-y-l-e H-a-r-l-o-w, and I am with Fillmore County Hospital in Geneva. I was also here probably six months ago and testified against the MCOs. And since then, all three of them have reached out to us, have tried to make improvements. But when Heritage Health Medicaid program began in Nebraska in January 1 of 2017, I think it's safe to say that providers were unaware what a huge undertaking this would be. All three MCOs did do their due diligence by having meetings regularly throughout the state with information about their company and tried to be as transparent as possible. For Fillmore County Hospital, Medicaid makes up about 7 percent of our total payer mix, Nebraska Total Care being about 4 percent of the total Medicaid patient population for FCH. Throughout this transition, Nebraska Total Care has been extremely helpful and diligent with any and all issues we have had. Nebraska Total Care has an excellent portal with innovative technology that helps providers work their claims, look for procedures that need prior authorization, and other policies and procedures. Additionally, they provide a provider representative resource to each provider to help with any other issues that cannot be resolved on their portal. This representative has been extremely helpful to FCH and is very responsive and timely in her responses. Additionally, she comes on site monthly to help our billers and other staff with claim or any other questions one-on-one to help ensure our claims are being paid correctly. Our provider representative, as well as other employees within NTC, reach out consistently to see how things are going, which is very much appreciated. Additionally, NTC has been very helpful with providing clarification for the extensive behavioral health billing process. Each MCO requires a different type of submission and each cover different levels of practitioners differently. In the beginning stages of the adoption of Heritage Health, the behavioral health billing side was very challenging but NTC helped us through it and we are now billing appropriately, as well as getting paid in a timely manner. All in all, in my opinion, Nebraska Total Care has done an outstanding job providing enough resources to providers, aiding in claims issues and any other questions, and paying claims on time. FCH and NTC have worked closely together, have formed an excellent provider-

payer relationship with the same goal in mind of providing quality healthcare to residents of Nebraska.

SENATOR RIEPE: Thank you.

DAYLE HARLOW: Sure.

SENATOR RIEPE: Let's see if there are any questions.

DAYLE HARLOW: Sure.

SENATOR RIEPE: And I would like to point out Senator Linehan has joined us and so...

DAYLE HARLOW: Okay. Thank you.

SENATOR RIEPE: Okay, thank you very much for being here. Additional people that want to be heard? Seeing none...oh, whoops. I saw someone stand up. So, okay, then anything more from the committee? Seeing or hearing nothing more, do you have any written documents?

TYLER MAHOOD: (Exhibits 12-14) Yes, I have three letters. I have a letter from Leo Weiler, representing himself; a letter from Faedah Karbouj, representing themselves; and a letter signed by...or a letter from Lauralie Rubel of WellCare, representing members of WellCare.

SENATOR RIEPE: Okay, thank you very much. That submitted, that concludes this sixth oversight hearing committee. We appreciate everyone that's attended and we appreciate everyone that has come forward and testified and shared with us your concerns and interest and appreciation. So thank you very much. We're adjourned.