HOWARD [00:00:01] [RECORDER MALFUNCTION] the Health and Human Services Committee. I'm Senator Sara Howard. I represent the 9th Legislative District in Omaha and I serve as Chair of this committee. I'd like to invite the members of the committee to introduce themselves, starting on my right with Senator Murman.

MURMAN [00:00:12] I'm Senator Dave Murman from District 38. It's Clay, Webster, Nuckolls, Franklin, Kearney, Phelps, and southwest Buffalo County.

WALZ [00:00:22] Lynne Walz, District 15, Dodge County.

ARCH [00:00:24] John Arch, Legislative District 14, Sarpy County.

WILLIAMS [00:00:28] Matt Williams, Legislative District 36, Dawson, Custer, and the north portion of Buffalo Counties.

CAVANAUGH [00:00:36] Machaela Cavanaugh, District 6, Omaha, west-central Omaha, Douglas County, and I have a guest, Barrett, today.

HOWARD [00:00:42] So today we'll be continuing a series of briefings we're conducting with members of the agencies, so today we'll be hearing from the Division of Medicaid and Long-Term Care. And I'd like to invite Director Van Patton up to tell us a little bit more about his section of the agency.

MATTHEW VAN PATTON [00:01:11] Senator Cavanaugh, that reminds me of home. I have four of those myself, so--

HOWARD [00:01:21] Whenever you're ready.

MATTHEW VAN PATTON [00:01:22] Yes, ma'am. Thank you. Chairman Howard and members of the Health and Human Services Committee, my name is Dr. Matthew Van Patton, that's M-a-t-t-h-e-w V-a-n P-a-t-t-o-n, and I am the director of the Division of Medicaid and Long-Term Care services for the state of Nebraska within the Department of Health and Human Services. Thank you for inviting me here today to share information about the Division of Medicaid and Long-Term Care, or MLTC, and the work it does to help Nebraskans live better lives. Today I would like to provide an overview of what Medicaid is, its rules, our populations and services, and the division's organization. Beginning on presentat-- our presentation on page 2, the Division of Medicaid and Long-Term Care provides health coverage for eligible low-income, aged, and disabled individuals. This equates to one in ten Nebraskans receiving Medicaid benefits. The program has over 600 employees working within the constructs of seven sections which will be reviewed later in this brief. Our management of the program and our performance goals and measures are guided by what is known as the quadruple aim, which is as follows:

one, improving the patient experience of care in both quality and satisfaction; improving the provider experience of care in both quality and satisfaction; three, improving the health of populations; and four, reducing the per-capita cost of healthcare. In all our work we strive to fulfill as many of these aims as possible. On the next two pages, the committee will find high-level information on the Medicaid program, its history, and some of the rules that govern it. Established by Congress in 1965, Medicaid is a jointly administered state and federal program, as well as one of the state of Nebraska's largest expenses. Approximately $2.1 billion was budgeted for Nebraska's Medicaid program in state fiscal year 2017. Slightly more than 50 percent of this came from federal funds. The federal government gives states a certain amount of flexibility in managing their Medicaid programs. Federal law requires each state's Medicaid program to cover certain populations and medical services. However, states have the option to include additional services and populations other than what federal law requires. For example, dental services are not required by federal government, but Nebraska has opted to include this service in the benefit package. The majority of Nebraskans' Medicaid services are covered via Heritage Health, a managed-care enterprise that combines our physical health, behavioral health, and pharmacy programs into a single comprehensive and coordinated system for Nebraska's Medicaid and CHIP clients. Turning to page 4, the committee will find examples of the federal and state entities that oversee the Nebraska Medicaid program. The Centers for Medicaid and-- excuse me, for Medicare and Medicaid Services, CMS-- don't ask me why that acronym misses an "M," but that's just the way it is, and I will tell you, it's better than the old HCFA acronym that goes back decades, so CMS it is-- in the U.S. Department of Health and Human Services is the federal agency that oversees all Medicaid programs. In Nebraska, this is the Department of Health and Human Services, DHHS, which manages funding, reviews policy, and determines eligibility. The Medicaid State Plan is a contract between CMS and DHHS that outlines our Medicaid program services, eligible populations, delivery methods and more. Adhering to the State Plan allows Nebraska to draw from federal matching funds for our Medicaid program. However, CMS does allow exceptions from the State Plan in the form of waivers which allow Nebraska Medicaid to provide services in addition to the ones outlined in the State Plan. The state currently has a 1915(b), which allows for our managed care program, several 1915(c) waivers, including the aged and disabled and traumatic brain injury waivers, and a pending 1115 demonstration waiver for substance use disorder treatment. Moving forward to page 5, the committee will find a graph showing the average monthly enrollment of the Nebraska Medicaid program. As you can see, our enrollment has been largely stable since state fiscal year 2013 hovering between 230,000 and 240,000 people. The next page breaks down our enrolled population into its separate eligibility groups. The chart on this page is for state fiscal year 2018. The committee will note that children make up two-thirds of our enrollees while parent caretakers of adult disabled children, the aged, and the blind or disabled make up the remaining third of enrollees. All eligibility groups share certain eligibility requirements like residency and citizenship. Applicants are grouped into either the MAGI or non-MAGI. The MAGI group, meaning modified adjusted gross income, has their eligibility based primarily on their income, whereas the non-MAGI group has other considerations, including age or disability. Turning now to page seven, we outline the constructs of our Medicaid managed care program,

Heritage Health. Heritage Health launched in 2017 and is now the primary delivery system for Medicaid benefits in Nebraska. Once a Medicaid applicant is found eligible, they then join one of three managed care plans in Heritage Health, either Nebraska Total Care, UnitedHealthcare Community Plan, or WellCare. The basic benefits of all plans are the same, but each plan has unique value adds which may appeal to particular members. Enrollment has been even between the three plans for most of Heritage Health's operations. The committee will note that in January each of the three plans were within a few hundred members of being equal. Dental benefits are administered through a separate managed care plan with MCNA Dental. On page 8 we provide an overview of our Medicaid providers. As of July 2018, there were 47,939 in-state and 7,168 out-of-state providers enrolled within Nebraska Medicaid. Providers must enroll with Nebraska Medicaid in order to be reimbursed for services provided to Medicaid clients. Providers must also be credentialed by each of the health plans. With the majority of Medicaid clients enrolled in Heritage Health, the state makes per-member, per-month capitation payments to the Heritage Health plans. The plans then coordinate provider networks and provider reimbursement. Before concluding my presentation, I would like to share with the committee a brief overview of the division's financials. On page 9, the committee will find a chart breaking down Nebraska Medicaid's vendor payments for fiscal year 2018, which total $2.1 billion. Integrated care capitation, namely Heritage Health, made up more than half of these payments, totaling $1.2 billion. Nursing facilities and waiver services were a majority of the remaining portion of vendor payments. On the next page we've broken apart the integrated care capitation spend into its different service types. Outpatient hospital and pharmacy services are the two largest spends in this category. Finally, I would like to share a bit of information regarding our division structure. MLTC is organized into four primary units and headed by deputy directors: delivery systems, health informatics, business integration and population health, policy and communications, and finance and program integrity. Additionally, the State Unit on Aging and Medical Director also report to me as the director. Eligibility field operations are overseen in partnership with the Division of Children and Family Services, CFS, by the CFS deputy director of field operations who reports to both MLTC and CFS. Full descriptions of each of these teams are available for the committee on page 11, as well as an organizational chart on page 12. Thank you again to the committee for inviting me to share more information about our division and the work we do to fulfill our shared mission of serving Nebraskans of all ages. I thank you for your interest in our work. This now concludes my presentation. And if I may, Senator, I would like to say that in the front row here are some of the deputies that fill out our org chart. It's Karen Heng is enrollment and eligibility. Ms. Leschinsky is delivery systems. Mr. "Rocky" Thompson is policy and communications. And a few of our other folks, childcare and snow impacted their ability to get in, so some of them are working remotely and some of them are in other meetings today. But I would like to take just a moment, if I could, with this esteemed group's indulgence to say how very proud I am of the people that I work with. We have a devoted group of public servants who come in every single day and they do an enormous amount of work on behalf of the people of this state and they do it with a servant's heart and I am very proud to be affiliated with each of them. They are a wonderful group of competent and devoted public servants and I would be remiss to not take a moment in this public light to say

thank you to them for the work that they-- they do. I'd also like, with your permission, Madam Chairman, to disseminate to the group a document that this team produced for the Unicameral at the end of last year. It is our annual report and, "Rocky," it may have already been disseminated. Oh-- oh, you see how good they are? He's ahead of me. This may help fill in blanks as we're limited in time today. It's more comprehensive, so some of the constructs that we gave at a high-level overview in the briefing today are outlined in deeper detail there as well. I'll also note for the committee that we produce I think nine different reports for the Unicameral that we're required to produce by statute. So you do see reports coming back periodically over the course of the year that we are obligated to produce. And so I just wanted to make that notation for the committee, and that will now end my comments.

HOWARD [00:12:55] Thank you. Are there questions from the committee? Senator Williams.

WILLIAMS [00:13:02] Thank you, Chairwoman Howard. And thank you, Director Van Patton, for being here today. I just wanted to ask a question going in just a little bit deeper on Heritage Health and the managed care organizations-- that's been something that a number of us have focused on over the last few years even before you arrived here just less than a year ago I guess now-- and-- and would just ask the question for you to expound on, how do you feel that system is working at this point and are we-- have we gained traction? Are we moving the right direction?

MATTHEW VAN PATTON [00:13:41] I appreciate that question very much because it is in large part the broad constructs of what Medicaid is today. And we are definitely moving into a new era, not just in Nebraska but I think in healthcare in general. And so as you see the constructs of managed care and the benefit of broader care coordination and an infrastructure of what I would consider beneficiary navigation capabilities, having someone within the constructs of the managed care paradigm to engage with vulnerable populations who may have not had access to healthcare heretofore entering the Medicaid beneficiary system and to have that individual help them make appointments or help guide them into a primary care practice to get that baseline history and physical, that is-- that is a monumental shift for folks who, you know, in large part, if you're even an educated person, the complexities of a healthcare delivery system are vast and having those navigators is key. It's been a very key component of what I have pushed with the MCOs. It is a reportable on our monthly scorecard that, as a matter of fact, we have our biweekly meetings with them tomorrow. We meet twice a month with the CEOs and their deputies to go over operational business issues, again, twice a month, and one of the things that they produce is that scorecard that we've provided the committee last year, and we'll be happy to produce that same scorecard so you can see the performance metrics that we are now assessing our MCOs against. I would say to go even deeper, Senator, for those of you who don't know my vitae and past experience, I was a provider for the vast majority of my career in a hospital. So coming into this enterprise, I had some expectations, I had some-- some notions. And what I will tell you is that in comparison, and as I've ventured into what I would consider the social network circles of other states through NAMD, which is the National Association of

Medicaid Directors, and I've talked to other state exper-- state directors about their experiences with managed care, trying to get that benchmark, how has it gone for you, what I will tell you is that-- and again, I would be remiss to not say about the people sitting behind me the thoughtfulness that these-- this team of individuals-- I take no credit for this. They laid the foundation for the deployment of this. And with any large endeavor and creating a new product for the marketplace, a certain amount of thoughtfulness has to be applied, and it was done so here such that moving into year three, really, of Heritage Health, normalized business practices are in place. And the amount of individuals, I think it's 98 percent, the percentage covered by managed care in the state at this moment. And when you look at what we consider our issue logs, they're-- they're evolving. But we went from at onset-- which, again, you're in startup mode, over 200 open issues across each of the three plans at one point-- I would be remiss again to not let Ms. Leschinsky tell you the number of open issues today--

HEATHER LESCHINSKY [00:16:56] Four.

MATTHEW VAN PATTON [00:16:56] --four across all the health plans. That is I think a phenomenal testimony to the efficiency and work cadence and, again, the partnership and collaboration of, again, managing this enterprise according to the objectives of the quadrupling aim: focusing on the experience, focusing on the health, and focusing on the per capita cost and reducing that spend. So I would say, Senator, I feel very good about where the state of Nebraska is with that enterprise and I'm-- I'm very proud of the work and the work cadence and the partnership approach that these MCOs have delivered back to us. I'm not sure if they're in the room or not. I know some of their representatives are. But I know their CEOs would each tell me, and they all have, you are my customer, the state of Nebraska is my customer, and they approach their work very much from that mindset, which I very much appreciate.

WILLIAMS [00:17:48] Well, I-- I want to thank you and your staff for your very hands-on approach to those issues and from the-- the-- the list of things that I have provided at times, I appreciate the fact that those were addressed very quickly and resolution was found. So thank you--

MATTHEW VAN PATTON [00:18:06] Thank you.

WILLIAMS [00:18:07] --Director.

MATTHEW VAN PATTON [00:18:07] I appreciate that, Senator.

HOWARD [00:18:08] Senator Arch.

ARCH [00:18:11] Thank you.

MATTHEW VAN PATTON [00:18:12] Yes, sir.

ARCH [00:18:12] Just in time for the next round, right? Medicaid expansion.

MATTHEW VAN PATTON [00:18:15] Yep.

ARCH [00:18:16] So--

MATTHEW VAN PATTON [00:18:16] Yes, sir.

ARCH [00:18:17] So, you know, adding-- I don't-- what number do you estimate, 90,000?

MATTHEW VAN PATTON [00:18:22] Ninety-four thousand.

ARCH [00:18:23] Ninety-four? Adding that to the 230,000 approximately--

MATTHEW VAN PATTON [00:18:28] 245,000.

ARCH [00:18:28] OK, well, obviously, a big percent increase. So your evaluation now of progress towards implementation?

MATTHEW VAN PATTON [00:18:38] Yes, sir. Once the initiative passed, and even before we knew the constructs of the build-- and being an old hospital planner, and you as a provider, Senator, you'll appreciate this and how it works-- we break the production plan down into what we categorize as swim lanes. And those swim lanes, there are eight of them that we're working in, so work within each of those swim lanes, some of it may be working now, some of it may be working in tandem with something else in another swim lane. But we know what we're building to and we'll be happy to share in a review of that with you as well if you're interested in that. What I will tell you is that we are approaching this as the construct of a new product for the marketplace. And whenever you create a product, whether it be a new service line that you're adding within the construct of the hospital, as much forethought and as much planning, as much research and as much benchmarking as you can do to work through what your build and what your build components are and to anticipate where you're going to hit stops and stalls will go into making a very successful product once you're ready to flip the switch and put it into the marketplace. And this team has spent a significant amount of time, I would say, engaging with other states to benchmark with their experiences, engaging again with CMS, what is your insight, even conversations directly with Director Verma about forethought that she may have in terms of what Medicaid could experience. There's an ongoing dialogue with Idaho and Utah, who are also going through expansion, so we're sharing information and we're learning from each other. We're also-- ask our MCOs, you're in other states, other markets with expansion, can you give us insight into those markets/ And they have been very forthcoming with their experiences there. And then of course we also have the resources of, again, organizations like NAMD or other think tanks that have reached out directly to us to share data and perspectives

that they have. So all of that information, Senator, goes back into what I would consider advance planning, what has defined those eight swim lines that we're currently working in. And I will tell you up-front our focus is on the production of the State Plan amendment. Again, that's the construct of the contract that gives us the authority to manage the program according to approved terms by CMS. The amendment going in will have a concept paper that will outline what we intend to do, and that will be attached. And I-- I guess the best way for the committee to think of that is that that's the opening conversation with CMS as we begin the dialogue around what they will allow us to do or not to do. And so that's where the majority of our focus is at this point.

ARCH [00:21:29] If I could-- if I could follow up with another question, the-- the-- the number of variables in-- in the equation for how to estimate cost, and I know that-- and I know that other states have underestimated and-- and-- and it can be one variable off and you could have significant differences in actual to-- compared to projected. So how in-- how involved is your division in estimating the cost and-- and estimating those variables so that the Appropriations Committee might be as close as possible to-- to budgeting--

MATTHEW VAN PATTON [00:22:06] Sure.

ARCH [00:22:06] --accurately?

MATTHEW VAN PATTON [00:22:09] So I will tell you, Senator, that was probably the first and immediate review that our team started is looking at and estimating and again pulling that data what-- what can we anticipate in. And so the budget numbers that we included and are now incorporated into the Governor's budget, and I believe on page 44 of the Governor's budget you will find a grid that outlines our numbers, so I'll refer you to that. But, you know, at this point I would tell you, Senator, we have done our dead-level best to reach what we think is a reasonable estimate. That being said, and you're wise to ask the question, there are going to be variables that we just won't see of individuals who will come on to the roll that we-- we maybe did miss. But those are our best estimates and again, we've-- we've gone through a vast number of reviews and benchmarks to reach those numbers and we feel-- we feel pretty good about them.

ARCH [00:23:06] And your-- and your contact with other states and their experiences and where-- where they were off the mark as well?

MATTHEW VAN PATTON [00:23:11] Yes, sir, that's-- that's true.

ARCH [00:23:13] Thank you.

MATTHEW VAN PATTON [00:23:13] Yes, sir.

HOWARD [00:23:13] Other questions? Senator Cavanaugh.

CAVANAUGH [00:23:16] Thank you. Thank you for being here today.

MATTHEW VAN PATTON [00:23:22] Yes, ma'am.

CAVANAUGH [00:23:22] Page 44 of the Governor's budget has that chart. Is that projection based on the assumption of 90,000 new?

MATTHEW VAN PATTON [00:23:32] Ninety-three-- 94,000 individuals, yes.

CAVANAUGH [00:23:34] OK. And is it your assumption that we will have full-- I guess I don't know what you call it-- registration of new Medicaid individuals? Because that's-- that's-- they-- that--

MATTHEW VAN PATTON [00:23:51] Our assumption is that that would be--

CAVANAUGH [00:23:52] That's the population that it's going to be available to.

MATTHEW VAN PATTON [00:23:55] That would be the estimated-- right.

CAVANAUGH [00:23:56] That doesn't mean that that's the population--

MATTHEW VAN PATTON [00:23:57] --that will necessarily take that benefit.

CAVANAUGH [00:23:59] Yes.

MATTHEW VAN PATTON [00:24:00] That is correct.

CAVANAUGH [00:24:00] OK.

MATTHEW VAN PATTON [00:24:00] So that's what we estimate the number to-- to be. It could be, as-- as Senator Arch asked, it could be more than that.

CAVANAUGH [00:24:10] That are eligible?

MATTHEW VAN PATTON [00:24:09] Yes, that are eligible. But then again, you may have the benefit out there. But then again, it's incumbent upon the individual to take advantage of-- of the benefit and apply for that benefit. So that's the number we think it will be, but there again, who takes advantage of it, that will be incumbent upon them.

CAVANAUGH [00:24:28] In other states that have enacted the expansion, have you looked at what percentage of eligible-- eligible individuals have actually taken advantage of that expansion?

MATTHEW VAN PATTON [00:24:41] You know, I believe our team has, but I don't have those numbers right in front of me, but they all take copious notes and we can follow up with you to give you--

CAVANAUGH [00:24:49] That would be great.

MATTHEW VAN PATTON [00:24:50] --give you that.

CAVANAUGH [00:24:51] I think maybe if you could share that with all of us, that would be very helpful.

MATTHEW VAN PATTON [00:24:53] Sure, be happy to do so.

CAVANAUGH [00:24:55] Thank you.

HOWARD [00:24:55] Further questions? Senator Arch.

ARCH [00:24:59] So one of the generally recognized weaknesses we've struggled with over the years has-- has been the infrastructure of our-- of our information systems, whether it be signing people up, whether it be processing claims, what-- whatever it might be. Could you give us just a very high-level perspective of-- of where we are, where we might be going with that?

MATTHEW VAN PATTON [00:25:24] I sure can, Senator. Let me say this about the state of Nebraska and its approach to managing its systems. MMIS-- I'm 45 years old. I think MMIS here is 44. I'll tell you, if I have gray around my temples, so does that system. But I'll tell you, you sure did get your money out of that plow mule. It's done yeoman's work. The problem that we have with that architecture is that it doesn't meet new standards set forth by CMS on modularity and modernization. It doesn't. And you will appreciate again, Senator Arch, understanding the nomenclature of integration and interoperability. That old system is Cobalt based and it is not interoperable, nor is it going to integrate with other systems, and so that becomes a challenge for us in getting data in and getting data out. So we've actively engaged in a process of-- of setting a strategic sunset for that architecture. Now that's important because it ties into other systems. And so one of those efforts is our DMA platform-- that's our data management and analytics tool-- and this probably for me is the most exciting new tool that-- that Medicaid is putting in place. And it sets us up for, again, the ability to be integrated and interoperable and draw into other data sets so that we again get those more complete pictures, as we talked about the connectivity to the PDMP, as I gave testimony to-- with Senator Howard's bill recently. So that enterprise is very important to me and we're moving that forward with all due haste. We

started that project in June of last year and our team has worked quite diligently towards getting the MVP, the most -- the minimally viable product ready in June of this year, and of course then you move into maintenance and operations and you begin to perfect the system as you start to use it. In terms of the enrollment and eligibility system, you all probably read in the newspaper that we did put that project on permanent hold and ended our relationship with the systems integrator. I will tell you at this point we are assessing our options to move forward and that will be a conversation I'll-- I'll have to have with you at a later date because I do not have a defined strategic direction on that. In terms of the onboarding of the new population for the expansion group, we are going to be building in N-FOCUS, which is, again, our old enrollment and eligibility system. It's not ideal. It's not-- it's not what I would consider the best option. I would love to have had the new enrollment and eligibility system on line to accommodate, but we are not there. And so we're going to have to work within the construct of that system and it's okay. We just met yesterday and we've got a-- I think a good plan again to move-- move forward with that. And that, again, is one of our swim lanes is the technology component that we'll be building to. What I will tell you about that-- and again, this goes to things that will drive the timeline of expansion-- is that N-FOCUS is, again, the current enrollment and eligibility system that accommodates our existing beneficiary group and those beneficiaries served. So we do have to be quite careful when we began to make changes to that old platform that it doesn't impact the existing operations of that. And so we're-- we're working through that and that subject was addressed yesterday again in the working group to make sure that our plans accommodate testing so that we aren't impacting the experience that our existing group has. Again, that's-- I hold the quadruple aim out against everything that we do within our business paradigm. If you're going to build this platform, again, are you managing to that experience, and what are they going to have when they go into accessing that-- that platform?

ARCH [00:29:29] Thank you.

MATTHEW VAN PATTON [00:29:31] Yes, sir, quite welcome.

HOWARD [00:29:32] All right. And I just have one final question.

MATTHEW VAN PATTON [00:29:34] Yes, ma'am.

HOWARD [00:29:36] When we had our discussion about Medicaid expansion and the swim lanes, and I'm hoping you'll share the swim lanes with the committee, you'd mentioned an 1115 waiver with a two-sided stair step. Could you tell us a little bit more about that?

MATTHEW VAN PATTON [00:29:49] I'll give you a high-level framework of that. The way we're looking at it is creating a tiered benefit structure. Nothing is set in stone at this point in terms of how that would work, but we're looking at it from the standpoint of creating pathways in the enterprise for life success and engaging with individuals against those socioeconomic determinants of health. And that, again, is what I would consider contextualized within case

management infrastructure. Then on the other side, you would have care management infrastructure, and that, again, is moving people on pathways towards wellness. And if you're engaging with a population that we believe coming in are going to have some unmet health care needs, probably going to come in with a higher acuity of care, complex comorbidities that will have to be managed, again, bringing that case and care management infrastructure in and around this population to figure out where they are at a baseline and then help them find those pathways to success both on life, as well as on wellness, and that's the construct that we're thinking in. Again, Senator Howard, we will outline this in greater detail within that concept paper that we prepare and will be submitted with the State Plan amendment. And it-- all of that's being fleshed out at this point in time.

HOWARD [00:31:05] Well, thank you. I think I speak for all of the committee that we're very grateful for the time that you took telling us about your program today. And this concludes the Division of Medicaid and Long-Term Care briefing. Thank you, Director.

MATTHEW VAN PATTON [00:31:16] Yes, ma'am. You're quite welcome. It's my pleasure.

HOWARD [00:31:19] And this will open up-- Sherry, are we ready? OK. This will open the hearing for LB716, Senator Hilkemann. I'm going to start with some policies and procedures here for the committee. So good afternoon and welcome to the Health and Human Services Committee. My name is Senator Sara Howard and I represent the 9th Legislative District in Omaha and I serve as Chair of the Health and Human Services Committee. I'd like to invite the members of the committee to introduce themselves, starting on my right with Senator Murman.

MURMAN [00:31:46] Hello. I'm Senator Dave Murman, Legislative District 38, Clay, Webster, Nuckolls, Franklin, Phelps, Kearney, and southwest Buffalo County.

WALZ [00:31:54] Lynne Walz, District 15, Dodge County.

ARCH [00:31:58] John Arch, District 14, Sarpy County.

WILLIAMS [00:32:02] Matt Williams from Gothenburg, District 36, Dawson, Custer, and the north portion of Buffalo Counties.

CAVANAUGH [00:32:08] Machaela Cavanaugh, District 6, Omaha, west-central, and Douglas County.

HOWARD [00:32:15] And we are joined by our legal counsel Jennifer Carter and our committee clerk Sherry Shaffer and our committee pages, Erika and Maddy. A few notes about our policies and procedures. Please turn off or silence your cell phones. This afternoon we'll be hearing two bills and we'll be taking them in the order listed on the agenda outside the room. On each of the tables near the doors to the hearing room you'll find green testifier sheets. If you are planning to

testify today, please fill one out and hand it to Sherry when you come up to testify. This helps us keep an accurate record of the hearing. If you are not testifying at the microphone but want to go on record as having a position on the bill being heard today, there are white sign-in sheets at each entrance where you may leave your name and other pertinent information. Also I would note, if you are not testifying but have written testimony to submit, the Legislature's policy is that all letters for the record must be received by the committee at 5:00 p.m. on the day prior to the hearing. Any handouts submitted by testifiers will also be included as part of the record as exhibits. We ask that if you do have handouts, that you provide ten copies and give them to a page. We do use a light system in this committee. Each testifier will have five minutes; that's four minutes of a green light, one minute of a yellow, and when it turns red, we'll ask you to wrap up your final thoughts. When you come to testify, please begin by stating your name clearly into the microphone and then please spell both your first and last name. The hearing on each bill begins with the introducer's opening statement, then we'll hear from supporters, then opponents, and then anyone wishing to testify in a neutral capacity. The introducer will then be given an opportunity to make closing statements if they choose to do so. We have a strict no-prop policy in this committee. And with that, we will begin today's hearing with LB716, Senator Hilkemann's bill to create the Medicaid Cost and Quality Data and Analysis Center of Nebraska. Welcome, Senator Hilkemann.

HILKEMANN [00:34:05] Good afternoon, Chairwoman Howard and members of the Health and Human Services Committee. I am Senator Robert Hilkemann, R-o-b-e-r-t H-i-l-k-e-m-a-n-n, and I represent Legislative District 4, which is west Omaha. I'm here to introduce LB716, a bill that would create the Medicaid Cost and Quality Data and Analysis Center of Nebraska. Since introducing this bill, many interested parties have come together with a common goal that exists at the heart of this issue: timely and accurate access to quality analysis of data. The question that remains is, how do we get there? The green copy that you have before you is a great starting point and I have also brought suggested language that would designate a health information exchange, two approaches with the same end goal. I first want to tell you how I arrived at the idea of this introducing of legislation. As a 35-year healthcare provider I am intrinsic familiar with the rising costs of delivering health care. I believe that accurate and timely analysis of data is critical when creating good public policy. And I have learned that in many states, that public academic health centers help the state department of Medicaid with analysis to stay on top of various data and trends in the Medicaid population. All of these factors brought me to reach out to UNMC and the College of Public Health to look at other models and to give me an idea for a possible solution. Now since the introduction of the bill, I have had conversations with director Matthew Van Patton, representatives from the Department of Health and Human Services, Jaime Bland from NeHII and other healthcare stakeholders who all have an interest in a collaborative-- collaborative solution to the timely and accurate analysis of Medicaid spending in Nebraska. You'll be able to hear from them today. Yesterday you may have read in the Omaha World-Herald an article told of the way that Blue Cross and Blue Shield of Nebraska is expanding the healthcare model in an Omaha clinic and that they say keeps patients healthier and lowers cost. What really caught my attention was that the clinics' cost of

care per Medicare patient in 2017 was $1,200 lower than the state average and $2,000 below the national average, according to the clinical data. This reinforced to me that we do every opportunity to bring down the cost of care and ultimately the cost to the state. State spending on Medicaid is growing every year and we've got Medicaid expansion to deal. With the imminent addition of that, we will be committing even more resource-- state resources. It is imperative that we develop an infrastructure that can deep dive into how our healthcare dollars are being spent, analyze those figures in a timely and accurate manner, and find ways to reduce cost and to continue to have better patient outcomes. After several conversations with director Van Patton and Jaime Bland from NeHII, I can see the vision that they have to create a fantastic health information exchange that would allow for a dynamic collaboration in access and analysis of healthcare data that can help direct us in developing the right policies and spending our money more effectively and efficiently. Everyone who has come to the table around this issue wants the same thing. It is just going to be a matter of ironing out the details as we move forward. I will let them each make their case to you with their testimony and at the end close with some final thoughts. I'm certainly grateful to the College of Public Health for their help in drafting this legislation and truly to all of the interested parties for bringing their expertise and goodwill in crafting a compromise that we can all support moving forward. Thank you, Senator Howard.

HOWARD [00:38:48] Thank you. Are there questions? Senator Arch.

ARCH [00:38:51] Thank you, Senator. Are we discussing LB716-- is-- is what-- is what was given to us, is it an amendment or is it--

HILKEMANN [00:38:59] That-- this-- this will sub-- this will replace LB716.

ARCH [00:39:02] This will replace it?

HILKEMANN [00:39:03] Yep, this replaces the green copy.

ARCH [00:39:05] So is this white copy what-- what is going to be testified to today?

HILKEMANN [00:39:09] That's correct.

ARCH [00:39:09] OK. Thank you.

HOWARD [00:39:12] Other questions? Seeing none, thank you, Senator Hilkemann. You'll be staying to close?

HILKEMANN [00:39:18] I'll be here.

HOWARD [00:39:19] OK. Wonderful.

HILKEMANN [00:39:19] You bet.

HOWARD [00:39:20] Now we'd like to invite our first proponent testifier for LB716.

ALI KHAN [00:39:22] Good afternoon, Senator Howard, members of the committee. I'm Ali Khan, A-l-i K-h-a-n, a physician, former Assistant Surgeon General and dean of the College of Public Health at the University of Nebraska Medical Center. I am testifying in support of LB716 which seeks to establish the Medicaid Cost and Quality Data and Analysis Center to be housed at the University of Nebraska Medical Center. I'm speaking as a Nebraska citizen. I do not speak on behalf of or represent the University of Nebraska. State expenditures of Medicaid are currently $2.2 billion per year, representing over 20 percent of the state budget and outpacing inflation at 3.8 percent per year. These costs and opportunities will dramatically increase with the proposed expansion within the state. The healthcare field is rapidly moving away from fee-for-service reimbursement of healthcare professionals and towards more value-based reimbursement models that focus on quality. Further effective population management strategies using large-scale, big data is becoming critical as we seek to bend the cost curve of healthcare downwards at the same time that we're facing a shifting-- aging demographic shift. Thus, there is an increasing need for advanced analytic modeling of risk factors, health behaviors, disease progression, resource utilization, cost, and, as you heard, social determinants of health. Establishing this center will create a productive, mutually beneficial-- beneficial relationship between UNMC and the state of Nebraska that has already occurred in several states across the country to make Medicaid more effective and more efficient. With timely access to state databases such as Medicaid claims data, the University of Nebraska Medical Center College of Public Health has the expertise to undertake these analyses to help support informed, evidence-based, and cost-effective policy decision making. For example, the College has nearly 30 Ph.D. faculties trained in economics, statistical modeling, population health, health service research, providing a strong analytical support for such a center. If established, the center's analytic ability would be of immense benefit for the Department of Health and Human Services, the state of Nebraska, and we believe the Legislature. For example, the Senate could identify cost-effective initiatives to generate systemwide cost savings from improving coordination and quality of medical care, adopting efficient alternative payment models and reducing preventable hospitalizations, and improving efficient healthcare service delivery, particularly in rural and underserved communities. Analysts at the center would forecast-- areas of analysis could include quality improvement initiatives, return-on-investment analyses, financial modeling, cost reductions, economic impact analysis, local healthcare needs, and also consider workforce planning needs across the state based on the available data. Based on the breadth and depth of the expertise and data needed, there are inherent synergies for state agencies and state public health agencies, public universities to collaborate to achieve these analyses. For this reason public university and Medicaid partnerships have already been established in Texas, Wisconsin, Illinois, Maryland, Massachusetts, New Mexico, Ohio, Oregon, and Pennsylvania. If given the opportunity and funding, the University of

Nebraska Medical Center College of Public Health is ready, willing, and able to help implement the Medicaid Cost and Quality Data and Analysis Center. Thank you.

HOWARD [00:43:19] Are there questions? Dr. Kahn, this seems like a brainchild that you would think up. We've met before.

ALI KHAN [00:43:27] Yes, we have, Senator.

HOWARD [00:43:27] OK. So-- so when we're looking at Medicaid partnerships in other states, are they Medicaid partnerships that look exactly like this where they're looking at all of the data from the MCOs and the claims and everything?

ALI KHAN [00:43:41] Yes, Senator. So there's a couple of different models across the United States in the states that I mentioned. For the most part, the model is between a university and the Medicaid division. And over time these have looked at more than Medicaid data because you want to see what's going on in the private-- private data, commercial data, what's looking-- what's going on with Medicare data also. So in time it gives you an opportunity to give better insights on what's going on in Medicaid as you look at what's going on in the rest of the market.

HOWARD [00:44:11] OK. Thank you. Any other questions? Seeing none--

ARCH [00:44:13] I--

ARCH [00:44:13] Oh, Senator Arch.

ALI KHAN [00:44:15] Senator Arch.

ARCH [00:44:15] Sorry, took awhile. So what-- what you are offering at the-- at the College of Public Health is-- is analysis, is that correct?

ALI KHAN [00:44:26] Absolutely correct, Senator.

ARCH [00:44:26] So it's receiving the data, not necessarily being the data repository, but receiving the data and doing the analysis.

ALI KHAN [00:44:34] Correct, in response to the needs of the department and the Legislature and others.

ARCH [00:44:39] Thank you.

HOWARD [00:44:41] Any other questions? Seeing none, thank you for your testimony today, Dr. Khan.

ALI KHAN [00:44:46] Thank you, Senator.

HOWARD [00:44:46] Our next proponent testifier for LB716. Good afternoon.

JAIME BLAND [00:45:01] Good afternoon. Good afternoon, Senator Howard and members of the Health and Human Services Committee. And my name is Jaime Bland, J-a-i-m-e B-l-a-n-d, and I am testi-- testifying in support of the amendments proposed to LB716. I am the CEO of the Nebraska Health Information Initiative, commonly known as NeHII. NeHII was designated as the statewide health information exchange by Governor Heineman in 2009. NeHII has had great success in achieving the vision of Nebraska leaders, some of which you will hear from today, as-- or have received written testimony, perhaps. As early as 2003, healthcare, business, and government gathered in Nebraska to discuss the data highway for the health information exchange and in 2008 the vision emerged as NeHII. From 2008 to today, NeHII has operated as a nonprofit public-private partnership of healthcare organizations and as a neutral convener of those interested in sharing health data for the benefits of the citizens of Nebraska. Since that time, NeHII has been recognized nationally as a leader in and pioneer in the industry. From the successes of the PDMP to the advancements in data management and reducing the burden of regulatory reporting, NeHII has been the model for the HIE public-private partnerships across the country. NeHII has cross-sector stakeholders and has been a neutral collaborator for CHI, Nebraska Medicine, Methodist Health System, Children's Boys Town, Blue Cross Blue Shield, WellCare, and Nebraska Total Care, and as well as the Department of Health and Human Services, specifically public health and Medicaid and Long-Term Care. A number of independent providers are also part of the NeHII stakeholder group and are-- and-- but there are noticeable holdouts, which is addressed in the white copy of the amendment. These are impactful to both sharing data for patients and health systems and payers. With all of NeHII's success and collaboration, some are choosing to withhold patient data from NeHII. The reasons vary from cost to investing in other technology to share within a closed network. To mitigate the cost of collection into NeHII, the Department and NeHII has worked diligently to bring CMS federal match dollars to Nebraska to mitigate this concern. I have provided you-- or I will provide you with a handout where Secretary Verma and the Centers for Medicare and Medicaid and the Office of Civil Rights have addressed data blocking. NeHII works closely with the department as a covered entity and currently has a BAA in place to share data with the department. Data blocking in health records not only contributes to cost and duplication, it prevents information from flowing to the point of care, which may be difference between a good outcome and a bad outcome. The amendment calls for mandatory participation for entities delivering-- delivering care and to support the data needed for the medical assistance program. I ask you to consider three points when reviewing the amendment. Clinical data must flow from the point of care and in collaboration with MLTC. We have secured the CMS funds between now and 2021 to make this a reality in Nebraska. Having a complete health history is an important-- is important-- is-- is as important a benefit as the complete data of the PDMP. If we are to control healthcare expenditure and bring cost down, we all need the data to do this, not fragmented data,

complete, comprehensive data. Otherwise, we perpetuate the problem and have few tools to cure the issue of rising costs in healthcare. With that, I can take your questions.

HOWARD [00:48:39] Thank you. Are there questions?

ARCH [00:48:43] Yes.

HOWARD [00:48:43] Yes, Senator Arch.

ARCH [00:48:44] Yes. Yes. In Section 8 of the white copy, it-- it indicates that providers-- and it's a pretty broad list of providers-- shall participate in--

JAIME BLAND [00:49:02] Yes, sir.

ARCH [00:49:05] And then it goes on to say if it is technically unachievable.

JAIME BLAND [00:49:07] Correct.

ARCH [00:49:07] So not financially burdened--

JAIME BLAND [00:49:14] Correct.

ARCH [00:49:14] --but technically unachievable. Could you talk about the-- I guess the-- your understanding of that-- that-- that-- the finances of it, I guess, if you could.

JAIME BLAND [00:49:26] So-- so there are costs that are incurred both from the provider's vendor as well as the solutions that NeHII chooses to-- to work with at this point. Those dollars, we have actually put applications forward to CMS to fund the connections both that would be incurred at the point of care with the providers, as well as cover cost for that connection to NeHII. So the-- the cost to connect is mitigated by the funds that CMS has matched to the state, to the department.

ARCH [00:50:03] And-- and those funds to CMS, are those ongoing grants or how-- what-- what's the mechanism for that?

JAIME BLAND [00:50:09] They-- yeah, they're not grants. They're called the high-tech 90-10 funding mechanism through CMS, so the department uses match dollars for a 90 percent match. So if the department allocates $100,000 in match, we can request $9 million in CMS match funds. And we've actually worked with the department to bring in $14.9 million in-- in CMS dollars to specifically address connection and other applications that would be a part of that.

ARCH [00:50:41] And that's all-- you've already brought in--

JAIME BLAND [00:50:42] Already done that, yes, sir.

ARCH [00:50:45] --$14.9 million. So this has--

JAIME BLAND [00:50:46] Yeah.

ARCH [00:50:47] --this has got money going forward--

JAIME BLAND [00:50:47] Correct.

ARCH [00:50:47] --that would address these issues from the providers?

JAIME BLAND [00:50:50] That would address those concerns, correct.

ARCH [00:50:52] And then your relationship to-- are-- right now you would be the data repository--

JAIME BLAND [00:50:56] Correct.

ARCH [00:50:57] --where you would not be the data analysis.

JAIME BLAND [00:50:59] We are currently. Correct.

ARCH [00:51:01] Right?

JAIME BLAND [00:51:02] Correct, yes, sir.

ARCH [00:51:02] So that's the--

JAIME BLAND [00:51:02] Yes, Senator.

ARCH [00:51:02] That's the distinction between--

JAIME BLAND [00:51:05] Yep.

ARCH [00:51:07] --public health and-- and NeHII.

JAIME BLAND [00:51:11] Correct.

ARCH [00:51:13] OK. Thank you.

HOWARD [00:51:11] I-- are there other questions? So I wanted to ask you, in the-- in the white copy, the green copy had indicated utilization of the Health Care Cash Fund for this, but that appears to be taken-- removed. Is that correct?

JAIME BLAND [00:51:26] That's correct for the purposes of-- of the LB716.

HOWARD [00:51:33] OK.

JAIME BLAND [00:51:36] I--

HOWARD [00:51:36] And so what it does is now at the bottom of page 3 it-- you may directly receive funding from the General Fund to support operations for this.

JAIME BLAND [00:51:44] So that's the match dollar mechanism--

HOWARD [00:51:46] Oh, the match--

JAIME BLAND [00:51:47] --for the 90-10.

HOWARD [00:51:47] --the match for the CMS.

JAIME BLAND [00:51:47] Yeah. So in this current budget, the current state appropriation, the electronic records initiative, NeHII has that appropriation in place and we've worked with the department for 90-10. We've also began conversations with CMS for a mechanism called 75-25--

HOWARD [00:52:05] OK.

JAIME BLAND [00:52:05] --which would address operations and maintenance, as well as a funding mechanism from H-- it's called H.R.6, the Family Support Act, which will fund different initiatives and planning for prescription drug monitoring and opioid intervention. So those are actually in play and we actually have several representatives from CMS ONC. These federal representatives are coming to Nebraska because we are a leader and are willing to work with us to bring additional funds to support both the PDMP and HIE and the work going forward.

HOWARD [00:52:38] Is it-- without this piece of legislation, are we still able to get that 90-10 match for some of this work?

JAIME BLAND [00:52:44] Without the additional appropriation?

HOWARD [00:52:46] Without this legislation.

JAIME BLAND [00:52:47] Yes, ma'am. Yes--

HOWARD [00:52:48] OK.

JAIME BLAND [00:52:48] --Senator Howard.

HOWARD [00:52:48] Great. Thank you. Other questions? Senator Arch.

ARCH [00:52:52] Another question. So who decides-- under this plan, under this legislation, who decides what data elements must be collected by the providers and-- and uploaded?

JAIME BLAND [00:53:07] So we are currently using the-- it's called the USCDI standard for data submission to us, and then other data elements that are beneficial for reducing regulatory reporting. So over the past year, for example, one of these reduction and regulatory reporting, NeHII has-- has worked with CMS to be a qualified clinical data registry so we can aggregate data for MIPS reporting, the Medicaid incentive performance system in which providers get paid for Medicare. So we actually aggregate data in our-- and report data for providers. And so currently providers have one view in their EHR. By working with-- with an HIE we can bring gap information to those providers and then they can have an enhanced score with Medicare because those gap closures can be documented.

ARCH [00:54:03] One of-- one of my concerns would be in the future. Is there-- is there the possibility that somebody who is wanting the data analysis-- let's say the Division of Medicaid. Division of Medicaid says, boy, it'd be great if we had this information, but you're not currently collecting it. Well, mandate, right? Just tell the providers now they have to collect that piece of information too.

JAIME BLAND [00:54:30] So we have a robust data governance process that looks at the data that we currently collect and-- and then we look at-- we know that providers have constraints with their electronic health records. So we meet providers where they're at. We have a standard which we would like folks to get to, but we document the technical lack of capability as to why they can or cannot submit that data. There's other ways we can document the data as well. We-- we certainly do not want to be a burden to providers, but we do think that there's a population health benefit, as well as a fiscal benefit to providers, to contributing data, and ultimately a fiscal impact to the state when we can look at a wide datasets that are from across all populations, Medicare, Medicaid, commercial populations, and so-- and-- and not only our information, data that we bring in from our-- our partner HIEs in other states for residents that live in Nebraska because we do have those relationships built as well.

ARCH [00:55:43] I have another question.

JAIME BLAND [00:55:43] Sure.

ARCH [00:55:45] Would-- do you-- do you have to have something like this to pull down more funds on that 90-10? In other words, do you have to-- do you have to have a mandate? Do you have to have-- do you have to have other conditions that are currently in this-- in this proposed legislation?

JAIME BLAND [00:56:00] So there's certain constraints under some funding mechanisms, like H.R. 6, in which we have to have the interstate data sharing. We-- and-- and I actually have an exhibit to provide to-- to the committee, which I will do, in which I do think that eventually CMS will limit the funding mechanisms we have access to if we don't have mandatory participation. For-- for example, the exhibit that you have states 11 things that Secretary Verma stated at HIMSS, which is a national conference that EHRs and hospitals and health systems go to around health information technology. There is data-blocking regulation coming from CMS and there could be a-- a fine imposed by CMS for those that do not participate. And the motivation is really to get everybody in the pool, in the data lake, essentially, so that we can say that, yes, we have mandatory participation from hospitals and health systems in the state and we have-- currently have the money to do so through 2021, which we think why this is the right time, because we've done the legwork on the-- on the financial peace.

ARCH [00:57:19] Thank you.

JAIME BLAND [00:57:21] Sure.

HOWARD [00:57:21] All right. Any other questions? Senator Williams.

WILLIAMS [00:57:23] Thank you, Senator Howard. And thank you for being here. A quick question because we're-- we're quickly changing gears from the green copy to the white copy. What would you envision the role of UNMC College of Public Health to be under the white copy as proposed?

JAIME BLAND [00:57:41] So currently NeHII responds to a number of research requests from a number of universities. So we actually, through the data governance committee, similar to the question that Senator Arch asked about a data element, we actually review research requests at that data governance committee which has multistakeholder, multi-cross-sector involvement. And those requests would come-- come to us-- or come to the data governance committee from the university and we would respond with the data, given certain parameters are maintained for Medicaid privacy laws, Medicare privacy laws, the Health Information Portability Act. And so within the HIPAA parameters, as well as the flow-down provisions in-- in HIPAA, so for behavioral health data, for sensitive treat-- treatment information, we safeguard all the information, prepare the data set, and send it to the researcher.

WILLIAMS [00:58:35] So we are attempting to use your current set of data that you are already collecting from--

JAIME BLAND [00:58:45] Yes, Senator.

WILLIAMS [00:58:45] --many of these sources to feed into the data collection that's necessary to make public health decisions.

JAIME BLAND [00:58:50] We are the data repository, um-hum, or what we call a population health utility for a number of--

WILLIAMS [00:58:56] Yeah.

JAIME BLAND [00:58:57] --requests.

WILLIAMS [00:58:56] Thank you.

JAIME BLAND [00:58:57] Yeah.

HOWARD [00:58:58] Any other questions? Seeing none, thank you for your testimony today.

JAIME BLAND [00:59:01] Yes, thank you.

HOWARD [00:59:03] Our next proponent testifier. Anyone else wishing to testify as a proponent? OK, is there anyone wishing to testify in opposition? Good afternoon again, Director.

MATTHEW VAN PATTON [00:59:26] How do you do? And let me just be very clear. My testimony was prepared based on the green copy and as having not yet read the white copy, everything is directed to the green copy. Good afternoon, Chairperson Howard and members of the Health and Human Services Committee. My name is Dr. Matthew Van Patton-- again, that's M-a-t-t-h-e-w V-a-n P-a-t-t-o-n-- and I serve as the director of the division of Medicaid and Long-Term Care at the Department of Health and Human Services. I am here to testify in opposition to LB716 as written. LB716 creates a new center to collect, analyze, and manage data and to create policy recommendations to decrease calls to the Medicaid program. In order to do this, LB716 requires all DHHS divisions to provide this center electronic access to all health data they collect. Finally, this bill requires DHHS to submit an application for a waiver or State Plan amendment to the U.S. Department of Health and Human Services Centers for Medicaid-- excuse me, Medicare and Medicaid Services, CMS, in order to fund the center. The Division of Medicaid and Long-Term care, MLTC, anticipates this bill's primary objective-- appreciates, excuse me, this bill's primary objective of lowering cost to the Nebraska Medicaid program and to allow better access to data. As I shared with Senator Hilkemann last week, LB716 would duplicate efforts long underway between the department and the Nebraska Health

Information Initiative, NeHII, which aims to create a market-neutral data and analytics infrastructure. That said, we have concerns about the center created in this bill. Medicaid data is tightly controlled according to state and federal laws, such as HIPAA, as well as Medicaid privacy laws which have requirements above and beyond HIPAA. As such, the endeavor outlined in this bill may be difficult, if not impossible. Even if privacy laws were not a concern, there would be a significant administrative and fiscal burden on all DHHS divisions in order to restructure the department's data systems to make them interoperable. At the present, DHHS divisions have notably different data systems which at this time lack integration and interoperability. We have reached out to the university and Senator Hilkemann and understand there is a willingness to amend the bill in its current form to address the aforementioned data governance, privacy, and collaborative dynamics. For these reasons I oppose LB716. Thank you for the opportunity to testify. This now concludes my remarks.

HOWARD [01:02:19] Thank you, Director. Have you seen a copy of the-- the white copy?

MATTHEW VAN PATTON [01:02:22] No, ma'am, but I have been told that there's components in there and there's been dialogue going back and forth. But since I have not yet read the actual text, I will refrain from commenting on it if that's okay.

HOWARD [01:02:34] Sure. Other questions? Senator Cavanaugh.

CAVANAUGH [01:02:42] Thank you. Thank you for being here again to testify. And I appreciate that you haven't read the other version, but you did hear the previous testimonies and based on what you've heard, do you have any reaction to that?

MATTHEW VAN PATTON [01:03:01] I would say we're moving in the right direction. And something tells me that the moment I clear these doors the friends that we've been working with are going to huddle very quickly, and I think that's a great thing that we have those conversations. But again, until I-- I read it to see, line by line and word by word, we'll-- we'll need to make sure that it's-- and our legal-- our legal team will need to vet it, as well, Senator.

CAVANAUGH [01:03:24] Sure. Thank you.

MATTHEW VAN PATTON [01:03:25] I will read something to you that I think you'll find interesting. This comes from CMS guidance issued April of 2011, "Enhancing [SIC] Funding Requirements: Seven Conditions and Standards" regarding Medicaid IT supplement. This is on page 8 of this report. "CMS expects that a key outcome of the government's technology investments will be a much higher degree of interaction and interoperability in order to maximize value and minimize burden and cost on providers, beneficiaries, and other stakeholders. CMS is emphasizing in this standard and condition an expectation that Medicaid agencies work in concert with Exchanges to share business services and technology investment in order to produce seamless and efficient customer experiences." So in the context of the collaborative

that Dr. Bland noted, and as well as Senator Hilkemann, the narrative has been focused, as I understand it, within the construct of that amendment and this intent. So until I read it, we'll see where things go from there.

HOWARD [01:04:32] Any other questions? Seeing none, thank you for your testimony today.

MATTHEW VAN PATTON [01:04:37] Thank you.

HOWARD [01:04:38] Our next opponent testifier. Is there anyone wishing to testify in a neutral capacity? Seeing none, Senator Hilkemann.

HILKEMANN [01:04:57] Thank you. First of all, I need to correct something from my opening. Senator Arch, you asked if this exhibit I had handed out was the intended replacement of the-- well, this was-- this was the NeHII proposal to the-- and there is now-- we-- we just were meeting just prior to this, just kind of a consolidated version of this that's going around. I thought that's what you'd gotten but-- but-- so it-- so there will be there-- as Dr. Van Patton said, we will be hopefully getting together and getting this squared away. So I-- I was hopeful that we would have that available but we didn't have it. So I believe strongly that as we implement Medicaid expansion, and we all know that healthcare costs are continuing to rise, and now it is the time for us to have greater oversight by this Legislature over how our Medicaid dollars are being spent, blending the two proposals that we have NeHII, from the proposal we had at the university, highlighted by Senator Arch's comments, these are what we want to work together and provide and I think that we're close. I was appreciative of the-- the testimony we had today. I think you can realize that, you know, we had a-- Dr. Pan-- Van Patton came on Thursday and on Friday he had further discussions. We had discussions early this morning. We had discussions over the noon hour. So it's-- it's in a process. I think that we've got something that could be really good coming forward and I hope that we can keep those conversations going, that we can-- Senator Howard, that we can get you a document that we can all be proud of and that we can move our state forward in this area, that we can get better data, better data that's available to-- not only at the university but available to Creighton, available to the hospitals, available to the state. And I think this is a real win-win-win possibility here. And getting all the parties together, and as you can understand, we've got lots of personalities involved, we've got lots of things involved, but I really think we can get this done together. And so with that, I would close what I have to say and take any more questions if you have them.

HOWARD [01:07:37] All right. Are there any final questions? Seeing none, thank you, Senator Hilkemann.

HILKEMANN [01:07:43] Thank you.

HOWARD [01:07:44] This will close the hearing for LB716. We will open the hearing for LB726, Senator Walz's bill to require a protocol for individuals eligible for medical parole to apply for medical assistance. Welcome, Senator Walz.

WALZ [01:08:06] Thank you. Good afternoon, Chairwoman Howard and members of the Health and Human Services Committee. My name is Lynne Walz, L-y-n-n-e W-a-l-z, and I appear before you today in introduction and support of LB726, a bill brought to me by the Lancaster County Board of Commissioners. LB726 adds language to the-- to the statutes to require the Division of Medicaid and Long-Term Care of Department of Health and Human Services and the Department of Correctional Services to establish a protocol to assist individuals who are eligible for medical parole to apply for benefits under the Medical Assistance Act. Nebraska Revised Statute 68-104 obligates the county board to provide medical services as required to those who are in need and who are not eligible for other medical assistance programs. Counties vary based upon the guidelines each county develops for services covered. The cost is on the high end for those individuals who leave a correctional facility due to a terminal illness and are needing costly end-of-life care. In the last two years, we have enacted legislation calling for medical parole for those individuals who have been diagnosed with a terminal illness. I fully support this policy. I do, however, want to note that certain counties have more facilities in them than others and, therefore, are more susceptible to individuals who are released choosing to remain in the county where those facilities are located to live out the remainder of their lives. One of those is Lancaster County. I believe they have made a case for the bill in front of us today to require the Department of Correctional Services and the Division of Medicaid and Long-Term Care to develop a protocol to assist these individuals to begin the process to become medically-- Medicaid eligible. Many states have an established process of ensuring all parolees are equipped with some form of medical insurance as part of their established reentry process. For example, Ohio uses peers to help incarcerated individuals learn about plan enrollment and apply for Medicaid. Illinois assists individuals through a navigator program. Massachusetts and other states work with contracted medical vendors to assist in the enrollment process. In my opinion, no successful reentry plan should leave an individual without a long-term plan for medical care. There will be two individuals from Lancaster County following me today, Sara Hoyle and Commissioner Rick Vest. I hope the committee will listen to them and avail them of their expertise in these areas. Thank you, Senator Howard. And, members, I will try-- try to answer any questions you might have.

HOWARD [01:11:01] Are there questions? Seeing none, will you be staying to close?

WALZ [01:11:07] Yes.

HOWARD [01:11:08] Great. We'll now invite our first proponent testifier for LB726. Good afternoon.

SARA HOYLE [01:11:23] Good afternoon. Senator Howard and members of the Health and Human Services Committee, my name is Sara Hoyle, S-a-r-a H-o-y-l-e. I am here on behalf of the Lancaster County Board of Commissioners to testify in support of LB726. I serve as the director for human services for the city of Lincoln and Lancaster County. The general assistance program is one of the divisions under the human services department. Nebraska Revised Statutes Section 68-104 obligates the county board to provide medical services as required for the indigent of the county who are not eligible for other medical assistance programs. Lancaster County general assistance provides short-term medical care for individuals who display a validated primary physical health need. This population may include individuals released from a penal institution on medical parole. Under Nebraska Revised Statutes Section 83-1,110.02, a committed offender may qualify for medical parole if they are terminally ill or permanently incapacitated. This virtually guarantees that inmates released on medical parole have significant medical problems which are expensive to treat. While Nebraska Revised Statute Section 68-145 allows us to recover these medical costs from the individual's county of legal residence, the process is time-consuming, expensive, and rarely successful. Presently, Lancaster County is attempting to collect on a bill of this nature totaling over $150,000 for a resident of another county, so far without success. Most likely the financial burden in this case will also fall on the property taxpayers of Lancaster County. The problem is made worse by the fact that Lancaster County is the location of five Department of Corrections penal institutions, the most of any county in Nebraska. LB726 addresses this problem by establishing a protocol to assist individuals eligible for medical parole to apply for and receive benefits under Nebraska's Medical Assistance Act. And Senator Walz already spoke to you about various methods that other states are doing. There's different processes, different things that they've implemented that could surely serve as a model for our state as we move forward with this. And again, Senator Walz also said it very eloquently when she said no successful reentry plan should leave an individual without a long-term plan for medical care. For these reasons, Lancaster County supports LB726. I'd be happy to answer any questions.

HOWARD [01:14:15] Thank you. Are there questions? Senator Williams.

WILLIAMS [01:14:20] Thank you, Senator Howard, and thank you for being here. I just wanted to be sure that I'm understanding what's really going on here.

SARA HOYLE [01:14:27] Sure.

WILLIAMS [01:14:28] So we have-- we-- we created medical parole and those people are being released oftentimes into the Lincoln market and your organization and-- and Lincoln are picking up the cost of that. And under this legislation, who picks up the cost of that?

SARA HOYLE [01:14:46] They would apply for Medicaid. They would go through the process of applying for Medicaid. What often happens--

WILLIAMS [01:14:52] Which they could do now, correctly?

SARA HOYLE [01:14:54] Right, except right now through Medicaid expansion-- before-- since we don't have Medicaid expansion right now, a lot of them are ineligible. So then what is happening is they have to apply for SSI and/or SSDI, which is a lengthy process. It can take six months to two years in some cases. And so we go through and we help them apply for that and then we go back and try to recoup our expenses once they be-- once they're eligible for Medicaid. Not all of them do receive Medicaid benefits, though, because not all of them are eligible. The other thing, too, with Lancaster County is that it's only for if they have an overarching primary healthcare, so we don't do preventative care. So we have a lot of people coming to us needing preventative types of care services and they're not getting that. We're not able to provide that. And so that's a big gap too. There's the-- the issue of us covering cost for terminally ill, incapacitated individuals. But then there's the other issue of we have folks out there that need care that just aren't getting it. And so there needs to be some type of process, which Senator Walz put forward.

WILLIAMS [01:15:58] And you mentioned in your testimony that you can attempt to recover these costs from the county where the person-- where their true residence is. But you said this is rarely successful. How-- why is that?

SARA HOYLE [01:16:11] That is-- sometimes they're smaller counties that don't have it in their budget, don't have the funding in their budget. Lots of times there's legal battles between they're your resident, no, they're our resident. Some counties, again, they have different guidelines set forth as to who they'll provide services for. So right now we're in dispute with a county who said that they won't provide any type of medical care for individuals who are felons. So there's-- just because each county can develop their own guidelines, it's-- there's always a battle over trying to get reimbursed.

WILLIAMS [01:16:44] Thank you.

HOWARD [01:16:47] Any other questions? Seeing none, thank you for your testimony today.

SARA HOYLE [01:16:52] OK. Thank you.

HOWARD [01:16:52] Our next proponent testifier. Good afternoon.

RICK VEST [01:17:10] Good afternoon, Senator Howard and members of the Health and Human Services Committee. My name is Rick Vest, R-i-c-k V-e-s-t, and I am a member of the Lancaster County Board of Commissioners. I'm here to testify on behalf of the Lancaster County Board in favor of LB726. You've already heard Sara Hoyle's testimony. She's thoroughly outlined Lancaster County's concerns regarding our liability for the medical cost of inmates granted medical parole and how LB726 provides a path forward in solving this problem. I would

like to touch on the following points and affirm the county board's support for this legislation. Medical parole is based on both humanitarian grounds and fiscal considerations. The Lancaster County Board agrees that the humanitarian aspects of-- with the humanitarian aspects of medical parole. An inmate with a terminal illness or who is permanently incapacitated and is no longer a threat to society can be considered for medical parole and allowed to spend their final days outside of prison walls. However, from a fiscal point of view, granting medical parole simply shifts the cost of treatment from the Department of Corrections to county property taxpayers. This is particularly unfair in Lancaster County because of the large-- large number of state correctional institutions based in our county. Assisting inmates who are eligible for medical parole with applying for and receiving benefits under the Medical Assistance Act make-- makes sense more than shifting the burden to our property taxpayers. And as pointed out by Sara, the Legislature should consider this practice for all inmates as part of the reentry process. Thank you for considering my testimony. It says here I'd be happy to answer your arguments.

HOWARD [01:19:09] Thank you, Commissioner. Are there questions? Senator Murman.

MURMAN [01:19:15] Yes. According to this bill it's inmates that are incapacitated or a terminal illness. I assume-- wouldn't just about all of those be eligible for Medicaid now? I should have asked the previous testifier, but if I understood there--

RICK VEST [01:19:34] I think you'd get more [INAUDIBLE]

MURMAN [01:19:34] --that they weren't all eligible. Do you-- do you have an idea?

RICK VEST [01:19:40] [INAUDIBLE] Sara? Is that--

MURMAN [01:19:41] Sorry, but--

HOWARD [01:19:41] No, she can-- she can tell you the answer, but you'd have to read it into the mike.

RICK VEST [01:19:46] Oh, is that right?

HOWARD [01:19:47] Um-hum.

RICK VEST [01:19:48] OK. Could you repeat your question, Senator? Folks that are released--

MURMAN [01:19:53] Yeah, I assume--

RICK VEST [01:19:54] --are eligible.

MURMAN [01:19:55] But most all would be eligible for Medicaid.

RICK VEST [01:19:58] Yeah, and my understanding, which is not as good as Sara's, we could all agree, but is that the processes that they have to go through to get reinstated or to get benefits is sometimes very lengthy and quite frankly, these folks don't always last a long time once they're released. You know, they-- they may go into hospice shortly after their release and they never really get the process to get their benefits reinstated.

MURMAN [01:20:26] OK I see they-- quite often they'll pass away before so--

RICK VEST [01:20:29] Right.

MURMAN [01:20:29] --so once they pass away, I don't suppose they get the Medicaid benefits.

RICK VEST [01:20:35] That's my understanding, yes, yeah.

HOWARD [01:20:40] Other questions? All right, seeing none, thank you for your testimony today.

RICK VEST [01:20:45] Thank you.

HOWARD [01:20:46] Our next proponent testifier. Seeing none, we do have two letters for the record: Larry Dix from the Nebraska Association of County Officials and Spike Eickholt from ACLU of Nebraska. Is there anyone wishing to testify in opposition? Is there anyone wishing to testify in a neutral capacity? Seeing none, Senator Walz, you are welcome to close.

WALZ [01:21:13] I will make this quick. I just want to thank Sara Hoyle and Commissioner Rick Vest for coming to testify today. I appreciate it. I believe that developing a protocol to assist individuals to become medical-- Medicaid eligible is just good practice. Not only does it help relieve some of the financial strain in counties but it also ensures that we are not releasing people without the support that they need. So I just thank you and appreciate your consideration on this bill.

HOWARD [01:21:42] Thank you. Are there questions? Seeing none, thank you, Senator Walz. This will close the hearing for LB726 and we are done for the day, but we will be going into an Executive Session so we'd ask you to clear the room.