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HOWARD [00:00:03] [RECORDER MALFUNCTION] and welcome to this joint briefing on the state's plan for implementing Medicaid expansion. 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. To my right is Senator Stinner. He serves as Chair of the Appropriations Committee. This is a joint briefing today. I'd like to invite the members of each committee to introduce themselves starting on my right with Senator Cavanaugh.

CAVANAUGH [00:00:27] Thank you, Chairwoman Howard. My name is Machaela Cavanaugh. I represent the 6th District in Omaha, Nebraska. It's west-central Omaha and County-- Douglas County.

WILLIAMS [00:00:37] Matt Williams, Legislative District 36, live in Gothenburg. That's Dawson, Custer, and the north portion of Buffalo Counties.

BOLZ [00:00:45] Senator Kate Bolz, District 29.

ARCH [00:00:47] Senator John Arch, Sarpy County, District 14.

WALZ [00:00:52] Lynne Walz, District 15, which is Dodge County.

CLEMENTS [00:00:55] Rob Clements from Elmwood. District 2 is Cass County and parts of Sarpy and Otoe.

ERDMAN [00:01:00] Steve Erdman, District 47, ten counties in the Panhandle.

B. HANSEN [00:01:04] Ben Hansen, District 16, Washington, Burt, and Cuming Counties.

MURMAN [00:01:11] Dave Murman, District 38, seven counties in south-central Nebraska.

HOWARD [00:01:15] The purpose of this briefing is to gain a better understanding of the details of the state's plan for implementing Medicaid expansion. And we appreciate the representatives of the Department of Health and Human Services, particularly the Division of Medicaid and Long-Term Care, for joining us today. After the initial outline for the plan was released last week, many members of the Health and Human Services and Appropriations Committees had additional questions and needed additional information to ensure we understand the plan and have the information necessary to meet our duties as legislators. Both committees have previously shared specific questions with the department and those will serve as the basis for our discussion today. A few notes about the procedure for today. We are only hearing from invited testimony. There will be no public testimony. We ask that you turn off or silence your cell phones while you're in the hearing room. As we've discussed with the department, there will likely be multiple persons at the testifier's table at any particular time to allow the experts in any

particular subject area to answer the questions as necessary. We would ask that each representative from the department introduce themselves and spell their names when they first come up. We also have those nameplate tents and would appreciate if you wouldn't mind using those as you come up. We have previously shared an agenda with the department to provide a structure to the briefing. As planned, we'll discuss the committee's questions by topic area. First we'll start with questions about benefits; second, questions relating to the administration of the plan requirements; third, questions on cost; and finally, questions about the community engagement requirements. In the interest of time, for each topic area, the department will have a certain period of time to present their answers to the questions previously provided. We will use a light system so you'll have-- the light will be green. When you have one minute left, it will turn yellow, and then it will be red when we've run out of time. We also have a set period of time for the committee members to ask follow-up questions and I'll be keeping track of that. We do look forward to learning more and better understanding the plan. And with that, we'll begin today's briefing. Welcome, CEO Smith.

DANNETTE SMITH [00:03:11] Good afternoon to everyone. Good afternoon. Good afternoon, Chairperson Howard, Chairperson Stinner, and the members of the Health and Human Services, Appropriations Committee. Thank you for the invitation to provide more information about the Heritage Health Adult Program. Chairperson Howard, thank you for meeting with Bryson and me on Friday, April 5, 2019. I appreciate that you had an agenda and questions about Medicaid expansion ready for us. On Friday afternoon, I received your letter, Chairman Stinner, with questions from the Appropriations Committee. That same afternoon I met with my team to discuss the questions from both committees. Implementation of the Medicaid expansion is important to the department and we are committed to making sure it goes smoothly. We are here to support Nebraskans and in this, in their path to wellness. With that in mind, my team and I are thankful for the opportunity to present to you again. We have organized our presentation to share our Medicaid expansion plan going forward in a more straightforward manner. And quite honestly, Chairperson Howard, I took your questions and I tried to organize them in a way that we would be able to expeditiously use the time but also a good chunk of the time to be able to answer any questions that you may have. And so-- so from your agenda and the questions that you gave me, here's how I organized it. We're going to start off by talking about benefits, administration, community engagement, finance and cost allocations. You will notice that when Dr. Van Patton comes up, in his remarks, he is going to make reference to the questions that you may have before you and the answer that is associated with that question. So we're trying to be very organized so that you can get a really good breadth of the work that's being done. Throughout today's presentation my team will attempt to answer all the questions you've provided to us. I want to reiterate something we have previously stated. The documents submitted to the Center for Medicaid and Medicare Services on April 1, 2019, began the discussion with the federal government about Medicaid expansion in Nebraska. Throughout the upcoming months, we will be negotiating with CMS regarding our plan. In fact, my team has already begun conversations with our partners at CMS with a last-- with the last call being on Friday, April 5, 2019. So we've already begun the process. I am asking you to allow us to remain flexible and agile as we move forward and receive feedback from CMS. Dr. Van Patton

will be sharing the technical aspects of Medicaid expansion in a moment, but I wanted to take a little bit of time to share an example with you of a scenario of someone who may be being served under the Heritage Health Adult Program. Imagine Jennifer. Jennifer might be a server who waited on you at lunch today, she might have been a person at the window where you dropped by and got coffee from the coffee shop this afternoon, or she might be a caretaker for a family member. She is an adult who is the new expansion population, meaning she's an able-bodied person between the ages of 19 and 64 years old and has an income of approximately $16,000 per year or less. Jennifer is not pregnant and has no dependent children. When Jennifer enrolls into the Heritage Health Adult Program, she'll be enrolled in the basic coverage. In six months she can move to prime coverage if she engages in care and case management and makes an appointment with a primary care provider. In second year of her eligibility, if Jennifer wants to continue with prime coverage, she'll need to participate in community engagement requirements which are engaging in job-seeking activities, caring for a relative, attending a postsecondary school or apprenticeship, or volunteering for a public charity for at least 80 hours per month. If she chooses not to, Jennifer will return to basic coverage for the next six months until the next eligibility check-in, at which time we will do verifications which includes residence and income. As long as Jennifer continues to meet the eligibility requirements, she will always have basic coverage in the Heritage Health Adult Program. Again, Jennifer can be anyone you know. Jennifer represents a number of people that I've met since I've been here in Nebraska, and I'm sure that there are constituents in your district that represents Jennifer. At the conclusion of my remarks, Lisa Taylor-Jones and Karen Vincent will be distributing to each of you a binder of information that will further clarify the design and implementation of Medicaid expansion. In that binder you will find planning and reference documents that have guided us throughout this process. Dr. Van Patton will be presenting again on the technical aspects of expansion. When he is finished, Jeremy Brunssen, Medicaid Deputy Director of Finance and Program Integrity, will address the specific questions from the Health and Human Services Committee and Appropriations Committee around finance and cost analysis. We have provided a PowerPoint in your-- for your review in front of your binder that you're going to be receiving shortly so that you can follow along with their presentations. Again, I want to thank you for your attention this afternoon. We are prepared to be able to give you good information and we are committed to a successful implementation of the Heritage Health Adult Program to serve our fellow Nebraskans. With that, I'm going to ask Dr. Van Patton to join me here at the table.

HOWARD [00:10:10] Would you mind changing out your table tent? Thank you. Does everybody have a binder? Are you ready?

MATTHEW VAN PATTON [00:11:33] I'm ready.

HOWARD [00:11:44] All right. Sherry, hit the light.

MATTHEW VAN PATTON [00:11:50] Good afternoon, Chairwoman Howard, Chairman Stinner, members of the Health and Human Services and Appropriations Committees. My name is Dr.

Matthew Van Patton and I am the director of the Division of Medicaid and Long-Term Care in the Department of Health and Human Services. I'm joined today by my deputy director "Rocky" Thompson, Heather Leschinsky, Jeremy Brunssen, Dr. Larra Petersen, Karen Heng, and our legal counsel Nate Watson. As CEO Smith indicated, we are providing you with a packet containing the following exhibits. Should have the table of contents on the front. Exhibit 1: Medicaid expansion briefing slideshow. Exhibit 2: Nebraska's Secretary of State petition sponsor sworn statement, Initiative 427. Exhibit 3: state plan amendments with a SPA, benefits SPA, the finance SPA, and the eligibility SPA. Exhibit 4: Heritage Health Adult Program implementation plan time line. Exhibit 5: articles from other states' expansion experiences. Exhibit 6: various federal Medicaid law. Exhibit 7: current Medicaid benefit packages by eligibility category. Exhibit 8: Heritage Health Adult Program Section 1115 waiver concept paper. Exhibit 9: introduction to Medicaid care management best practices. Exhibit 10: State Medicaid Director, SMD, 18-002, opportunities to promote work and community engagement among Medicaid beneficiaries. Exhibit 11: state differences in the application of medical frailty under the Affordable Care Act 2017 update. Exhibit 12: Heritage Health Adult Program eligibility and enrollment process chart. Exhibit 13: Heritage Health Adult Program prime basic scenarios. Exhibit 14: analysis, fiscal impact of Initiative 427. And Exhibit 15, "Press Release: Nebraska Medicaid Director Dr. Matthew Van Patton Comments on Centene/WellCare Merger Announcement." We are providing these documents to let you know in detail about our planning efforts as well as to provide reference materials that have shaped our thinking in designing the Heritage Health Adult Program. A copy of our slides is provided as Exhibit 1 in your packet. In my remarks I will address most of the written questions we have received from Chairwoman Howard and then Deputy Director Brunssen will address Chairwoman Howard's cost questions as well as written questions we have received from Chairman Stinner. Pursuant to the initiative, a copy of which is attached as Exhibit 2 in your pocket, the Heritage Health Adult Program will cover all able-bodied adults between the ages of 19 and 64 who meet the various requirements, including the adult expansion and caretaker relative populations. This program would use our existing managed care health plans to provide medically necessary care to people who cannot afford it and promote wellness and life success. In response to administration question number 5, it is important to note that any legislative action that would significantly affect Medicaid, including the ability to use managed care, would inevitably delay our ability to begin benefits on October 1, 2020. We have success-- successfully fulfilled the first step in the expansion process, the filing of the state plan amendments with the federal government on April 1. This was the one and only deadline in the initiative. A copy of the submitted state plan amendments is provided as Exhibit 3 in your packet. Benefits begin on October 1, 2020. Sign-ups start on August 1, 2020. We understand that many people would like these benefits to begin sooner. However, our priority is making sure the necessary preparations have been made, the services are available, and that people know how to access care. We are taking the time needed to do this right. In the pocket, at Exhibit 4, you will notice a time line of the work that needs to be done. Furthermore, the experience of other states demonstrates the wisdom of taking the time necessary to do this right. Anything less would be letting down the people we serve and the taxpayers who pay for it. In your packets, at Exhibit 5, you will also notice news articles that demonstrate this reality. This is the second slide, if you're following. There are several different

ways to become eligible for Medicaid. Many people understandably think that Medicaid currently provides the same package of benefits to everyone enrolled, but it does not. Pursuant to federal law, for example, Sections 1902, 1915, 1920, and 1920A of the Social Security Act, copies of which are provided as Exhibit 6 in the packet. Medicaid covers a variety of persons with different needs. For example, children receive additional and different services than adults. Persons with disabilities have different services than others who are not disabled. Pregnant women have services designed for their specific needs. Residents in nursing homes receive services tailored to their circumstances. In your packet, at Exhibit 7, we have provided you a chart comparing the benefits of those persons currently eligible. The Heritage Health Adult Program is designed for able-bodied adults on Medicaid. In short, all persons similarly situated are treated similarly in line with federal law and the initiative. Third slide. In response to benefits questions number 7 and administration question number 3, to design a program that best fits the needs of Nebraska, we intend to submit a Section 1115 Medicaid demonstration waiver to the federal government. This process began when we submitted a concept paper on April 1. The concept paper, which is Exhibit 8 in your packet, covers a number of proposals that not only provide healthcare coverage but also provide an innovative route to wellness and life success. The 1115 process involves negotiations with the federal government. Federal law requires at least two public hearings as a part of this process. We will hold at least four on dates and at locations to be determined, including at least one public hearing in each congressional district. Fourth slide. In response to benefits question number 1, Heritage Health Adult Program participants will receive basic coverage that is comparable to the type of health insurance many Nebraskans receive through employment. The precise package of services will be defined after negotiations with the federal government, though it will be similar to the Blue Cross Blue Shield Pride plan. A point-by-point comparison of Medicaid state plan services and this commercial insurance product is included within the benefit state plan amendment, which is part of Exhibit 3 in your packet. In response to administration question number 7, unlike some other states, there will be no so-called work requirements to receive basic coverage. I will say that again. There will be no work requirements to receive basic coverage. The Heritage Health Adult Program is designed to empower people. In response to benefits question number 2, to earn prime coverage which includes additional benefits like dental, vision, and over-the-counter medication coverage, members will be required to participate in care and case management and see their healthcare provider within one year of signing up. In response to benefits questions number 4 and 5, those who have participated in care and case management and have visited a healthcare provider within the last year will receive prime coverage at the program's start date because they are not new applicants. Their situation is different. In response to administration question number 6, existing systems will let providers know whether a person has basic or prime coverage. Fifth slide. In response to community engagement question number 1, care and case management are the core components of the benefit package provided by the health plans today. We intend to build on this existing structure. Care management is the professional function by which a set of supportive activities to improve health and reduce the needs for future medical services is accomplished. This includes patient education, care coordination, and helping manage difficult health conditions. For example, care management includes assistance with finding the right healthcare provider and making an appointment. People who have not gone to their doctor for

regular checkups in a while might not know where to begin. Exhibit 9 in your packet contains additional information about care management. Case management is the professional function by which a collaborative process of evaluation, planning, facilitation, and advocacy for options and services that support the social determinants of health and assist with communication and resource needs for improved well-being is accomplished. For example, case management includes finding and accessing other resources that are needed to be healthy, such as food banks, housing, and transportation. Participating in care and case management is a major benefit that allows us to understand completely people's current circumstances and get them the healthcare and other assistance that they need. In addition, seeing a healthcare provider at least once a year is really important in addressing healthcare needs, especially if someone has a chronic condition that has gone untreated for some time. Seeing a doctor regularly helps a person understand his or her current health and allows the person to make a plan for wellness. The sixth slide. In the second year of the program, members who want prime coverage will also be required to meet certain community engagement requirements. Good health is about getting regular healthcare and living a productive life. We care about treating the whole person and want them to live a full and productive life. Caretaker relatives already have more than a full-time job, so they will meet this requirement. For every other able-bodied adult, to earn prime coverage, they will be expected to do things such as volunteer for a public charity, be attending a college, trade school, or apprenticeship, looking for a job through the Department of Labor, or holding a job for at least 90 hours a month. In response to community engagement question number 5, other options to meet this community engagement requirement are being explored, including participation in treatment for substance abuse. In response to community engagement question number 2, we will leverage existing resources to monitor this requirement. Our model aligns with guidance provided by the federal government, which a copy is provided in your packet as Exhibit 10. Seventh slide. In response to administration question number 4, in order for Medicaid staff to begin receiving applications and for benefits to begin, we are working hard to make the necessary changes to our existing eligibility and enrollment system, even though it will be phased out later. We're also working with the health plans to leverage their technology and processes to assist in the provision of benefits. We have provided you a chart, which is part of Exhibit 4, that goes through the timeline for technology changes to incorporate required updates to accommodate the Heritage Health Adult Program. Eighth slide. There are a few other remaining questions from Chairwoman Howard's list that I would like to address at this time. In further response to benefits question number 2, dental services currently include oral evaluations, re-evaluations, comprehensive periodontal evaluations, radiographs, diagnostic cast, preventative services, restorative services, endodontics, periodontics, prosthodontics, oral and maxillofacial surgery, orthodontics for children, and adjunctive general services. Vision services currently include examination, diagnostics, treatment, frames, lenses, and contact lenses when medically necessary. Over-the-counter drugs currently include things such as analgesics, antihistamines, and cough and cold products. In response to benefits question number 3, the program will not charge premiums. Copays in place today will apply. In response to benefits question number 6, regarding foster, former foster care, federal law Section 1902(a)(10)(A)(IX), a copy of which is included as part of Exhibit 6 in your packet, does not allow this so-called mandatory group to be included in the adult expansion group. In response to

benefits question number 8, some of the newly eligible Medicaid population, the medically frail, will have increased healthcare needs. We intend to contract with a consultant to develop a clinically sound definition to serve this population appropriately. I have provided you examples of how other states have accomplished this task, which are found at Exhibit 11 in your packet. In response to administration question number 1, redeterminations of eligibility will take place every six months instead of annually. This is to avoid issues that have arisen in other states regarding ineligible individuals receiving coverage. Information has been shared with you in your packets at Exhibit 5 regarding the experiences of other states. In response to administration question number 2, Medicaid traditionally provides payment to providers for services rendered up to three months prior to the date of application. In order to align to private insurance and to encourage members' timely access to healthcare, we are requesting to shorten this period to make coverage retroactive to the first day of the month of application. Furthermore, we will be engaging with providers on processes that support increased use of presumptive eligibility. In response to community engagement question number 3, we will use the health plans to monitor attendance at appointments. In response to community engagement question number 4, in addition to caretakers of minor children currently covered by Medicaid, if a relative is caring, for example, for an adult child, he or she will also meet the community engagement requirement. Now I would like to turn your attention to Exhibit 12 and walk you through the Heritage Health Adult Program eligibility and enrollment process, the sheet that looks like this under Exhibit 12.

HOWARD [00:29:02] And, Director Van Patton, we had actually only allocated 15 minutes for the benefits portion but it-- it appears as though you've combined benefits, administration, and community engagement all into one. And so we'll put all of that time together then.

MATTHEW VAN PATTON [00:29:16] Very good, very good. So I'm going to walk you through this process, this infographic, to explain the process to you so you-- so you understand. Again, this is the document titled Heritage Health Adult Program Eligibility and Enrollment Process. Application: Applicants or representatives completes application on-line via ACCESSNebraska Web site, in person at 50 local offices, by phone to the ACCESSNebraska customer service center, or via the federally facilitated marketplace. Manual processing: DHHS eligibility workers extract application from ACCESSNebraska and compare information to the federal data hub for household composition and modified adjusted gross income. Verification: DHHS eligibility workers use the federal data hub to verify the Social Security number, citizenship, immigration status, and adjusted gross income. DHHS eligibility workers use Department of Labor and ResCare for job search verification. DHHS eligibility workers call applicant on volunteerism or self-employment. N-FOCUS determination: DHHS eligibility workers enter information into N-FOCUS budget module for eligibility determination and notify applicant of eligibility decision. Beneficiaries enroll in a health plan. Initial eligibility: Basic coverage provided to new beneficiaries, parent caretaker relatives without a primary care provider claim in past year. Prime coverage provided to parent caretaker relative with primary care provider claim in past year. Reverse side: Member engagement. Member has a primary care provider claim in the past year. Member participates in active care and case management with the health plans, again, care management, health-focused set of supportive activities based on a care plan to improve

beneficiary health and reduce the need for future medical services through individual-centered education, coordination of care, elimination of unnecessary service duplication, and effective management of health conditions. Case management: Again, working with the social needs focus, collaborative process of evaluation, planning, facilitation, and advocacy for options and services based on social determinants of health and assist with communication and other resource needs towards improving well-being. Redetermination: At six months interval, DHHS eligibility workers reassess the eligibility factors such as income and household composition. A review is completed of claims to primary care provider, participation in care and case management, and a history of three or more missed appointments. In year two, DHHS eligibility workers verify participation in 80 hours a month in any of the following activities: parent caretaker relative; college, trade school, or apprenticeship; volunteer with a public charity; job searching; and employment. This will determine if a beneficiary will receive the basic or prime benefit package. Prime coverage adds dental, vision, and over-the-counter medications. The last infographic: ongoing support. DHHS eligibility workers support the beneficiaries throughout the eligibility term by answering benefit questions, updating records with changes in circumstance, demographics, and other information. At this time I want to make clear that we will work to transition current adult members who will join the Heritage Health Adult Program. In addition, we're also looking at our home and community-based waivers to allow the newly eligible adult group access to those services when appropriate. In addition, I want to point out that we have provided helpful scenarios about basic and prime coverage as Exhibit 13 in the packet. Exhibit 14 is a copy of the fiscal impact of the initiative, and Exhibit 15 is a copy of our press release regarding the Centene and WellCare merger. Thank you for allowing me time to come speak with you again today and answer many of your questions regarding Medicaid expansion through the Heritage Health Adult Program. I now ask Deputy Director Brunssen to answer Chairwoman Howard's cost questions, as well as Chairman Stinner's questions. Deputy Director Brunssen--

HOWARD [00:34:37] So actually I think we're going to stop here and see if there are questions about benefits administration and-- and community engagement, and then we'll go on to cost. Does that sound good?

MATTHEW VAN PATTON [00:34:49] Senator, if I may, we've set up a cadence where we're proactively trying to answer the questions and then I'd like to bring my entire team up and begin to field those questions at one consolidated time. I think you'll get a better flow and I think you'll get the responses in a much more accurate and expeditious manner, if that works.

HOWARD [00:35:10] I'd-- I'd-- I want to make sure we get these questions answered first and I believe there are follow-ups pending, so let's do these and then we'll come back to cost, OK? Are there questions from the committee?

ARCH [00:35:22] I have a question.

HOWARD [00:35:24] Senator Arch.

ARCH [00:35:24] Thank you, Dr. Van Patton. That was very thorough and a lot to absorb, needless to say, so it'll to take some time for us to go through the material and understand exactly what that testimony was. I want to go back to eligibility just so I understand it for a second. Six-month eligibility test--

MATTHEW VAN PATTON [00:35:45] Um-hum.

ARCH [00:35:46] --It-- can-- can a recipient of these benefits lose their eligibility for any other reason during that six-month period?

MATTHEW VAN PATTON [00:35:55] So at this point the reason we're assessing the six month-- at the six-month interval, in December of last year the Governor and I had an early phone call with CMS Administrator Verma. The, I would say, first point of counsel given to us as we embarked on this journey was to define how we were going to be proactive in making sure that those who came into the beneficiary pool were eligible for those benefits and to be cognizant of the need to build solid program integrity pieces. So for us, the six-month interval is our way of staying on top of what happens within this population, as things do change within this population and they change rather quickly. Someone could be unemployed that one month, the next month they could be employed. So our intent is to keep it on the six-month cycle. But again, to also-- this is also the point of active care and case management is that you're in contact with this beneficiary so you know what's going on in their life to accommodate those changes and-- and also at the six-month interval when the-- when the assessment is done, you've got a fair and accurate representation of what has happened in that individual's life. Senator Howard, the reason I wanted to insist that my team join me here is because each of these deputies have a very specific role and have played a very integral part in putting these pieces together, so they all have subject matter expertise that I think I would be remiss in not letting this group hear from them, in particular around eligibility because I understand that that's something that is of interest to everyone. So the intent was to get through our presentation, as I asked, and then collectively come up so that we can begin to field these questions because I really would like for you to hear from them as well as myself today.

HOWARD [00:37:50] Thank you. Are there other questions from the committee? Senator Wishart.

WISHART [00:37:55] Well, thank you so much for being here today and for putting this together. And I-- I've asked this question before and I'm going to ask it again because I-- I'm-- I'm not-- my concern is from-- from serving on the Appropriations Committee. Anytime we are requiring a bunch of different hurdles, it usually means more staff and it means an expansion of government. So my-- my question is, couldn't we have just expanded Medicaid and gone through the similar stream of our current Medicaid program?

MATTHEW VAN PATTON [00:38:40] This is a new population. Again, we had all-- if you go back into the-- into the book, send some time going through it, you'll see they're different populations. So those benefit packages, those portfolio of those-- those different eligibility groups, they're all managed differently. This is a new product with a new group, so there are going to be some administrative cost associated with it, regardless of the approach that you take. So for example, again, going back to the question that I just answered from Senator Arch, program integrity components, whole new population, we are adding a third of what we already have to the rolls, or what we anticipate to be a third. So again, because we need to stay on top of this population, its dynamics are changing and we have to stay ahead of that and accommodate that, that will require additional staff infrastructure.

WISHART [00:39:33] Because, well, I'd assume, though, our current Medicaid program has integrity. So if we expanded it, we would be expanding a program that-- that already has integrity.

MATTHEW VAN PATTON [00:39:43] We're adding staff, that's correct. We're adding staff in that space. And I'm also creating a new deputy director position for program integrity. It currently rests under our deputy director for finance, which is Mr. Brunssen.

WISHART [00:39:56] And I-- some of the-- and again, some of the concerns I have, and again this is looking at it from an appropriations perspective where, and Chairman Stinner knows this, we are fighting to-- to fund the programs that we currently have. And when I look at this and you're going to have staff who have to verify participation of 80 hours a month in these activities, that's going to take a lot of staff to be following people's sort of monthly records to make sure that they're doing this. I guess the concern is, are-- are we really creating such a complex system that it's going to cost our state a lot more than if we had just simply expanded Medicaid?

MATTHEW VAN PATTON [00:40:46] So what I would encourage you to do, Senator, is flip to this side of the chart. As you go through this, especially point number two, manual processes, the same people who are making these eligibility determinations are the same people who are going to be redoing reevaluation. It's the same workforce. I already have to hire them to accommodate this expansion population to begin with, and they're added to our existing workforce who are already functioning in this area. No way around it, Senator. It has to occur.

WISHART [00:41:21] I would just push back and say that any time we add layers of requirements and-- and regulatory requirements, it comes with a fiscal note. And so my concern is we are creating a program that is more costly to the state than by-- by simply utilizing the current structure we already have with Medicaid and-- and more simply expanding that out.

MATTHEW VAN PATTON [00:41:50] Your statement is noted. Thank you.

HOWARD [00:41:51] And actually that's a really good point, Senator Wishart. Director, perhaps we should talk about cost. Who's your next speaker?

MATTHEW VAN PATTON [00:41:58] That's Deputy Director Brunssen.

HOWARD [00:41:59] Great. Don't forget your name tag. [LAUGHTER] Good afternoon.

JEREMY BRUNSSEN [00:42:19] Good afternoon. I'm Jeremy Brunssen, deputy director of finance and program integrity for Medicaid and Long-Term Care. Good afternoon, Chairwoman-- Chairwoman Howard and Chairman Stinner and members of the Health and Human Services and Appropriations Committees. Excuse me. I appreciate the opportunity to respond to the budget and cost questions on behalf of the Division of Medicaid and Long-Term Care. For easier presentation and transparency in responding to your questions, I'm going to respond to them separately as the questions were presented from a different perspective. I'd like to begin my-- by addressing the questions we received related to cost from Senator Howard and Health and Human Services Committee. These topics are on slide nine for your reference. To answer the first question received from Chairwoman Howard, the objective of the 1115 waiver is not cost savings. The primary objective is intended to meet people where they are to provide pathways for wellness and life success. It is important to note that part of the 1115 waiver demonstration is a financial demonstration that requires that the waiver pass a budget neutrality test. While there may be potential savings in aid cost as a result of administering the Heritage Health Adult benefit package, any potential savings or cost differentials have not been determined as key components of the benefit plan need to be reviewed and approved by CMS as part of the 1115 demonstration waiver process. Regarding question 2, additional administrative cost will be expected. To operate under the structure proposed for the 1115 waiver, IT costs and staffing, such as for the six-month redeterminations, are the primary drivers. While there is an investment on the front end for these administrative costs, this investment positions MLTC to mitigate long-term risk for program integrity issues identified from other states' expansion experiences where states having incurred large fine-- federal disallowances for federal share payments made to ineligible beneficiaries. I would reference the articles included in Exhibit 5. The investment also allows us to ensure that we provide a high-quality experience with the Heritage Health Adult Program for beneficiaries and providers and to maximize on the value of the buy we already make with the managed care organizations for our beneficiaries. To that end, we do not anticipate increasing capitation payments to the MCOs to administer the program. Currently, the MCOs receive an administrative load of around 10 percent of their per-member, per-month medical costs. This administrative load compensates the MCO for the value they bring as a managed care organization, for things such as care and case management, utilization management, claims processing, providing value adds, provider and community engagement activities, and program integrity activities. Furthermore, we have not quantified any savings anticipated as a result of community engagement requirements as this is not the intent of the waiver. In response to question 3, currently Nebraska is 1 of 47 states covering adult dental services in some form, most of which offer the benefit in a limited capacity for adults. I would like to note that Nebraska Medicaid reduced the adult dental benefit limit from $1,000 to $750 per person, per state fiscal year beginning in state fiscal year '18. Emerging data does not show any material increase in emergency department visits for dental

issues from this change, despite an average reduction of utilization per 1,000 beneficiaries for adults of around 15 percent. More detailed analysis will be a part of the budget neutrality financial projections for the 1115 waiver demonstration. Furthermore, we would not anticipate an impact to providers for the services not included in the basic coverage. On question 4, Medicaid supports consumer choice as a part of the Heritage Health managed care program. We issued a press release regarding the news of Centene's potential acquisition of WellCare and have communicated the department's expectation that the health plans honor the terms of the current contract period which ends effective December 31, 2021. This press release is provided as Exhibit 15. Regarding question 5, the MCOs have not expressed concerns about the Heritage Health Adult Program. MLTC has engaged in the stakeholders to date for feedback and we'll continue to engage them as we work on the 1115 waiver. Finally, to respond to Chairwoman Howard's sixth question, MLTC will amend the contracts to include the enrollment of the Medicaid expansion population on or around April through June of 2020. This is noted in our time line, Exhibit 4 in your binder. Medicaid does not negotiate terms and conditions or rates for our MCO contracts. At this point, I would like to transition to slide ten and address the questions we received related to the budget from Senator Stinner and the Appropriations Committee. Medicaid continues to update the expansion cost estimates for each state fiscal year of the upcoming biennium. We do not agree that a prorated approach of nine months, relative to the start date being 10/1 as opposed to 1/1, is appropriate. We are in agreement that there should be no reductions or offsets to aid for Program 348 for women with cancer, Program 347 for state disability, and Program 038 for behavioral health in state fiscal year '20. We are updating-- providing updates for the offsets amounts for these programs for anticipated cost of offsets in state fiscal year '21. The program is anticipating a significantly higher ramp-up of members due to the additional time to the implement-- implementation plan, heightened public awareness, and the early beneficiary application period. We're assuming a full ramp up as of October 2020 and-- and our offsets assume 9 months of offsets versus 12 in state fiscal year '21. Similarly, for Medicaid expansion aid costs, the assumption of a prorated reduction is not appropriate given that we've estimated a full ramp-up on October 1, 2020, as noted above. We are providing an updated aid estimate assuming that full ramp up for nine months of state fiscal year '21. Medicaid is not estimating any aid expenditures for state fiscal year '20. We would also caution that while we've done significant research, there still remains some uncertainty as to what to expect for counts of individuals that currently have insurance availability that may become eligible for Medicaid. Nearly every state that has implemented expansion has seen higher enrollment than what was initially estimated, as documented in articles in Exhibit 5, specifically the article titled Medicaid Expansion Enrollment is on Track to Surpass Projections. We'll also be providing an update-- an updated estimate for the administrative cost for the Medicaid expansion, implementation, and operations. Most notably, we do anticipate increased-- increased IT-related costs and additional staff to implement the Medicaid expansion plan as submitted. We are asking to move some preliminary aid appropriations to administrative appropriations to implement the program. This is a thoughtful and purposeful plan to implement a program that is aimed at hiding-- at providing a high-quality experience for beneficiaries and providers, as well as to increase our program integrity and data and analytics infrastructure to mitigate significant financial risks that have been experienced by other states that have

implemented without that proper infrastructure in place. While we have researched and planned extensively for this implementation, we continue to assess and learn as we work with internal and external partners. As such, we respectfully ask that the Appropriations Committee support the total amount the Governor has recommended to implement Medicaid expansion for the two-year biennium. This will allow the department to have the resources necessary to implement successfully without delay. Any unexpended appropriations that accrue during the upcoming biennium should be preserved to address the remaining and any new uncertainties related to Medicaid expansion and the potential growth of enrollment for the following 2021 through 2023 biennium. We would like to reiterate that while we have worked hard to prepare a sound plan, there are several items that have surfaced as new learnings that are not fully incorporated as documented expenses in our estimates. We do not have sufficient information or data to document the request. The items include things such as the fact that nearly every state that has expanded has experienced more eligible persons in the expansion population than the original state or national estimates projected, also that the program integrity issues including-- included significant audit findings that carried millions of dollars in disallowances for benefits paid to persons that should not have been eligible, for increased infrastructure to support the data and analytics platforms and processes to prove our outcomes and experiences for members and providers, and to increase our infrastructure for formal processes and resources to perform provider rate studies to ensure proper payment and access. Thank you again for the opportunity to speak to the questions provided on cost and budget from both committees. I would now like to invite the Medicaid director, Dr. Matthew Van Patton, to return for final remarks before taking questions.

HOWARD [00:52:23] Thank you.

MATTHEW VAN PATTON [00:52:23] Senators, I now invite my team to stand and join me here to answer any additional questions. I would also like to let the public know these documents will be made available on the expansion Web site. I would be remiss in not acknowledging this team's work and professional competency. I would also like to thank this group of public servants for their work and commitment to building and implementing the Heritage Health Adult Program. This concludes my remarks. We'll take your questions.

HOWARD [00:52:59] Thank you. Do you want additional chairs?

MATTHEW VAN PATTON [00:53:03] We're happy to stand, Senator.

HOWARD [00:53:06] Unfortunately, actually, it's a hard time for the microphone and then people in the back can't hear you so--

MATTHEW VAN PATTON [00:53:10] Why don't we-- if-- if somebody is answering, why don't we step forward.

HOWARD [00:53:11] Maybe we'll just tag in. How does that sound? You actually will want to leave the chair there because they can't hear you if you're standing.

MATTHEW VAN PATTON [00:53:22] OK.

HOWARD [00:53:23] All right. Are there questions? Senator Bolz.

BOLZ [00:53:31] I have several. I'll-- I'll maybe start with a couple and then let other members ask questions as well. Let-- let me start here and ask, your-- your slide 10 fiscal analysis assumes average monthly enrollees of 88,602. Previous projections and fiscal analysis that we have seen, and specifically I've spent time with some analysis that our Legislative Fiscal Office has done, assumes a ramp-up. The one version of an assessment that we've seen assumed 53,000 in the first year. And so in-- in terms of trying to understand what the implications on the aid budget would be, can you help me understand what-- why is it we would assume kind of a 0 to 60 enrollment process?

JEREMY BRUNSSEN [00:54:32] Sure, so thank you for your question, Senator Bolz. And I think in our-- to reiterate, in our original projection, the September, from the department we had the same ramp-up period. Given that we have more time, we're engaging the public more in this plan, that-- given that we have the early enrollment period and given, frankly, the information that we've been able to gather since the fall around experiences of other states with applications coming in at a higher rate up-front than those states had planned for, we felt it would be the best course of action to assume full ramp up, which the 88,000 was essentially the full ramp up, which would have been year three of-- state fiscal year three, two and a half years in, just because we've seen the experience in other states show the applications coming in at a much higher rate than they anticipated.

BOLZ [00:55:25] It-- it might be helpful to share with the Appropriations Committee the-- those-- that first year of ramp-up information from other states, because I think that-- that because we have seen other projections that show a slower ramp up, we probably also need to get that verification that that's a fair assumption to be making from-- from the beginning. I-- I think the thing that I'm having the hardest time really understanding and making a judicious decision about is your assumption that you won't need any changes in the aid budget. It-- it-- I don't mean to oversimplify. This is obviously a very complicated set of circumstances. But it's very hard for me to understand why you would have a nine-month change in eligibility and no change in what you expect to expend in aid.

JEREMY BRUNSSEN [00:56:22] So there actually is a change in-- and I-- maybe if I get my book, I can walk through it with you because that chart is-- just to help follow along. The-- the aid is reducing. So we're not asking for-- we're not anticipating any aid request in state fiscal year '20, for obvious reasons. We're not-- the plan-- we're not paying any benefits for-- for beneficiaries or for members at that point in time. And in state fiscal year '21, we did provide what we anticipated to be the net aid request, which is full ramp-up but at 9 months versus 12,

so it is a little bit less, I believe, than the original ask. I'd have to go back and pull all the spreadsheets. But in addition, we put in the contingency aid just for the fact that we could have an overrun. We've seen experience in other states where they've had program integrity findings. And so, for example, I think where I would want to go with that is the expansion population audits that have been done have revealed some troubling costs for states. So what-- what would happen would be if we pay-- if we have a-- if we were to ever have a situation where there is an issue where we pay for benefits where a member is not eligible for any given period, while we've already paid the 10 percent state share up-front, say that's a million dollars for however many people that-- I'm just using round numbers for easy math. If we were to have a finding, we-- the finding would be for the full $10 million and we would have to pay back the $9 million, the federal share. So there's a lot of risk in that. So there's a lot of unknowns with the overrun. We're just trying to make sure that we have the money that we think we need to cover the biennium. It's very possible that we would have funds that are accrued, not spent, as I mentioned in my remarks. But given the experience that we've seen in other states with the overruns, I-- I think it would be-- we're recommending that we leave that there for the Medicaid expansion population.

BOLZ [00:58:23] But how-- how much of a cushion do you-- I mean, I appreciate that you want to mitigate risk. That makes sense to me. How much of a cushion is-- is fair-- fair to expect? It --10 percent, 20 percent? I mean what you're saying is that we should prepare for the contingency that you enroll noneligible members. Is a-- is a reasonable expectation that you get nine out of ten right, eight out of ten right? I'm not trying to be hard on you. I'm trying to understand.

JEREMY BRUNSSEN [00:58:49] No. Yeah, I understand. I think that that's-- that's-- I can't make a definitive statement as to what percent should be in the contingency. I-- I-- that would just be making something without any facts in front of you and I don't want to do that. So we can continue to go back and refine. I-- like I said, this is a process that's going to be an ongoing process. And I appreciate the position you're in where you have limited time to put a budget together, and we're here to work with you on that as collaboratively as possible.

BOLZ [00:59:14] I-- I-- two more questions if-- if I may have the patience of the committee. The first is I just want to make sure I'm clear. The Governor's budget recommendation is in front of me and I'm looking at the aid in 2021, General Funds, Medicaid services, and the-- the allocation in my Governor's preliminary budget recommendation is $49.2 million, right? That's the-- the-- that was the request in the Governor's budget recommendation.

JEREMY BRUNSSEN [00:59:47] In total before the offsets, is that correct?

BOLZ [00:59:49] Right.

JEREMY BRUNSSEN [00:59:50] OK.

BOLZ [00:59:51] Aid, Medicaid services, General Funds, 2021. OK. So I'm cross-walking that with what I've seen, and maybe I'm just not understanding your chart--

JEREMY BRUNSSEN [01:00:00] Yeah.

BOLZ [01:00:00] --but I'm cross-walking that with net aid, state funds, '21, of 49.8. Can you-- can you help me understand why the aid would be the same for the second year if we have a nine-month eligibility and enrollment difference?

JEREMY BRUNSSEN [01:00:19] So we-- when I-- I'm not sure I followed exactly where you-- where you are. So I see where you're talking about on the net aid. What I can talk to is the fact that we-- in state fiscal year '20 there should be a stark difference. There should be zero dollars versus the $19 million, roughly, $19 million that were in there.

BOLZ [01:00:40] Right.

JEREMY BRUNSSEN [01:00:40] For state fiscal year '21, let me pull out my chart. I apologize. It'll be easier for me to talk to this way you.

BOLZ [01:00:53] You-- you've got for--

JEREMY BRUNSSEN [01:00:53] Yeah, so in state fiscal year '21, the-- the gross aid that we were projecting, based on around 71,000 average monthly enrollees, in state funds was around 49.2. The-- the total gross aid that we're projecting now was, what, 46.1 in state fiscal year '21, not the net aid, the gross aid, the-- kind of the apples-to-apples comparison. And the difference is we would assume full ramp-up, the 88,000, but 9 months versus 12. So it's-- that's how it plays out, assuming the same per-member, per-month cost.

BOLZ [01:01:32] OK. I'm still not sure I'm following you, but I'm not going to take any more of the committee's time. I do want to ask one last question which is, when we had the Governor's preliminary recommendations, there wasn't any specific recommendation or any note or comment yet about the medically fragile population. Do you have any estimates of additional expenditures that would be associated with-- with what you expect to come in under the medically fragile population?

JEREMY BRUNSSEN [01:02:02] So nothing at this point because those folks would be in that 1115 waiver demonstration. So right now it's-- it's-- that's part of the process of putting together kind of the budget neutrality test. So it's very complicated. A lot of it's going to depend on what exactly that definition says. There will be higher cost, more than likely, because it'll be more like a disabled type populate-- benefit package or need for that-- that-- that member. So I don't have any detailed information I can provide from a financial perspective to you today.

BOLZ [01:02:30] OK. Thanks for your patience, committee.

HOWARD [01:02:35] Other questions? Senator Hilkemann.

HILKEMANN [01:02:36] Yeah, I just-- I have a question regarding the benefits. You have-- you have your basic benefit and then you have your prime benefit. And with the prime benefits here says it has-- it adds dental services to it. Are you including all optional services in basic coverage?

MATTHEW VAN PATTON [01:02:51] All optional services in basic coverage?

HILKEMANN [01:02:56] That Medicaid optional services in basic coverage.

MATTHEW VAN PATTON [01:02:59] No. So the--- go ahead.

ROCKY THOMPSON [01:03:04] Hi, Senator. The basic benefit package and the prime benefit packages are not-- they're-- they're not established yet because we're working on that with CMS. We're not anticipating that all optional benefits will be covered in those and the basic benefit package.

HILKEMANN [01:03:23] You're not-- you're saying that you will not cover all optional services?

ROCKY THOMPSON [01:03:26] We're not anticipating that all optional services will be covered.

HILKEMANN [01:03:29] Why?

ROCKY THOMPSON [01:03:29] This can be comparable to commercial insurance.

HILKEMANN [01:03:34] Well, commercial insurances covers all the optional services.

ROCKY THOMPSON [01:03:39] They cover it at different degrees.

HILKEMANN [01:03:42] I would-- I would challenge you in this to find one state that cut out optional services in Medicaid that ever didn't go back to-- finding that it was more costly to cut out the optional services in Medicaid than to continue those optional services.

ROCKY THOMPSON [01:03:59] And you-- we-- we are-- we are working on that benefit package and we will have at least four public hearings about that. So we are-- we are seeking public input into the final benefit package.

HILKEMANN [01:04:09] So you've not made any definitive decision yet whether you're going to-- because you-- you specifically mention dental services coming in your prime, which is also an optional service in basic-- in Medicaid.

ROCKY THOMPSON [01:04:22] That's correct, but we haven't made any final decisions about the exact benefit packages.

HILKEMANN [01:04:30] And it would be-- why would you-- why would you even-- I guess I have a hard time understanding why you even considering now-- consider-- who's going to be providing the dental services in the first six months when people are all on basic services?

ROCKY THOMPSON [01:04:49] Who will be providing, is that what you're--

HILKEMANN [01:04:52] That's correct. In other words, if you're add-- if you're adding dental benefits after-- when you qualify for prime, who's taking care of them during the basic period when they're on basic coverage?

ROCKY THOMPSON [01:05:02] We anticipate these will be the newly eligible population so they will be new to the Medicaid program. And so we will--

HILKEMANN [01:05:10] Well--

ROCKY THOMPSON [01:05:10] --work with our case and care managers.

HILKEMANN [01:05:12] But it's a six-month period of time. Are you saying for a six-month period of time they're not going to have any dental care?

ROCKY THOMPSON [01:05:17] We anticipate that most of them will go into the prime package where dental care will be available.

MATTHEW VAN PATTON [01:05:24] I think, Senator, that's also the point of active care and case management. Now I want to continue to reiterate what this means.

CAVANAUGH [01:05:30] You need to--

HOWARD [01:05:31] Director, could you sit down.

MATTHEW VAN PATTON [01:05:32] My apologies, yes. I want to continue to reiterate what this means. This is using our managed care organizations. Getting from-- getting from basic to prime within that first six months to the reevaluation of eligibility, all you have to do is engage with the MCO. That's as simple as taking a call and having a phone conversation about where you are and finding out what you need and then helping you track to that provider. So there's no lift here. This is-- this is what our managed care organizations already do when they on-board someone into the program. They already have this initial reach. So again, moving from basic to prime, we've made a process that makes that a very easy activity for the beneficiary. At the same time, it pushes the value of the buy the state's already making to the forefront of what we get from those MCOs as they engage with this new population, again, so we can help them figure out

where do you need to be, do you need dental services, do you need vision. You know, you've got to get in to get to the primary care exchange first. That's your baseline history and physical. That tells the picture of what-- what we're going to be managing to. And again, all you have to do is have that initial conversation with-- with the care and case manager. You've hit the switch. You're done. And then you got to get in to go see the primary care provider, and then from there we know how to help you care navigate. That's the intent.

HILKEMANN [01:07:18] So what you're saying is, is that for the first six months, that as long as they've checked-- at least checked in with their primary care physician, if they end up having an abscessed tooth or something of that sort, that they can go to a dentist to get it taken care of.

MATTHEW VAN PATTON [01:07:36] Well, again, as-- as Deputy Director Thompson reiterated, we're at the beginning of a process. We have to negotiate our package with CMS, first thing to remember. Second thing to remember is we're going to have public hearings where we solicit this feedback from the public. We want to hear how they want to approach based on what we've put forward. And that's the intent of the 1115 waiver. It gives us those opportunities to engage and hear those feedback and then help us take that back and negotiate what we end up completing a package with from CMS. Would anybody else like to add?

HOWARD [01:08:15] Senator Arch.

ARCH [01:08:18] A question and maybe, Dr. Van Patton, you'd be the best one to answer this, I don't know, but you can let anybody else answer it as well. What I-- what I see you attempting to do here is patient engagement, personal responsibility, becoming active in their care--

MATTHEW VAN PATTON [01:08:36] Yes.

ARCH [01:08:36] --and-- and taking a personal interest in that care. I-- I think across healthcare, I-- that is generally accepted as-- as-- as how we are moving in healthcare so-- because outcomes are anticipated to be better with that for the patient. I-- I guess my-- my question is the follow-up then. So this is a demonstration waiver. This is something that we are going to make an attempt to do. Your outcomes data, your analysis of results, what do you-- we will be very interested in seeing does it work, you know, does the engagement of the patient, does the incentives actually, you know, improve care, quality of care, which is what we want for the-- for the-- for the state to be investing in this, we want to see a healthier population in the state of Nebraska. What-- what are your plans for outcomes data?

MATTHEW VAN PATTON [01:09:39] Absolutely. So I think that's-- you're really getting into frankly why I took the job to begin with, because this is where I see the real benefit of-- of public benefit portfolios like Medicaid really meeting the individual and serving their needs where they are. And also I think from the state standpoint, and I know many of you have heard me say the quadruple aim, is you're assessing the experience of care and quality and satisfaction. That's-- that's-- that's both the cost and the consequences. Same thing for the provider, again, impacting

the health of populations on the whole, and are we reducing the per capita cost of healthcare? The constructs of that, the latter two components in particular, get into the discipline that you and I know to be population health. That said, you've also heard me say we've been building with Deloitte a new data management and analytics tool. You've also heard me reiterate our connectivity to NEHII and on-boarding new data such as the PDMP where we can begin to bridge the gap between encounter data that comes in off of a claim, diagnosis data, and RX. So you're moving from diagnosis to RX and you can begin to paint that picture of broader connectivity. That's the enterprise that Dr. Larra Petersen, who we on-boarded in September, has been working to build, starting first with the establishment of the data management and analytics platform. And I would-- I invite Dr. Petersen to add any comments to that as well and come join me here at the table.

LARRA PETERSEN [01:11:14] So one of-- one of the articles that we asked to be included is Exhibit 9. You'll see this article was actually published by our federal partners at the Center for Health Care Strategies in 2011. Much to your point, Senator Arch, this is an ongoing initiative in healthcare. We know that providing care in a siloed manner only facilitates a more disruptive healthcare experience for our beneficiaries. We also know that individuals with increased social determinants of health, such as a Medicaid beneficiary providing care in that siloed manner, can be more dangerous to their healthcare outcomes than any other patient that hospital systems may experience. It's our responsibility at Medicaid to ensure that we provide an infrastructure that's safe, it's responsible and accountable. The data management and analytics tool that we're building with Deloitte, but more importantly whether we pull this from our N-FOCUS using interoperability with NEHII and the PDMP, we provide a value back to ourselves and to the taxpayers in Nebraska by understanding what is the offset in cost and quality through care management. If you have the opportunity to read the article from 2011, there's five different state demonstration projects documented there where they consistently prove over and over again the value of engaging patients in a manner similar to what we're requesting to do in the 1115 waiver. It's also not just to reduce cost through unnecessary duplication of services such as a local health system I worked at here in Nebraska. We had an unfortunate beneficiary who went into the ED with migraine pain multiple times and received multiple MRIs. There's now enough data to suggest the difficulties with that multiple MRI may have health consequences to beneficiaries. Those are individuals often who cannot necessarily bring their entire portfolio of care with them. They may not be savvy enough from a patient education or health literacy perspective to be able to communicate all the disparate needs they have. So we're taking that responsibility to try to put an infrastructure in place up-front. The best way to do that, because many people who have mistrust of the federal system, of state bureaucracy and Medicaid in general, may not actively engage in care management without finding a way to incentivize their ability to engage, and then use patient engagement techniques after that first visit to help them find a better healthcare experience throughout the silos of care that exist in healthcare today. It's not that anyone provides bad care. It's just a byproduct of how health systems are established. So to your point, we have a number of what we're calling key performance indicators. If you are able to look at the roadmap, the Gantt chart that's established I believe in Exhibit 4, you'll see on the very bottom, which is of one of my tracks, implementation metrics under Track 9,

postimplementation metrics above that. Implementation metrics are what we're holding ourselves accountable to for the implement-- successful implementation of this program I've been through several implementations from the federal system through local health systems and now as part of state government. Implementing a program is never the problem. It's doing it successfully and accountably to your stakeholders is always the difficulty. And I'm asking for us to have key performance indicators and metrics that we report back on a regular basis without being asked. Postimplementation metrics will tell you the success of the program. Did we reduce cost, did we improve quality, and do we have better engagement strategies? We've had a lot of conversation about dental. If you look at the research nationally, many patients in these particular groups are not using appropriate preventative dental services. Providing appropriate preventative dental services doesn't negate emergency dental care, unfortunately, because we haven't provided the skills to bridge the gap between using disparate emergent care until it is an urgent condition that's painful and their ability to do it proactively, and that's what we have to be able to incentivize, the engagement and care management.

HOWARD [01:15:45] Senator Stinner.

STINNER [01:15:46] I got to go back to my friend Jeremy. [LAUGHTER]

JEREMY BRUNSSEN [01:15:53] Can I add one more comment to Dr. Petersen and then take your question, Senator?

STINNER [01:15:57] Absolutely.

JEREMY BRUNSSEN [01:15:57] I'm not the expert on this; my counterpart Heather Leschinsky is. But I also think it's important to note, in addition to the KPIs we developed with Dr. Petersen, there are-- submitting the waiver, getting the waiver approved for an 1115, it's not-- the demonstration doesn't stop when you start. That's really the starting line. You know, there's-- there's follow-up data submissions and proof-of-concept work that happens as part of that waiver.

HEATHER LESCHINSKY [01:16:26] There is a research and evaluation component of the demonstration waiver that CMS, through our terms and conditions, CMS will also define what outcomes they want us to report back to them and will incorporate the KPIs in their performance metrics and our design and evaluation process, and then we do have to report to CMS and all of that's publicly available. To help Jeremy [INAUDIBLE]

JEREMY BRUNSSEN [01:16:50] Yes. Thank you.

STINNER [01:16:52] So I'm-- I'm just looking at the same page on Appropriations Committee, your ask-- I'm going to treat this like your ask on-- as it relates to the Appropriations Committee. So you wiped out all the dollars that you were asking for in '20, which I believe was $12 or $13 million. That's gone. But you did add a contingency aid line of $9,000,672 plus a contingency

of-- the total for the two years for administration is 1.5. OK. That in my estimation is a cushion, but that's my interpretation. Eighty-eight thousand six hundred and eight people are used in your analysis. Is that on day one? They show up on day one?

JEREMY BRUNSSEN [01:17:40] That's-- that's correct. So when I referenced full ramp up as of October 2020, that's exactly what I was referencing--

STINNER [01:17:46] OK--

JEREMY BRUNSSEN [01:17:46] --was everyone's on board.

STINNER [01:17:48] --because you have a two-month period that you're taking--

JEREMY BRUNSSEN [01:17:50] Right.

STINNER [01:17:51] --applications and processing [INAUDIBLE]

JEREMY BRUNSSEN [01:17:52] And those individuals that apply during the month of October would be eligible back to the first of the month, so it's really three full months of processing applications.

STINNER [01:18:00] But this is a simple math problem for me. OK? So I'll agree with you on all of those things and I'll take a look at your request for contingencies and we'll do the best we can. But I'm going to say this. We used the same amount of dollars that was in the request, the Governor's request for 2021. We used the same amount of dollars you're asking for, but the length of time isn't 12 months, it's 9 months, so one would say, OK, I'll do the math and divide 88,000 participants and do-- do a monthly, and now it's times nine and I got $34 million, or a difference of about $12 million that should be saved.

JEREMY BRUNSSEN [01:18:45] That-- so--

STINNER [01:18:46] So we're going to continue to see 9 plus a million five, plus you're asking me to save another 12 as a buffer. Is that-- is-- is--

JEREMY BRUNSSEN [01:18:57] I would--

STINNER [01:18:57] --that what you're saying?

JEREMY BRUNSSEN [01:18:58] I would-- I would say that the original submitted state fiscal year '21 number wasn't 88,602. That still had some ramp-in period. That number was around 70,880.

STINNER [01:19:11] You know, I could go back and use those numbers as well and use a ramp up which would lower my number further that you're asking, the difference of the numbers, but I'm not going to. I'm going to assume all the-- all the things that you assumed, but I'm going to point out that you're taking a 12-month ask versus a 9-month ask and the difference is about $12 million-plus we're going to give you $9,600 in contingency-- or nine-- $9,600,000 in contingencies and $1.5 million for administration and-- I-- I guess we as a committee have to look at that and say, is that extraordinary, can we do that? And you're saying because of experiences we need to have that as a cushion. I think that's what you were saying to me.

JEREMY BRUNSSEN [01:19:54] Thank you, Senator. So I think just to clarify, yes, so what we're asking for is us to-- to-- to follow the Governor's budget recommendation in terms of total funds for the biennium. We are asking to-- to move some of those dollars to admin, which we've talked through. And you are correct that because we have a full ramp in, in 2021, for nine months on-- based on 88,000 per month, that number is more than in state fiscal year '21's original ask because it was based on 12 months of 70,000-- 70,000. So there's a-- there's a difference there because of the count of people, which does drive the cost, you're correct.

STINNER [01:20:36] OK. And I was just adding that all up and it's about 22, $23 million of cushion that you'd like to have. So that's something our committee will have to discuss. We'll work with you though to try to figure out what the right answer is. Appropriations dollars are awful precious right now. I just [INAUDIBLE].

JEREMY BRUNSSEN [01:20:51] I-- I can-- I can appreciate the position you're in. And we would just-- we would just reiterate, you know, we've seen a lot of experience and we want to make sure that we have the dollars to pay for the benefits for these new persons that are coming on.

STINNER [01:21:02] I truly get that and I respect that. And I think [INAUDIBLE] done a marvelous job putting this together so thank you.

JEREMY BRUNSSEN [01:21:09] Thank you.

HOWARD [01:21:11] Senator Hansen.

B. HANSEN [01:21:12] Yes. Thank you, Chairman Howard. I'm just happy I understood that math problem you guys just threw out there. [LAUGHTER] I actually worked through all that in my head so that was good. I kind of want to echo a little bit what Senator Arch mentioned that I appreciate the fact that you guys are trying to take a little more patient-centered approach, a little bit more patient responsibility and accountability and I hate to use the term "monitoring" but making sure that our money is being well spent. And so I think I just maybe had a couple questions on maybe some definitive terms first. When you say "job-seeking activities," what does that mean?

MATTHEW VAN PATTON [01:21:50] So that would be engaged-- my-- my apologies. That would be engagement with what I would refer to as a workforce investment board but through the Department of Labor so you're actually engaged with an enterprise as part of the state array that's maybe helping an individual find a new job if they're currently out of employment. Or they're maybe looking to gain job skills but they don't know where to start. They don't know how to make that point of connectivity back to a community college or a university. Or maybe they're working part time and they're going to school again. I think this is again pushing that patient-centered care and case management-- meeting that individual where they are in their life circumstances; finding out where they-- where they are today, where they want to be, what their resources are around them that's maybe inhibiting their ability to move forward. And so, again, that's pulling all those-- those existing governmental services components back together and using it, for example, the jobs connectivity back to the Department of Labor. And Deputy Director Karen Heng engages with this population on the enrollment eligibility side. And we already have some connectivity with the Department of Labor today and I'd like to invite Deputy Director Heng to elaborate on that if she would.

KAREN HENG [01:23:23] So right now the eligibility staff works not only with the Medicaid program but we also have the Aid to Dependent Children program which does have a work requirement tied to it. And through that program we have a contract right now for Employment First services. That's with ResCare. And so some of this population has the ability to also work with ResCare too. And they help with job-seeking activities, job coaching, meeting the person where they're at and what they'd like to do for a career, where-- where we need to go to find a job. And maybe there's a barrier that's in the road like childcare or something that we can resolve that will help them get on a path to self-sufficiency. We also started a program called SNAP Next Step. And in this program, it's a voluntary program that's attached to our Supplemental Nutrition Assistance Program which assists people in finding-- that have a job already and trying to go down the next step in the career path. And we've had several people find successful. We've been doing it now almost three years. And in that time we've had successes where people have on an average increased their income $10,000 a year by working with us to-- maybe it's attend a job training thing, a trade school to advance your skills. Maybe it's just let's tweak your résumé and you could be the-- at Wal-Mart is in charge of a section by becoming a supervisor and moving that next step because we helped you with your resumé and some interviewing preparation. So we've had a lot of success with that program, and it's open to the same people that will be in the adult population for Heritage Health.

B. HANSEN [01:25:16] Can I follow up with that?

_____ [01:25:18] Sure.

B. HANSEN [01:25:18] When you say caring for a relative, what is-- what's the definition of "relative"?

ROCKY THOMPSON [01:25:29] Yes, Senator. There's a federal definition for a relative. So it's an immediate relative so a parent, a grandparent, a sibling, a child.

B. HANSEN [01:25:42] I figured. I just want to make sure. And have we ever considered-- because I like the idea that we're also trying take almost sort of a wellness approach, [INAUDIBLE] the wellness of the patient as well by seeing a primary care physician once a year, including dental, vision, stuff like that. Have we ever considered if the patient is smoking will there be any repercussions for Medicaid?

ROCKY THOMPSON [01:26:04] Senator, there was consideration of that early on. I think that's something that we can consid-- continue to consider based upon the negotiations of 1115 and the public input. If you have any ideas of good ways to track that and good strategies to-- but we do have smoking cessation currently in our state plan for services.

B. HANSEN [01:26:23] We're helping get the patient off of smoking or, you, know.

ROCKY THOMPSON [01:26:25] That's correct.

B. HANSEN [01:26:25] Looking for [INAUDIBLE] And just a quick question, sorry. I kind of want to play off a little bit what Senator Wishart said as well. Let me just kind of flip it a little bit because she talked about some of the maybe burdensome regulatory requirements for enrollees or participants and maybe that might cost the state some more money in the long term. Do you see how that can maybe save the state money in the long term?

ROCKY THOMPSON [01:26:48] Senator, I think the best person to answer that would be Deputy Director Brunssen to talk about the different policy findings.

B. HANSEN [01:26:54] Musical chairs. I'm going to see if I can go through all of you here by the time it is over.

JEREMY BRUNSSEN [01:27:00] Thank you, Senator. So I think I addressed this to a certain degree earlier. And, you know, we've been researching and continue to read and try to learn from implementations in other states. You know, I think the fair thing to say is this is a really complicated program to implement no matter how you implement it. And no state has done it perfectly. And we hope to do it as well as possible. But we want to make sure that we put-- put practices in place in terms of processes and people and quality checks that we can try to prevent as much of that risk as possible. So we see it as an investment on the front end to mitigate long-term risk because the risk to us isn't what we invested. It's times nine. It's the federal share. So there's a lot of risk if we were to have a misstep, and that's what we're really trying to focus on, on that side. And it was-- I'll be honest. I don't think that was something that I personally was focusing on initially. And then we received a call from Director Verma, Administrator Verma, and she underscored you need to look into this; you need to have a plan; this needs to be a pillar of what you're doing. And so, you know, as Dr. Van Patton relayed that

message back to us, we made sure that we started to take a closer look at the experiences in other states. And, you know, it's not a discredit to other states. This is complicated. We just want to try to do what we can to do it as well as possible.

B. HANSEN [01:28:30] Can I ask one more quick [INAUDIBLE] I don't mean to take [INAUDIBLE] time.

HOWARD [01:28:32] No. Actually--

B. HANSEN [01:28:33] Just let me--

HOWARD [01:28:33] Sorry, Senator Hansen. We actually have to keep going.

B. HANSEN [01:28:35] No, go for it. That's fine. I'm done.

HOWARD [01:28:35] Before Senator Vargas, I just want to be really clear. Do we have to do the 1115 waiver? Is that required by any statute or required by 427?

MATTHEW VAN PATTON [01:28:47] I'll take that and then folks can fill in.

HOWARD [01:28:49] And then we'll go Senator Vargas, Senator Erdman, and then we'll come back over here.

MATTHEW VAN PATTON [01:28:52] This is our-- our choice to do it this way based on looking at, again, what are our strengths as a state as it stands today? Ninety-eight percent of our beneficiaries are currently enrolled in managed care and that infrastructure is something the state's already paying for: claims processing, again, care management, case management infrastructure, to a degree their data and analytics enterprises. We're already buying that. And so this really allows us through this construct to take that by that we make, that care, that case management point, that piece that you just made of really pushing it forward in getting engaged with that individual who comes into this beneficiary pool as quickly as possible to meet them where they are. That is an incredible benefit. And we feel like the 1115 waiver lets us-- lets us meet that person where they are best. It gives us the constructs to build a program that we feel like fits Nebraska best.

HOWARD [01:29:53] OK. Thank you for that clarification. It's good for me to understand that we don't have to do it. Senator Vargas then Senator Erdman.

VARGAS [01:29:59] Yep, two quick questions. The first is so I think holistically I actually appreciate and understand the case management aspect, the wellness on the forefront. There's a lot of things we can do on the forefront. The question I have is about the cost-benefit analysis. It seems like this is more extrinsic and punitive when we're saying that, you know, to then keep Prime coverage if you don't update, there's changes, you lose the enrollment periods and, you

know, you have to update community engagement requirements in a timely manner. Have you-- do you have any numbers from other states or from audit findings from a cost-benefit analysis of people moving off and off-- off and on plans rather than keeping them on the plans and trying to work to figure out to make sure that they're making appointments?

MATTHEW VAN PATTON [01:30:49] I haven't looked at any-- any data in that space. But again, this is where our ongoing conversations with our MCOs are going to be unfolding as well as our ongoing research. We've spent the last five months in deep dives and bringing as much understanding from these other states' experiences to the table as is relevant for where we are in this production cycle so it will be a space that we look at. Again, I think that also goes to Dr. Petersen's point and what is the bottom work line on your Gantt chart there which is your key performance indicator. What do we want to accomplish? What do we want to look at proving in this space?

VARGAS [01:31:29] And I think that's great. I think we need to listen to MCOs and their feedback. I just want to make sure that patients are lost in these KPIs too. I don't know if you can talk to any-- any indicators you're using for patients' KPIs on satisfaction, patient experience throughout this process. I just imagine that some of these punitive things might-- I don't know how they're going to affect--

MATTHEW VAN PATTON [01:31:49] She's queuing up because she's already heard your question and she wants to answer I do believe.

VARGAS [01:31:54] OK. Thank you.

MATTHEW VAN PATTON [01:31:56] I want to reiterate the strict-- that part of the reason I wanted this team here is I wanted each and every one of you to see, to meet, and know that these folks have invested in this. They have devoted the last five months of their professional career at the state working to make and build this product, and I want you to see and understand their expertise. So, Dr. Petersen.

LARRA PETERSEN [01:32:23] Me? So I think to your point, yes, we would track patient satisfaction, so there are many ways that you can look at patient satisfaction. One of the most common ones is the HCAHPS coming through healthcare systems. The MCOs do provide us some satisfaction numbers today. My experience has been in the area of patient engagement, which has been long for me since being in the VA and working with some of our veterans who have struggled to find adequate care. It doesn't really tell a full story, so some other ways that we have thought about is using a qualitative approach which does more focus groups outreach from those individuals who may feel more disenfranchised from their care or to the point of may have lost prime coverage for one reason or another. What we don't want to do, I think, is what may-- some of you may be questioning, is to penalize individuals for not engaging in their care. And so moving someone back down to basic, they would remain in the health plan. We would continue to monitor that engagement and continue to work and support them through trying to

engage them in care management. However, it is the patient's right to refuse that and because some of them may for many reasons not want to participate, we can't require that, we can only incentivize it. And so we'll-- we'll continue to work with the patient and try to understand why it may not have been effective. I know I have a son with asthma and I've gotten those calls at times from various health plans and it's not always-- it doesn't always feel valuable to me, so sometimes I don't answer those calls in the middle of my workday. But those would be things that we could learn and certainly will be an indicator at some point. We just may also have some depth to the quantitative piece.

VARGAS [01:34:15] Yeah, I just want to make sure that that piece is there because I represent one of the highest populations that are going to benefit from Medicaid expansion, and the punitive side of this, I'm just worried that we're creating more hoops for people to walk through. And if they don't have a feedback mechanism, that's just a-- a hole, a gap I want to make sure is not there.

LARRA PETERSEN [01:34:32] Yeah, I'm a firm believer in the value of beneficiary advisory groups, and I think that there are many ways that we can seek beneficiary input. We're just at the start of this process by doing it in how the plan will be implemented. But I think that that's an ongoing process because you never have a perfect plan.

HOWARD [01:34:51] Senator Erdman.

HEATHER LESCHINSKY [01:34:54] [INAUDIBLE]

HOWARD [01:34:54] Oh, Heather? Sure.

HEATHER LESCHINSKY [01:34:57] I just feel it's important to add, in the packet is the-- the applicable Social Security Act that governs the Medicaid expansion benefit package. And I know there's concerns about basic versus prime. But if you'll-- when you see that, you will see that there are ten essential health benefits that must be covered for the expansion population, and we have to benchmark that off an alternative benefit plan, but substance use disorder services, preventative services, restorative services, so there are-- they're listed in the-- in the act. There are still basic benefits and essential health benefits that will be available to everyone, regardless of prime versus basic coverage. Thought that was important to add. Thank you.

HOWARD [01:35:40] Thank you. Senator Erdman.

ERDMAN [01:35:42] Thank you, Senator Howard. I think this question would probably be for Mr. Brunssen. [LAUGHTER] I was listening to your conversation with Senator Stinner and on slide 10, if you have slide 10, if you would turn to that, maybe you don't need to, maybe my question will be clear enough, but on slide 10, on the left side, it's the gross aid and then the net aid, and so for $476 million in '20-21 for gross aid. But on the left side it's an administrative cost. Are

those administrative costs on the left-- on the right-hand side, are those all contributed to Medicaid expansion?

JEREMY BRUNSSEN [01:36:20] Yes, Senator. So these figures that we have put in are specific to Medicaid expansion.

ERDMAN [01:36:27] So it's at $27 million for the two years, right? Or-- or it's 16, 12, yeah. So you have, whatever it is, $26 million and then you have another $3 million for contingency, right?

JEREMY BRUNSSEN [01:36:43] That's correct, Senator, in total funds.

ERDMAN [01:36:44] So the administrative cost of doing this is going to be nearly $30 million.

JEREMY BRUNSSEN [01:36:49] As we have estimated right now, so this is based on our estimates with the plan that's been submitted with the 1115 waiver. That-- that is what we're projecting as-- as our estimated cost for the first two years of the program, this upcoming biennium, that's correct, sir.

ERDMAN [01:37:07] But I see the second year, '21, is slightly less than the first because I suppose of the enrollments, the initial month up. Is that correct?

JEREMY BRUNSSEN [01:37:14] So that would be related to just design, development, implementation work--

ERDMAN [01:37:18] Correct, I know.

JEREMY BRUNSSEN [01:37:18] --that is going to be heavier on the front end.

ERDMAN [01:37:21] I get it.

JEREMY BRUNSSEN [01:37:23] Yeah.

ERDMAN [01:37:23] So the feds are going to match us 60 percent the first year and about 52 percent the second year. Is that because it's a 50/50 match on administration? Why don't we get the 90/10?

JEREMY BRUNSSEN [01:37:33] So there's a-- there's a lot of blending of different match rates in the administrative side because we have staff that will be 50/50, we have staff that will be a potentially higher match rate that are in eligibility field. And then there are other administrative costs that might be 90/10, some that might be 75, some that might be 50/50, depending on what the activity is. Part of this is we have to submit an advanced planning document with CMS to get

federal authority to get an enhanced match rate for those activities on the aid, on the admin side, so--

ERDMAN [01:38:05] So with this--

JEREMY BRUNSSEN [01:38:05] --we've had to make some assumptions but, you know, that's--

ERDMAN [01:38:09] OK.

JEREMY BRUNSSEN [01:38:09] --directionally correct.

ERDMAN [01:38:10] So the administrative cost is about 7.5, 8 percent of the total? That be a fair way to say it?

JEREMY BRUNSSEN [01:38:16] Sure.

ERDMAN [01:38:17] Is that--

JEREMY BRUNSSEN [01:38:18] I haven't done the math in front of me, so, but, yeah, I mean, that's--

ERDMAN [01:38:20] Have you looked at other states, how they administrate theirs? Is their expenses about the same for administration?

JEREMY BRUNSSEN [01:38:25] I can't say that we've looked specifically at the ratio of the admin cost versus their aid, but that's something we can go back and revisit.

ERDMAN [01:38:32] That would be interesting to see--

JEREMY BRUNSSEN [01:38:32] Yep.

ERDMAN [01:38:32] --how they do that.

JEREMY BRUNSSEN [01:38:33] Great question.

ERDMAN [01:38:33] Thank you.

HOWARD [01:38:35] Senator Wishart.

WISHART [01:38:37] Yeah, I wanted to add to that conversation, and along the lines of Senator Hansen, because I-- I actually-- first of all, I-- I do commend you with thinking about a wellness system, putting that in place, because I do think it's-- it's a good investment to make. But I have

participated in wellness systems that have worked and I've participated in wellness systems that were a complete joke in terms of actually requiring and-- and supporting kind of personal responsibility and wellness. So again, my concern is that we need to make sure if we're doing these additional investments in these additional steps that-- that cost more administrative dollars to do, that it truly is effective and-- and that it's not-- that it's not a duplicate service, because aren't the managed care entities supposed to be doing all of this anyway?

JEREMY BRUNSSEN [01:39:37] So I think to-- to kind of hit on that, so not all of this is related just because of the prime versus the basic tier. This is just us becoming smarter over time with more time to research what all we need to put in place to expand properly. So not all of this is-- the cost is tied purely because we have the tiered package. Some of it is we're more informed and we have better information around the risks and what we can put in place to mitigate the risks in other states. A lot of the cost is driven from the enrollment and eligibility piece, which is something we handle. The MCOs have a-- you know, we partner with the MCOs today on the program integrity side when we look at it from a provider perspective. This is more focused on member, like an SIU, special investigations unit, member-focused type of activity, so it's a little different.

WISHART [01:40:26] And then the one other-- I had one more.

LARRA PETERSEN [01:40:29] Oh.

WISHART [01:40:30] I'll--

LARRA PETERSEN [01:40:30] Go--

WISHART [01:40:30] Yeah, I just have one more question about the managed care entities, but if you wanted [INAUDIBLE]

JEREMY BRUNSSEN [01:40:33] You want to add something to that? Sorry.

LARRA PETERSEN [01:40:34] Yeah, I'll just lean over. I was just going to say, so I think one of the KPIs that we've already suggested for a postimplementation metric is part of a typical value analysis for a program implementation which would look at-- Jeremy had mentioned that PMPM. So we would look at does the PMPM change over time. Our anticipation is not in one year that we will see an adequate PMPM change to be statistically significant. However, what we would do is also look at metrics which are indicators of where we would see a longer-term shift in that cost offset in things around more costly acute care such as hospitalizations, hospitalizations after an emergency visit, meaning we probably didn't do proactive outreach after they had an emergency visit to stabilize them that landed them in the hospital. So in the first year, we will have to look at some additional metrics to look at are we implementing the program and getting the value back to the taxpayer that's desired, and then longer-term we may see that actual cost of care in a PMPM capitation rate go down. That does take a little while.

WISHART [01:41:40] Because it's my understanding that 73 percent of the population we're talking about is already employed, so are we talking then-- when we're looking at job searching and those kind of things, Is it to get them to an employment level where they will then not have to require on-- on public services?

JEREMY BRUNSSEN [01:41:59] Potentially. I'll-- I'll punt this to Mr. Thompson. But if they're already employed, they already qualify for prime. But that does not mean that we won't be care managing them and helping them improve their situation, regardless if-- if they even perceive themselves to be in a kind of an OK spot. They may still have aspirations. They may have a roadblock into getting a management position or something similar so--

WISHART [01:42:20] OK. And then in terms of the managed care entities, my understanding is that-- that two of them have merged. So is that correct? So will we be going through an RFP during this process as well to look at an additional managed care entity to bring on?

MATTHEW VAN PATTON [01:42:40] So again, that's-- that's noted. The press release that we had on that subject between the Centene/WellCare, it's the Centene acquisition.

WISHART [01:42:49] OK.

MATTHEW VAN PATTON [01:42:49] It's proposed and I think the important thing to remember is that that is, in and of itself, a process that is going to be working over time. I would also say that our expectation is that we have three plans and one of the fundamental tenets of Heritage Health is that there be consumer choice in the marketplace. And we've articulated back that to our MCOs and that-- that has been supported coming back to us. Now in terms of what this does to our reprocurement, because these contracts, as-- as Deputy Director Brunssen noted, do end at the end of 2021, so that does put us in a position where we will begin to work through the processes of reprocuring and we'll begin those processes under Deputy Director Leschinsky's auspices. And I would ask Heather if she'd like to add anything to that. She's welcome to.

HEATHER LESCHINSKY [01:43:41] [INAUDIBLE]

HOWARD [01:43:42] Senator Williams.

WILLIAMS [01:43:42] Thank you, Chairperson Howard. And you're sitting in the right spot. Two quick questions, Dr. Van Patton. First of all, early in your testimony, and maybe I misheard you, on the-- the-- the working requirement, are we talking 90 hours or 80 hours?

MATTHEW VAN PATTON [01:43:58] It's 80 hours.

WILLIAMS [01:43:59] Eighty hours a month, OK. Second question, we've learned a lot over the last two and a half years about managed care, what has worked, what hasn't worked, those things, and appreciate everybody's work around that, and-- and especially your meetings that you continue to have on that. When we talked and when Senator Hilkemann talked about the dental coverages and those, are we going to use the current model of managed care that is working successfully, at least that's what we are hearing, for the dental coverage under this expanded population?

MATTHEW VAN PATTON [01:44:38] So we currently have a dental benefits manager, which is MCNA, and they are in place to accommodate the existing population. Our intent would be to look at where they are at this point in time. But then there's also, and I think this is just good business assessment, as you're integrating a new population in, the preexisting three healthcare MCOs could also add that, that benefit, as well, to their portfolio. So we're going to look at both, but right now we do have an infrastructure that's in place with MCNA. I've had a very good conversation with Dr. Hunke and Dr. Wieting, with that team, and I have shared with them our desire to show how these two systems connect back, and he seems to be very enthusiastic in helping us find those paths. So--

WILLIAMS [01:45:22] Thank you for that--

MATTHEW VAN PATTON [01:45:22] --again--

WILLIAMS [01:45:23] --for that analysis. In that analysis, I hope you will be taking some time to ask the dental providers and the other providers about their experience ratings in the Heritage Health three-MCO package that's dealing, and then those on the dental side--

MATTHEW VAN PATTON [01:45:42] Absolutely, we will.

WILLIAMS [01:45:43] --because it is certainly our input from the briefings that Senator Howard has organized for us that there is a major difference in that satisfaction level.

MATTHEW VAN PATTON [01:45:53] Yeah, absolutely.

WILLIAMS [01:45:53] Thank you.

MATTHEW VAN PATTON [01:45:54] Happy to.

HOWARD [01:45:53] Senator Dorn.

DORN [01:45:54] Thank you. Thank you, Chairman Howard. And I-- I think my question is maybe for Jeremy, and I see he keeps moving farther away. [LAUGHTER]

MATTHEW VAN PATTON [01:46:05] it's always the money man.

DORN [01:46:05] But-- but maybe you can. I don't know who can. Part of what-- what was in Jeremy's conversation early on, you talked about the Programs 348 and 347 and some of those that now will be affected by the first year of not having the plan implemented. And I don't remember all of the numbers, but I remember behavioral health. They had a negative drawdown on there but they also had a-- an amount to cover that that was going in there. How is that going to be handled or how will they be expected to have their budget affected the first year of that?

MATTHEW VAN PATTON [01:46:33] Let me answer a part of-- let me give a preface and then let Deputy Director Brunssen fill in on the back end. Heritage Health in its package construct today is both the-- physical health, behavioral health, and drug benefit is all comprehensively managed, so many of the behavioral health providers are already in the Heritage Health program and we already manage that part of the health benefit array as it exists today. And I think-- and I'll let him elaborate, but I think part of what the challenge for us is, is knowing exactly how many of those beneficiaries that would currently be under existing behavioral health service array in the Department of Behavioral Health are going to come over as a member of the new Heritage Health Adult Program. What I will also say is I think, and I hope it's been showcased here today as what we've been working towards building with this adult program in the way of management, is that we're trying to leverage the full service array of government benefits and really connect the dots for the beneficiary and pull things together for them. And I have been deeply engaged in conversations with Deputy Director-- or, excuse me, with Director Dawson in Behavioral Health, and she and her team now regularly sit in those monthly-- or, excuse me, those every-other-week meetings with our three MCOs. So we're working again to deeply integrate those service points together and-- and-- and moving forward, getting back to the auditing, quantification, and surveillance piece, one of the things we're going to be looking at is utilization rates within the behavioral health space. And there's still challenges with that. Now best example I can give you, Senator Dorn, on that-- that front is take, for example, a-- a woman who's just delivered. She goes in to see the OB/GYN after delivery and she receives a diagnosis that says she's maybe suffering from postpartum depression. So she gets a script. Well, you may not ever get the diagnosis because the way it's coded in the encounter data is it's just a follow-up visit. The only way you know that there's been an event that may tie out to that is you've got a-- they've got RX that coincides. So again, that's where our data and analytics becomes really powerful and why we need to work to build that infrastructure that Dr. Petersen is working to do, so that we can make those more comprehensive studies and threads. But I'll turn it over.

DORN [01:48:59] Well, thank you for that part of the explanation. But I-- I still--

MATTHEW VAN PATTON [01:49:02] Go ahead.

DORN [01:49:03] They said they're going to have a $1.8 million, I know, behavioral health reduction in their current or in the '20 fiscal year because of income that they were expecting or was budgeted for from expanded Medicaid.

JEREMY BRUNSSEN [01:49:19] Yeah.

DORN [01:49:19] That's not happening now the first year. How is that being handled?

JEREMY BRUNSSEN [01:49:23] So-- so, Senator, thank you. What we've recommended is that we not reduce their appropriation by the amount that we thought those services would transfer into the Medicaid expansion population. So we recommend not reducing their appropriation in state fiscal year '20 to-- to have those dollars for those regions because they will be providing the services because we will not have expansion in place.

DORN [01:49:46] And--

JEREMY BRUNSSEN [01:49:46] And we've prorated that based on the numbers that are used in the ramp-up--

DORN [01:49:51] Great, OK.

JEREMY BRUNSSEN [01:49:52] --for this following state fiscal year.

DORN [01:49:53] And in fiscal-- the second fiscal year, that should come back into play. I mean it should come back into the equation, part of the amount.

JEREMY BRUNSSEN [01:50:00] Yes, it certainly will, yeah.

DORN [01:50:03] Thank you.

HOWARD [01:50:05] Other questions? Senator Clements.

CLEMENTS [01:50:10] Thank you, Chair Howard. I had a question just about capacity of family physicians to take on an increased number of people and requiring a family physician visit. Are there going to be physicians who will accept more patients on-- that are on the Medicaid provider rates?

HEATHER LESCHINSKY [01:50:35] Currently we allow family practice, general practice, internal medicine, pediatricians, and OB/GYNs to be primary care providers. We also allow nurse practitioners that are-- have that specialty to be primary care providers and physician assistants. Additionally, we also allow the practitioners within our federally qualified health centers and our rural health centers to be primary care providers. So we have a very large pool in which to draw upon. With that being said, we do know that the-- the managed care plans will need to look at their network, their network provider-- network-- provider of network-- network providers, there we go, especially around the internal medicine, because we know that this population is more-- they're not the-- the moms and the kids. And so we-- we need to look to

see if we have adequate networks or if we do need to build that capacity. And that is also part of the time frame is allowing our health plans to build that capacity so that we do have enough primary care providers for the new population coming on.

CLEMENTS [01:51:40] Do you have an estimate of what percentage of the new population already have a primary care provider?

MATTHEW VAN PATTON [01:51:54] I think-- I think, Senator, for the population that we currently serve, we can certainly pull those-- those numbers to begin to look. But beyond-- beyond that, it's a very hard thing to-- to estimate.

CLEMENTS [01:52:09] Right. Yeah. You haven't been in touch with that population yet.

MATTHEW VAN PATTON [01:52:13] Yeah. And I think that, again, is an important up-front piece of helping them find that point but then also giving the MCOs or the health plans time to assess network adequacy, to look at who's in, and to accommodate that. And I think just reiterating the point that Deputy Director Leschinsky made, this is an adult population, so we know from experiences from other states is that they're going to come in with some higher care needs. And that's going to require higher acuity or level of care that internal medicine docs are going to be better suited to taking care of in an adult population. So we'll need to allow times for those three MCOs to build out their provider networks to accommodate that.

CLEMENTS [01:52:53] Thank you.

HOWARD [01:52:54] Senator Arch.

ARCH [01:52:56] Thank you. I've got-- I've got a follow-up question to Senator Clements'. On-- on networks, do you-- and I don't want to get too far down into the weeds here, but do you anticipate that-- that for the MCOs they will have a-- a Medicaid expansion network and a, what I would call, a regular Medicaid network is-- if you're in, you're in, if you're out, you're out?

MATTHEW VAN PATTON [01:53:17] I think it's building upon-- so what I would tell you today is you'd have to start with what you-- you currently have and who you're currently serving. And it's 70, 72, 73 percent of our population is women and children, as was indicated, so that sort of dictates what your-- your care infrastructure is going to be. This is adult, and so adults with chronic disease states and things that may not traditionally have been emblematic in the population that we serve, as well as higher-level specialty that we're probably going to have to, again, assess and build that network. And again, that goes to engaging these folks very early on, getting them in to see primary care providers to make sure that as we're pushing them up, as they seek out greater and more complex care exchanges and specialties, that we've got that network. It's an ongoing process of evaluation and it's actually one of our existing metrics on our-- our scorecard that we shared is-- is assessing network adequacy.

ARCH [01:54:12] But understanding that the new population will bring in adults, I mean, there are certainly adults covered under Medicaid now, but this would be a major expansion.

MATTHEW VAN PATTON [01:54:22] Springboard off of.

ARCH [01:54:22] Do you-- I guess back to that question, do you-- do you anticipate that this is going to be two networks, two provider networks, one provider network--

MATTHEW VAN PATTON [01:54:29] I think it's--

ARCH [01:54:30] --and there will-- it will be a provider network that will include pediatricians and OB but a desire to expand the internal medicine specialty?

MATTHEW VAN PATTON [01:54:39] I would see it-- I would see it in that space, yes.

ARCH [01:54:40] OK. OK.

MATTHEW VAN PATTON [01:54:40] it's- it's-- it's-- you're an MCO with the provider network. It's just building off of what you have--

ARCH [01:54:45] OK.

MATTHEW VAN PATTON [01:54:45] --or adding, adding to.

ARCH [01:54:46] All right. Thank you.

MATTHEW VAN PATTON [01:54:47] Yes, sir.

HOWARD [01:54:49] And we've only got about five minutes left, so I wanted to ask you for the-- I know other states have applied for the six-month renewal in their 1115 waivers. Have any of those been approved?

MATTHEW VAN PATTON [01:55:01] Not to my knowledge, so I don't know--

HOWARD [01:55:02] Director Thompson?

MATTHEW VAN PATTON [01:55:03] --what's happened in that space, but I'll let Deputy Director Thompson answer.

ROCKY THOMPSON [01:55:07] I can't name them right now, but there have been states that have six-month renewals approved.

HOWARD [01:55:12] So you'll-- you'll--

ROCKY THOMPSON [01:55:14] We could send that to you.

HOWARD [01:55:14] --give us a follow-up?

ROCKY THOMPSON [01:55:14] Yes.

HOWARD [01:55:15] Because I had-- I couldn't find any when I was looking and-- and it felt strange that we were applying for something that hadn't been approved in other states. And then I know that there are some statutory changes that you're going to need as you process through the 1115 waiver, particularly the EPSDT disallowance that's already in statute. And so if you do that for a different population, you'll need us to change that statute. How does that impact your time line?

ROCKY THOMPSON [01:55:38] That's something that we would have to work through. I don't think that will impact the time line because that's something that's just requested from CMS.

HOWARD [01:55:46] Oh, perfect. And then tomorrow-- you mentioned in an e-mail on LB645 that tomorrow you're going to tell us a little bit more about your MMIS sunset plan or the plan for your sunset for the claims broker system. Do you want to give us a quick preview?

ROCKY THOMPSON [01:56:01] I think that we can have Dr. Petersen--

HOWARD [01:56:06] Everybody [INAUDIBLE]

ROCKY THOMPSON [01:56:10] --speak to that.

HOWARD [01:56:12] Dr. Petersen?

LARRA PETERSEN [01:56:12] It gets to that. No one wants to take that one, so that was-- that was easy to point the finger. So you are correct. We did have a systems integration interoperability meeting scheduled for tomorrow. In order to best prepare for the briefing today, we rescheduled that, as it was a systems meeting. One of the things that I'd like to share, however, is that MMIS sunset strategy and-- and to align it with the Governor's kind of IT vision of leveraging the value of interoperability and-- and the 90/10 funding through CMS, we're partnering at a very high level with all the divisions at DHHS. So it would be disingenuous for me to kind of lay out a plan. I do-- we do have a roadmap that we are planning to share with the division directors as well as the OCIO as well as other important stakeholders. However, they have not had a chance to view the suggested interoperability plan for the state of Nebraska. What I can say today is MMIS and N-FOCUS have been a significant part of the state's infrastructure. To completely come off that, and when we say sunset, not use it for any business purposes today, is not in-- in-- even at the end of the roadmap that you will soon be presented with. And the reason for that is it wouldn't make a lot of sense for us to do that without doing a

significant value analysis that would look at where is that floor of cost per claim and the ability to just maintain ongoing operations. We will move to a modular approach, which was what's-- is what's being pushed by CMS and the only thing being funded at that 90/10 funding. But even with that plan being laid out, in order to successfully implement, much like I stated with Medicaid expansion, we need to ensure that we have the time and resources to do each module properly so that we don't have a failed implementation. So I don't really foresee, at least in my illustrious state career, that there will be a complete sunset of MMIS or N-FOCUS without some really thoughtful approach to we've reached that floor of the value in those systems. But we will continue to build modularity so that we have options to do things like claims broker or fiscal agent or other things that are supported by N-FOCUS and MMIS. So that will be in a roadmap that other directors and the OCIO's Office have yet to vet the draft that we're proposing based on just best practices and the seven standards and conditions that are required by CMS.

HOWARD [01:58:52] Thank you. All right. I see we're at time. Senator Stinner, do you have any closing thoughts for us?

STINNER [01:58:56] You know, thank you. Thank you for bringing your people. This was informative. It's nice to see how-- how this all fits together. So thank you very much, Director. You got some great people here.

MATTHEW VAN PATTON [01:59:10] I know that. Thank you.

STINNER [01:59:09] It's a heck of a challenge. So it was very informative, certainly for me and certainly for, I think, everybody here. So thank you.

HOWARD [01:59:17] Yes. Thank you for your time today.

MATTHEW VAN PATTON [01:59:17] You're welcome.