Health and Human Services Committee November 1, 2019

HOWARD: All right. Good morning and welcome to the Health and Human Services Committee. We're gonna get started.

WALZ: Is that on?

HOWARD: Is it on, Mandy? OK. All right. Good morning. We're gonna get started. Welcome to the Health and Human Services Committee. My name is Senator Sara Howard and I represent the 9th Legislative District in Omaha, and I serve as Chair of this committee. I'd like to invite the members of the committee to introduce themselves starting on my right with Senator Murman.

MURMAN: Hello. I'm Senator Dave Murman from District 38: Clay, Webster, Nuckolls, Franklin, Kearney, Phelps, and southwest Buffalo County.

WALZ: I'm Lynne Walz. I represent Dodge County. I represent District 15, which is all of Dodge County.

ARCH: John Arch, District 14, Papillion and La Vista in Sarpy.

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

CAVANAUGH: Machaela Cavanaugh, District 6, west central Omaha in Douglas County.

B. HANSEN: Senator Ben Hansen, District 16, Washington, Burt, and Cuming Counties.

HOWARD: Also joining the committee, we have our legal counsel, Jennifer Carter; and Mandy is filling in for as clerk today. So we're really grateful for that. And then we also have Aaron, Senator Williams' AA, who is helping us out as page this morning. A few notes about our policies and procedures. Please turn off or silence your cell phones. This morning, we'll be hearing one interim resolution. And we don't have to worry about order then. On each of the tables near the doors to the hearing room, you'll find blue testifier sheets. If you're planning on testifying today, please fill one out and hand it to Mandy when you come up to testify. This will help us keep an accurate record of the hearing. Any handout submitted by testifiers will also be included as part of the record as exhibits. We would ask if you do have any handouts that you please bring ten copies and give them to our page Aaron. We use a light system for testifying. Each testifier will have five minutes this morning. When you begin, the light will be green. When the light turns yellow, that means you have one minute left. And when the light turns red, it's time to end your testimony and wrap up your final thoughts. When you come up to testify, please begin by stating your name clearly into the microphone

and then please spell both your first and last name. And each interim hearing study will begin with the introducer's opening statement. Just a reminder, this is a little bit different than a bill hearing. We won't hear from proponents, opponents or neutral testifiers. We'll just take testifiers in the order in which they appear. If the legislative resolution is a committee resolution, I as chair will introduce it and then return to my seat. If it's a personal resolution, we ask that members return to the audience after they've done their opening. We do have a strict no-prop policy in this committee. And with that, we'll begin today's hearing with LR216. Senator Walz's interim study. Welcome, Senator Walz.

WALZ: Thank you. My sheet says, good afternoon, Chairwoman Howard, but good morning, Chairwoman Howard and members of the Health and Human Services Committee. For the record, my name is Lynne Walz, L-y-n-n-e W-a-l-z, and I proudly represent District 15. My office, along with the help of those that will follow me today, and thank you for coming, in conjunction with the information we have available from the department, have taken this interim not only to examine, but to be a part of the lives of people we are talking about today. We wanted to know the impact changes in the day services have on youth under the Home and Community-Based Services Waiver, how we can better serve state wards with disabilities, the effects on the families who are on the waiting list, and how we can best serve those eligible with the

state and federal dollars we have available, how this funding affects people with developmental disabilities in our state, options for strengthening, communication, and outreach to families with children transitioning with IEPs, gaps in various waivers, and the effect of decreased transition services. That is a lot to unpack in a short time we have, so we'll try to do our best. In order to best understand these concepts, I felt it was necessary to first try and better understand the situation that we are in now. We reached out to the Department requesting information on the number of individuals currently on the Medicaid HCBS Waiver waiting list. In addition, we asked for a breakdown of any and all available population information such as age, race, gender, marital status, income, education, and employment status for those on the waiting list, an analysis of the healthcare services being provided to individuals currently on the waiver, the range and average time an individual resides on the waiting list before moving on to the H-- HCBS Waiver, and the number of individuals and monetary amount dedicated to each of the different funding priorities. A quick reminder of the waivers we have, since it has been a while since we've heard about it for many of us. The first waiver is Emergency Developmental Disabilities Court-Ordered Custody Act; the second is the Transition of Institutional Persons; the third is for Transition from Foster Care System; the fourth is the Transition for High School Graduates; the fifth is for Dependents of Members of the Armed Services; and the sixth is the Date of

Application or the Waitlist. When we requested this information, 4,835 individuals on the Home and Community-Based Services Waiver and roughly half of those were on the HCBS Developmental Disability-- Developmentally Disabled Waiver. The average annual expenditure for all HCBS waivers amounts to $66,198. If you are interested in a more detailed breakdown, you can find a more detailed version of the services provided on page three of the Department's response. As of July 22, 2019, when we contacted Department of Health and Human Services, the average wait time for an individual on the Priority 6 Waiver before they received funding-- a funding offer was six and a half years and there were 2,326 individuals on the waiting list. These services amounted to a total of $320 million in total spending in 2018. Of that, $215 million was dedicated to residential services, employment services represented $9 million, day services around $100 million, and all other waiver services around $5 million. In follow-up e-mails, we continue to inquire about the different programs provided, their budget allocations for the state fiscal year 2019, how much has been spent so far, how much is allocated for administrative functions, how much is allocated for this subsidy, if we receive a federal match, and the last time the program benefits were updated or reviewed, and when the last time income and resource limit-- limits were updated. We also reached out to former Children and Family Services Director Wallen to determine: number one, the number of DHHS wards who are deemed eligible for services from the department, from the Division of

Developmental Disabilities by service area; number two, the number of DHHS wards who are deemed eligible for DD services and are currently not receiving services under the waiver because of insufficient emergency slots; number three, the estimated average daily cost of services for this population; and number four, the current adoption and/or guardianship stipend that is available to families who are standing ready to provide permanency. What we found was that of the 68 wards on the waiting list for HCBS DD Waiver, all of them met the eligibility requirements for DD Waiver services. Seven from the central service area, four were from the northern service area, 14 from the southeast service area, and one from the western service area. And 42 were from the eastern service area. Further information on the daily-- average daily cost by the service-- by service area and the current adoption stipend available to families can be found on the back of the page of the response from DHHS. There was a lot of history behind these programs and there is much that can be done to improve the lives of those receiving services. This can be done through a more efficient waiver service ensuring that waivers are-- ensuring that the waivers we are providing that work stay in place and making every effort we can to reduce the waitlist for those who are receiving services. I would also like to note that there are two parent testifiers we had lined up that wanted to come speak to you today, but unfortunately they were not able to make it. I am told they would still like the opportunity to speak with all of you about their

experience and will be reaching out to your office in the next couple of months. The people behind me today are involved in this process every day from one extent to another. Hopefully, they will be able to give us some better perspective as to how these facts and figures are impacting the lives of those served by the waivers. Thank you. And with that, I'd answer any questions if I can.

HOWARD: Thank you. Are there questions for Senator Walz? Seeing none, we'll invite our first testifier up. Good morning.

SHAUNA DAHLGREN: Good morning. I guess they'll pass around the information I brought. But my name is Shauna Dahlgren, it's S-h-a-u-n-a D-a-h-l-g-r-e-n, and I'm the work incentive and community outreach specialist for Easterseals Nebraska. And I just want to thank you, Chairwoman Howard and members of the committee for the opportunity to share today. First, I wanted to let you know that Easterseals Nebraska is a community-based organization serving youth and adults with disabilities throughout the state of Nebraska. A particular relevance today is our experience working with transition age youth ages 14 to 21, experiencing intellectual or developmental disabilities, including autism spectrum disorders, and also individuals 18 and older who are receiving Social Security disability benefits and want to work. So we work with individuals as they are graduating out of school or even out of transition programs through school-- excuse me, through school. During the last couple of years,

reduced federal funding for supported employment services through our state VR agency and lack of access to services through Nebraska's Developmental Disability Services has led to difficult situations for many individuals, families, and providers of supported employment services. Lack of funding or lack of access to funding has not only left Nebraskans with disabilities without services, it has also left service providers without revenue, leading to reductions in staff or elimination of services. I've worked in this field for more than 20 years and this is the first time our state VR agency has implemented a full order of selection due to lack of available funding. Individuals applying for VR services are assessed, determined eligible, and placed on a waiting list according to Priority Group. There's three Priority Groups with Priority Group 1 being the one that receives the dollars first, and then if any money remains, they may be able to serve Priority Groups 2 and 3. Nebraska VR is currently working on reducing the Priority 1 waitlist, but still well over a thousand people remain on that waitlist and additional people to continue to sit on the Priority Groups 2 and 3 waitlists. Therefore, it continues to be the case that many individuals with intellectual or developmental disabilities sit on a waitlist for supported employment services through Nebraska VR and they may also sit on a waitlist for DD-- the DD Waiver. Even if individuals on the VR waitlist are already eligible for the DD Waiver, they're not able to access supported employment services through the DD Waiver while waiting for funding through VR.

DHHS has expressed that the DD Waiver cannot pay for supported employment services if the individual is eligible for vocational rehabilitation, even though no funding is available to the individual through VR. It seems that only after employment is obtained and VR milestones and closure are complete can a participant utilize the DD Waiver for supported employment services to assist in maintaining his or her employment. So what this means is that at, at critical transition points, supported employment services are interrupted and individuals are without access to essential supports that would provide for greater independence and success in life and employment. Any skills developed through school or other transition programs may be lost while individuals sit and wait for services. The importance of having continuous services and supports in place cannot be overstated. Individuals with disabilities are basically an untapped talent pool for Nebraska employers who are struggling to find and maintain talent. I recently learned that approximately 85 percent of individuals with autism are unemployed, even if they have a college degree. But they need the support of employment services to help them get and maintain jobs. Preparing individuals for the work force and providing access to services essential to successful employment is not only a benefit to the individual and their family, but also a tremendous benefit to Nebraska employers and Nebraska's economy. Ensuring that Nebraskans with disabilities have access to needed services is Nebraska's

responsibility for both the state of Nebraska and for its citizens. Thank you.

HOWARD: Thank you. Are there questions? Senator Cavanaugh.

CAVANAUGH: Thank you, Chairwoman Howard. Thank you for being here today. In your testimony, you stated that DHHS expressed that the DD Waiver cannot pay for supported employment services if the individual is eligible for vocational rehabilitation, even though no funding is available for the individual through VR.

SHAUNA DAHLGREN: Right.

CAVANAUGH: So is that in your understanding, and I apologize that I don't know this answer myself, is it your understanding that, that is a state regulation or federal regulation?

SHAUNA DAHLGREN: It's-- my understanding the two statutes I referenced, the two statutes--

CAVANAUGH: Yes.

SHAUNA DAHLGREN: --in there, and I actually provided copies of those two statutes in case they were helpful. But I'm not an attorney, so-- but when I read through it and what I understand, it's the state's interpretation of the Nebraska statute--

CAVANAUGH: Um-hum.

SHAUNA DAHLGREN: --that prevents them from being able to use their dollars when the person is eligible for other services or other funding.

CAVANAUGH: Sure. And I do see you highlight the statute about the Legislature's direction to the state to draw down--

SHAUNA DAHLGREN: Right.

CAVANAUGH: --federal funds when available. So thank you.

SHAUNA DAHLGREN: Yes.

HOWARD: Other questions? Senator Arch.

ARCH: Thank you. I'm not familiar, and maybe you're-- maybe somebody else can answer this question later, but I'm not familiar with the criteria or the tools that are used for placing individuals into these Priority Groups. Are you, are you--

SHAUNA DAHLGREN: For VR?

ARCH: You, you Priority Groups 1, 2 and 3?

SHAUNA DAHLGREN: Yeah.

ARCH: Yeah, for VR.

SHAUNA DAHLGREN: There's basically a checklist that they use. I didn't bring a copy of a checklist with me, but it assesses their functional

barriers. And so the more functional barriers that they have that prevent them from being able to work, the higher they are on the priority.

ARCH: OK.

SHAUNA DAHLGREN: So essentially Priority Group 1 are the individuals that have the most functional barriers or are the most severely disabled. So they would be the ones that would be eligible for the dollars first.

ARCH: OK. Thank you.

HOWARD: All right. Any other questions? Seeing none, thank you for your testimony today.

SHAUNA DAHLGREN: Thank you.

HOWARD: Our next testifier. Good morning.

EDISON McDONALD: Morning. Hello, my name is Edison McDonald, I'm the executive director for the Arc of Nebraska. We represent people with intellectual and developmental disabilities. Over a decade ago, the Nebraska Legislature set in LR156 that Nebraska is at a crossroads with its obligation to Nebraska citizens with developmental disabilities. Several Nebraska senators have recognized the urgent need to develop a strategic plan to address the current and future needs of citizens with DD and their families. And it seems that we

have still failed to take the serious action needed to help people with disabilities. We believe that it is fully time-- that it is time to fully fund the waiting list. It will ensure that we can protect the sanctity of life by protecting the most vulnerable citizens. It will ensure that we prioritize our values of maximizing local initiative, fiscal conservatism, and private enterprise. The best way to ensure that we are in line with these values is by fixing the waiting list to ensure access to services. Nebraska used to be a national leader in addressing these issues. Now we've fallen to 23rd in the nation. With this in mind, we began a petition drive today that we have collected 1,532 signatures to go and dig further into these issues in more depth. So looking at this study, we wanted to dive into a few pieces of it in a little bit more depth. First, the data acquired from this study clearly shows a story. If you look at the chart in page 24 of our waiver study, institutional placement in Nebraska costs approximately $221,000 per year. Community-based services starting with Priority 1 category, the Emergency and Developmental Disability Court-Ordered Custody Act costs about $134,000. The second transition-- the second category of transition of institutional persons is about $109,000; transition from foster care is about $97,000. And then the fourth priority category, that transition category, is about $19,000. Fifth, we don't have data usage for yet; and then the sixth is based-- that's based upon the date of application, so the waiting list is about $33,000. These numbers

always blow me away. I think, ultimately, they really kind of lay out the story that when we go and we invest early, like that Priority 4 category allows us to do, we save in the long-term. If you look through our study, you see stories of how this has impacted families like those that you have heard on the Aged and Disabled Waiver who are waiting for DD services. You also hear next the story of my friend Erin Phillips [PHONETIC] and her family and how that looks in their day-to-day life. We frequently receive calls where we know that someone will soon be homeless or in a situation that is deteriorating into chaos, or that a long-term caretaker will one day no longer be able to continue to provide care. Yet, we can't do much until the individual is actually in that emergency situation under that first priority category. In order to address these issues, we recommend increasing the funding on the DD Comprehensive Waiver to serve those who are waiting for services, allocating funding to train direct care workers and build a career path for them to increase skills, remain in the field, and provide quality services, providing funding for other Medicaid waivers such as a Family Support Waiver, an Autism Waiver and/or an Intellectual and Developmental Disability Mental Health Waiver with residential funding, as the overlap there has been one of the most difficult areas to figure out care for, conducting a legislative review to investigate the number of children with disabilities placed in foster care, those with IDD or correctional setting, and those being court ordered into DD services. We also

wanted to go and talk a bit about some of the gaps and holes in the system like those we've talked about on the A&D waiver issue. While we found a quick Band-Aid solution, this will not help all families. For those who do not meet the DD level of criteria that are still faced with the problematic A&D level of care assessment tool, this especially would hurt families with rare conditions who may not fit neatly into a checkbox. Number two, for anyone who is not already A&D Waiver eligible, they will not be able to transfer. So this is only helpful for the kids who are currently on the A&D Waiver and able to transfer. Some of the other barriers we see include lack of cohesive care regarding age and level of care criteria, barriers between accessing services for those who have intellectual and developmental disabilities and mental health issues, gap in coverage for Applied Behavior Analysis, barriers to accessing specialized child care for children, lack of funding for access to transportation, insufficient providers, specialized providers for intensive need and for respite care. Some potential solutions: ensuring the A&D Waiver or any other waiver does not punish families for improvements, for example, cutting eligibility when a child exceeds oral feeding by 51 percent over a feeding tube; number two, implementing a Family Support Waiver; and number three, identifying programming to support children with autism, intellectual disabilities, and those with more challenging behaviors.

Thank you for your time, and I hope that you will consider some of the options we presented today. Any questions?

HOWARD: Thank you. Are there questions? Senator Williams.

WILLIAMS: Thank you, Senator Howard. And thank you, Mr. McDonald, for being here. And I appreciate the going through the numbers on the cost analysis.

EDISON McDONALD: Um-hum.

WILLIAMS: When you, when you add all that up and look at the number of people on those various categories that have been assigned, did you put together any kind of a total number that would need to be budgeted?

EDISON McDONALD: The total number of people who are on the waiting list is about 2,300 different people.

WILLIAMS: But they're in three different categories that have different costs. Right?

EDISON McDONALD: Yeah. So then each of those categories, those are priority categories. And then-- you know, the big bulk of folks are in that bottom category, category number 6, which is that waiting list category which is based upon date of need.

WILLIAMS: Again, did you add those up? Did you take the, the number of people in each priority category times the annual dollars that it would take to fund that-- the, the services and let us know what the total cost would be?

EDISON McDONALD: I'm not sure if I'm clear what you're asking for.

WILLIAMS: If you have a thousand people in a priority category that was $130,000 per person per year, have you completed the calculation to take a thousand times that and add it to all the other priority categories to come up with a grand total?

EDISON McDONALD: So the, the subtotals are in this study that we've given you--

WILLIAMS: OK.

EDISON McDONALD: --and that you have in your e-mail. And I can go and total that up.

WILLIAMS: If they're in there-- that's, that's I have not seen the study yet. I just wanted to be-- I'm looking for what the total number is.

EDISON McDONALD: OK.

WILLIAMS: And it's-- you're telling me it's in there, I just need to add those together.

EDISON McDONALD: Yeah.

WILLIAMS: Thank you.

HOWARD: Other questions? Senator Cavanaugh.

CAVANAUGH: He answered it.

HOWARD: He answered it. OK. All right. Thank you for your testimony today.

EDISON McDONALD: Thank you.

HOWARD: Our next testifier. Good morning.

MARY PHILLIPS: Good morning.

HOWARD: We're very nice.

MARY PHILLIPS: Good morning, everybody. My name is Mary Phillips and Edison just briefly referred to my daughter Erin. And I am here to provide testimony on the impact of the DHHS waiting list and the impact it had on, on my family. I do serve as a director of special education at an educational service unit. But I want to make it very clear that while I am professionally concerned about the gap in service delivery between school-based and residential services, I am not here on behalf of my position. I am here as a parent of a 30-year-old woman born with developmental disabilities who was on the list for seven and a half years. My husband and I have three children.

Our first two children were typically developing and they're currently employed as a speech language pathologist and an occupational therapist; helping professions for persons with disabilities. My husband and I are both college educated and we've maintained continuous employment in the state of Nebraska. I work with public schools and he was in the U.S. military and Homeland Security. Our third child was born with cerebral palsy and she started receiving special education services as an infant and that continued through the year in which she turned 21. As a result of those school-based services, she left school successfully completing a six-hour-day workday in a community work practice site, five days a week during an entire school year and every summer of her life. She needed minimal job coaching with the ratio of one teacher and one para for 10 to 12 students. She had support from VR and she learned to independently manage the bus. She was happy, hopeful disposition. She was ready to learn new tasks and work with minimal supports. And most likely, they were the natural supports already in place at each of her business sites. She had job practice at a local grocery store, a newspaper, and a community college, and she left each new job with a new skillset and really high hopes. We were not aware of what her future would actually be. We were not told about the waiting list. We were never told about the waiting list as, as she was growing up. We did not know or even thought that we should be applying for DHHS services when she was in sixth grade or seventh grade or ninth grade or even eleventh grade. So

that when she was issued her diploma, she would have options for supports and services. So we applied for services after she was determined eligible for Social Security, which was the instruction from the Social Security office who told us to wait for their eligibility determination before we applied for DD eligibility. This was in 2009 when we received her diploma, she was 21 years old. In 2010, there were historic budget cuts, cuts to transition services, cuts to Medicaid, which led many people, including us, to face new struggles and to reconsider institutions for her supports. Our daughter became eligible for residential supports in the spring of 2016. She was 28-years-old. She lived with her father and me all those years. She started begging to move out around age 25. She wanted to live, quote, on her own, quote, just like her older brother and sister. During those seven-plus years, she did go to day programming. She started working at Super Saver. She participated in social clubs with Parks and Rec and through the Arc of Lincoln. She participated in Special Olympics. We did what we could do to advocate for her. We sought out opportunities to keep her integrated into the community. Her assigned services coordinator did not know when her name would come to the top of the list. We asked every year. Every year we saw and we were asking at her annual meetings, and we were told things like, well, there were some tobacco money and some people got moved off, but she didn't know. She never told us. And maybe she didn't know where Erin was on the list. She didn't know when she would be able to

move out of our house. We had to learn about many of the services to help her on her own. We had to learn how to apply for personal assistant services and how to get respite so we could actually leave and travel overnight without her. We shared our concerns about her deteriorating behavioral health that we were witnessing before our eyes. We shared them with the service coordination. We shared them with-- we shared them with anybody who would listen. And at that time, our biggest supporters and, and moral supporters was the Arc of Lincoln. So we were talking all the time. We were told that we would actually have to make her homeless to move her up on the list. And we were told that by her services coordinator. When her behavioral health deteriorated to the extent that through her frustration, she started becoming physical with me, damaging our personal property, her depression and anxiety was so significant, significant that we were seeking out mental health supports. Then we were told, well, we could move her into an O.U.R. Home, which I understood was a residential placement for persons with mental illness. My husband and I could not think of anything worse than moving our most vulnerable child with cognitive language and developmental delays, with physical mobility issues into a residential placement for persons with such significant mental illness that they needed to live there or to drop her off at the City Mission so she could move to the top of the list. Those were nonnegotiables for us. These were the recommendations given to us by our services coordinator. She also told us we should be calling the

police whenever our daughter had a meltdown, which we felt was an abuse of taxpayer money. So we filed a request for an emergency placement through DHHS. We went at the recommendation of the Arc of Lincoln. We went to a hearing and we went through the whole process of the hearing, which we didn't have an attorney. We did it all on our own very naively. We did everything on our own. And we were told at the end of the hearing that while it wasn't a desirable situation that we were living in, it did not rise to the level of an emergency placement. So while the Arc of Lincoln did help us, they could not get her moved off the list any faster. So while we waited, we found her a therapist who told us she was not benefiting from cognitive behavioral therapy. We found a dual diagnosis psychiatrist from UNMC who began treating her with medication. We found and hired in-home providers once or twice a week to help with respite or to help her with daily living skills. I adjusted my work schedule so I was home by lunch every day just to get her up and make the plan for the afternoon. She lost so many of the work skills that she had left school with. She regressed tremendously. She found out that she really liked sitting at home. She really liked to do nothing and to just be there watching TV, being on screen time, whatever, because of the lack of supervision. She started refusing requests by her day providers. She gained 40 pounds or more. Her depression and anxiety increased. She became very argumentative, very non-compliant. And all of this was happening before our eyes while we were waiting, waiting for that day when she

was gonna come to the top of the list that we had no idea when that day was gonna come. So I shared this really personal and very private story with you, and with you all here for one reason, to inform you what it was like waiting. We are a two-income family. We did all we could to provide our child with the best opportunities we could to allow her to live independently, to learn employability skills, to be able to work and support herself to the extent that she was going to be able to. We did what any of you would have done in the same circumstances. And we really hope that no other family has to go through what we did and watch that regression of work skills, communication skills, and increase of mental health skills that we did. It's cost us as taxpayers and parents more time and more money to recoup those skills than if we would have just continued expanding them when she left high school. As a post note, she has moved out two and a half years ago, almost three years ago. She now currently lives in an Extended Family Home that she views as living on her own. And, and to that extent, it really is. While she has not recouped all the skills to work five full days a week full-time or even 30 hours a week, she has gained back enough skills to work as a disability policy advocate for People First of Nebraska. Even our daughter understands how important it is to speak up to make sure that you, our state legislators, appropriate the funding necessary to support this most

vulnerable population. Thank you for listening. And I am open to questions.

HOWARD: Thank you. Are there questions? Seeing none, thank you for sharing your story with us.

MARY PHILLIPS: Yeah. Thank you.

HOWARD: Our next testifier. Good morning.

ERIC EVANS: Good morning, Senator Howard and members of the committee. My name is Eric Evans, that's E-r-i-c E-v-a-n-s, and I serve as the chief executive officer at Disability Rights Nebraska. We're the designated Protection and Advocacy System under the federal Protection and Advocacy for People with Intellectual and Developmental Disabilities Act. And we work, protect, and advocate for the legal and human rights of Nebraskans with developmental disabilities. I'm here today to discuss with the committee our recent report on the waiting list, which is being handed out and provide a long-view perspective on the waiting list. I especially want to thank Senator Walz for introducing LR216. It identifies, as Mr. McDonald noted, a number of significant issues regarding developmental disability services that need to be addressed to maximize the potential for community inclusion of Nebraskans with developmental disabilities. And we appreciate this opportunity to begin a serious discussion about how Nebraska can move forward to address system inefficiencies and barriers involving

multiple, multiple perspectives: perspectives of policymakers, parents, people with intellectual and developmental disabilities, and advocates. During the 46 years that I've worked in the intellectual developmental disabilities field, I've appeared before the Legislature on at least six separate occasions and participated on numerous work groups that were formed to study the waiting list issue. Over the years, several reports have been produced and on occasion the Legislature has acted on those recommendations that led to the movement of people off the waiting list. Unfortunately, these actions were generally only partial in nature and a waiting list problem has existed for over three decades, during which time it has continued to balloon. As part of our preparation for this hearing, Disability Rights Nebraska and the Nebraska Consortium for Citizens with Disabilities contracted with Scioto Analysis to conduct an analysis of Nebraska's waiting lists for individuals with intellectual and developmental disabilities. I've brought hard copies of the report for members of the committee and I want to highlight briefly several of the general findings of our study. While almost 5,000 Nebraskans received developmental disability services in 2018, another 2,300 sat on the state waiting list not receiving services. Of those on the waiting list, about three quarters are between the age of 10 and 30. And this is important while only 1 in 6 are over the age 30. The typical person who's been pulled off the waiting list in 2017 and '18 was on the waiting list for 6 to 7 years, with some having waited

almost 8 years before receiving services. Now Nebraska tends to use less of its resource on developmental disability services when compared with other states ranking 39th nationally in spending as a percentage of personal income. And in the past three years, the Nebraska Legislature has slowed spending on developmental disability services, especially developmental disability aid, even reducing spending in fiscal year 2019. Typically, during past efforts to address the problem, one of the major roadblocks to addressing the waiting list was cost. This is not to say that the Legislature has acknowledged the importance of supporting people with intellectual and developmental disabilities, and the data clearly shows that developmental disabilities expenditures have been in the top 15 line-item increases in the state budget in 8 out of the last 10 years. So the Legislature is acknowledging the importance of developmental disability services aid. The data clearly also shows what is likely to happen if we don't act on the waiting lists in a timely manner. During the course of the next five years, the state would need to increase its annual spending on developmental disabilities by $113 million to account for annual growth and service costs. And that's approximately a 50/50 split between state and federal funds. In terms of the costs to eliminate the waiting list-- Senator Williams, you asked that question, we looked at out years and by 2024 the state would have to allocate an additional $67 million, again, that 50/50 split. However, this estimate also assumes that we continue to do services in the same

way that we currently do. This also raises the question as to whether the current system of services and supports allows us to utilize funds in the most efficient and effective way. Now there's a lot to have-- that's been going on with the waiver and with the Social Security Administration moving towards serving people with the most integrated setting, and we now have a prime opportunity to reform our approach to providing services and supports. Our report emphasizes that it's not necessary to break the bank to provide essential services and we can initiate a systematic approach to reduce the waiting list. Our report offers several recommendations: create an ongoing monitoring system to ensure the state is keeping up with its demand for services; encourage in-home services for those who can benefit from them instead of providing residential services and costlier provider-owned settings; expand employment opportunities so that people can move from day services programs to competitive employment; expand early intervention services for children since there's 260 children on the waiting list; and we need to reframe our thinking about intellectual and developmental disabilities as a tool for fighting poverty; and understand that the state and federal funding for services is a key tool for ensuring human rights, promoting independence, and enabling self-sufficiency. Our report discusses the cost of services, breaks it out by the different kinds of service funding sources. And you can see in my testimony how those services are broken out and the costs of those services and the average cost per person for services in the

various settings. So there's clearly an economic argument for us here that we can do things differently than we're doing now and we can realize efficiencies and greater effectiveness in our services. As Mr. McDonald pointed out, we can look at different waiver operation-- options than we currently have. But cost is only one argument. There's a moral argument that I think is compelling, and I think Erin's mother, Erin Phillips' mother, talked about that eloquently. Nebraska was the first state in the nation to make a commitment to serve people with developmental disabilities in community settings. We were number one. No one else had done that anywhere in the world. Here in Nebraska is where it started. And this idea has spread to all other states. It has spread internationally. In the early 70s and 80s, we had people coming from all over the world. My wife hosted a person from Japan for two weeks to come and study how we do services, how we provide services and to community people with disabilities.

HOWARD: Mr. Evans,--

ERIC EVANS: Yes.

HOWARD: --you have the red light. Would you like to wrap up?

ERIC EVANS: And, and I will wrap up. So we provide a lot of services to people with developmental disabilities when they're children and youth. And suddenly when they're 21, we don't provide the services anymore. You have to get on the waiting list. So we make a massive

investment in human capabilities. And when it comes, 21 for some reason, our investment stops. That's a moral issue. We have an obligation to do better for our citizens with disabilities and for the families. Thank you.

HOWARD: Thank you. Are there questions? Seeing none, thank you for your testimony today.

ERIC EVANS: You're welcome.

HOWARD: Our next testifier. Is there anyone else wishing to testify for LR216? Seeing none, Senator Walz.

WALZ: Thank you. I want to thank everybody for coming today. The last couple stories were, I think, very eye opening. Eric, thank you for your testimony. I-- you know, you forget that we were the leaders and in the world when it comes to providing services for people with disabilities. The story of Erin is pretty disappointing to me. The lack of communication regarding the services that are available for her and that they had no idea that those services were available. The fact that she was a thriving young lady who had so much potential to go further and from going to that to a place where you have somebody telling you that she would have to become homeless to receive services is devastating. And as I listen to these stories and so many others, I think, is this the picture of Nebraska that we want? Is this the good life for everybody, regardless of who you are or what abilities you

have or disabilities you have? Is this the good life? I-- we are here asking to design a plan that would provide opportunity and quality of life to all people, to break down barriers, to grow our work force, and to just continue to move Nebraska forward and be that leader. With that, I thank you. And I would answer any questions that you have if I can.

HOWARD: All right. Thank you. Are there questions? Senator Cavanaugh.

CAVANAUGH: Thank you, Chairwoman Howard. Thank you, Senator Walz, for bringing this very important interim study and for having these invited guests today. If Erin's parents had been informed 7 years prior to her turning 21, is it your understanding that if they had gotten her on the waitlist that maybe she would have transitioned directly onto the waitlist or could she have still been on the waitlist for another 7 years?

WALZ: I don't have the answer for that, but at least she would have had the opportunity.

CAVANAUGH: Sure. Yeah.

WALZ: And that's what I think-- you know, we need to provide to everybody--

CAVANAUGH: Right.

WALZ: --is the opportunity.

CAVANAUGH: Yes, I agree. And one of the solutions potentially to this would be to draw down federal funds--

WALZ: Um-hum.

CAVANAUGH: --that we're not currently drawing down.

WALZ: Correct.

CAVANAUGH: Right. So I know that that's something that we all debate whether or not we should be drawing down federal funds. But I would say when it comes to our children, our most precious resource, we should do everything we can,--

WALZ: Absolutely.

CAVANAUGH: --because I really appreciate you doing this today.

WALZ: Yep.

HOWARD: Any other questions? Seeing none, thank you, Senator Walz. This will close the interim hearing for LR216, and we are done until 1:30. But committee members, can I borrow you for a second, because we want--

WILLIAMS: We could start now.

HOWARD: --to do some scheduling.

[BREAK]

HOWARD: All right. Good afternoon and welcome to the Health and Human Services Committee. My name is Senator Sara Howard, and I represent the 9th Legislative District in Omaha, and I serve as chair of this committee. I'd like to invite the members of the committee to introduce themselves, starting on my right with Senator Murman.

MURMAN: Senator Dave Murman from Glenvil, representing seven counties of south-central Nebraska: Clay, Webster, Nuckolls, Franklin. Kearney, Phelps and southwest Buffalo County.

WALZ: Lynne Walz, District 15: Dodge County.

ARCH: John Arch, District 14; it's in Sarpy: Papillion-La Vista.

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

CAVANAUGH: Machaela Cavanaugh, District 6: west-central Omaha in Douglas County.

HOWARD: And we're joined today by our committee legal counsel, Jennifer Carter. And our committee clerk, Sherry, is actually out sick, and so we've got Mandy covering for us from Natural Resources,

which we're very grateful for. And then Timoree is serving as our page this afternoon. A few notes about our policies and procedures: Please turn off or silence your cell phones. This afternoon we won't be hearing an interim study; we're hearing a, we're having a hearing about the 1115 waiver proposal for Medicaid, but that's on the agenda outside of the room. On each of the tables near the doors to the hearing room, you'll find blue testifier sheets, and if you're planning on testifying today, please fill one out and hand it to Mandy when you come up to testify. This will help us keep an accurate record of the hearing. Any handouts submitted by testifiers will also be included as part of the record as exhibits. We would ask, if you do have any handouts, that you please bring ten copies and give them to Timoree. We do use a light system for testifying. Each testifier will have five minutes. When you begin, the light will be green. When the light turns yellow, that means you have one minute left. And when the light turns red, it's time to wrap up your final thoughts. When you come up to testify, please begin by stating your name clearly into the microphone. Then please spell both your first and last name. I don't believe we have an opening today. We do have a strict no-prop policy in this committee. And with that, we'll begin today's hearing on the 1115 waiver proposal for Medicaid per Statute, 81-604. And we'll open with Mr. Matthew Van Patten to tell us a little bit more about the 1115 waiver.

MATTHEW VAN PATTON: Good afternoon, Chairwoman Howard and members of the Health and Human Services Committee. My name is Dr. Matthew Van Patton; that is M-a-t-t-h-e-w V-a-n P-a-t-t-o-n. And I'm the director of the Division of Medicaid and Long-Term Care within the Department of Health and Human Services. I'm here today to provide an update about the department's progress in implementing Medicaid expansion. Low income, able-bodied adults, ages 19 to 64, will become eligible for Medicaid as a result of expansion. Heritage Health Adult is the name of this new program, which will build on our existing Heritage Health program. Heritage Health is our managed care program, by which health plans coordinate all physical health, behavioral health, and pharmacy benefits for their Medicaid enrolled members. Nebraska Medicaid is currently in the process of applying for a Section 1115 demonstration waiver from the federal government. This will allow us to waive some of the existing default rules surrounding Medicaid in order to create an innovative new program. We will cover necessary medical care to participating Nebraskans in a way that leads to better and more cost-effective health outcomes. I would like to note, however, that this demonstration waiver is only one piece, though an important one, of building a successful expansion program. As a part of the waiver application process, Medicaid staff have been traveling the state to meet with Nebraskans and gather their feedback on our waiver application. Two of these meetings were held this week in Scottsbluff and Kearney. Thematically, people have expressed concerns

about administrative costs, while also seeking clarification regarding the optional and mandatory components of the benefits package. Others have expressed an appreciation for the state's approach-- proposed approach, specifically access to coverage for all eligible beneficiaries, this being a mark of distinction among the other states' programs. We will also be visiting Norfolk on November 7 and Omaha on November 12. These meetings are the official forum for the public to provide feedback on the process. In addition, comments can be submitted to the department in writing. Instructions are available on our Website. Nebraska Medicaid first shared our plans to apply for an 1115 waiver on April 1, when we also submitted our state plan amendments to the federal government. Since April, the department has focused on hiring staff and building the technology systems needed for Medicaid expansion. I will provide additional details on both of these areas shortly. We have been busy drafting our 1115 application and engaging in productive discussions with the federal government. We released our waiver application, including the actuarial study on budget neutrality, for public comment last Friday. We will continue to accept comments until November 26th. Then we will review all comments, and a copy of all comments and our responses will be included when we submit our application to the federal government in mid-December. Among the most important parts of the demonstration is an innovative two-level benefit structure. The basic benefits package is a robust, comprehensive package of physical, behavioral, and pharmacy services.

Participating Nebraskans can choose to earn additional prime benefits-- vision, dental and over-the-counter medications-- by participating in wellness, personal responsibility, and community engagement activities. Unlike other states, if a participating able-bodied Nebraskan chooses to earn those additional prime benefits, he or she will not lose the robust, comprehensive basic benefits package. Wellness activities include: choosing a primary care provider; seeing your healthcare professional once a year; and participating in your health plan's case and care management. The health plans will help participating Nebraskans find a doctor, make an appointment, and get a ride to that appointment, if needed. As with current Medicaid beneficiaries, these participating Nebraskans have a personal responsibility to report to Medicaid any important changes in their life that may impact eligibility, such as a change in income or residency. We have an obligation to the taxpayers and an accountability to our federal partners to ensure that benefits are provided only to those persons eligible to receive them. Other personal responsibility activities for persons seeking to earn additional prime benefits will include: not excessively missing appointments without good calls; and maintaining employer-sponsored health coverage, when available. Good health is not only about getting regular health care; it is also about living a productive life. People in the expansion group are in a variety of life circumstances. Recognizing this, we are providing a variety of ways a person can meet

the community engagement activities to earn additional prime benefits. For some, it might be work. For others, it might be schoolwork or volunteering, and so forth. As a reminder, Medicaid eligibility is not tied to any of these voluntary activities: wellness; personal responsibility; and community engagement. Nebraska is leading the nation with this innovative approach. We will encourage people to utilize fully all available and appropriate services so they can get on a path of wellness and life success. Some of our original plans presented in the April 1 concept paper have evolved as a result of discussions with the federal government. The department appreciates the feedback and ex, expertise they have provided throughout this process. These modifications have been included in the Medicaid expansion monthly reports the department has submitted to the legislature since July. I would like to highlight some of the most important items in these reports. The vast majority of parent caretakers currently on Medicaid will continue to receive Medicaid how they do today. Early and periodic screening, diagnostic and treatment, or EPSDT services, will continue to to be provided to 19- and 20-year-olds. Full eligibility redeterminations will continue to occur on an annual basis, though periodic checks, as needed, can occur throughout the year, which will utilize existing interfaces, whenever possible, to minimize the need for beneficiaries to provide information. Part of the 1115 waiver demonstration application will seek to waive retroactive Medicaid coverage for expansion adults and a

number of other groups currently on Medicaid, which will align Medicaid with the commercial insurance market. Children, pregnant women, nursing home residents, and Medicare/Medicaid dual eligibles can still receive up to three months of retroactive Medicaid coverage. Aligning coverage to the month of application encourages individuals to maintain coverage and to apply for Medicaid in a proactive manner. Many have rightly pointed out that Heritage Health Adult will be an expensive build. All product builds involve front-loaded cost, no matter how you do it. However, we are confident our approach will lead to better and more cost-effective health outcomes, which we hope will sustain the financial viability of the program for years to come. The department estimates about 90,000 Nebraskans will be newly eligible for Medicaid through expansion. The experiences of other states show that approximately two to three times as many will apply. This will be a substantial increase in work for our eligibility staff. However, I am proud to say that recruiting additional eligibility staff has been going well. Eligibility operations is adding approximately 70 staff members statewide for Medicaid eligibility, and more than half of those have already been hired. These new hires are currently being trained, and all eligibility staff will be trained specifically on Heritage Health Adult. In addition to hiring, DHHS is working to find new opportunities to streamline our processes, such as colocating eligibility staff in high volume, acute care centers and a federally qualified health center. We have not forgotten the provider's role in

successfully launching expanded Medicaid. The health plans are currently focused on building out their provider networks. With two-thirds of our Medicaid enrollment currently consisting of women and children, the plans' provider networks need to be expanded to accommodate the able-bodied, working-age adult population. With this in mind, the managed care plans are currently conducting provider network stress tests, including specialty providers necessary to provide a full scope of care for an adult population. At the department, plans are underway to improve our provider on-line and phone eligibility services, as well as our onl-ine and phone client accounts. Client and provider education is a priority for the department as we approach the program's launch so that the benefits of our program will be fully realized. In addition to staffing efforts, department staff are currently building the technology systems needed for Medicaid expansion. These technology builds are currently on schedule, but teams are working on detailed system designs, which are on schedule to be completed next month. Building out the needed system changes will begin in December and finish in the second quarter of next year, with testing immediately to follow. Our systems will be ready for Medicaid expansion by August 2020. Applications will start on the start to be accepted on August 1, 2020, and our implementation date is November 1, 2020. I am pleased to report that we are on track and meeting our deadlines, and we are well positioned to continue to do so. Thank you for your interest in Medicaid expansion and allowing

me the opportunity to testify today. I am happy to address any questions. This now concludes my remarks, Madam Chairman.

HOWARD: And just to clarify, you said that the implementation date is November 1, but it's October 1.

MATTHEW VAN PATTON: I'm sorry, October 1, 2020.

HOWARD: OK. Just--

MATTHEW VAN PATTON: Thank you.

HOWARD: --just making sure it didn't change.

MATTHEW VAN PATTON: There's a glare here, and then my glasses-- I'm trying to stay on point there, so my apologies.

HOWARD: Yes, you're very well lit [LAUGHTER]. All right. Let's see if there are questions from the committee. Are there questions? Senator Arch.

ARCH: Yeah, thank you. And Dr. Van Patton, thank you for coming today. And I have several, but I'll take a few and then others can ask questions, as well. We probably have some similar questions. I, I want, I want to start first with the question of eligibility, the determination of eligibility. My understanding is that is state staff that will be, that will be doing that work.

MATTHEW VAN PATTON: That is correct. Yes, sir.

ARCH: Is that, is that correct? What, what is the process of eligibility? Will it be different than what our current Medicaid program is now? Does it require a face-to-face? I see you have some things in here about wanting to improve our provider on-line and phone eligibility. I'm assuming that's checking up to make sure somebody is eligible before providing services. But as far as initial eligibility determination.

MATTHEW VAN PATTON: So, Senator, let me, let me walk you through. I'll try to paint a picture of the process so it will maybe help fill in the blanks on how things move. It begins for the beneficiary. If they put the application in through ACCESSNebraska, which is a Web portal, it's really-- if you think of it as nothing more than just a data collection portal, where the data is put in and it's submitted into a data repository. There are certain questions that are part of the application process and part of what we're assessing or what other questions do we need to begin to ask as will be relevant to this new adult population. So we have more data to begin to streamline how we most effectively engage and meet with that beneficiary, using those care and case management mechanisms that we already have in place with both our teams, as well as the managed care organizations. But that data goes in initially through ACCESSNebraska. Once it goes in, we have eligibility teams who extract that application from the

ACCESSNebraska data repository. And then they manually enter it in to a system called N-FOCUS, which is the eligibility determination system. So that's taking in all of the data, as well as pulling in other data feeds from Department of Labor and the IRS that began to build out the full picture of that individual's application. And so it's a really two-part process and that component in the middle, where you have staff who are extracting and then manually entering. That's why we have a ramp-up requirement for those 70 individuals that we were talking about needing to hire and going ahead and getting them in. One of the things that we have learned from other states' experiences is that they have an anticipated amount of eligible adults, but that doesn't preclude two, three, four, five times as many people applying, or thinking that they do, and therefore they submit. And those have to be processed. Where some states have systems that are automated, meaning that their system, once the data goes in from the beneficiary-- potential beneficiary-- the system makes the determination in real time. We don't have that here in Nebraska, so it's still that two-part process and therefore that labor intensive. So what we're looking at are, again, there's additional questions that we need to add to the application to help us manage the beneficiary pool more effectively, as well as how we begin to streamline some of those processes to tighten up the turnaround time between application, submission, and application determination. I will tell you our teams do an incredibly good job of turning those around. I think our average

turnaround time is seven days and among the best in the country right now. Matter of fact, I recall Deputy Director Karen Heng bringing in a letter from CMS that pointed that out. So I'm-- I think beyond that, I would also let you know that we're looking, as I, as I noted-- as a matter of fact, Deputy Director Heng, for enrollment and eligibility, as well as Deputy Director Matt Litt, for experience\d management and provider relations, are in Lexington today. And there are several facilities that are participating in this project to put colocated eligibility staff in those facilities so that we meet the beneficiary there, and we can begin to use mechanisms of the presumptive eligibility, which can then springboard that process into an application for full-on eligibility determination and to tighten that up. But again, putting those, those eligibility staff, co-locating him in those facilities so we can begin to manage that experience and hopefully get people moving on to the roll faster if there is a determination of viable eligibility. So they're pulling all of that together and building it out now.

ARCH: So a follow up question on eligibility. You mentioned going to the Website and putting information.

MATTHEW VAN PATTON: Yes.

ARCH: Are there alternative ways for an applicant to provide you with--

MATTHEW VAN PATTON: Yes, yes.

ARCH: --information besides going to a Website?

MATTHEW VAN PATTON: Yes, and I should have expanded on that. Yes, they can use the phone and call in to our systems, call centers, and they can also print the application and mail it in-- bring it in-- or they can come in to an office and do an application face-to-face, as well.

ARCH: Thank you.

MATTHEW VAN PATTON: Yes, sir.

HOWARD: OK. Other questions? Senator Hansen.

CAVANAUGH: No, you go ahead.

B. HANSEN: Thank you. Thank you, Director Van Patton. A couple questions. It's my understanding, I think it's-- you know, obviously the federal government pays 90 percent, you know, just in vague terms. They pay 90 percent [INAUDIBLE] the patient. And if a patient is later found to be ineligible, I think then it's our responsibility, I think, to refund that. What if somebody is found to be under fraudulent circumstances? What's, what's the responsibility of the state?

MATTHEW VAN PATTON: That's a very good and fair question. And I will tell you, Senator, we have the-- I think not only did we have, I think, in building our application, the foresight to see what was

coming from the feds. We got ahead of it. And so CMS has issued guidance on what will be expected of the states in that regard. And so you're exactly right. If we do have determinations because of what's been experienced in other states, like California, like Louisiana-- and I don't mean to pick on those states, but there are articles in the newspaper easily searchable, you can find them-- we will have to pay back not just the 10 percent that the state contributed, but we'll have to pay back the federal 90 percent, so nine times back what the cost was. And so from a state standpoint, there there is a penalty in terms of what the state does in terms of process. If there is fraud, I would have to defer to legal counsel on what those legal processes would be and follow up on that with you, because I, I just can't speak to that. But we can certainly do that.

B. HANSEN: OK.

MATTHEW VAN PATTON: And I can see Nate out of the corner of my eye, writing the question down for follow-up. So we'll get that to you.

B. HANSEN: And we do offer, from my understanding, the 13 required services and we also offer, I believe, 19 other--

MATTHEW VAN PATTON: Yes.

B. HANSEN: --services, as well, optional services. How does that compare to other states?

MATTHEW VAN PATTON: So we-- there are-- I would refer to them as service buckets. So there are 13 required service buckets that the feds say, this is what all Medicaid programs have to, at a minimum, cover. And then states have the option of going and adding additional service buckets. And we-- you rightly pointed out there are 19 additional service buckets that we cover. So in those things such as your, your professional background: chiropractic; podiatric medicine; pharmacy benefits; vision; dental-- all of those are optional services that the state of Nebraska has, I think, generously chosen to add to the service portfolio here. How that compares to other states? There have been several reports, and it's a moving target as things change from state to state, year to year, but I would say Nebraska is probably among some of the top states with their robustness of their service portfolio.

B. HANSEN: OK. And just one more quick question. It kind of pertains to that 90 percent that the federal government is responsible for. Maybe it's kind of a personal question, but also a professional question. Do you ever foresee that changing at all in the future? Like could the federal government ever come along and all of a sudden say we're only going to pay 75 percent now?

MATTHEW VAN PATTON: Well, when, when the Affordable Care Act was passed, it started as a step-down system, right? So it started as 100 percent federal, and then it's gradually moved down to the 90 percent.

We've already seen, with CHIP, a reduction in the federal allocation where it was expanded CHIP. So I would tell you, I don't predict what my wife is going to do [LAUGHTER]. I therefore don't predict what Congress may do. And so what I will simply tell you, as, as my wife always says: Anything's possible, Matthew. I would tell you, Senator, that anything's possible. It depends on the will of Congress and how they decide to expand or change, or what financial constraints may be present in the market at any given time.

B. HANSEN: Thank you. I'll remember that question next time with my wife, so thank you [LAUGHTER].

MATTHEW VAN PATTON: Well, I can tell you, Senator, that the wisest words ever told to me by my grandfather were: yes, dear [LAUGHTER].

B. HANSEN: Thank you.

HOWARD: And actually, Director Patton, I may have you clarify that a little bit, because what you meant was that the 90 percent is set in statute, as opposed to our FMAP, which fluctuates every year.

MATTHEW VAN PATTON: Right.

HOWARD: Do you just want to specify--

MATTHEW VAN PATTON: Right.

HOWARD: --between the two?

MATTHEW VAN PATTON: Right. So our federal match, that is a percentage that is adjusted annually and we're-- this population, the federal match is a percentage. And so currently it's set at 90 percent. And I think the question that Senator Hansen had asked was, can that percentage be changed? Is there a potential for that percentage to be changed? And as long as Congress comes in every two years and has the prerogative to make laws, then the answer to that is: Does that potential exist? The answer is yes.

HOWARD: Absolutely. They're wildly productive in Congress, passing laws. Other questions from that committee?

WILLIAMS: I'm [INAUDIBLE].

CAVANAUGH: You can go.

WILLIAMS: Go ahead.

CAVANAUGH: I also have a few questions, so I'll ask a few and defer to my colleagues. So Senator Arch had talked about eligibility, and I have some questions around that, so maybe I'll, I'll start with that. But I'd like to say, first of all, thank you very much for this draft of the 1115 expansion demonstration. When you give more information, it's delightful but also, you know, a little bit scary because I love information. So I've got a lot of questions. I'll try to keep them as concise as possible. I wasn't clear, from what you said in your, in your statement and then what's in the demonstration here. So is the

review of eligibility going to be on an annual basis or every six months?

MATTHEW VAN PATTON: No. So it will be on an annual basis, which is currently how we do it now for the Medicaid population.

CAVANAUGH: OK.

MATTHEW VAN PATTON: So it's annual for the members. So whenever they came in, that's when they will have their annual review, nine months-- no, excuse me-- twelve months out from when they were onboarded.

CAVANAUGH: So there's a few places in here where it says six months.

MATTHEW VAN PATTON: So what that's talking about is us doing those periodic checks, looking--

CAVANAUGH: OK.

MATTHEW VAN PATTON: --in just to make sure that the eligibility status is still present. And part of that comes back again-- as I said, we've had these ongoing conversations with the federal government. And I think, because of those other state experiences where they did have individuals who were not supposed to be on or their status changed, I think the good thing about the population you're talking about is that their status can change. They can get another job and they can begin to make more money. And if that does occur, then that's something that they are incumbent upon to report back that that status has changed,

because that may affect their eligibility. Or if they've onboarded into a new job that does have commercial insurance provided through that job, then they need to report that change of status. But our objective is, since we do have some of those data feeds coming back from the Department of Labor and the IRS, we can pull some of those data points into our system and so we can look at it and we can proactively reach out if we see that something has changed, just to clarify.

CAVANAUGH: So it's not an automatic six-month review. It's a, it's-- if there's information provided to you from like the Department of Labor, that would trigger a review.

MATTHEW VAN PATTON: We will begin to look in at six months, but it's not a full on redetermination of eligibility at that point. It's just to check in to see that things are as they were when the beneficiary came in.

CAVANAUGH: OK.

MATTHEW VAN PATTON: It's, it's a way of maintaining, I think, program integrity and accountability, which was one of the-- I think you may have heard me testify previously-- was one of the points of concern when we first had the conversation with Director [SIC] Verma.

CAVANAUGH: And then are there other states that, that follow that same process? Is this modeled after something you've seen other places or would Nebraska be the first state implementing this?

MATTHEW VAN PATTON: As specific to 12-month return-- determinations of eligibility?

CAVANAUGH: No, the six month sort of periodic review.

MATTHEW VAN PATTON: So 12 months is-- that's the standard.

CAVANAUGH: Right.

MATTHEW VAN PATTON: And so what I would tell you about what we have proposed here is that this is a very Nebraska-specific program that we have put forth. And I will tell you, we've, we've had the benefit of looking at what has happened in other states and learning from experiences that those states have had, so that we can make what we put forth, I think, a better product. And I see on your page there-- you've got the waiver opened-- the quadruple aim is something I know you all have heard me speak about. And Senator Arch is probably over there saying to himself, oh, Lord, here he goes again. It is embedded in me that we really focus on the experience that the beneficiary has with us programmatically. We want them-- if they have the benefit, we want them to be able to use it fully, and we want the provider community satisfied with the engagement that they have with the state, with the MCO, with the beneficiary. We want to improve the health of

the population, but we want to do it in a fiscally responsible manner. And it's very clear, from the guidance that we've gotten back in and around program integrity and eligibility, that they are expecting states to do better, in part because of what has happened in other states.

CAVANAUGH: So you're-- you've talked about feedback from the federal government-- and this will be my last question for a few minutes-- but feedback from the federal government. And have you received feedback on this specific point of the six-month-- I'm calling in a six month review? But has the federal government indicated that this is appropriate and would be approved?

MATTHEW VAN PATTON: So what they have told us is that it would be, that we would need to do the 12-month redetermination, that that would be expected. And so on the six-month piece, they know that that will be coming in the 1115. And so from their specific feedback on, you know, the look in, you know, at this point, I think, in the conversations that our staff have had, we haven't exceed, received any feedback that says that's not a reasonable thing. I think they would probably think it is being reasonable, again going back to their recent guidance, as well as those experiences in other states.

CAVANAUGH: And if you do receive feedback from the federal government that they will not accept that, then that change would be made, so as not to delay the process.

MATTHEW VAN PATTON: So that's part of what moves forward with this, is once the application goes in, then it becomes a negotiation--

CAVANAUGH: OK.

MATTHEW VAN PATTON: --between the state and federal government. So it would be inappropriate for me to speculate what will and what will not--

CAVANAUGH: Yeah, I understand.

MATTHEW VAN PATTON: --come out at the end.

CAVANAUGH: Thank you.

MATTHEW VAN PATTON: Yes, ma'am.

HOWARD: Just for clarification for my benefit, for the six-month sort of reevaluation that you're talking about, is it just for prime or is it for basic and prime?

MATTHEW VAN PATTON: So that's, that's really a-- just around the eligibility, whether or not somebody's life circumstance has changed, such that it, it would make a new determination that they wouldn't be eligible at that point. Looking at it.-- did you get a new job? Has

your income changed such that you no longer meet the eligibility criteria? It's looking at those, those indicators. This isn't about--

HOWARD: It doesn't matter which tier you're in? It wouldn't take you out of a tier? It would more just be whether--

MATTHEW VAN PATTON: Whether or not--

HOWARD: --you're still eligible.

MATTHEW VAN PATTON: --you are, you are still eligible to be a Medicaid beneficiary; that's the point of that.

HOWARD: And may I ask, is that for every everyone in this expanded category, or is it for current Medicaid enrollees right now?

MATTHEW VAN PATTON: This is for those who will be coming into the new program. This waiver is specific to the new programmatic components of eligibility determinations unless-- and if I'm wrong in this, I will make sure staff correct it-- but that is my understanding, is that this is just for the new adult population, unless you see Nate shaking his head.

HOWARD: No, he's nodding, he's nodding. All right, thank you. Senator Williams.

WILLIAMS: Thank you, Chairwoman Howard. And thank you, Dr. Van Patton, for being here. A couple of questions. In your testimony, you state

that many have rightly pointed out that Heritage Health Adult will be an expensive bill. Would you like to expand on it a little more so that I can more fully understand why we would want to have an expensive bill if there is a way to do it cheaper, and what the benefit of that expensive bill is?

MATTHEW VAN PATTON: You know, Senator, I would tell you, regardless of the approach you take, you're going to have an expensive bill proposition. It's like starting any new business line. It requires system upgrades to technology. For our situation. It requires the addition of staff, 70-plus staff just on the field side of the social workers who come in and make those eligibility determinations, new contracting for services like, you know, the actuary coming in to do the actuarial studies. All those things are front-loaded, what I would consider business expenses that are going to be present in the process, regardless. And so when you're looking at what we've proposed here in this waiver, what I would tell you, Senator, is that we're front-loading costs that we believe, in this waiver, give us tools and flexibility to most effectively manage this population over time, so that we can really use the value of what we're currently buying in infrastructure from our managed care partners to really wrap their services, in addition to other government services that we can align with this population, in a way that we hope to sustain the program longtime by really using mechanisms to bend that cost curve over time.

So the front-loaded cost, if you will, again, they're going to be there. But the things that we're doing in this waiver are really intended to help give us that flexibility to really effectively manage the, the, the population in a way that we get a good value for them. But we also can do it in a way that we can manage outcomes such that those outcomes can bend that cost curve over time.

WILLIAMS: OK. Moving on to another topic, we have had testimony, at previous briefings and hearings, from people that have indicated that, in their judgment, it may be highly unlikely that this type of plan could get approved to get the waiver, based on the two tiers and maybe some other states' applications. Could you address that specifically, your feeling on the ability to obtain the 1115 waiver on this one, and then the, the Plan B kind of approach as if we have struggles getting that waiver?

MATTHEW VAN PATTON: Sure. I would tell you, Senator, that's, that's sort of the process and why we've really been engaged with our federal partners as we've moved through this process, asking questions. Where we started out in the concept paper and the things that we've moved off of, as I said in my testimony, that's a direct result of those conversations, to really reach a point to where, in the 1115, what we've put forth out now for the public to review and what we're preparing to submit officially, I think at this point we're probably in a very good position, that what is put forth will, will ultimately

come out approved. Now what we put forth, is that to say that we won't have to negotiate certain terms as we do enter into those conversations with the federal government in a more deep, formal, and pronounced fashion? Yes, we will have to negotiate. That's, that's, that's part of the process as it is. But I'm really-- to be very candid, Senator, I'm very encouraged around what we're doing. And I think there's, there's a very pointed mark of distinction in what Nebraska is putting forward. This is a very Nebraska-specific.-- we, we've done a Nebraska-specific model, again learning from the experiences of other states. We don't have work requirements in this. We have engagement, and personal responsibility, and community engagement requirements. But nobody under this model loses benefits. They all-- if they have a determination of eligibility, they have access to that already robust basic package; that's going to be there. And that is a very pointed mark of distinction in what our proposal is versus what other states' experiences have been.

WILLIAMS: And I' would like to probe just one, one step further on the, the basic model--

MATTHEW VAN PATTON: Um-hum.

WILLIAMS: --the robust basic model.

MATTHEW VAN PATTON: Um-hum.

WILLIAMS: And Senator Hansen talked to you and asked questions about the buckets of coverages. In your experience, and looking at other states that have implemented expanded Medicaid, how would you compare our basic bucket-- you know, that bucket-- to what other states have, if they don't have a tiered system and just put one system out there?

MATTHEW VAN PATTON: Right. Well, I guess--

WILLIAMS: I know it's hard to compare it 'cause we're-- but I [INAUDIBLE].

MATTHEW VAN PATTON: But I always leave with the disclaimer, if you've seen Medicaid in one state, you've seen it in one state. It's very different. But I think if you look at it-- and I believe our mandatory and optional services-- if you flip to the back of that blue binder, I believe you will find the comparison there so you can see what those services are. I would tell you that what you're looking at in the mandatory buckets and those optional buckets, they get everything of those 19 and the optional, with the exception of 3, which is the dental, vision, and over-the-counter. Those are the parts that go into prime. And those are the pieces that we want to incentivize folks to stay engaged with us so we can really effectively work with them and then open up those additional benefits so that when they begin to use them, they use them really effectively to a good outcome for them. And so I think the other important piece that I would note is that, when

you look at the commercial market, and you look at what beneficiaries, and the commercial side who are working and getting it through their insurance-- excuse me-- through their employer, look at us as a state, we pay for vision and dental separately as premiums and policies. We get a core benefit package, but dental and vision are separate. And that's pretty much how the commercial market aligns. So I would tell you, I think that in comparison to other states, and I'm going to just say at a very high level, I think that the good people of Nebraska have been incredibly generous in the options that they put forward, things like podiatric medicine or chiropractic medicine, those things aren't traditionally included in a lot of state plans across the spectrum, and we've included those elements here.

WILLIAMS: Thank you.

MATTHEW VAN PATTON: Yes, sir.

HOWARD: Other questions? Senator, Arch.

ARCH: Thank you. You've--in, within your documents, it appears as though you're making a change to retroactive Medicaid eligibility. And in your testimony, I heard you use the term "presumptive eligibility." Could you please define those terms and the changes that you, that you'll be making with this plan?

MATTHEW VAN PATTON: Sure. So presumptive eligibility is a tool by which providers can make a care decision about an individual, making a

presumption that they would be eligible and go ahead and make care under the presumption that a eligible beneficiary would, at some point, become a full-on Medicaid beneficiary. So retroactive is a very different thing. Retroactive eligibility says that an individual who comes into the Medicaid program currently, under rules can go back three months for any care exchange that they've had. And those three months, if they've had a care exchange within those three months, those exchanges can be covered. Now where we want to move-- again, if you look at what's in the commercial market today or even in what I would consider other insurance products in the market, you can't go have an automobile accident today and not be covered and then go get a premium tomorrow and then have the accident you had today covered; it just doesn't work like that. So what we're doing is we're really aligning the payment structure and that eligibility criteria to align with what's already happening in the commercial market for the vast majority of folks in Nebraska today. The other piece to that I would tell you, Senator, is we want, and why we're doing the modeling with putting our staff in those facilities that have high volumes of folks coming through, is that we want to tighten that up. We want to use the presumptive tool more effectively. And we want to get more folks determined to be eligible if they truly are, based on a care exchange at that moment, so that we can then, if, if they are to be covered going forward, we can then immediately wrap the resources of managed care around them, because we believe that it's better to do full-on

managed care of that person's condition over time than to let them linger with episodic periods of care, going into inappropriate care venues that oftentimes are inappropriate from the standpoint of it probably not being the best base to get care, like the ED for something that may be a cold or something that may be ongoing chronic disease management, like diabetes. So we want to get those resources of managed care wrapped around them quicker and get them in sooner.

ARCH: So on, on, on what basis would a provider make the presumption? And what if the provider is incorrect in that presumption, they are not eligible for Medicaid after all?

MATTHEW VAN PATTON: What I would tell you, Senator, and that is a, that is a variable, but there are also mechanisms that are in the marketplace, currently provided by Medicaid today. And as a hospital executive, you'll know that the safety net has a mechanism called disproportionate share payments that go out in the form of millions of dollars, to hospitals across the state, from the Medicaid program already today. It's intended to cover that gap,or to help cover that gap, for individuals come in that don't have a form of payment or that they see a disproportionate share of Medicaid patients coming in every day. So you will have individuals that they just are going to fall through that gap, they won't be eligible. But there is that mechanism

already in place, within the marketplace, to really have some, some additional supports for the safety net.

ARCH: My understanding is the federal government is reducing those "dispro" share payments over time but they're-- and because of Medicaid expansion, they intend for that to cover that.

MATTHEW VAN PATTON: Yes.

ARCH: But, but back to the presumption for a second. So a patient walks in and a provider has a conversation with the patient-- or at the front desk, I have no insurance, and questions are asked. And well, it appears as though you'd be eligible for Medicaid.

MATTHEW VAN PATTON: Yes, and that's really what, at that juncture, you have to go on, which is, again, also why, when we're looking at it from a process standpoint, you can start with the presumptive. But if, in those certain situations where we're going to have individuals in those facilities, we can begin to take the presumptive piece and go on--

ARCH: Sure.

MATTHEW VAN PATTON: --quickly into that eligibility determination.

ARCH: Right. And not all providers will obviously have those people in the office and-- but high-volume providers, I'm sure you're, you're looking at those as--

MATTHEW VAN PATTON: Yes.

ARCH: --as, as an opportunity. So if they, if they presume that that eligibility exists and provide services and they are wrong, will the provider be paid? Will the provider be paid, based on presumptive eligibility? Or must it actually prove to be true that that patient was, indeed, eligible?

MATTHEW VAN PATTON: You know, Senator, I, I, I probably need to follow up with you on that, on the exactness of the presumptive eligibility criteria--

ARCH: OK.

MATTHEW VAN PATTON: --and the mechanics of it. And what I'd like to do is just offer a conversation and follow-up with Karen Heng, in enrollment and eligibility. I think that probably would get to the specifics of it. I don't want to tell you wrong.

ARCH: All right, thank you.

MATTHEW VAN PATTON: Yes, sir.

HOWARD: Other questions? Senator Hansen.

B. HANSEN: I want to follow up a little bit what you talked about with the IT system, 'cause I've seen varying numbers from different states who've implanted Medicaid expansion that cost either $20 million or $200-some million, depending on whether they had to just tweak a few things or overhaul the complete system. Where are we at in that spectrum? Are we tweaking a little thing or are we doing a, almost a complete overhaul? And do you know like the approximate costs of what that would be?

MATTHEW VAN PATTON: Senator, that's part of where we are currently, Senator, in terms of the upfront costs. And we do have, I think, some estimations of around where those costs are because, at this juncture, what we're having to do is work with what we have. And what we have-- again, there are multiple systems that will have to be modified. We'll have to modify ACCESSNebraska, that front-end portal. We'll have to modify in NFOCUS, which is a 26-year-old enterprise system. So that's, that's the piece there that, from the standpoint of how you go in and make those modifications where we have to be very careful, is that our existing enrollment system for beneficiaries who are currently under existing enrollment and eligibility criteria. So when you make those modifications to a system in real time, you have to really be careful with what you're doing, although I think we've got proper safeguards to mitigate that. But those are in-house systems and they do have some costs. Most of those costs are going to be on technical consults and

staff time to build. Now where, where we end up going, that's a different conversation. So currently it's modifying existing enterprises because that's our only path to do it in a timely manner to reach the October 1, 2020, date. At the same time, the institution is looking at that next path to take, to create a new enrollment and eligibility system that does get to the point of automated determinations. That's something we're looking at now as we pick that, that back up probably after the middle of next year.

B. HANSEN: Do you see all this change in the, in the, in this area to affect the providers very much at all?

MATTHEW VAN PATTON: Yes.

B. HANSEN: OK.

MATTHEW VAN PATTON: There's a reason why our focus is on the quadruple aim. And as I've had many conversations with staff, it's an ecosystem. And if you look at who sits around the executive table in Medicaid, there are as many people like me. I recently was at a conference with Dr. Bland, with NeHII, talking about some of the work we're doing there. And I said, I'm really a hospital executive masquerading as a Medicaid administrator. That's the orientation that I have because that's my professional training. And there are several clinicians who come from the provider background. We have to take that provider perspective into account in the shaping of our policies and our work

processes, in part because we have to respect that provider's role in their willingness to engage and become a Medicaid provider and to stay incentivized to stay in the Medicaid system, to be part of that safety net. And so absolutely, we stay on top of that. We look at it from the standpoint, again, as I said, we've really been working with the MCOs on where are your networks now, and where do we need to go, where do we have holes, where do we have opportunities? Is it going to be a geographic issue? How do you account for that as you're taking in an adult population that may have a county that doesn't have access to very specialized care practitioners? How do you build those referral patterns that get them into those networks? So those are the conversations that are really-- and have been ongoing for the last several months, and will continue to be ongoing as we begin to prepare to start those network expansions where they need to occur, and the MCOs need to go out and expand their networks with new providers under their contracts.

B. HANSEN: OK, thank you. Can I ask one more quick question?

HOWARD: Sure.

B. HANSEN: I think like Senator Arch was kind of digging into some of, a little more of the specifics about this, the expansion process and some of the eligibility between basic and prime.

MATTHEW VAN PATTON: Sure.

B. HANSEN: The one question I had was about how many appointments they can miss.

MATTHEW VAN PATTON: Yes.

B. HANSEN: And who determines that? Is it still, like is a three a year, I think? Or three--

MATTHEW VAN PATTON: Three.

B. HANSEN: --three missed appointments--

MATTHEW VAN PATTON: Three, and--

B. HANSEN: --in a period? And who determines that? Like does the-- does the--

MATTHEW VAN PATTON: Right.

B. HANSEN: --secretary then call in, and communicate, and say, oh, they missed their appointment? Or how is that tracked?

MATTHEW VAN PATTON: So it's one of the processes that we're currently working through with the MCOs. It could be a code that's submitted by the, the provider that they missed an appointment, and it just goes into the system, missed appointment. It could be a call-in. It could be documented in follow-up, where the MCO, who had worked with-- you know, if it's a high acuity patient and they're working with a managed care entity and a case or care manager, and they've set up an

appointment and they've missed it, you know, it could be recognized in the fact that that MCO called and got that from that, that beneficiary directly. But that also gives an opportunity to figure out why. Why did you miss it? We have consistently heard from providers that one of their, their issues with the Medicaid population is that they schedule and they don't show up. And depending on how the physician is paid, if they're paid on RVUs, which is productivity, that is missed time and missed revenue for them. And it's also a missed appointment opportunity for somebody else who may legitimately have been trying to get into that, to that care provider's office. So you know, we believe that there are always going to be exceptions like, let's say, the, the beneficiary had the appointment made with the MCO. At the time the appointment was made, the MCO schedules a ride to go pick them up. They don't have access to transportation, but for whatever reason, the ride didn't show up. That doesn't count. We would not be arbitrary in [INAUDIBLE] that account. So there will be some reasonableness associated with it. At the same time, if you schedule three times with the dentist and you just don't show up and you don't call to cancel and you don't give them notice, you know, there's a personal accountability in using that time and that potential infrastructure that, that is a, an issue of productivity for that provider that we need to be sensitive to.

B. HANSEN: Thanks. I think that's kind of a-- being one of the, being a provider myself, I think that is one of the big drawbacks, I think, of taking Medicaid as a provider. And that's when I call the calls, the, the emails I've gotten from providers about those missed appointments and how that, how they report that. And it is a concern, I think, among providers, and why they drop Medicaid, I think.

MATTHEW VAN PATTON: Yes.

B. HANSEN: So thanks for the clarification.

MATTHEW VAN PATTON: Yes, sir.

HOWARD: Senator Cavanaugh.

CAVANAUGH: Thank you, Chairwoman Howard. I' wanted to go back to the demonstration waiver. And I don't know if everybody has a copy of it, but I was looking at page 5, where you have the demonstration, goals, hypothesis, and evaluation. So you have the four goals stated, which are clearly informed by the quadruple aim. And kind of, Senator Hansen was just talking about the provider experience side of it, and I do have concerns about that, as well, as if we're adding extra administrative layers to providers for-- Medicaid patients are going to be their lower paying-- or reimbursed-- patients. But in looking under-- at the hypothesis-- so I have, I have a question, but let me give you a little background on where I'm coming from on my question. So your hypothesis is the evaluation plan and methodology for, for the

hypothesis. And so you have it outlined here: a few different hypotheses and then the method and the measurements. And I understand the two tiers of benefits, but I am a little confused as to why we wouldn't start at prime and then move down to basic if, if they didn't meet those qualifications after-- like if they met-- missed, started missing appointments and didn't meet the work requirements. Why we wouldn't start at Prime is sort of my first piece of the question. But before I have you answer, in looking over the hypothesis, it talks about beneficiaries-- like the second line one: Beneficiaries participating in community engagement activities will have higher average income compared to nonparticipating beneficiaries. And that hypothesis, in and of itself, seems discriminatory towards the lower wage earners or the people that are less able to work that might be in community engagement activities. And so we're tying our methodology to sort of a discriminatory premise, it seems to me. And if we started with giving everyone those prime benefits, regardless of these hypotheses, could we then prove out if those prime benefits are what is really the key to success. or is it the engagement, because if you have all those robust benefits to start with, you don't want to lose them, like you don't want to lose dental, you don't lose getting dentures if you need them, you don't want to lose vision if you need glasses. So if we start out by giving those things at the beginning and say if you don't meet, if you don't continue to meet these requirements, then you lose them and then measure the differences

there. Does that-- very long winded, but does-- could you maybe just speak to that, as to why that's the way that, that, that you're approaching the waiver and what your anticipation is versus what my sort of anticipation is?

MATTHEW VAN PATTON: Senator, I mean no disrespect in asking the question I'm going to ask, but I'm not sure what your question is.

CAVANAUGH: So my question is, I'm viewing it flipped, like I view that the benefits would-- everyone would benefit more if we started with prime and then moved down to basic. If we're gonna do two tiers, that everyone starts with the highest level of benefits and they have to prove, from there, that they can't--

MATTHEW VAN PATTON: Yeah.

CAVANAUGH: --that, that we're putting resources into a population that isn't going to maintain our standards, and so we move them down to two basic. But you're starting with the premise of put everyone in basic and have them earn prime.

MATTHEW VAN PATTON: Let me, let me, let me explain-- and part of this is, is 15 years of experience as a hospital administrator and working in health services. There's a very human element in the approach to healthcare, and we tend to go to what we know, and we tend to go to what is comfortable and known. The assumption that an individual will effectively use a benefit, just because they have it, I believe is

quite flawed, which is why we have put into this active care and case management. That again, is using the resources of the state's front-end staff to educate our beneficiaries when they're working with them, which is why we have managed care partners to effectively work with them. When you give someone the benefit, and they haven't had access to a payer source or they haven't had access to a coverage element like dental, like vision, assuming that they will simply use it, I think it's a flawed premise. And our objective is, let's start with where we can take them on their physical, behavioral, and their pharmaceutical elements of care. Let's get them into a primary care practitioner to really begin to evaluate them and get a baseline history and physical, so we know where to take them next. And I will suggest to you that the mechanics of what is put forth here to-- again, to earn and open up into that prime, those things we're putting forth picking a primary care practitioner, calling and seeing the physician within the first year. Those are things that, from an advocacy standpoint, I want the beneficiary to use those services. I want them to get in and get that care. From a care and case management standpoint, it gets the data that we need to really know what we're we're managing to, long-term. But it also lets our MCOs know where they concentrate their resources to help an individual move along the path. So if someone hasn't seen a dentist-- and I'll just use that as an example-- ever or in 20 years, just because they have a benefit doesn't mean they're going to use it. And I think starting with where

we can, with the, with the basic elements of physical health, and then moving to those additional elements, and incentivizing them to stay engaged in the process, to stay communicative with the MCOs, and to be engaged and use those resources effectively, to help use all those additional elements, and to create those natural incentives that move them there, I think, is a right and proper path for us to take.

CAVANAUGH: Thank you, thank you. That was-- I was looking for that explanation. So when it comes to the prime versus the basic tier benefits, is there an opportunity still to consider making over-the-counter medications part of basic, because that does seem like the most cost-effective, low hanging fruit thing that we could be doing to help low income people access? Like if you get allergy medicine, then you won't get all those sinus infections that take you to the emergency room, like those kind of things and you can just get over the counter. Is there a reason that that is considered prime?

MATTHEW VAN PATTON: I would tell you, Senator, that that's probably something-- if you look at, again, what's available to most Nebraskans who are working and getting their insurance through their employer, over-the-counter medications for me, if we want over-the-counter medications, we buy those through a health savings account. I have those.

CAVANAUGH: But, but--

MATTHEW VAN PATTON: And--

CAVANAUGH: IYou don't qualify financially for these benefits, and so this is something that this is for people who really are struggling financially. And something like that could be extraordinarily impactful, so I guess I just wondered if there was any consideration, even though that's not a standard for our health insurance, if that could be something considered as a benefit, basic benefit.

MATTHEW VAN PATTON: Well, as I recall, there are certain over-the-counter medications that are already part of that benefit. This is the broader, expanded scope of over-the-counter medications. So there are certain things like Tylenol, as I recall, are already part of that from a normal care, care component.

CAVANAUGH: OK.

MATTHEW VAN PATTON: And I see Nate shaking his head in agreement.

CAVANAUGH: I do have more questions, but if others--

HOWARD: Let's see if there are some others. Are there other questions [INAUDIBLE]? I may ask a few and then you can--

ARCH: I have one, too.

HOWARD: You have more, too. OK, great. OK, I am really glad Senator Hansen asked about the missed appointments. But are there are there

any exceptions to the missed appointments that you are considering, whether it's you are a dependent, or you're thinking of if there was a transportation issue? But are there any exceptions that would be as part of when we're thinking of the missed appointments problem?

MATTHEW VAN PATTON: I mean, well, there are reasons why we have appointments that get scheduled, other things conflict that just come up in the normal course of life. I think this is a, this is a question of reasonableness, Senator. And I think, as you have the benefit, just as I have a benefit that I get through my coverage through the state, if I make an appointment with a physician, but I see that I've got a scheduling conflict, whatever it may be, I think it's just a matter of calling that office with with enough courtesy and notice to say, hey, doctor, I'm not going to be able to make this appointment, but I need to reschedule. And so you don't just not show up for it. And I think that's the piece that that we really want to incentivize, that as our beneficiaries are using the infrastructure, that they are also respecting the provider's time, just as anybody else would respect the provider's time in that equation. But that's not to say something doesn't come up. You-- maybe you have the appointment and you have a sick child at school, and you can't make it because you have to go get the sick child. Reasonableness is always going to be, you know, part of the equation and looking at it. But again, go back to if you scheduled three times and you just don't bother to show up three

times, you know that, that's-- are you really respecting the benefit, and are you respecting the providers who are part of the provider network that's there to support those who are in the program?

HOWARD: Thank you. And you mentioned case management earlier. And I want to be clear that those case managers, will they be state FTEs or will, will they work for the managed care companies?

MATTHEW VAN PATTON: You know, Senator, I think this is probably where, you know, as a healthcare executive, this is where this gets really exciting for me, because what this does is it now begins to align where I see three clear resources around care management. The state-- on the front end, we have caseworkers, and those caseworkers are beginning to collect the front-end information that really starts to drive an understanding of who that individual is.

HOWARD: My apologies. Are you calling ACCESS workers, caseworkers?

MATTHEW VAN PATTON: They are caseworkers. So if they're enrollment and eligibility workers, they're caseworkers.

HOWARD: Um-hum, um-hum.

MATTHEW VAN PATTON: So they're starting to collect data, and I think that's where, when I said we're looking at our current application. But what are we currently collecting? But what can we also collect that may help drive and inform a better understanding of who the

individual is, coming into the program? So that's one element. I think we're currently buying a tremendous amount of infrastructure and resources from the managed care organizations. And they have their systems by which they risk stratify patients when they come into their system or beneficiaries when they come in, based on, you know, historical data or based on certain risk screenings that they may do that then push up where they go and their intensity of care and case management. So you've got the state and you have the resources of the MCO, but if you're a hospital provider, you also have case managers or care managers in the hospital who are working at beneficiaries. Maybe they're working a discharge plan or they're working a care coordination plan as someone is discharging. I see there being efforts that blend how we effectively use those three distinct resources-- effectively around that beneficiary. And I think up front, where we're starting, is how do you engage the state to do better with collecting more data that informs? And how do we begin to use our managed care resources in ways that are new and different? And I think part of that surrounds some of those social and economic determinants, data and how that begins to shape and inform. Again, the experience going back to questions about do you have access to reliable transportation. If you don't, how do you schedule an appointment to attend a physician or a dental visit? IAnd if you don't have a reliable way to get there, that tells the MCO, OK, if we're going to schedule it, we probably need to go ahead and schedule the rideshare, as well. So I think it's going to

start out where we use our data from the state and where we use our data from the MCOs and how we push data between the two. But then it also opens this up as we move forward in time. I like to say there's a reason why Apple started the iPhone and its iPhone-- whatever it is now-- 11. Anybody in here still use the first iPhone? I have mine. I hope one day it's worth something, but I don't use it. It's because Apple started and they got better, and better, and better over time. And that's what we have to look at here. How do we build systems, technologies and processes that improve this experience, not just where we are today? We know it's not going to be perfect, but we know we're also going to be in a system of constant process improvement so that we do make it better over time. We do integrate those resources of the hospital into that paradigm more effectively than the way we use them today. Although we do use them, how do we use them differently and more effectively with this population?

HOWARD: So back to the original question, which was the case management, the actual case management of someone's healthcare. So I wanted to make sure that I was clear that an ACCESS worker, you're using an ACCESS and eligibility enrollment worker in the same way that you would consider a case worker?

MATTHEW VAN PATTON: No, that's different. So what I'm saying is that it's all part of the data that begins to inform how you manage that person's care. And I would say that's probably from a clinical

standpoint. That's really going to rest on the MCO side as well as the provider side. And that's why I say it will go between those two. But how do we improve those processes over time? That's what I'm getting to, because that's really, from a clinical standpoint, that's going to rest with the provider and with the MCO at this point.

HOWARD: OK. And then you also mentioned performance improvement as you were talking about that. And one of my concerns with sort of this tiered is that we'll start to see people showing up to the emergency room with dental issues because they-- and then dental isn't covered. And then how do we get them dental care? And that becomes sort of a challenge to the system. Do you have sort of a time line for reevaluating how this is working? If you start to see that issue coming up and sort of a cost or a burden to the system, what's your time line for reevaluating the-- whether or not the prime benefits-- or looking at Sarah Cavanaugh's comments on the over-the-counter medications, whether or not there are cost savings to be had by ensuring that there's access to certain types of benefits that may be only available in prime?

MATTHEW VAN PATTON: Sure. I think it's a very fair question, Senator. I think it's a good question. I think first things first, we have to start somewhere. And this is our first proposed start. Again, we need to understand the population as they come in, comprehensively. Get the baseline history and physical. Let's move from the baseline history

and physical by getting them those proper care exchanges on the physical, behavioral side of the equation and then move into where we go. And I think once we get in, once the population is established, and you're two, three years in, you will have data that, over time I think, at that juncture you'll know what's happening within the marketplace. And it needs to be reevaluated, I would say, around that three, three-and-a-half-year mark, because you'll have a good base of data to work from at that point.

HOWARD: Thank you. I have more questions, but I know-- Senator Arch, did you have additional questions?

ARCH: Yeah, I do. I have one other. You and I have had discussions about the, the po, the possible, the opportunity, I guess, that Medicaid expansion could provide to-- we never use this term, but as I was thinking about it, I thought, well, maybe we need a-- quintuple goals here instead of quadruple. But you know, improving the total quality of life.

MATTHEW VAN PATTON: Right.

ARCH: I mean, more than just more than just health care, more than-- but, but improving the total quality of life for an individual. Is it-- have you given any consideration of any, of any tying of this into work force development, for instance, that you would, in your eligibility or in your scan or in your screen or in something like

that, you would have, you would have a question regarding it? And this would be voluntary on the part of the individual-- I could, I could use some help--

MATTHEW VAN PATTON: Sure.

ARCH: --in, in better job, better employment, better, you know, all of that--

MATTHEW VAN PATTON: Sure.

ARCH: --whether, whether that be writing of a resumé or actually getting into an apprenticeship program. I mean, it could be a variety of things. Do you ever, do you consider tying that, because I know you have a pilot you have a pilot project that's going now where you're putting the Department of Labor together with HHS? Have you considered that as part of this?

MATTHEW VAN PATTON: Sure. I think that's-- it is very much a part of what I think-- again, when you've heard us-- Medicaid, as myself and deputies have talked about this, this product as it goes out into the marketplace, we've said meet the individual where they are. There are going to be individuals who are in a position where they are looking for new job skills, where they are looking for new employment opportunities. Again, if you can ask those questions up front so you understand who they are as an individual, then you can begin to use those levers of government where you can make those referrals back to

the Department of Labor. Or that gets pushed into the case file with the managed care company, who then follows up with the individual, says, look, I see your interested in employment. Have you looked at new job training opportunities at the community college? Or just get an understanding--what would you like to do in life? Do you have an interest in becoming a welder or do you have an interest in becoming a nurse? I think it's also-- one of the conversations I recently had with one of the MCOs is, we have Medicaid currently have job opportunities open. You know, how do we-- when we're working with beneficiaries, they may actually end up having an opportunity in the Medicaid program. We have job opportunities out there that we have ongoing staff needs to fill, and that may be an opportunity to close the loop. So how do you, how do you, again, align those opportunities? I think it has to start, Senator, very candidly, with understanding where that individual is from a social and economic standpoint. And that's why we're pushing the upfront data collection and how that ties back into what we do comprehensively with the MCOs.

ARCH: Thank you.

HOWARD: Just to clarify, because I think this is a really interesting idea that Senator Arch is discussing, are you thinking that eligibility and enrollment workers at ACCESSNebraska would be able to

sort of handoff someone to the Department of Labor or something like that?

MATTHEW VAN PATTON: Well, we can certainly make a referral. If you're talking to the individual and you're talking to them about their employment status, then if you do know of a path to help them go into, maybe they just don't know that those opportunities are there. That's an opportunity to educate them on the full array of government. So where we have, I think, good alignment in the state of Nebraska is our enrollment and eligibility folks also work economic assistance, right? So you're looking at them from the standpoint of food security. You're really beginning to look at those full social and economic determinants of health. Do you have stable housing? Do you have access to transportation? Do you have a stable food source? All those elements really begin to inform who the person is as an individual. And if you're just treating an episodic care exchange without getting to the fact that they may be transient, they may be moving from this house to this house or this venue to this venue, that's an element of quality of life that I think, if we can begin to look at the person, again holistically from both a healthcare standpoint as well as a social and economic determinants standpoint, we can then begin to point that individual in the right direction to say, have you ever thought about applying for this or have you ever thought about going and working with the Employment Security Commission, to find a job

here? Those are the opportunities that I'd like to really begin to pull again, those full array of government services, around that point when we get them up front and can begin to direct them on a way that really makes, I think, their, their experience with, with the state a very positive one, because they may simply not know that those other resources are available to them.

HOWARD: Thank you, Other-- oh, Senator Walz.

WALZ: Thank you, Chairwoman Howard. Thanks for coming today. I really like when you said meeting the person where they are. I totally agree with that. My question is, sometimes what's preventing that person from getting that job is a medical condition. It might be a mental health condition, it might be a dental condition, it might be vision. How, how can we-- if we're meeting that person where they are, and they're talking about employment or we're getting somewhere with that, but they just can't because of that medical barrier, what can be done if--

MATTHEW VAN PATTON: Well, that's the point of--

WALZ: --they're only getting the basic?

MATTHEW VAN PATTON: Right. That's the point of medical, medical frailty. Some of those individuals may fit into that category of medical, medical frailty. We, we acknowledge that there are going to be individuals who come in, that they may be in a position where they

are looking for that next life opportunity and they want to get there. They just lack the the social resources to get there. But there are going to be some that do come in to this population that will be, by definition, medically frail. And so we know that those individuals may not require the same managed care resources to direct in that, that spot. And I think that ,there again, Senator, that gets us back to what data do we have up front, getting them into that care exchange so that we know who they are from a baseline history and physical, so that we can really begin to align all of those resources around who they, as an individual, are and what their needs, in the system are best suited for them as a person.

WALZ: OK.

HOWARD: All right. Senator Cavanaugh.

CAVANAUGH: Thank you. I feel like we're going to make you very thirsty.

HOWARD: Timoree, do you want to give him more water?

CAVANAUGH: Would you like some more water?

MATTHEW VAN PATTON: Sure. Thank you.

CAVANAUGH: It's been over an hour, seems like maybe we-- you know, we don't want to torture you here. So-- also, I have coffee, so you

should have, you know, had some coffee, too. OK, implementation. And you mentioned, I think it was--

MATTHEW VAN PATTON: Thank you.

CAVANAUGH: --to Senator Howard or perhaps Senator Arch's comments, that we need to start somewhere. And I think we all agree we need to start somewhere. And one of the things that I've struggled with,with the 1115 waiver, is why not just start with the Medicaid expansion first and then do the 1115 waiver, because we are spending this amount of time on the 1115 waiver, not providing healthcare to a massive population in Nebraska? And so I understand that there are lots of reasons to, to put in these practices and this-- I mean, there's been a lot of work and energy by the department, obviously, into, into going through this proposal and this demonstration. And I think there's a lot of value to that, but there's also value to just providing healthcare to Nebraskans now. And so I guess I'm wondering if you could provide a little bit more explanation for us, and for those who are listening who voted for Medicaid expansion. Why have we not just implemented Medicaid expansion out of the gate, back in April, and then moved forward with the 1115 waiver?

MATTHEW VAN PATTON: I think that's a, that's a good question, Senator. And I think to be very, very clear, the-- whether you choose to do waiver or whether you choose to do straight expansion, because of

where we are from a staffing standpoint-- I've already walked you through the labor-intensive piece of our application and what we have to build in these older systems-- we have to hire talent and we have to train that talent to accommodate those that are going to be coming in to the system. And I think three, when you look at who is coming in to this population and you look at what we currently serve today, 76 percent of the Medicaid beneficiaries today are women and children. So if you think about that in the context of a provider network to serve that population, that's pediatricians, also ob-gyns. And in certain parts of the state where those specialists maybe don't exist, that's general practitioners, family medicine doctors that are in the system. Now the, the MCOs do have some of those specialists because of the other portions of the population that we serve, but do we have it to the robustness of needs of those coming in direct as an adult? I'm a 45-year-old man, relatively healthy. but if you look at my counter at home in the bathroom, you'll see a pillbox that has seven pills that I have to take every day. I may not look like I need them, but I promise you I do. And I think that's a piece-- you know, when I look at who I see to get those providers, that there's a urologist in there, there's an internal medicine doctor in there, those are higher functioning specialists in the marketplace to take care of a very pronounced adult population. And those needs, those networks need to be built out. So I'm, I'm getting to your answer. The time piece, whether you went straight expansion or you did the waiver, would still be present

because of those three dynamics. You have to build the networks, you have to change and update the technology, both ours and the MCOs, and you have to have the talent in place to accommodate the application process. There is no way to, no way around it. And I will tell you, whether it's me sitting in this seat or somebody else sitting in this seat, who for the last nine, ten months have dealt with how do you build this product, they're going to be faced with those same challenges, period. What I will tell you about this waiver is that this is our path. This is our up-front opportunity now to use what I would sit or, consider innovations based off those experiences that we've been able to look at what's happened in other states, to look at what kind of a population we anticipate onboarding, to really think about the value that we already derive from our MCO partners today and expand it in a way that we can effectively manage the care over time, is our best hope for bending the cost curve to build a sustainable program, our best hope.

CAVANAUGH: I appreciate that answer. Thank you. I do have additional questions, but again, I don't want to take up if other people want to jump in.

HOWARD: Well, let me-- may I ask you about the-- maintaining private coverage. Can you sort of walk me through what that means? So it--

well, I'm going to have you walk me through the maintenance of private coverage if it's, if it's available. Is that the language?

MATTHEW VAN PATTON: So someone may actually be employed that would hit the eligibility criteria, but through their employer, they have private coverage. The intent is that, if they have the private coverage, they should maintain that private coverage.

HOWARD: Is there is there any consideration for affordability? So if maybe it's unaffordable for them to maintain it, and that's why they're discontinuing that type of coverage?

MATTHEW VAN PATTON: Well, I think certainly there's the eligibility criteria, but if that is available, I think that the intent here is that we, we keep that in place for them as it exists today. As we move forward-- you saw in the, the application that we'll intend to amend the 1115 waiver to work on the HIP program, which is designed, moving forward, that it-- basically, if we look out across the marketplace, if there is a alternative in the market, that you, the coverage can be bought through the private commercial market, we'll, we will buy it there if it's less expensive than bringing them into the Medicaid program. So that will be something that we intend to look at, moving forward in that space.

HOWARD: So it's not that-- I want to make sure I understand this. So it's not, so they're working, they don't-- maybe not for primary care,

but they would have dental coverage offered to them, but they can't afford it. So is it just the availability of the, of the private insurance through your employer, say, that they have to take up the availability option even if they can't afford it? Or is it that they're enrolled, and then it's sort of like woodwork, where they drop that coverage and then they're going to come and try to get [INAUDIBLE]?

MATTHEW VAN PATTON: The intent is to incentivize them to stay with that coverage.

HOWARD: To stay on the current coverage. It's not that you're trying to incent them to take on a new type of coverage that is available to them.

MATTHEW VAN PATTON: Yes.

HOWARD: Nate's, Nate's nodding. That's why I was-- he, he seems very into it. And then I did also have a question, just the nitty gritty-- and I'll look at Nate, as well. For the timely notification of change in circumstances, when does the clock start for the ten days? And are they ten business days? Is it ten calendar days? What does that mean?

MATTHEW VAN PATTON: You know, Senator, that's probably something I'll have to go back and clarify--

HOWARD: OK.

MATTHEW VAN PATTON: --and get an answer on the technical piece.

HOWARD: I figured maybe [INAUDIBLE]. And then, and then when you're thinking about the ten-day clock, what kind of information do you need to supply? Is it sort of like "I lost my job and here's the letter" thing, "I lost my job?" Just very curious about how that clock starts and how many days that means.

MATTHEW VAN PATTON: I think those are process issues that, from a technical management standpoint, we can outline and get a reply back to you.

HOWARD: Yeah, and then, Nate, just as a follow-up, would then you be subsequently required to send sort of your proof of your change in circumstance to your ACCESS worker? Or how, how would that work? Is it sort of like you mail it in to ACCESS, it gets penned and tagged, and then it gets attached to your case file and ACCESS? That's that's-- it's sort of a broader question about the ten days.

MATTHEW VAN PATTON: Yeah, let us, let us outline the process in a formal response, and we'll get back to you, because there are a lot of in, a lot of, lot of moving parts there that I think will help be painted in a more vivid picture if we can outline in a formal response.

HOWARD: Thank you. Other questions? Senator Walz.

WALZ: I have one more question. Thank you. I don't know how to ask this, really. Who? When you're talking about providing, you know, this whole health situation for people, let's say that somebody-- transportation is an issue. Again, you said that, you know, we're going to have a provider provide that transportation. My question is, who's doing that?

MATTHEW VAN PATTON: Um-hum.

WALZ: Like where are those people coming from, and how many where will there be?

MATTHEW VAN PATTON: We already do that today. And in anticipation of the Heritage Health adult population coming in, we carved in ride services, non-emergency ground transportation into managed care, in part so that as our MCOs take on the adult population, the ability to coordinate with their rideshare companies will be able to do that as they're-- let's just say they're working with the beneficiary to set up the appointment. The question can then be asked, do you have a reliable form of transportation to get you there?

WALZ: Um-hum.

MATTHEW VAN PATTON: If the answer is no, then they can go ahead and, at that point, say the appointment is booked with your physician. We're also going to go ahead and coordinate your rideshare at the same time. So it's, it's a synergetic process with the MCOs. And again, the

state, anticipating the adult population coming in, had the foresight to go ahead and carve that service into managed care so that we could take advantage of it as the population was on boarded.

WALZ: And those are the same people that we'll be tracking, missed appointments and all those other, all those other things?

MATTHEW VAN PATTON: Right.

WALZ: OK. Thank you.

MATTHEW VAN PATTON: Um-hum.

HOWARD: Senator Cavanaugh.

CAVANAUGH: Thank you. And thank you again for your explanation about the different types of why you proceeded with 1115 waiver. I am, as I think everyone, and yourself included, are interested in implementing this as quickly as we can in a thoughtful manner. And so I want to take a step back and see if you could maybe go into a little bit more detail about, you know, the process with the federal government. Is it-- I still have concerns that this will be rejected by the federal government, from what we've seen in other states. And if the federal government comes back-- and I think Senator Williams asks questions along this line, as well-- if the federal government comes back with stated problems with, with what is in the demonstration waiver, are, is the department willing to make the changes that the government

wants to see in this waiver in order to implement this on the time line outlined here?

MATTHEW VAN PATTON: Well again, Senator, it's, it goes in and then it's negotiated. So we have made changes to waivers. On the substance use waiver, there were things that CMS wanted to see included in the substance use disorders waiver that we have. It's also an 1115. So again, it's a negotiation. Things are put in, pulled out; it's, it's part of the ongoing process that we have with our partner.

CAVANAUGH: But at the end of the day, if our federal partner says we will not approve this because of X, and there's-- the negotiation is over, that's the end of it. If you don't remove X, we won't approve it,--

MATTHEW VAN PATTON: Right.

CAVANAUGH: Is the department committed to doing whatever it takes to ultimately get us to that implementation?

MATTHEW VAN PATTON: It, it, yeah. Here's what I'll say, Senator. We've been in dialogue with our federal partner, in ways throughout the course of this, that they know what we're doing and, and our intent. We've worked through issues already with them, things that we had intended, as we said in our concept paper, that they said, no, you need to back up or you need to push it this way or push it that way. And I think, if there were red flags that indicated we were going to

have a problem that said what you're doing is so fundamentally off, we would have already heard that by now. I think where you get into this is going to be in the nuance of the negotiations going forward, what technical pieces would get in, stay in, what technical pieces would come out. And again, as I said, that's a negotiation with the federal partners. We haven't fully started on the formal side of this yet. But I am, at this juncture, very optimistic that the work we've done, the relationship that we have, the dynamic of the understanding where we are and what we're trying to intent-- intending to do, I think it's, it's been very encouraging at this point. So I appreciate your concern, but I, I will tell you that I don't believe that it's well-founded at this juncture. And what I would commit to is, if it is well founded, you'll be the first to know.

CAVANAUGH: Well, thank you. I just-- what I'm looking for is just reassurance that we, as, as, as the Legislature and the department are all committed to doing whatever it takes to get this approved and move it forward. And so I mean, I appreciate that it's not necessarily well founded, because of the intricacies that you just discussed. I just-- I'm looking for reassurance that if something is to come up at any point in time, that it becomes critical that we change.

MATTHEW VAN PATTON: Right.

CAVANAUGH: Is the department willing to do what it takes to get this implemented?

MATTHEW VAN PATTON: Senator, there is a ballot initiative that said the state will build an expansion project. What I'm telling you is that this is the path we're on. We've gotten good feedback to get there. I don't see any red flags at this juncture, so I'm very optimistic about where we are. But that said, should something come up, you'll be the first to know.

CAVANAUGH: I bet I won't be the first to know, but maybe the fifth or sixth.

MATTHEW VAN PATTON: Shortly thereafter then. How about that?

CAVANAUGH: I, I have no more questions.

HOWARD: All right. Any other questions? Before we let you go, I wanted to just ask you about staffing and infrastructure. I know you mentioned that you need to sort of staff up your ACCESS call centers.

MATTHEW VAN PATTON: Um-hum.

HOWARD: What does that look like? Where are people going to go? Can you tell us a little bit more about that before you go?

MATTHEW VAN PATTON: Sure. There are several call centers around the state: Scottsbluff; Lexington; Omaha; and there's one more, off the top of my head, I'm blanking on, Senator. And we're--

WALZ: Is it North Platte?

HOWARD: Is it in North Platte?

ARCH: Fremont.

WALZ: Fremont.

ARCH: Fremont.

HOWARD: Fremont.

_____: Fremont.

MATTHEW VAN PATTON: Fremont. Sorry. We are-- as I go through the counts, I think we have now hit to the, to, to date, The Omaha Center staff requirement on the expansion part is full. So I believe we're down to no, zero there. And I think Scottsbluff and Fremont were the two that still had the highest number of folks that we needed to staff up to in those spaces. But we are-- as I said, we've hit half of those numbers already, and we have recruiters that CEO Smith has brought on board to help us with this effort. I'll also tell you something that I found that she did with our staff when they were all together for an annual event. She challenged each one of them to make a referral to a

friend to bring them in to see if they could potentially come in and get a job. And we've had a fantastic response to that. And I think shortly thereafter is when we started getting an increased number of applications and folks coming in so that we were making those hires. So we're doing, I think, extremely well. We're going to continue to work with those folks. And I think it's important to realize, too, that they're being trained in enrollment and eligibility. So these folks coming in, once they're trained, they just get pushed into the mix and they start working on the cases that come in, just like every other case worker that we have. We're also monitoring churn in this particular space. We have about a 12 percent churn rate. And so we do know that we have to keep up with that, but we keep our eyes on it very, very closely. And we also know that our recruitment efforts in this space, they will be ongoing. So it's not like it just will stop at a certain point. No, we will have to continue ongoing recruitment so that we have a pipeline of individuals to come in and fill these jobs.

HOWARD: And then, will you need an additional call center?

MATTHEW VAN PATTON: At this point, I don't believe so, Senator. I think we're certainly looking at options, but right now I believe that infrastructure is, is pretty good the way it is. It may change, but

we, we, we're looking at some different options. But right now, I think we're okay.

HOWARD: OK, thank you. All right. Any other-- oh, Senator Murman, coming in at last.

MURMAN: Yeah, I've been pretty quiet, so I thought I'd-- I have one question that hasn't been covered yet, and maybe it'll be covered later. But as far as the cost to the state, I know after the initiative passed, there were estimates as to what it was going to cost. And I know we're still early in the process. The number of applicants will be a big determining factor. Are-- do you anticipate that, as far as like the number of employees and so forth, that, that this is necessitated? Is everything kind of in line as-- with what was anticipated? Or are we over or, by some miracle, maybe under it? Or--

MATTHEW VAN PATTON: Are you talking about--

MURMAN: Yeah--

MATTHEW VAN PATTON: --just on the folks that--

MURMAN: On, on the cost--

MATTHEW VAN PATTON: --we need to onboard?

MURMAN: --to the state--

MATTHEW VAN PATTON: Yeah.

MURMAN: --of the Medicaid expansion.

MATTHEW VAN PATTON: I think, from our request in this biennium, we're good.

MURMAN: OK, thank you.

HOWARD: All right. Any other questions? Seeing none, you are off the hook. Thank you for visiting with us.

MATTHEW VAN PATTON: Well, you filled me full of water; you're in-- just in time [LAUGHTER].

HOWARD: Yeah. The committee will take a brief ten-minute break. We'll reconvene at 3:15.

[BREAK]

HOWARD: Good afternoon. We'll continue our 1115 waiver proposal hearing, per our Statute Section 81-604, and invite any public testimony wish, wishing to speak to us. So our first testifier? Good afternoon.

ANDREA SKOLKIN: Good afternoon. Chairwoman Howard and members of the Health and Human Services Committee, my name is Andrea Skolkin; and that's A-n-d-r-e-a S-k-o-l-k-i-n. And I am the chief executive officer at OneWorld Community Health Centers in Omaha, and here today

representing the Health Center Association of Nebraska and our seven federally qualified health centers that serve over 100,000 Nebraskans annually. We have a firm belief in, and commitment to, ensuring that all Nebraskans deserve access to high quality, comprehensive healthcare, including medical, dental, behavioral health, and vision services. It is in this spirit that I come to provide testimony regarding implementation of Medicaid expansion, as proposed in the draft 1115 waiver. Nebraska's health centers historically have experienced one of the highest rates of uninsured patients compared to health centers nationwide, with nearly 50 percent of our patients lacking health insurance. And while we serve everyone that comes through our doors, regardless of insurance status or ability to pay, we do not provide secondary or specialty care services, nor do we have clinics in all parts of the state. But we do witness daily the struggles caused by being underinsured or uninsured. The opportunity to expand Medicaid in Nebraska is pivotal to ensuring consistent medical, behavioral health, dental, and vision services for all Nebraskans. We build the proposed 1115 waiver will create barriers to accessing and maintaining healthcare coverage. In addition, the reporting requirements will place an undue burden on providers and may further reduce an already limited pool of Medicaid providers. Many of the questions that you asked today are within our comments. First, the tiered benefit structure is likely to cause disruption in treatment plans, particularly considering oral health will not be covered under

the basic tier. Health centers find that patients accessing oral healthcare, especially initially, present with persistent needs and that may take a series of appointments to address them. If a patient is moved between benefit tiers, access to coverage may be lost midtreatment, resulting in disruption or discontinuation of those services because the patient is unable to afford care. The waiver assumes that nearly one-third of Medicaid expansion enrollees will be in that basic tier, meaning they will lack access to critical dental and vision services. Second, wellness and community engagement, engagement requirements have been demonstrated to be a barrier to accessing and maintaining coverage. With respect to wellness requirements, it is unclear who will be responsible for tracking those missed appointments, and it, we feel, is likely to fall upon the providers. The process of assigning patients currently to providers by Heritage Health managed care companies is very complex. Our health centers report that as few as 25 percent of the patients attributed to them by the managed care companies are actually seen in the health centers, and there is not a simple process for attributing these patients to the correct providers. Documenting when appointments are missed or that annual wellness visits have occurred is very difficult when the roster of patients assigned to the health center is problematic and, in some cases, we don't even have it. Moreover, only allowing a ten-day period to which to notify DHHS of beneficiary changes is an incredibly narrow time frame that's likely to result in

a high rate of churn from prime to basic coverage. Community engagement requirements, as was talked about early, have been struck down in three other states already and have been shown to result in thousands losing coverage. Evidence indicates that this was largely driven by confusion and reporting burden due to additional red tape created by the waiver rather than actual noncompliance. Just last week, Arizona announced the delay of implementation of work requirements, given the uncertain and high administrative cost, and now Michigan is considering the same path. As it yesterday, Indiana has also announced they will suspend their work requirements because of pending litigation. Given the recent actions of other states and pending litigation, it seems administratively and fiscally irresponsible for Nebraska to pursue community engagement requirements at this time. As providers who work directly with the individuals who will benefit from Medicaid expansion and be impacted by the requirements of the 1115 waiver, we have concerns about any program restrictions that hinder access to coverage, increase that administrative burden, and increase the overall administrative costs of the program. We are committed to working with DHHS and the Legislature to ensure that Medicaid expansion is implemented in a way that meets the intent of the ballot initiative and ensures all eligible individuals can have access to these vital benefits. And I'd

be happy to answer any questions. And thank you for the opportunity to speak with you today.

HOWARD: Thank you. Are there questions? Senator Arch.

ARCH: I do have a question. Thank you for coming. This might be an extremely technical question, but is some oral health covered under medical benefits and some under dental benefits? Is there a, is there a, is there a medical situation that would require oral health? Do you, do you know?

ANDREA SKOLKIN: I would not be an expert on that question, but oral health is under oral health. I believe, like in commercial assure, in insurance when there is like an accident that might cause severe damage to the teeth, that may be covered under the medical side. But I believe most is under the oral healthcare.

ARCH: Yeah, I--

ANDREA SKOLKIN: And there is a Medicaid, currently, limit to how much care that can be provided to a patient.

ARCH: I'll, I'll look into that myself--

ANDREA SKOLKIN: Yeah.

ARCH: --because, I mean, I think of a patient with a major infection in the jaw--

ANDREA SKOLKIN: Um-hum.

ARCH: --and so forth, you know. Is that oral health? Is that medical? And, and anyway. But I'll look into it; thank you.

ANDREA SKOLKIN: Yeah. That would be regular oral health care.

ARCH: OK, thank you.

ANDREA SKOLKIN: Um-hum.

HOWARD: Senator Williams.

WILLIAMS: Thank you. And thank you for being here. And in previous testimony, you have always testified in a critical manner of a tiered system. I think that that's obvious.

ANDREA SKOLKIN: That would be--

WILLIAMS: And my question is very basic. From, from the standpoint of, of who you represent, would you rather have a single-tiered system that did not include prescription drugs, dental, or a tiered system where there was a possibility of people achieving those coverages?

ANDREA SKOLKIN: Senator, that's a difficult question to answer.

WILLIAMS: It's meant to be.

ANDREA SKOLKIN: Yes.

WILLIAMS: It's meant to be a difficult [LAUGHTER], because that's the question we're faced with.

ANDREA SKOLKIN: I would prefer a tiered system, as was described here, that all people would be enrolled in the prime system and then, if there was to be a tier, a lower tier for a disincentive for not complying.

WILLIAMS: I thought I asked a yes or no question. And I, I would rephrase the question and ask, would you rather have a single tier that did not have those coverages or the possibility of coverage with a multitiered system? We only get to push a red and green button.

ANDREA SKOLKIN: Yeah, it's a no-win answer for me, Senator, but I would have to say the tiered system.

WILLIAMS: Thank you.

ANDREA SKOLKIN: Um-hum.

HOWARD: Other questions? Senator Hansen.

B. HANSEN: I just want a little-- thank you. I just want a little clarification about one of your main contentions. You mentioned Indiana, Arizona and some others-- Michigan and some other states--

ANDREA SKOLKIN: Um-hum.

B. HANSEN: --that are implementing work requirements. It's my understanding, are, we're not doing work requirement, work requirements, work requirements with our Medicaid expansions; It's more community-based engagements. Those are totally different things, from my understanding.

ANDREA SKOLKIN: Senator, my under, your understanding is correct. However, I think it can be work or volunteer kind of position for 80 hours. And in what we anticipate to be the population that will be enrolled, there are many that live complicated lives where those 80 hours, where, whether volunteer or paid, may be a challenge.

B. HANSEN: OK.

HOWARD: Senator Cavanaugh.

CAVANAUGH: Thank you, Chairwoman. Thank you for being here. How does Medicaid current benefits that your clients receive-- how does that compare? Is it more aligned with the basic or with the prime cover, proposed coverage in the waiver?

ANDREA SKOLKIN: Thank you, Senator. It's more aligned with prime.

CAVANAUGH: OK.

ANDREA SKOLKIN: Current Medicaid recipients receive coverage for their preventive care, as well as restorative care.

CAVANAUGH: So this would--

ANDREA SKOLKIN: And they don't go on levels.

CAVANAUGH: So you already-- so back to Senator Williams' question of one type of coverage versus tiered coverage. You currently-- your clients do receive one type of coverage. It's just not the coverage that we were just discussing. It's the prime, not the basic.

ANDREA SKOLKIN: That is correct.

CAVANAUGH: OK. Thank you.

HOWARD: Other questions? I'll ask Senator Williams' question in a different way. Would you prefer just current coverage or would you prefer the tiers?

ANDREA SKOLKIN: Oh, Chairwoman Howard, the current coverage is far superior to moving into more regulated kinds of coverage. And the opportunities of moving between two is very complicated.

HOWARD: One other question. We heard from the director that they've set up eligibility and enrollment stations and federally qualified health centers. Do you know which ones and where?

ANDREA SKOLKIN: I do not have the answer to that. I know as of this day, I have not been included in those discussions. I do not believe any of the other health centers have either.

HOWARD: OK, thank you. Any other questions? Seeing none, thank you for your testimony today.

ANDREA SKOLKIN: Thank you.

HOWARD: Nice to see you.

ANDREA SKOLKIN: Thank you.

HOWARD: Good afternoon.

DEB SCHARDT: Good afternoon. Chairwoman Howard, members of the committee, my name is Deb Schardt, De-b S-c-h-a-r-d-t. I'm a public health dental hygienist, representing the Nebraska Dental Hygienists' Association. The Nebraska Dental Hygienists' Association does not support the removal of dental benefits through the 1115 waiver. Currently, over one-half of the 93 Nebraska counties are in a dental shortage area. One-third of Nebraskans have not had a dental visit in the last year, and 80 percent of American adults have some form of gum disease. Less than one-third of Nebraska dentists even take, accept Medicaid as a payment source. By adding additional burdens on people to get the dental care that they need, we are setting ourselves up for bigger costs down the road. The number of Nebraska emergency room visits from nontraumatic dental conditions have dramatically increased over time. For example, there were 4,829 visits in 2003, and almost doubled to 8,213 visits in 2015. This equates to an average of $1,375 per visit in 2016, leaving total emergency room visits for dental

conditions a staggering $10 million in 2016, as compared to $1.4 million in 2003. The mouth-body connection is one that cannot be denied. Ninety five percent of Americans who have diabetes also have periodontal disease. Treating gum disease lowers annual medical costs associated with diabetes, stroke, heart disease, and preterm low birth weight babies. Oral bacteria have been implicated in the development of Alzheimer's disease and dementia. People with gum disease are nearly twice as likely to suffer from heart disease. Bacteria in the mouth have been linked to oral, esophageal, lung, colorectal, pancreatic and breast cancers. Oral bacteria travels through the bloodstream and can have an effect on many organs and processes. Having gum disease can also interfere with the success of joint replacement surgeries. Poor oral hygiene is common in elderly populations, further increasing the risk of aspiration pneumonia. Aspiration pneumonia causes high mortality in nursing homes, where it is the second most common infection, with a prevalence between 30 to 70 percent. This is also a huge expense when it comes to hospital readmissions for this bacterial infection. Nebraska public health dental hygienists have worked to meet the needs of the underserved in the places where they live, work, and go to school. In 2018, these hygienists provided over 100,000 services. Only about 40 percent of these were reimbursed by Medicaid. As a public health provider, navigating the Medicaid system is cumbersome enough without these additional tiers and restrictions. It is obvious that the Heritage

Health adult program with this waiver will not achieve the goals of the quadruple aim: to improve the patient experience of care; improve the provider experience of care; improve the health populations; and reduce the per capita cost of healthcare. Thank you for your time. And if anyone has any questions, I would be happy to answer.

HOWARD: Thank you. And before we go to questions, do you want to tell us what this handout is about?

DEB SCHARDT: That is the medic-- or the emergency room visits for Nebraska. And I don't have that one in front of me-- oh yes, I do. So it just shows that, from 2009 to 2016, the increase in utilization of emergency rooms for dental problems. And in answer to your question, Senator Arch, earlier, I think a lot of times what happens in the emergency room situation, if someone has an abscessed tooth, they'll be given an antibiotic and a pain medication and-- pain medications probably cheaper-- so they'll do the pain medication and not the antibiotic. They're referred to a dentist, but there again, there's not-- dentists that accept Medicaid are few and far between, especially in rural areas.

HOWARD: Thank you. Are there questions? Senator Hansen.

B. HANSEN: Thank you. Thanks for coming and testifying.

DEB SCHARDT: Um-hum, yeah.

B. HANSEN: Just a quick question about one of your stats. When you say the average cost per emergency room visit for dental conditions was $712 in 2012, and it pretty much doubled in four years, why do you think that is? That seemed kind of staggering--

DEB SCHARDT: Yeah.

B. HANSEN: ,--in four years that it doubles.

DEB SCHARDT: Because I think people don't-- they're-- it's so hard for the clientele that we see to be able to even get a dental visit if they need it, if we refer them to a dentist. I think that's their-- that's their dental home is the emergency room. For costwise, you mean?

B. HANSEN: Um-hum, yeah.

DEB SCHARDT: Not the number of--

B. HANSEN: It just seems like it would-- doubling in four years--kind of not-- I would assume some of that's maybe to do increase in diabetes and other kinds of stuff that might affect oral health.

DEB SCHARDT: Right.

B. HANSEN: But--

DEB SCHARDT: Right.

B. HANSEN: All right. It just seems like--

DEB SCHARDT: It's all, it's all connected. Unfortunately, we just kind of siloed everything.

B. HANSEN: Oh, OK.

DEB SCHARDT: And we should be in clinics, hospital-- or hospitals, doctors' offices, working together as opposed to being siloed.

B. HANSEN: All right, thank you.

DEB SCHARDT: Um-hum.

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

DEB SCHARDT: Um-hum.

HOWARD: Our next testifier? Good afternoon.

MARY SPURGEON: Good afternoon. My name is Mary Spurgeon, M-a-r-y S-p-u-r-g-e-o-n, and I speak today on behalf of myself, a citizen of Nebraska who has advocated for the expansion of Medicaid for six years, through the legislative process, and as a volunteer in 2018, collected signatures In Sarpy, Douglas, Cass, and Scotts Bluff Counties through the initiative legislative process, for Initiative 427. I have a passing interest in this issue. First, thank you to Senator Walz for your wisdom and foresight in introducing this

oversight bill, LB468. And thank you also to the Unicameral, who were equally wise in passing it into law. I commend the Department of Health and Human Services for submitting to the federal government, by April 1, 2019, the state plan amendment indicating Nebraska's intention to expand Medicaid; well done. However, I am alarmed because provision 2 of Section 2 of Initiative 427 is the only one of the four provisions requiring the action of the department, with which DHHS has complied. Section 2, number three of the law states, "(3) The Department of Health and Human Services shall take all actions necessary to maximize federal financial participation in funding medical assistance pursuant to this section." Postponing implementation to your 2020, through this waiver, ensures that the state of Nebraska will not receive $460 million in federal matching funds for this year, a clear violation of this section of the law. The waiver plan, which requires people to engage in certain activities, including-- well, I guess not work requirements now, but, but volunteer and pretend-- like you pretend your working-- is or is also a violation of Section 2, number four of the law, which states, "(4) No greater or additional burdens or restrictions on eligibility, enrollment, benefits, or access to health care services shall be imposed on persons eligible for medical assistance pursuant to this section than on any other population eligible for medical assistance." Finally, Section 2, number 5 reinforces the status of provisions 1 through 4 of Section 2 stating, "(5) This section shall apply

notwithstanding any other provision of law or federal waiver." Even the attempt to implement the proposed waiver appears to violate Section 2, number 5 of Initiative 427. Clearly, the waiver proposal is new legislation, not mere administrative guidelines. Therefore, it violates the Nebraska State Constitution, which states, "Article II, Distribution of Powers, Section 1, Legislative, executive, judicial. (1) The powers of the government of this state are divided into three distinct departments, the legislative, executive, and judicial, and no person or collection of persons being one of these departments shall exercise any power properly belonging to either of the others, except as expressly directed or permitted in this Constitution." The administrators of the Department of Health and Human Services, Danette R. Smith and Dr. Matthew Van Patton, seem to be well-educated, educated, qualified professionals for whom comprehending Initiative 427 would not be difficult. Is it possible that they are not aware that, as citizens of this state, they, too, are to follow the law and the Constitution? Or have they been given orders requiring them to break the law? By delaying Medicaid expansion, they are sentencing to an early death approximately 500 people per year who urgently need care. Postponing implementation through this waiver ensures that the 93 counties in Nebraska will not receive their share of $460 million in federal matching funds for this year, which could be used to support their hospitals and nursing homes, and reduce their counties' property taxes. This is harming individuals and entire communities.

The executive of Nebraska state government is failing in his role to execute. Clearly, for a man who purports to value the rule of law, he has lost his way. May someone in his sphere of influence please have a "come to Jesus"-- or Mohammed or Buddha or Krishna or Moses or other source of ethical values-- meeting with him and remind him of his sworn duties under the Nebraska Constitution. See Article 4, Section 6. This waiver should be trashed and Medicaid expanded as required by law. If I can be of any help in averting this approaching train wreck for the state, please don't hesitate to contact me.

HOWARD: Thank you. Are there questions? Seeing none, thank you for your testimony today.

MARY SPURGEON: Thank you for listening; appreciate it.

HOWARD: Our next testifier? Good afternoon.

KATHY WARD: Hi. Good afternoon, Chair Howard and members of the Health and Human Services Committee. My name is Kathy Ward; that's K-a-t-h-y W-a-r-d. And thank you for the opportunity to testify on the 1115 waiver project that is proposed by Nebraska Department of Health and Human Services. I'm here today on behalf of AARP, as a volunteer-- AARP-Nebraska. AARP is a nonprofit, nonpartisan organization that works across Nebraska to strengthen communities and advocates for the issues that matter the most to families and to people who are aged 50 and above. AARP's Public Policy Institute estimates there are more

than 19,000 Nebraskans between the ages of 45 and 64 who are currently uninsured, who have incomes below 138 percent of poverty. Expanding Medicaid will help those who've lost their jobs, are caring for loved ones, or are struggling in jobs without health benefits. We have concerns that the 1115 proposal is not consistent with the primary objective of Medicaid to provide access to a central healthcare. Expanding Medicaid with cumbersome requirements is likely to worsen health outcomes, create financial hardship, and increase administrative costs, all while resulting in uncompensated care for healthcare providers and exacerbating access issues. When Initiative 427 passed, Nebraskans voted to include medical services through Medicaid for 90,000 low-income residents. They did not vote to redesign the Medicaid program, as currently being proposed in the state plan amendment, or vote for a nearly two-year delay. The delay fails to capture $149 million in federal reimbursement, while also further delaying access to Medicare-- or to Medicaid. The proposal will involve most of the adult population in need of basic or prime coverage, and having two levels of coverage with different requirements, frequent redeterminations, and implementation of work requirements will lead to ongoing significant movement between the two programs. Taking away dental, vision, and over-the-counter prescription drug benefits could cause conditions to worsen and increase healthcare costs in the long term. Often over-the-counter medications, as discussed, will keep a beneficiary out of the hospital

or the ER. And as well covered, research shows a collaborative relationship between oral health, vision health, and overall wellness. Gum disease is linked to a host of illnesses, including heart disease and diabetes. Regular eye exams assist in detection of serious medical problems, such as: high blood pressure; diabetes; and some cancers. Providing prime coverage to all beneficiaries will eliminate confusion and the unnecessary two-tiered system, and reduce administrative burdens to the state and to providers. AARP has opposed, both here and across the states, the imposition of work and community engagement requirements in Medicaid. Not only are work requirements counterintuitive to the intended program benefits, but they also create an increasing cost. According to the October 2019 Government Accountability Office study, administering work requirement waivers was estimated to cost anywhere from $10 million to over $250 million in five of the states that it reviewed. We recognize the importance of wellness visits, but we struggle with the additional hurdle that it might create. A lot of factors, such as transportation, childcare, and limited provider office hours, inhibit the ability of the beneficiary to be compliant. AARP believes the work community requirement is not necessary. According to the Kaiser Family Foundation, about 60 percent of nondisabled adults under 65 who are on Medicare are employed. The large majority of persons are already working, they're ill, they're disabled, they're taking care of home and family, or they're going to school. AARP believes any work community requirement must include

clearer exemptions for family caregivers beyond those that are proposed by the state. We strongly urge consideration to ensure that family caregivers, regardless of their direct, familiar relationship are exempted from these work requirements. Regardless of their blood relation, family caregivers in Nebraska are providing millions of hours of uncompensated care. Defining how tracking and increased outreach will be provided to reach low health literacy individuals, those with no Internet access, as well as those with disabling conditions, will remain critical. It's unclear how an individual or a provider or an employer will document the work, community, or wellness requirements. And any new reporting system will impose administrative burdens. As part of the proposal, those entering the adult Medicaid program would be subject to redetermination eligibility every six months, instead the current annual review. At least that's what's written in the proposal. This could lead to a large number of people with increased movement in and out of the tiers, while also creating confusion and loss of reimbursement to providers. Eliminating retroactive eligibility undermines current policy that allows the effective date of coverage to go back three months prior to the month the application was filled. The goal of retroactive enrollment is to ensure people receive the care when they need it, without incurring medical debt. As the program is implemented, it's vital that outreach, education, and ongoing support to all eligible Nebraskans be made available. Working with existing public health programs, such as Every

Woman Matters, can provide much of the experience, and the expertise, and community connections for success. The outreach needs to be culturally and linguistically competent and accessible to people with disabilities. Resources and supportive services, such as job training, child care, transportation, and assistance with reporting, need to be widely available. Healthcare is a basic human right. AARP supports the adult Heritage Health program because it provides coverage for hardworking Nebraskans. Expanding affordable coverage, without delay and additional hoops to jump through, gives those eligible access to care that saves lives and reduce costs. We thank you for the opportunity to comment. We appreciate the department's work on the initiative, and we appreciate the opportunity to express our thoughts and our concerns.

HOWARD: Thank you. Are there question? Seeing none, thank you for your testimony today.

KATHY WARD: Thank you.

HOWARD: Our next testifier? Good afternoon.

JORDAN RASMUSSEN: Good afternoon. Chairwoman Howard and members of the committee, my name is Jordan Rasmussen, J-o-r-d-a-n R-a-s-m-u-s-s-e-n. I serve on the policy staff at the Center for Rural Affairs. Rural Nebraskans are at a distinct disadvantage in their ability to access healthcare coverage. Combined with limited availability of healthcare

providers and facilities, this disadvantage grows as consideration is given to the socioeconomics of healthcare access. Rural populations are older, have fewer financial resources, and have more health concerns than the general population. Nebraskans in the state's rural counties have much to gain with the state's expansion of Medicaid coverage. Of the state's residents that are estimated to be in the Medicaid coverage gap, nearly 36 live, 36 percent live in our rural counties. These uninsured residents account for nearly 4.2 percent of the total rural population. These percentages matter, not only because of the number of rural Nebraskans who are left uninsured, but also for those in their communities who are left to shoulder the higher cost of insurance premiums and the radiating effects of uncompensated care on our healthcare systems. Those who go without health insurance are not just faceless data points. They are hardworking Nebraskans, trying to take care of themselves and their families as residents in our state's rural communities. Those left without coverage include: a daughter trying to to care for an elderly parent while working at a local grocery store; the neighbor who lost his job at the local manufacturer just a few years short of retirement; the new college grad who came home to farm. These are our family members, our friends and neighbors who live and work alongside us, working to care for their families and their communities. And yet they cannot, not access the healthcare they need because of the delay of implementation of Medicaid expansion in Nebraska. And the proposed 1115 waiver stands to impose further

barriers to their care. Take, for instance, dental care coverage, which would become a prime benefit under the waiver. In Nebraska, the cost undoubtedly inhibits residents from visiting the dentist. The American Dental Association found that 54 percent of Nebraskans who had not visited the, their dentist in the past 12 months did not go because they could not afford the cost associated with care. Unsurprisingly, this percentage is significantly higher for low-income households, where 74 percent of which say cost prevented them from seeking care. If you look at it from a higher-income perspective, that's only 1 percent that couldn't afford the cost. When Nebraskans cannot access the dental care coverage they need through planned visits to the dentist office, they go to our emergency rooms. As Ms. Shardt noted before, these visits in Nebraska have nearly doubled, and with a staggering price tag. Of those emergency room visits, more than 28,000 were made by rural residents in our counties. Creating additional barriers to dental health care coverage for current and expansion Medicaid clients through the proposed 1115 waiver will not only exacerbate the utilization of dental-- will only exacerbate the utilization of emergency services for dental care. These are costs that are unnecessarily shouldered by our rural hospitals and communities. Beyond increased premium costs passed onto consumers is the burden faced by rural, rural- and critical-access hospitals. Fourteen percent of rural hospitals' gross revenues come from Medicaid payments. For many hospitals, the ability to provide services to

Medicaid patients allows them to remain viable. Yet it is estimated that Nebraska's failure to expand Medicaid will continue to result in a $1.6 billion loss in reimbursements between 2013 and 2022. When rural hospitals remain open on very narrow margins or ultimately face closure, it's not only residents in the gap that are left without access to care; it affects the whole community. When a hospital closes, behind, beyond the loss and care of basic healthcare access is the economic and social void this leaves. Expansion doesn't cover, doesn't solve all of the challenges in rural healthcare access and delivery, but we demand that there be an expedient and unencumbered implementation of Medicaid expansion here in the state, and to care for the thousands of rural residents and the communities they call home. It's time to move forward with the will of the voters and implement, implement Medicaid expansion without barriers. Thank you.

HOWARD: Thank you. Are there questions? So before you go--

JORDAN RASMUSSEN: Yes.

HOWARD: I was at the Kearney hearing--

JORDAN RASMUSSEN: Yes.

HOWARD: --a couple nights ago. You were there.

JORDAN RASMUSSEN: Yes.

HOWARD: Did you go to the Scottsbluff hearing, as well?

JORDAN RASMUSSEN: I was not there for that one.

HOWARD: OK. Well, so I want to ask you, because I was rereading Director Van Patton's testimony, and he said that-- and I just want to get your feedback on this--

JORDAN RASMUSSEN: Sure.

HOWARD: --'cause I feel like I heard something different, and maybe I'm-- so he said two of the "meetings were held this week, in Scottsbluff and Kearney. Thematically, people have expressed concerns about administrative costs, while also seeking clarification regarding the optional and mandatory components of the benefits package. Others have expressed an appreciation for the state's proposed approach, specifically access to coverage for all eligible beneficiaries, this being a mark of distinction among other states' programs." Is that your impression of what we heard in Kearney?

JORDAN RASMUSSEN: Based on the Kearney testimony, no. That was not what I heard. There was nobody that spoke in support of the waiver that was implemented. Instead, it was stories of people talking about what happens when they were not able to access vision care or dental care, and how that impacted their ability to work and take care of their children. And in fact, there was a story of a woman who said-- was there on behalf of her friend, who had been, has been an advocate

for Medicaid expansion, and he's passed away because he couldn't access care. That's-- those are the stories I heard, and hear in our rural communities all the time. So I'm sorry to refute that, that-- Dr. Van Patton's notes-- but that, those were the comments that I heard.

HOWARD: And then is your understanding, because I know Deputy Director Watson went over how they have to manage the comments that they're receiving, so do-- and you heard it, too. So it was like they have to aggregate this?

JORDAN RASMUSSEN: Yes, I-- it was my understanding, yes, they're going to collect that. They will kind of keep notes, but there's also that the comments will be made public, as well. That was, I think, another question that was asked kind of after we dispersed, so--

HOWARD: Great. Thank you. Are there any other questions? Senator Cavanaugh.

CAVANAUGH: Sorry. Thank you. Do you have any information, or does your organization have any information-- probably not off the top of your head-- but to share with the committee on the potential utilization for the populist, population you represent?

JORDAN RASMUSSEN: Off the top of my head, no, I don't. I don't have that. But I mean, we have, we've put together the, we've put together where folks fall in the coverage gap, and our, our rural counties are

bright red. That's, that's where there are populations of folks that are going uninsured. And so being able to open up this access to care quick--

CAVANAUGH: Um-hum.

JORDAN RASMUSSEN: --more quickly than we are doing currently would help make our rural counties healthier and have broad impacts there.

CAVANAUGH: And could you share what, what you're hearing from rural providers?

JORDAN RASMUSSEN: I haven't heard a lot from rural providers. I have talked with, with Ms. Shardt, that was here previously, and some other folks. They're concerned that, that there is this delay. These people are continuing to show up at their clinics and in need of care, and they're, they're not able to do that. And there's that concern, too-- and maybe there's some others behind me that can speak to this more directly-- but that uncompensated care weighs so heavily on some of those rural, those rural hospitals, I think it's like 43 percent of our rural hospitals are on, operating on like a 2 percent margin. That's that's very dangerous, and it-- I mean, it impacts so many more beyond just those that are uninsured currently.

CAVANAUGH: Thank you.

JORDAN RASMUSSEN: Thank you.

HOWARD: Are there any other questions? Seeing none, thank you for your testimony today.

JORDAN RASMUSSEN: Thank you.

HOWARD: Good afternoon.

MOLLY McCLEERY: Good afternoon. Chairman Howard and members of the Health and Human Services Committee, my name is Molly McCleery, M-o-l-l-y M-c-C-l-e-e-r-y, and I'm the director of the healthcare access program at Nebraska Appleseed. We are a nonprofit legal advocacy organization that fights for justice and opportunity for all Nebraskans. And one of our core priorities is working to ensure that all Nebraskans have access to quality, affordable healthcare. We have a number of concerns about the proposed 1115 waiver to establish the Heritage Health Adult plan. A lot of those have actually been raised in the questions that were asked today. The first point I would like to bring up is that a Section 1115 waiver is not necessary under the statute that was passed by voters through Initiative 427. If you look at Nebraska Revised Statute Section 68-992, a Section 1115 waiver is not required. The language does, does not require or contemplate a two-tiered benefit system, work requirements, wellness requirements. It certainly does not include any information about individuals needing to fulfill nine separate requirements to retain-- excuse me-- dental, vision, and over-the-counter drug coverage, or changes to

retroactive eligibility, which impacts other Medicaid populations outside of the expansion group. Rather, this is an option that our state is pursuing, and I think we've talked a lot today about the administrative complexity. The questions that have been asked and that have been raised by testifiers before me demonstrate that it's extremely confusing. The number of questions that we've gotten, from folks who are in the coverage gap or who are currently enrolled in Medicaid, about how this will apply to them, is really significant. And we have a lot of questions about how this plan will be implemented. Some of the sort of more technical questions about who's tracking what information, who is keeping track of those missed appointments, and things like that. One issue that really hasn't been discussed today, that I think is really important, is who's tracking the work hours. We talked to a lot of folks who are working in hourly-wage jobs-- don't always have the best access to pay stubs to prove up that they're working a certain number of hours. So they're asking questions like, is that on me to go to my employer, get pay stubs? Is my employer, then, going to have an additional burden of monthly providing me with information of how many hours I'm working? I think a lot of the pieces in this are presupposing a system where people have predictable schedules, have hours that you're able to take an hour or take that time off of work to be on the phone doing change reporting, to be trying to report these elements that folks are trying to meet. So just to kind of reiterate, there's questions about how to

prove up those work requirements. I think some of the questions that were asked, that were sort of framed as being process management questions, are actually extremely important to Medicaid enrollees and how that works, and can be things that will mean the difference between getting the prime benefits and the basic package. Our Medicaid benefit-- or a Medicaid system-- should be one in which enrollees have the best chance at health and advancement. And we agree that we should be meeting people where they are, but this plan does not do that. We're concerned that it creates many barriers to care that will actually reduce the health and financial benefits that enrollees could experience through expansion. The only attempt at addressing barriers that were brought up like childcare, transportation, things like that, has been transportation, which is an existing benefit we already provide. There's been discussion about how the number one issue that providers discussed is missed appointments. If transportation is an existing service that we already provide, and not as something where folks are still missing their appointments, I'm not sure how that really addresses the problem. There were discussions about unstable housing, childcare, education. Nothing in this plan addresses someone having the ability to go back to school to get a degree, even if they wanted one. There was also part of the discussion earlier that I have some questions about and, if someone else is able to find this in the waiver proposal, I would be interested in hearing it. But over the past week when we've been reviewing it, the additional periodic checks

on eligibility is not something that is included in the draft waiver. So there is the 12-month eligibility redeterminations, which is the wholesale eligibility redeterminations, the 6-month benefits tier redetermination, but the additional periodic checks for program integrity is not something that is mentioned. And so if that is something that is impacting eligibility for this program, that should be included in the draft waiver. I have a lot of things that I could bring up that folks have brought up to me over this past week. I will say, on that dental issue, that's the number one issue that we hear from people of what they need. And they know exactly what services they've need, needed due to episodic care in the past. We can learn from other states. And even if this is a truly Nebraska-specific approach, what we can learn is that any attempt to put into place barriers or hurdles that people have to go through will be-- the end result will be that folks lose access to that coverage-- the more paperwork, the more challenges, the more likely that folks are going to lose coverage. The last thing that I would say is that we have-- may I?

HOWARD: Finish what you have.

MOLLY McCLEERY: OK. We have additional concerns about the nature of the work requirements, even though they're being kind of framed as being different from other states due to the consequences of noncompliance with them. We would still put forth that the purpose of

Medicaid is to provide medical assistance to folks who cannot afford it, and that taking away benefits due to noncompliance with work does not comply with the purpose and intent of Medicaid. And so I think there are still some legal questions as to the work requirements. So with that, I'd be happy to take any questions.

HOWARD: Thank you. Are there questions?

WALZ: I--

HOWARD: Sure, [INAUDIBLE].

WALZ: I just have a statement, not really a question. But you, you really brought up a good point. I'm curious about the work requirements. Do you have-- how-- I should have asked this before, but do you have any idea how that, how that's going to work? Have you--do you have any idea on how that's going to work?

MOLLY McCLEERY: The only pieces that I think we can pull out of the waiver draft are talking about alignment with the requirements with SNAP and our Aid to Dependent Children program, our TANF program. So I'm not sure if the reporting requirements in this will be similar to how someone reports for SNAP or for TANF. And so I'm, I don't know if that's something that we'll be going to kind of MCOs in that, in that care or case management piece. That doesn't seem to be something that

is contemplated under their current contracts, to do employment counseling and, and things like that, but--

WALZ: Employers have to do the reporting, though? Is that--

MOLLY McCLEERY: It's on the employee, but what we've heard from folks is that it's sometimes difficult to access that information. So for-- will self attestation of how many hours someone is working, will that be sufficient to say you're actually working those hours?

WALZ: Right.

MOLLY McCLEERY: Or will there need to be some sort of proof from your employer, like pay stubs--

WALZ: Verification.

MOLLY McCLEERY: --or something like that.

WALZ: Right. Yeah, that's-- thank you. Just brought up a good point, something to think about.

HOWARD: All right. Other questions? Senator Cavanaugh.

CAVANAUGH: And-- maybe Senator Howard can speak to this, but we do have a draft of the demonstration and it has information in here about this six-month review. But I share your confusion. I'm trying to figure out what page that was on-- page 15. There's a couple of different points where it talks about the six-month review. But when

Director Van Patton was here earlier this afternoon, it seemed-- and maybe I misunderstood, and we'll have to review what he said-- but it seemed like they were just reviewing the benefits-- or the requirements-- and not actually changing them because federally they can only change them every 12 months. So I also am confused, but I do believe that their six-month benefits review is discussed here, but it's still confusing-- not really a question so much as--

MOLLY McCLEERY: Yeah, I think I would echo that. And I, you know, don't want to speak for the department, but I, I will say that, in one of the previous reports to the Appropriations Committee, there was a statement that the initial April 1 plan included the, like the 25,000 parent care, caretaker relatives in the plan and also six-month eligibility determinations. And there was a statement that, due to conversations with CMS, those two pieces have been taken out. But then I think we're sharing your confusion as to whether there is a 12-month wholesale determination of eligibility, eligibility, a 6-month redetermination of benefits tiers, and then a periodic check on eligibility if there are some sort of like paying in the system and then asking folks to kind of prove up their continued eligibility-- and that's the overall eligibility, not the eligibility for prime versus basic, basic. That's just based on what was discussed earlier today.

CAVANAUGH: Yeah. I think it would appear to me-- and we'll have to follow up with the department-- that it's a review of the tier.

MOLLY McCLEERY: OK.

CAVANAUGH: But I don't know, so--

HOWARD: So but I think that this is the confusion, though, because I asked a question. I said how--

CAVANAUGH: Yeah.

HOWARD: --you're going to review these, is this for everyone or is it just for tiers? And he said everyone. So I think that's the confusion. So we may need to follow up and ask them.

CAVANAUGH: Because everyone is moving to tiers.

HOWARD: Yeah. Yeah.

MOLLY McCLEERY: At the end of the day, it's a question that we can--

CAVANAUGH: Yes.

HOWARD: Yeah.

CAVANAUGH: Or four or five questions.

HOWARD: Yeah, right. Right. All right, other questions? Before you go, Appleseed has filed a lawsuit in regards to Medicaid expansion. Do you want to tell us a little bit about the theory of your case?

MOLLY McCLEERY: Sure. So we do have a pending lawsuit before Lancaster County District Court on the timing for implementing Medicaid expansion. It was mentioned earlier, the obligation under Section 68-992 for the state to maximize federal financial participation in expanding this program. Because the federal match drops from 93 percent in 2019 to 90 percent in 2020, our client's position is that the-- that obligation to maximize federal financial participation has not been met if October 2020 is the timeline for implementation. The status of that case-- it is, it is currently pending before the Lancaster County District Court and in briefing right now.

HOWARD: Thank you. All right. Any other questions? Seeing none, thank you for your testimony today.

MOLLY McCLEERY: Thanks.

HOWARD: Is there anyone else wishing to testify? Oh-- you, you don't? No [LAUGHTER], OK. It's like why are you waving your hands? All right. This will close the hearing on the 1115 waiver proposal for Medicaid for Statute Section 81-604. Happy Friday.