HOWARD: 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, District 38, seven counties south of Kearney, Hastings, and Grand Island.

WALZ: Lynne Walz, Legislative District 15, which is all of Dodge County.

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

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

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

HOWARD: Also assisting the committee is our legal counsel, T.J. O'Neill, and our committee clerk, Sherry Shaffer. And our committee pages today are Taylor and Nedhal. A few notes about our policies and procedures; please turn off or silence your cell phones. This afternoon, we'll be hearing four bills and we'll be taking them in the order listed on the agenda outside the room. On each of the tables near the doors to the hearing room, you will find green testifier sheets. If you're planning to testify today, please fill one out and hand it to Sherry when you come up to testify. This will help us keep an accurate record of the hearing. If you are not testifying at the microphone, but want to go on record as having a position on a bill being heard today, there are white sign-in sheets at each entrance where you may leave your name and other pertinent information. Also, I would note if you are not testifying, but have written testimony to submit, the Legislature's policy is that all letters for the record must be received by the committee by 5:00 p.m. on the day prior to the hearing. Any handouts submitted by testifiers will also be included as part of the record as exhibits. We would ask if you do have any handouts, that you please bring ten copies and give them to the page. We do use a light system for testifying. Each testifier will have five minutes to testify. 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, we will ask you to 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. The hearing on each bill will begin with the introducer's opening statement. After the opening statement, we will hear from supporters of the bill then from those in opposition, followed by those speaking in a neutral capacity. The introducer of the bill will then be given an opportunity to make closing statements if they wish to do so. We do have a strict no-prop policy in this committee. And with that, we will begin today's hearing with LB932. Welcome-- Senator Wishart's bill to require expansion of the Medical Assistance Program as prescribed. Welcome, Senator Wishart. Good afternoon.

WISHART: Good afternoon. Good afternoon, Chairwoman Howard and members of the Health and Human Services Committee. My name is Anna Wishart, A-n-n-a W-i-s-h-a-r-t, and I represent the great 27th District in west Lincoln. I am here today to introduce LB932, a bill that would codify, in statute, the deadline by which the Department of Health and Human Services has said they plan to expand Medicaid. As you are all well aware in this committee, in November of 2018, the people of Nebraska, our second house, spoke clearly and directed their government to expand Medicaid to cover low-income parents and childless adults, 19 to 64 years, who fall into a healthcare coverage gap. In April 2019, the Department of Health and Human Services announced that they plan to start coverage for this Medicaid expansion category on October 1, 2020. DHHS has maintained, since that announcement, that the October 1 start date will be met. This bill simply ensures that DHHS adheres to that due date and acts as a safeguard for the thousands of Nebraskans waiting for coverage. Individuals eligible for Medicaid expansion have now been waiting for over a year for coverage since the initiative passed. And I want to ensure, with this bill, that what voters intended is carried out without any additional delays. The average time frame for states who have passed Medicaid expansion, by ballot or legislature, is approximately seven to nine months. And many of those states who have been able to do that in seven to nine months have pulled it off in, in that time frame with much larger populations that they will be covering. Other states who have decided, like Nebraska, to submit a waiver have been able to expand Medicaid coverage while undergoing the waiver application process. In fact, Nebraska is fairly unique in deciding to delay expansion until after the waiver is submitted. I have been told we should expect to hear an outcome of the waiver application around April of this year. If that waiver is denied for some reason, like many other states who have had waivers denied or have had to, to fix some of the issues with their waiver, we can do

what they have done and simply expand our current Medicaid program and get people signed up while working on addressing the issues that caused the waiver to be rejected and submitting another waiver. As a member of the Appropriations Committee, I feel a deep obligation to ensure budget accuracy and predictability. Our committee spent numerous hours planning for Medicaid expansion last year. The budget our Legislature voted on last year includes the cost of Medicaid expansion as revised and updated by DHHS on April 11, 2019. And we worked with them and built our budget for their aid and operation needs based off of their commitment to an October 1, 2020 start date. And if you look at your electric orange budget books from last year, every time that we-- you pretty much mentioned Medicaid expansion in this budget book, the date of October 1 is mentioned as well. Failure to adhere to the October 1, 2020 start date not only potentially impacts our budget for the Medicaid program, but also our programs; 38 behavioral health and 347 State Disability Public Assistance. We calculated a decrease in their need for aid in those programs because it would-- they would be offset by expansion. You can review all of these budgetary decisions in your budget book, but I've also included a copy of the specific page addressing Medicaid expansion for your ease of reviewing it. I believe that due dates are important. They are a very important part of government running efficiently and being accountable to the public. There are many talented people at DHHS working diligently to get this program up and running and I am confident that they will be able to meet their start date on October 1, 2020. This still adds an additional assurance that our government will enact the will of the people. Thank you and I'm happy to answer any questions.

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

WILLIAMS: Thank you, Chairwoman Howard. And thank you, Senator Wishart, for bringing this to us. My question is kind of a-- I'll just ask it. What would happen if we put the date certain in here and something unforeseen happens that we don't project could happen, that could delay that? Is there any kind of mechanism that could protect against that?

WISHART: Well, the reality is that we can do-- we have a fallback option, as many other states have moved forward with, which is just-- we currently have a program that covers people under Medicaid and we can just expand that program while we're dealing with any other issues

related to the waiver or other issues related to the department expanding a program that's different than the current Medicaid program.

WILLIAMS: So from your standpoint, you don't see a risk with that?

WISHART: I-- my goal is that we have already been longer than we should have been in expanding Medicaid and we have an obligation to put in a due date and to adhere to that date that we have promised the people and we need to stick to that. And I have full confidence that people at the Department of Health and Human Services will be able to do that.

WILLIAMS: Thank you.

WISHART: Thanks.

HOWARD: Senator Cavanaugh.

CAVANAUGH: Thank you. This is-- thank you, Senator Wishart. This is sort of a follow up to Senator Williams' question. So by expanding the program, we're not talking about expanding services, we're talking about expanding enrollees, correct?

WISHART: Correct.

CAVANAUGH: And so we're talking about expanding federal dollars that we're drawing down--

WISHART: Correct.

CAVANAUGH: --that the department will pay to the MCOs to administer the program?

WISHART: When I say expand, I mean, we, we could-- if we decided to right now, even while we're undergoing the waiver application process, start to sign people up under our current Medicaid program and just expand our current Medicaid program while we're looking at doing this-- a more intricate waiver system.

CAVANAUGH: Well, I noticed that the department's fiscal note was zero--

WISHART: Yes.

CAVANAUGH: --so I was kind of going towards--

WISHART: Yes.

CAVANAUGH: --the point of this doesn't actually impact the department's operations to that-- I mean, it will to a certain degree, of course, but is it your opinion that it is feasible because they don't have to expand their operations beyond what they're currently doing?

WISHART: Oh. I mean, this, this bill puts in place-- like, it's a belt and suspenders approach. This bill puts in place some suspenders that go along with the belt of the budget that we passed last year and the decisions by the department when we, when we worked with them and talked with them, that they would be able to have the program up and running by October 1. And that date is a date that they have given to us. That's not a date that, that we are pushing on them. That's a date that was publicly announced in April when the department asked for an additional extension because of the waiver. So again, I, I feel really confident that they'll be able to handle that. And the reason there is no fiscal note is the fact that we are putting in statute a date that already is reflected in our budget.

CAVANAUGH: I'm just-- a follow up question: so if this were to be enacted, there's nothing in this that-- if they, if they are successful in the 1115 waiver that they're currently seeking, great, they implement it.

WISHART: Yes.

CAVANAUGH: And then if they're not successful, they just move forward with implementation, but can apply again, correct?

WISHART: Correct. I anticipate-- with the amount of work that they've put into the waiver, that-- I anticipate it will likely go through. And I anticipate then in October, we will start the program. And nothing in this legislation that I bring before you does anything but to assure the public that we will move forward with what we had promised in our budget and the department had promised.

CAVANAUGH: Thank you.

WISHART: Thank you.

HOWARD: Other questions? Just-- and this is-- you will not know the answer to this, but just out of curiosity, are there other ballot initiatives in the state of Nebraska that have taken a year and 11 months to implement?

WISHART: I do not know that offhand, but that's definitely information we could get to you. I anticipate, though, in the time that I've been sort of aware of state government, as a, as a young person in this state and then, and then as a senator, that we have not had the level of concern around a ballot initiative getting implemented, at least from my perspective, than we have with this.

HOWARD: Thank you. Any other questions? Senator Walz.

WALZ: A quick question-- thank you, Senator Wishart. Do you have this in front of you?

WISHART: Oh, yes.

WALZ: I just want a clarification so I understand what this means. Underneath where it says Medicaid expansion-- it's the third paragraph. It says "this revision delayed the operative date for expansion until October 2020 and included a higher amount for administrative costs due to implementation changes."

WISHART: Yes.

WALZ: Do you know-- can you explain that? Do you-- can you explain it a little bit to me, like, what it-- the cost?

WISHART: Right, so and-- so I don't have the exact numbers, but I can get those to you and they're in this budget book here.

WALZ: OK.

WISHART: But last year, during negotiations with the department, when they came before us to talk about the program that they were unveiling, where they would have a two-tiered system and the waiver program, they anticipated additional administrative cost. There are always going to be additional--

WALZ: OK.

WISHART: --administrative costs for expanding Medicaid because you need more staff and you have technology upgrades and all of those kind

of things. But in addition to that, when, when we were working with them, they requested additional administrative costs for running the, the program, as it would be reflected if the waiver is adopted.

WALZ: OK. And then those additional administrative costs now are doubled or, or more because of the time that it has been--

WISHART: No.

WALZ: --because we delayed the implementation, but I understand there are probably initial administrative costs and then we delayed it so now there are more costs?

WISHART: You know, I think-- it's the-- we anticipate that-- can you ask that question again?

WALZ: No, that's OK. [LAUGHTER] I'll just talk to you about it--

WISHART: OK.

WALZ: --because now I'm confusing myself with that question.

WISHART: OK. I'll just-- just to, to clarify, the additional administrative cost came about because of the request by the department for just the need for staffing to do their two-tiered program. And also, there are just additional costs that, costs that come up when you're expanding Medicaid. But we don't foresee-- if we stick to this plan on October 1, I don't foresee there being any additional budgetary changes. I think we put a good budget forth and we reflected the needs of the department.

WALZ: OK, all right.

HOWARD: Can you just elaborate a little bit on the reductions to the state disabilities and the behavioral health and when those go into effect?

WISHART: Yes. So if you-- well, you don't have your budget books, but I gave you that, that sheet in front of you. I'm actually going to go to the notes here, though, so hold on for one minute. So what we anticipate is that when we expand Medicaid, there will be a certain population of people that are currently utilizing those two programs that I mentioned that will now be covered. And so we reduced the amount of aid that we anticipated would go towards those programs because we increased it in the Medicaid expansion aid that we

anticipate happens. And you know, I talked with the Fiscal Office and I would-- I want to be really clear here. I anticipate that, that no matter what happens if, if that due date is not met, we will be able to, to manage those budgets in terms of aid and, and correct that. But in terms of predictability and accountability with the budget, it is concerning that we have already made decisions about different programs in terms of what their needs would be. And if we don't meet that due date, then we are, you know, then we are not sticking to, to what we had originally intended with our budget.

HOWARD: OK. So these reductions won't go into effect until, until Medicaid is expanded?

WISHART: No, they will-- that's in our budget.

HOWARD: Oh, OK.

WISHART: We have budgeted for that.

HOWARD: OK.

WISHART: The Legislature passed those reductions in aid. So we would have to come back next-- if the October 1 deadline is not met, we would need to come back next year and rebudget aid and shift that around so that we can right those programs.

HOWARD: All right. Any other questions? Thank you, Senator Wishart.

WISHART: OK.

HOWARD: Will you be staying to close?

WISHART: I won't; I've got another hearing to be at.

HOWARD: OK.

WISHART: Thank you.

HOWARD: Thank you so much. All right. Our first proponent testifier for LB932. Good afternoon.

KATHY NORDBY: Hello. Thank you, Senator Howard and members of the committee. I am Kathy Nordby, K-a-t-h-y, Nordby is N-o-r-d-b-y. I'm going first. I don't even remember how this goes from last year. So good afternoon and thank you, Chairman. I am Kathy Nordby and I'm here today representing the Health Center Association of Nebraska and our

seven community health centers. I'm the CEO of Midtown Health Center in Norfolk and I'm representing the, the health centers. And we provide comprehensive, culturally-appropriate care to over 100,000 patients and we have 69 different locations across the state. As a health center, we, of course, are the safety net and 47 percent of our patients are uninsured currently and over 93 percent are low income. Today we are here in strong support of LB932. And I'm going to drift a little bit from some of the language here, but it's-- these are true statements, but in essence, that by setting the date and holding the date, you can help us be ready to plan and prepare and assist people in enrolling. I think if you were to ask the average voter out there whether they voted for it or against it, everybody believes it's already in place, unless they're politically involved or, or suffer the consequences of this. But we're direct frontline workers and we have staff, 30 staff, I believe, serving over 69,000 people every year and helping them stay enrolled, keep their enrollment, get enrolled, and we get-- one of the most frequently-asked questions is about am I eligible for Medicaid now? Can I get it now? And so we really want to respond for that and plan for that. And the more notice we have, the better we can be prepared for that and get the support that we need in place, into our education so that we have good consumers of the, of the extra eligibility. And that's really where we're asking for that. And I think as the previous speaker talked about, is, is the ability and the impact on the budget and knowing where you stand. If they were to move the date, if-- I've already hired an extra provider and some of our staff are at capacity or some of our facilities are at capacity so if you added a provider and then the expansion doesn't hit, that-- you know, I have a tight budget and I can't keep people on if I don't have the people to see them. And so we want to make those decisions and having that concrete date can really help us and I think help everybody and just hold to that. So that, kind of, summarizes what's all in the notes here. But we really do support LB932 and we hope you will as well.

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

KATHY NORDBY: Um-hum, thank you.

HOWARD: Our next proponent testifier for LB932.

KATHY WARD: Good afternoon.

HOWARD: Good afternoon.

KATHY WARD: Chair Howard and members of the Health and Human Services Committee, my name is Kathy Ward. I'm another Kathy. It's K-a-t-h-y W-a-r-d. I'm here as a volunteer to testify for AARP Nebraska in support of LB932. I've volunteered for AARP Nebraska since the date that I retired from the Department of Health and Human Services six years ago because AARP is such an important voice for legislation and programs that improve the health and welfare of Nebraskans. Its support of Medicaid expansion throughout the years has been debated in Nebraska, has been a prime example of AARP's force for good. Although the primary population for AARP's advocacy are people aged 50 and older, I've long admired the recognition that persons in this age group care just as deeply about their children, their grandchildren, and the community at large, as they care about themselves. Medicaid expansion is critical for all of these populations. People who are 50 and over, in their pre-Medicare years, all too often find themselves without insurance. Many have lost their jobs through no fault of their own. They've had layoffs, corporate restructuring, or they're just not able to cope with the physical demands of their jobs. Or in a lot of cases, they find it necessary to leave their job to care for loved ones such as an elderly parent. Age discrimination is still an unfortunate fact, so finding a new job with health insurance or a decent salary may be difficult or impossible. But another part of AARP members' interest in Medicaid expansion is in the needs of those younger family members, friends, and neighbors. Over and over again, I've heard the words that person in the coverage gap is me or that person in the coverage gap is my child, my son or daughter, or my grandchild or is my hairdresser or it's the person that comes over to shovel my walks for me. Back in November of 2018, voters heard both sides and they carefully weighed facts and they made a clear decision to approve Medicaid expansion. They did so after six years of waiting for the Legislature to adopt Medicaid expansion and follow the lead of most of the other states. They expected and they had every right to expect that the state would listen and enact this important program quickly. It's interesting that Idaho voters made the same decision at the same time and enrollment in their program began on November 1 of last year and coverage for the enrollees began on January 1 of this year. Nebraskans have waited long enough. Waiting past the October 1, 2020 implementation date chosen by DHHS would be extraordinarily unfair to the voters, to the people, the volunteers who worked for the passage, and most importantly, to those Nebraskans who have been waiting all this time for health coverage. Although there's long been

debate on the benefits of Medicaid expansion, it bears mention that there are new studies and that these studies continue to demonstrate advantages to the states that have implemented it. Among those benefits are increases in early diagnosis of cancer or better access to cancer surgery and improved treatment of opioid care. Economic benefits that have been found in recent studies show a reduction in the U.S. poverty rate and improvements in employment in the labor market. And most analyses that looked at rural-urban coverage find that Medicaid expansions had a particularly large impact on reducing uninsured rates in rural populations. A new study in Louisiana found that they derived an additional $103.2 million in overall state tax receipts and that exceeded the state budget-- dollars budgeted for the Medicaid expansion program by close to $50 million. And beyond the benefits to the larger community, there are important benefits to individuals, including people who can buy their insurance through the marketplace. Two national studies showed that marketplace premiums were significantly lower in expansion compared to nonexpansion states, with estimates ranging from 7 percent lower in 2015 to 11 to 12 percent lower in a later study that looked at 2015 to 2018 data. So I will conclude to say that respect for the will of the voters in Nebraska and with the knowledge that anything can happen to delay waiver proposals to the federal government, we ask that you move LB932 from committee to the legislative floor and we ask that you use your considerable influence to convince your fellow legislators to pass that bill. Thank you so much for the opportunity to comment.

HOWARD: Thank you. Are there questions? All right, seeing none, thank you for your testimony today. Our next proponent testifier.

ASHLEY FREVERT: Good afternoon.

HOWARD: Good afternoon.

ASHLEY FREVERT: Chairperson Howard and members of the Health and Human Services Committee, my name is Ashley Frevert. That's A-s-h-l-e-y F-r-e-v-e-r-t, and I serve as the executive director for Community Action of Nebraska. We are the statewide association for Nebraska's nine community action agencies. I'm here today to express Community Action's support for LB932. Community Action is about dedication to the elimination of poverty and committing ourselves to a battle of helping each other overcome immense barriers like hunger, inadequate and unaffordable housing, unemployment, discrimination, and insufficient health and social services. Just one unexpected medical bill, one car repair, one notice, or one layoff can change our

circumstances. We believe that poverty can and will be eliminated because serving the best interest of those experiencing poverty is in the best interests of everyone. We know people have the potential for change. Even further, we believe systems can change. The timely and successful implementation of Medicaid expansion in Nebraska is exactly that. It's a systematic change that is meant to promote and ignite lasting effects. Community Action of Nebraska saw the potential-- excuse me-- Community Action of Nebraska saw the potential in Medicaid expansion would bring to our state as a recipient of the federal Navigator Grant from 2013 to 2018. And we continue to support the benefits provided by the Affordable Care Act to those who serve. Also, personally, I was a navigator for 14-plus counties in northeast Nebraska from October of 2013 through November of 2017. So through most of those years, I was helping in that capacity. However, in Nebraska, with the thousands who fall in the coverage gap, what is needed at this pressing time is for our government to work quickly, efficiently, and for them and their families. It is both lawful and ethical to give residents of this state what they need when they need it most and what it is that they asked for, as they've worked so hard to get to where we were when Initiative 427 passed. Our nonprofit organizations and for-profit businesses often need to be creative with the limited funds we have to meet specific needs of communities. But our government has the opportunity to directly influence, implement, and change systematic inefficiencies that cannot be addressed by any other body. It is the uniqueness of our Legislature that allows us to speak directly to senators and express our plea for a government that operates well and in alignment with the values and needs of everyone living here. People are essentially the government and this is the time when we must work together for the health of people now who cannot wait for the well-being of our future generations because we cannot keep them waiting. All people from every region, every county, every community, both rural and urban, deserve a successful implementation of Medicaid expansion because it has not only health-related impacts, but positive social and economic impacts that will be felt for years to come. Lastly, we believe it is imperative that our government, its divisions and departments, be held to a high standard because hardworking Nebraskans-- that's low-wage earners included-- deserve nothing less. Our successful partnership and success for the Department of Health and Human Services is fulfilling this commitment to our communities, neighbors, coworkers, and family members without extensions, roadblocks, or barriers. We ask that the

committee please support LB932 and I'm happy to answer any questions you have.

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

ASHLEY FREVERT: Thanks so much.

HOWARD: Our next proponent 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. As we've talked about many times and it's been noted; expansion was passed in 2018, yet we sit here, more than a year later, and our neighbors still have nearly nine more months to wait for access to coverage due to the Department of Health and Human Services unnecessarily drawn-out implementation, timeline, and waiver application. By enacting LB932 into law, the Legislature has the opportunity to hold the department to the coverage start date of October 1, 2020, as was noted in April 2019. This action will assist with planning and budgeting for the state and for our providers. Moreover, this legislation takes a stand and helps hold the will of Nebraska's voters. 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 coverage gap, nearly 36 percent live in our rural counties. These uninsured residents account for nearly 4.24 percent of the total rural population. By not expanding Medicaid coverage in a timely manner, the department has continued to ask our healthcare providers to provide uncompensated care, placing our rural communities and the rural communities they serve in peril. During this delayed period of implementation, providers have had to continue to write off these uncompensated care costs, either as bad debt or charity care, and shift the cost to all patients and policyholders. We need to stop this shift and ensure that expanded coverage is in place by October 1 of this year. Beyond the increased premium costs passed on to consumers is the burden faced by rural and critical access hospitals; 14 percent of our state's rural hospital gross revenues come from Medicaid payments. For many hospitals, the ability to provide services to Medicaid patients allows them to remain viable for all residents. Our hospitals should not have to wait any longer or continue to provide uncompensated care for thousands of patients in a state that has expanded Medicaid. Holding the department to an October 1, 2020 start date for expansion coverage will help ensure that our rural hospitals

continue to remain an asset in our communities. Medicaid expansion, again, will make a difference for thousands of rural residents in our communities. It's time to move forward with the will of the voters and implement expansion without these barriers and delays. LB932 will ensure the Department of Health and Human Services adheres to those timelines set forth and that thousands of Nebraskans will be able to access the care they need. Thank you and I'll take any questions.

HOWARD: Thank you. Are there questions? Seeing none--

JORDAN RASMUSSEN: Thank you.

HOWARD: --thank you for your testimony today. Our next proponent testifier. All right, anyone wishing to testify in opposition to LB932? Seeing none, is there anyone wishing to testify in a neutral capacity? Good afternoon.

JEREMY BRUNSSEN: Good afternoon. Good afternoon, Chairman Howard and members of the Health and Human Services Committee. My name is Jeremy Brunssen, J-e-r-e-m-y B-r-u-n-s-s-e-n, and I am the deputy director for finance and program integrity for the division of Medicaid and long-term care within the Department of Health and Human Services. I'm here to testify neutral to LB932. The department identified October 1, 2020 as our intended implementation date from the onset for our, our planning of the implementation of Medicaid expansion. We've been diligently working towards this implementation date. We've provided monthly updates to the Legislature on our progress and we do remain confident that this date will be met. Thank you for the opportunity to testify today. I'd be happy to answer any questions.

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

WILLIAMS: Thank you, Chairwoman Howard. Thank you, Mr. Brunssen, for being here. I want to go on record today of thanking you for stepping up in your new role with the department and in particular, for the assistance that you have given the nursing home industry over the past several months and working very closely with them and your, your attitude of collaboration is appreciated and sincerely appreciated. You stated in, in your testimony that you are confident in hitting those dates. So the, the potential of something unforeseen that could come up, have you thought about that and are you comfortable still with the support investment?

JEREMY BRUNSSEN: Yeah, so I think from my perspective, obviously-- well, I'm just now stepping into the interim director role and I haven't been in every meeting. I can tell you that the meetings I've been in with our staff and what I'm hearing from their conversations with our federal partners and from the meetings I have been a part of, I feel like we're on a good path and I have no concerns about the October 1, 2020 date and the approvals that we're going to need from our federal partners.

WILLIAMS: Thank you.

HOWARD: So I just want you to be really clear; if the, if the Legislature decided to pass this, you don't see a harm because it aligns with what you're already working on?

JEREMY BRUNSSEN: It, it aligns with the date that we've set forward on and that we're working towards and that we feel comfortable that we're going to hit.

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

JEREMY BRUNSSEN: Thank you.

HOWARD: OK, Senator Wishart has waived closing, but I do have letters, which I am remembering today. Proponent letters are Andi Curry Grubb from Planned Parenthood North Central States; Nick Faustman, the American Cancer Society; Mary Sullivan, National Association of Social Workers, Nebraska Chapter; and Molly McCleery, Nebraska Appleseed. No opposition letters, no neutral letters, and this will close the hearing for LB932. And we will open the hearing for LB851, Senator McCollister's bill to change provisions relating to eligibility for services under the Medical Assistance Act. Welcome, Senator McCollister.

McCOLLISTER: Thank you, Chairwoman Howard and members of the committee. Hi, my name is John, J-o-h-n, McCollister, M-c-C-o-l-l-i-s-t-e-r. Today I'm introducing LB851 to provide a 12-month continuous eligibility period for Medicaid-eligible children under the age of 19 and adult Medicaid recipients in modified adjusted gross income categories, MAGI, which include subsidized adoption and guardianship assistance, institution for mental disease, parent/caretaker relatives, and Heritage Health adult. Currently, Nebraska provides continuous eligibility for pregnant women, newborns

up to age one, and six months of continuous eligibility for children from the date of their initial application. All other medicated individuals must complete a redetermination of eligibility every 12 months. However, at any time during the year, enrolled individuals must report a change in their circumstances, such as income, family size, or employment status within ten days. LB851 would extend continuous eligibility to all children and adults who are subject to the budgeting process known as the modified adjusted gross income, MAGI. This methodology is a simplified eligibility process required by the Affordable Care Act that uses federal income tax rules and tax filing status to determine an individual's Medicaid eligibility. For the most part, this would include parents and individuals newly eligible through the Medicaid expansion. Currently, 24 states have continuous eligibility for children in traditional Medicaid, 26 states have continuous eligibility for children through the CHIP Program, and two states have expanded continuous eligibility for adults. Continuous eligibility would enhance continuity of care, reduce the administrative burden for patients and providers, and save the state of Nebraska administrative costs by allowing those dollars to be spent correctly on parent care. Having access to continuous Medicaid coverage reduces churn, reduces churn, people moving in and out Medicaid coverage because of temporary fluctuations in factors that influence eligibility, including income. Lower-income individuals are more likely to experience shift in income from month to month due to the factors like changes in hours or seasonal employment. Under our current requirements, these changes can result in an individual moving in and out of coverage multiple times throughout the years. Turning on and off Medicaid can have a profound effect on overall health. As you will hear from the testifiers after me, disruptions in coverage result in an increase of emergency room, decreased access to preventive care, and a reduced likelihood of chronic disease remaining controlled. Churn also costs more. A diabetic without constant, consistent access to health insurance is more likely to access more expensive hospital care in a three-month period following a disenrollment, costing the Medicaid program nearly $240 per patient, per month more than the individual lost coverage. The administrative burden associated with additional paperwork and reporting requirements can also cause individuals to churn off of Medicaid. We've all heard about the reports of 18,000 individuals in Arkansas losing coverage because of confusion and lack of awareness around the reporting requirements. Colorado recently reported that 15 percent of letters mailed to public assistance recipients are returned as undeliverable each year, approximately 131,000 households. Officials estimate that as many as

33,000 individuals lose access to benefits due to this issue. Reducing the number of times an individual must report changes alleviates some of these administrative burdens. From a purely financial perspective, the 12-month continuous eligibility will reduce administrative costs within DHHS, although the fiscal note doesn't reflect that. The administrative cost of just one individual churning off on health coverage is estimated to be between $400 and $600, roughly the same cost as one month of Medicaid coverage. For states that have implemented continuous eligibility, cost increases have been minimal, cost increases have been minimal, approximately 2 percent. These costs, however, are related to the provision of healthcare services and are offset by administrative cost savings and lower spending per patient because of greater coverage stability. Doesn't it make sense to make sure our Medicaid dollars are being spent on preventative, continuous healthcare instead of bureaucratic red tape? Colleagues, our Medicaid program is intended to serve individuals who otherwise cannot access healthcare coverage. We have a duty to ensure that the program is administrated in a way that does not hinder access to care. LB851 would provide the opportunity to encourage continuity in healthcare coverage and reduce undue administrative expense. I encourage you to support and would be happy to answer questions, if I am able.

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

CAVANAUGH: Thank you. Thank you, Senator McCollister. I'm looking at the fiscal note and on the first page, the last sentence, it says "for adult populations, if the waiver is not approved the costs would be substantially less." But it doesn't reference-- is this talking about the 1115 waiver that we're currently doing? So if that waiver is rejected and we implement Medicaid expansion as--

McCOLLISTER: I--

CAVANAUGH: --or just expand our current program, then your fiscal note would be less?

McCOLLISTER: That's, that's my belief as well.

CAVANAUGH: OK. That's-- I just want to make sure I was understanding that correctly.

McCOLLISTER: That would--

CAVANAUGH: And then you are seeking to expand from the six-month re-eligibility to the 12-month re-eligibility?

McCOLLISTER: Yeah, for those, those particular populations.

CAVANAUGH: --those particular populations. So again, going back to the fiscal note, it is assuming that those individuals would not, at six months, be re-eligible for that, that time period. So is the fiscal note-- I guess I'm, I'm, I'm just wondering if, if they were currently-- if they-- how many of those people who are currently being reupped every six months are, are still getting a 12-month coverage and we're just eliminating that administrative burden?

McCOLLISTER: I think the people following me can perhaps address that--

CAVANAUGH: OK.

McCOLLISTER: -- a little bit better, but--

CAVANAUGH: Or maybe I just needed to dig into it off the line.

McCOLLISTER: It's my contention, it's my contention that this "churn" that we talked about inside the bill--

CAVANAUGH: Um-hum.

McCOLLISTER: --people going off coverage and on coverage because their income is so unstable, that there is a cost associated with that. And this fiscal note does not recognize that churn.

CAVANAUGH: Right.

McCOLLISTER: And, and as Medicaid programs go-- continue in various states, you know, we're going to be able to document what that, that churn actually does cost.

CAVANAUGH: OK.

McCOLLISTER: And so I, I--

CAVANAUGH: I can also sit down with the Fiscal Office to dig in a little bit more, but thank you. That was just--

McCOLLISTER: Well, thank you very much.

CAVANAUGH: It was jumping out at me.

HOWARD: Any other questions? Seeing none, will you be staying to close?

McCOLLISTER: We have a big agenda in Revenue, so I think I'll pass.

HOWARD: OK.

McCOLLISTER: Thank you very much.

HOWARD: Thank you, Senator McCollister.

McCOLLISTER: Thanks.

HOWARD: All right, we'll invite our first proponent testifier for LB851 up. Good afternoon.

ANDREA SKOLKIN: Good afternoon, Chairwoman Howard and members of the Health and Human Services Committee. My name is Andrea Skolkin, A-n-d-r-e-a S-k-o-l-k-i-n, and I am the board chair of the Health Center Association of Nebraska, representing Nebraska's seven community health centers. And I'm also the CEO of One World Community Health Centers in Omaha. As you know, Nebraska's health centers provide comprehensive, culturally-appropriate primary care to over a 100,000 patients statewide at 69 service locations. Nebraska federally-qualified health centers are a critical component in the safety net in Nebraska. Nearly 47 percent of the individuals we care for are uninsured and 93 percent are low income. Nebraska's health centers provide care to 12 percent of Nebraska Medicaid enrollees and over 20,500 children with Medicaid coverage. We would like to express our strong support of LB851, which would adopt 12-month continuous eligibility for the Nebraska Medicaid program for children and adults. As we heard from Senator McCollister, 26 states provide 12-month continuous eligibility for all children, including our neighboring states Kansas, Iowa, Colorado, and Wyoming. Both Montana and New York provide 12-month continuous eligibility also to adults. This continuous eligibility has been proven to increase continuity of coverage for healthcare. As you heard about the churn on and off Medicaid due to difficulties in understanding what the mail was that actually came to them and the paperwork-- in 2003, as an example, in Washington state, they ended their 12-month continuous eligibility and 5 percent of children fell off and lost coverage. When they reinstated

it, those children became re-enrolled again. Continuity of coverage is essential to providing [SIC] gaps in care. People with chronic diseases with interruptions in care are more likely to need more complex care and hospital care. In addition, those without medical insurance also may forgo that care, including filling their prescriptions and preventive visits. Recent studies indicate that individuals who lack prescription coverage only fill about half or 50 percent of their prescriptions. This can lead to worse health outcomes and a less efficient Medicaid program as costs are shifted away from this preventative care to treatment. Alternatively, children without gaps in coverage are nearly 25 percent less likely to have preventable hospitalizations. Offering 12-month continuous eligibility can shift costs away from program administration to providing high-quality care. Income verification checks and the resulting churn do come, as we heard from Senator McCollister, with a significant cost not just to the state, but to providers. This cost has been documented in reports between $400 and $600 per person. These same administrative costs at a community health center would pay for a year of healthcare. Continuity of care leads to this more effective care management. Another study found the individuals who experienced the lapse, again, as Senator McCollister stated, they were $239 more per member for those that had to re-enroll. Similarly, those diagnosed with depression experienced an increase of cost at $650 per member, per month due to breaks in coverage. Ensuring that limited Medicaid dollars go toward coordinated medical care should be a priority. Adopting 12-month continuous eligibility for both children and adults is a proven strategy to insure and maintain enrollment and good care. I'd like to thank the committee and urge you to support this bill and be happy to answer questions.

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

CAVANAUGH: Thank you. Thank you for being here. Do you have an idea of how many of-- children are reevaluated every six months; what percentage of those children are not re-enrolled?

ANDREA SKOLKIN: Senator, I don't have that exact data. I can only speak to our anecdotal experience and we have a fair amount of both children and adults that go on and off Medicaid.

CAVANAUGH: OK, thank you.

HOWARD: Any other questions? Seeing none--

ANDREA SKOLKIN: Thank you.

HOWARD: --thank you for your testimony today. Our next proponent testifier for LB851. Good afternoon, again.

KATHY NORDBY: Good afternoon, again. Thank you, Chairwoman Howard and the members of the Health and Human Services Committee. My name is Kathy Nordby, K-a-t-h-y N-o-r-d-b-y, and I'm here, again, on the Health Center Association of Nebraska and as the CEO of the Midtown Community Health Center in Norfolk. As my colleague testified, Nebraska's health centers are a critical component of the safety net in Nebraska and I want to really emphasize my role as a representative from the rural communities. Over 27,000 patients are seen in rural community health centers. And moreover, the health centers are more often one of the very few facilities that will accept Medicaid and new Medicaid patients, in particular. I would like to emphasize the testimony of my colleague, Andrea, that the 12-month continuous eligibility is a proven strategy to improve health and quality and efficiency and care. I'd like to talk a little bit about the impact of churn and maybe talk about it a little directly; that, that mail to Norfolk from, from Lincoln is about five days. So in a ten-day notice, you've lost five days to that. And I was thinking about this on my drive, on the foggy drive down here. I thought about-- I wondered if any of you had a family member or yourselves had ever applied for Medicaid. And I used to-- I have the unique position that early in my career, I actually approved Medicaid applications. And at that time, they were paper and they were 15 pages long and it took 45 minutes per appointment. So I watched that process happen and when I liken it to my life now, I think of it more like going to the Department of Motor Vehicles. And right now, we only have to get our tags renewed once a year. So imagine, in your life, if you had to go to the Department of Motor Vehicles twice a year. And so we're, we're doing the converse. We're just taking it backwards and saying, yes, I want my car relicensed. So, you know, you send me the notice six weeks ahead of time that I'm due for renewal. And we go through a lot of paperwork to get the-- get this reapproved at a time that may or may not be imminent about my life. I could be really busy because I'm working and it's the busiest time of my, my yearly seasonal work that I do because these people aren't out-of-work engineers, these are frequently farm workers. They're, they're service workers at McDonald's; those kind of roles. So it's not like they're hopping from hundreds of thousands of dollars down to nothing or living on unemployment, they're, they're kind of fluctuating right on that cusp of eligibility for themselves

and especially their children. And the kind of care that we deliver is frequently not isolated. Yes, a sinus infection while you have Medicaid is very nice, but frequently, we're doing a health screening or a dental screening and then we're authorizing two or three follow-up visits to, to cover the fillings. So if today I saw you for a screening and I said you need, you need three fillings, let's schedule you. Oh, it'll take you three weeks. Oh, wait, that goes into February, where you're no longer eligible. So you show up thinking you have an appointment, but your Medicaid card is no good. So those are the kind of things that we deal with on our end and they have to decide, do I go away? At our clinic we, of course, say, well, we'll see you, we'll bill you, let's help you get back enrolled, those kind of things. But I think it, it impacts decision making. And if they said no, I don't want to, I don't want to create a bill, I'll go get re-enrolled and then that night, the abscess balloons and you're in the emergency department, now the cost of that uncompensated care is a burden. And so I think there's some discussion you can have about whether the, the tag or the fiscal impact is legitimate, whether it compensates for the less bureaucracy, in and of itself. But I would suggest that a part of that is not going away. It's not like, oh, we don't have that need for medical care. I suggest that it shifts and it shifts on the back of people that have access, which is your rural health clinics, FQHCs, emergency departments. Those needs, if they exacerbate, need to be covered and they're covered at a much more expensive rate. So a lot of what we're saying was a repeat of what Senator McCollister presented and I don't want to belabor that, but I do want to emphasize that we want to work as partners to reduce the churning. And we have staff on hand to assist patients every day and we try to do that for them, but really giving us the continuity and using other tools-- we get records from the Department of Labor quarterly or I used to when I was a worker. I would get reports on income, you'd get reports on child support. Those things are already tools that are there. Having the 45-minute appointment redone every six months could go away and I would, I would think you'd see little impact, but more stability for our patient care. Thank you and I would answer any questions that you have.

HOWARD: Thank you. Are there questions? All right, seeing none, thank you for your testimony.

KATHY NORDBY: Thank you.

HOWARD: Our next proponent testifier for LB851.

JULIA ISAACS TSE: Good afternoon. My name is Julia Isaacs Tse, J-u-l-i-a I-s-a-a-c-s T-s-e, and I'm here today on behalf of Voices for Children in Nebraska. Voices for Children believes that Nebraska's children deserve every opportunity to grow up to be happy, healthy, and productive adults. Access to consistent and preventive healthcare ensures that children get the best start in life and public health insurance programs are an essential investment in the health of Nebraska kids. Voices for Children supports LB851 because it ensures that low-income Nebraska children have stable health coverage during key developmental years. Together, Medicaid and the Children's Health Insurance Program, or CHIP, provides health insurance coverage to nearly 29 percent of all Nebraska children. Three-quarters of enrollees in Nebraska's public health insurance programs are children, but children are also the least expensive to insure, accounting for just over one-quarter of our Medicaid and CHIP expenditures. Strengthening access to healthcare for our youngest Nebraskans, especially those in families that would otherwise be unable to afford private health insurance, is a wise investment. Children in Medicaid and CHIP have better access to preventive care and routine visits and even have better health outcomes, including lower rates of hospitalizations that could have been avoided and even child mortality, than their uninsured counterparts. Research links a lack of health insurance to developmental losses, poor educational attainment, and in the long run, healthy kids means healthier families and healthier communities. LB851 provides 12 months of continuous eligibility for children and this is important because low-income families, as other testifiers have mentioned, experience a significant amount of income volatility. There is one analysis from the US Financial Diaries project that found fluctuations of 25 percent in just six weeks of time for lower-income families. So this can really help smooth some of those volatilities over. Continuity, continuity of healthcare coverage improves health outcomes, prevents increased costs during gaps, and reduces administrative burdens for families and the state agency. Others have mentioned that some-- 26 states have the policy for children in CHIP and 24 in Medicaid. I would also just add that up until 2002, Nebraska had this policy. 2002 was a rough year for policies that relate to kids and families. It was a tough budget cycle and this is also the year that some of you may have heard me mention that the childcare subsidy was cut from 185 to 120 percent of federal poverty. So this would actually be restoring it to what we used to have in 2002. Others have mentioned studies from other states about administrative churn, which is a significant concern. And we appreciate that the fiscal note here is also very significant. We

would just like to draw the committee's attention to some analysis conducted by other states. California estimated $120 million in costs to re-enroll 600,000 children who left Medicaid and then returned, mostly within just four months of leaving. For children who are enrolled in Medicaid longer, their average monthly expenditures also lower over time due, in part, to increased access to preventive care and also, in part, to accessing healthcare services in the first few weeks of enrollment that they may have delayed during their coverage gap. Early analyses of 12-months continuous eligibility has found reduced administrative costs, increased average months of coverage for children, and reduced average monthly costs per enrollee. Healthcare access for children plays a critical role in healthy development. Children need continuous healthcare coverage to ensure that they receive timely immunizations, developmental screenings, and preventive services. It is also important that children establish a health home so that their doctor has an ongoing relationship with the child that makes it easier to identify and address developmental issues and treat, treat chronic conditions. We thank Senator McCollister for bringing this important issue forward and would urge the committee to advance LB851 and take an additional step towards meeting the health of-- the health needs of all children in our state. Thanks.

HOWARD: Thank you. Are the questions? All right--

JULIA ISAACS TSE: Thank you.

HOWARD: --seeing none, thank you for your testimony today. Our next proponent testifier for LB851.

SARAH MARESH: Hi, Chairperson Howard and members of the Health and Human Services Committee. My name is Sarah Maresh, and that's S-a-r-a-h M-a-r-e-s-h, and I am a staff attorney in the healthcare access program at Nebraska Appleseed, here testifying on behalf of Nebraska Appleseed. Appleseed is a nonprofit legal advocacy organization that fights for justice and opportunity for all Nebraskans and one of our key priorities is ensuring that all Nebraskans have access to quality, affordable healthcare. And before I get into my testimony, I wanted to address a question that I think, Senator Cavanaugh brought up earlier about the mention in the fiscal note to the waiver. And so actually, the waiver reference there is separate from the current pending Section 1115 waiver. And what the bill is doing is having-- instructing the department to submit a separate waiver so that they can implement continuous eligibility for the adult population. And if that separate waiver is not approved, the

state cannot provide continuous eligibility for adults. They can do so for children under the state plan amendment, which is also separately directed. And in that instance, the state-- if the waiver isn't approved for adults, then the state could not have continuous eligibility for adults. So I just want to clear that up real quick and I'm happy to answer any questions at the end if you have any others. But getting back to my testimony, frequent changes in Medicaid eligibility, which is often referred to as churn, as you've heard mentioned, interfere with the continuity of care for beneficiaries, which results in high healthcare costs and increases administrative burdens for providers, managed care organizations, and state agencies. Nebraska Appleseed supports LB851's continuous eligibility for adults and children because continuous eligibility promotes health for beneficiaries, while decreasing the healthcare system costs, unnecessary coverage losses, and administrative costs. Continuous eligibility helps beneficiaries maintain consistent care and access to preventative services. There is evidence that changes in coverage are associated with increased use of the emergency room and result in higher healthcare costs. Keeping beneficiaries covered helps providers develop relationships with beneficiaries to better manage their care and monitor the development of children. Guaranteeing coverage continuously for low-income adults and children also helps combat unnecessary coverage losses and gaps in coverage. There is ample evidence and examples that paperwork and periodic checks and inadequate notices can cause eligible individuals to improperly lose their coverage. And this bill would help reduce the unnecessary costs of those loss of coverages and will be less burdensome on beneficiaries. And this could also help address the number of eligible beneficiaries who are not currently enrolled in Medicaid, even though they are eligible. And in 2016, there were estimates in Nebraska that 9 percent of the children eligible for Medicaid are not enrolled in Medicaid and over 40 percent of the parents eligible for Medicaid are not enrolled in Medicaid. And that kind of gets, I think, a little bit to your question earlier, Senator Cavanaugh, about the folks who are eligible, but not enrolled in Medicaid. And finally, continuous coverage helps reduce those administrative costs we've been hearing of for providers, managed care organizations, and the State Department of Health and Human Services. When individuals churn on and off Medicaid, the providers in managed care organizations have a difficult time providing the effective low-cost care that they are encouraged to provide and are faced with administrative burdens associated with managing beneficiaries switching on and off coverage. Furthermore, the continuous eligibility will reduce the workload of DHHS employees and

will provide administrative efficiencies by decreasing the amount of paperwork that must be verified and processed. Because this bill encourages the continuity of care, better health outcomes, and provides administrative efficiencies, Nebraska Appleseed supports this bill. And I'm happy to take any questions if you have any.

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

SARAH MARESH: Thank you.

HOWARD: Our next proponent tesifier for over LB851. Good afternoon.

EDISON McDONALD: Good afternoon. Hello, my name is Edison McDonald, E-d-i-s-o-n M-c-D-o-n-a-l-d, representing the Arc of Nebraska. We are a nonprofit with 1,500 members and nine chapters covering the state, representing individuals with intellectual and developmental disabilities. We are here today in support of LB851 and want to thank Senator McCollister and cosponsors for bringing this bill forward. Nebraska needs a comprehensive vision and a continuum of services and supports that support individuals with disabilities and their families. It also needs to develop a work plan, which systematically addresses the gaps and barriers. Cutting programs to reduce Medicaid in state expenditures may decrease state expenditures in the short term. However, history and time have demonstrated that this is likely not the most fiscally-responsible response, nor leads to the best improved health outcomes. Increasing Medicaid expenditures are concerns across all states and our aging population adds additional urgency and concern to this issue. To address these issues, some states are starting to implement programs that deter institutional placements and support family caregivers in efforts to decrease Medicaid expenditures. They have adopted programming that individuals in the workforce and also individuals with disabilities in their homes-- approaches that have historically been shown as cost-effective strategies. Unfortunately, Nebraska has not systematically addressed how current programming is accessed, nor has it assessed if current programming across all DHHS and other state agencies could be structured in a manner that removes duplicity, improves health and long-term outcomes, and reduces expenditures. LB851 is one direction we could take, in which we would be able to better cover the scope of age and of disability. While we've provided another course in our waiver study report that we believe may be a little bit more cost effective in dealing with some of these issues, we are supportive of other paths, such as this forward, that we can find to ensure that

individuals with disabilities and, particularly, children have access to coverage. We ask that in your consideration of directions forward, that we look at plugging holes that are created by problematic notices, increase understanding of programs in the community, avoid harmful cuts for others, maximize federal funds, consider what will help us beyond just this biennium, and reinvest savings towards continuing to deal with these issues. If we do not comprehensively deal with this issue, then we will continue to see ballooning costs, detrimental effects to families, and decreasing life quality for individuals with intellectual and developmental disabilities. Thank you. Any questions?

HOWARD: Are there questions? Seeing none, thank you for your testimony today. Our next proponent testifier for LB851. Seeing none, is there anyone wishing to testify in opposition? Good afternoon.

JEREMY BRUNSSEN: Good afternoon, Chairman Howard and members of the Health and Human Services Committee. My name is Jeremy Brunssen, J-e-r-e-m-y B-r-u-n-s-s-e-n. I'm the deputy director for finance and program integrity for the division of Medicaid and long-term care within the Department of Health and Human Services and I'm here to testify in opposition to LB851. LB851 would require the Department of Health and Human Services to implement a one-year continuous Medicaid eligibility for certain groups by using a combination of different federal authorities. DHHS has a number of concerns about implementing this bill. Continuous eligibility means that a beneficiary remains eligible for Medicaid for a period of time, regardless of circumstances that may change their eligibility. For example, this could include a new job or a raise at a current job that pays higher than the Medicaid income, income limit. Nebraska Medicaid currently has continuous eligibility in place for children from birth to age one if their mother was on Medicaid when the child was born and for six months if the child is enrolled in Medicaid at any other time. Pregnant women are also continuously eligible through the 60-day postpartum period. According to federal regulations, Medicaid beneficiaries must report any changes that may affect their eligibility for Medicaid, notably income. LB851 would require the state to seek an 1115 waiver of this requirement for adults in order to create periods of continuous eligibility. However, 1115 waivers must be deemed budget neutral to the federal government and DHHS has concerns that such a waiver could be proven budget neutral, as otherwise ineligible individuals would remain on Medicaid, which would lead to significant expenditure increases. The only way such a waiver

could be proven budget neutral to the federal government could possibly be for these increases to be covered with state General Funds. This bill could also complicate how Medicaid receives federal dollars to pay for services. Some Medicaid groups receive enhanced federal funding and continuous eligibility for both children and adults would affect Medicaid's ability to move beneficiaries in or out of these different groups. This could result in the state not receiving enhanced federal funds it's eligible to receive and potentially, also, in the state having to repay the federal government funds, which we should not have received. For example, children who are over the income for Medicaid are currently reviewed for eligibility in the Children's Health Insurance Program, or CHIP, which has a higher federal match rate than Medicaid. However, under LB851, they would remain on the Medicaid program and the state would not leverage the enhanced CHIP funding. Also, with the implementation of expansion, adults eligible, as a parent or caretaker relatives, or PCRs who are over income for the PCR group, should be moved to the expansion group where the state can receive a higher federal match. However, under the bill, they would remain in the PCR group and the state would forgo the increased federal match. In summary, LB851 will make it more difficult to comply with the federal regulations and thus, receive the maximum amount of enhanced federal funding necessary to ensure Medicaid services are properly financed. We respectfully request the committee oppose this legislation. Thank you for the opportunity to testify and I'd be happy to answer any questions.

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

CAVANAUGH: Thank you. Thanks for being here. And I would second Senator Williams' comments earlier; thank you for taking over a position that is much needed. I-- at the start, you said a combination of different federal authorities; could you explain what you mean by that?

JEREMY BRUNSSEN: Yeah, so I think others have mentioned as well, but continuous eligibility is currently allowed as an option for states through state plan services. But for adults, we would need to seek the 1115 waiver, basically waiving the federal requirements--

CAVANAUGH: OK.

JEREMY BRUNSSEN: --by enrolling the adults continuously eligible.

CAVANAUGH: OK and that's something that the department does not wish to do?

JEREMY BRUNSSEN: Well, I think, you know, the testimony that I spoke to is that we would have to be able to prove budget neutrality to the federal government.

CAVANAUGH: OK.

JEREMY BRUNSSEN: And so we would have concerns about the ability to do that when we're essentially paying for benefits in months when that beneficiary would otherwise not be eligible and not having expenditures in those periods.

CAVANAUGH: So if we had expanded Medicaid today, this population that we're talking about would be in that population?

JEREMY BRUNSSEN: So my understanding is that this, this-- the proposed bill, LB851, would affect all adults. So it would be anybody that's currently in the Medicaid program or that, that would apply and become eligible under the regular Medicaid FPL limits and anybody, also, that would apply and fall within that expansion of FPL limits.

CAVANAUGH: OK. I'm just trying to understand the opposition a little bit more clearly because what I'm taking from this is that Senator McCollister's intention is to address the cliff effect. So even if someone's income is going up-- and I'm not speaking for Senator McCollister, I'm just-- this is my interpretation. If someone's income is going up, giving them that extra six months of Medicaid eligibility so that they don't have to turn down a raise is actually good for the state financially. Is that something that the department has considered when-- in preparing whether or not to support or oppose this bill?

JEREMY BRUNSSEN: So I think-- when we are preparing testimony, we're considering the impact of Medicaid. So we have to make sure that we communicate the impacts to the Medicaid program. And so that's what we're here-- what I am here--

CAVANAUGH: Sure.

JEREMY BRUNSSEN: -- who I'm representing. And so, you know, there-- so essentially, I understand there are other, you know, potential, you

know, impacts and, and considerations that you all have to take into consideration, but I can speak to the Medicaid piece.

CAVANAUGH: So does, does the Department of Health and Human Services then not converse with the Department of Labor to discuss, sort of, those fiscal impacts that-- if we're restricting an employee from taking a pay increase so that they still have healthcare?

JEREMY BRUNSSEN: Well, I would say that the department is not restricting anybody from making-- from doing whatever--

CAVANAUGH: Sorry--

JEREMY BRUNSSEN: -- choice of words. We're, we're trying to educate what the-- what we think the impact--

CAVANAUGH: Sure.

JEREMY BRUNSSEN: --in the Medicaid program.

CAVANAUGH: I didn't mean to say that you're restricting, but individuals may feel restricted from taking a pay increase. And so there is a-- an impact on the labor and the workforce and so-- but I understand, thank you.

HOWARD: OK. Any other questions? So this is just hypothetical; if this was just for continuous eligibility for kids, since it sounds like a lot of our neighboring states have done that, would it-- would we see the same opposition from the department if it was just for children?

JEREMY BRUNSSEN: Well, I don't think I could speculate on that. You know, I don't-- I can't say that. I don't know the exact difference in the fiscal impact for the adult versus the children groups, but I can't-- I don't want to speculate.

HOWARD: I hate to put you on the spot, you're new in this gig. OK. All right, any other questions? Senator Arch.

ARCH: Thank you. Thank you for coming and, and testifying. Could you please help me understand budget neutrality, that, that concept, that definition; what-- what's required for the waiver?

JEREMY BRUNSSEN: Yeah, I'll try to-- it's complicated for me and I've been deeply involved. So I want to make sure I can communicate it in a way that-- that it's coming through in a meaningful way. So

essentially, when we're applying for an 1115 demonstration waiver, we're-- essentially, what we're doing is we're asking to waive federal rules. So oftentimes, it could be how we actually implement a program or how we provide services. And sometimes it's asking for expenditure authority to do things that otherwise wouldn't be allowed. So in this case, for adults, since there's not a state plan option for continuous eligibility, my understanding is we'd be asking to waive the requirement, which would have us requesting expenditure authority. So somehow, we have to show, in totality, to the federal government, not to the state, but to the federal government, that it's neutral in costs over a five-year demonstration period.

ARCH: OK, that, that helps. That makes sense. The government, I mean, the federal government doesn't want waivers that increase their cost.

JEREMY BRUNSSEN: Exactly. They like innovation as long as it doesn't cost them more money.

ARCH: Got it, thank you.

HOWARD: Senator Cavanaugh.

CAVANAUGH: I apologize, that brings me back to my earlier question. Then if you're looking at budget neutrality, shouldn't you be talking to the Department of Labor to see what income tax revenue we are not getting as a result of people not-- not that you're restricting them, but that they are restricting themselves from taking that pay increase? Because it does seem like there's an opportunity for more-- getting closer on that budget neutrality if our agencies, state agencies are working closer together on this issue.

JEREMY BRUNSSEN: Well, I think that's definitely a consideration. I can say that we've, we've done our best to be as responsible as we can in responding in the time frame that we've had since the bill has been introduced to the time that we've prepared our testimony. But certainly, always opportunities to continue to collaborate across the different agencies.

CAVANAUGH: And is the Department of Health and Human Services willing to work with Senator McCollister on looking at that budget neutrality option?

JEREMY BRUNSSEN: I think we would be willing to do anything reasonable. You know, we're focusing our efforts right now on the many

objectives that we have and the deadlines that we've set for ourselves right now. But we're-- I mean, I think-- I hope you feel, through our other work, that we're willing to, to work with other stakeholders as needed.

HOWARD: Thank you. Senator Arch.

ARCH: A question because now I'm confused again; so I thought budget neutrality had to do with the Medicaid program--

JEREMY BRUNSSEN: It does.

ARCH: --not, not the total impact to the state or where there are other dollars because that has nothing to do with the Medicaid program, so-- and the strictest definition is you're trying to guarantee or assure there is budget neutrality. Those dollars couldn't be taken into consideration?

JEREMY BRUNSSEN: You're accurate, right. So it's, it's to the-- it's for the Medicaid program--

ARCH: OK.

JEREMY BRUNSSEN: --the federal share.

ARCH: Thank you.

HOWARD: Any other questions? All right, seeing none, thank you, Mr. Brunssen. Our next opponent testifier for LB851. OK, seeing none, is there anyone wishing to testify in a neutral capacity for LB851? Seeing none, Senator McCollister waives closing, but we do have letters. Letters in support: Joey Adler, the Holland Children's Movement; Todd Steubbendieck, AARP Nebraska; Dr. Steven Williams and Josue Gutierrez and Brett Wergin, the Nebraska Academy of Family Physicians. No letters in opposition, no neutral letters. And this will close the hearing for LB851 and the committee will take a brief break and we'll reconvene at 3:00 p.m.

[BREAK]

HOWARD: This will open the hearing for LB955, Senator Walz's bill to change provisions relating to eligibility for medical assistance. Welcome, Senator Walz.

WALZ: Thank you. Good afternoon, Chairwoman Howard and members of the, as Senator Howard says, best committee, Health and Human Services Committee.

HOWARD: You really want us to pass this bill. [LAUGHTER]

WALZ: For the record, my name is Lynne Walz, L-y-n-n-e W-a-l-z, and I proudly represent Legislative District 15. I'm here today to introduce LB955, a bill related to medical assistance and to change provisions regarding discontinued eligibility. Right now, according to a federal requirement as well as DHHS rules and regulations, if the department is removing an individual from Medicaid, they are required to send out a notification in the mail at least ten days prior to the date that they are to be removed. If the individual wishes to appeal the decision and maintain their benefits during the appeal process, they must do so within that ten-day time period. If they don't, they can still appeal, but they would not continue to receive their benefits during that process. Seeing how this is-- how this assistance is so crucial to the daily lives of so many individuals and the sudden removal of said benefits can not only cause a lot of stress, but, but put the individual's health at risk, I felt it was necessary that we expand this time period. When you consider the fact that the notice is sent through the mail, this ten-day notification requirement shortens considerably. If someone doesn't check their mail every day, this can further exasperate the problem. Then when they finally open the piece of mail, they will likely need a lawyer to explain the process to them or if they even have a case to appeal. Finding a lawyer to take on a case, allowing them to review the information, and then coming to a decision adds more hurdles to that already constrained time limit. If an individual with a cognitive disability receives this notification, they might need even more assistance. There are a number of problems here that an extended time period for a notice would go a long way to solve. If the individual appeals the department's decision, the department is then required to continue Medicaid payments until the appeal is settled. If the individual loses the appeal, they are required to pay the amount that was spent during the appeal process. This is not something that we are attempting to change. This bill idea was brought to me by a friend of mine and a citizen of Nebraska who has dealt with this issue directly and has experienced problems this can cause. He will be following me to share with you his story and personal experience with this issue, as well as other families. All we are asking for is more time to understand a complicated process and a greater explanation of the reasons for the removal. It is my hope that

we can make this small change to make people's lives just a little bit easier during what, I can only imagine, is a stressful situation, having this safety net pulled out from under them. Thank you and I would be happy to try and answer any questions that you may have.

HOWARD: Thank you. Are there questions? Why 30 days?

WALZ: Why 30 days for the extended notice?

HOWARD: Yeah, yeah.

WALZ: It was just the-- it was the number.

HOWARD: All right, thank you. Will you be staying to close?

WALZ: Sure.

HOWARD: Cool. All right, our first proponent testifier for LB955.

PHILIP GRAY: Good afternoon.

HOWARD: Good afternoon.

PHILIP GRAY: My name is Phil Gray. It's P-h-i-l-i-p G-r-a-y. I have lots of documents because this is a matter that deals with statute, federal statute and state statute. And we can't discuss it without discussing statutes, court hearings, and the results of those court hearings and statutes. This is my testimony; enough for everybody. This is my documentation and copies of the statutes. I did not print all of those for everybody. You have references to them you can look up. There's one, one copy of all of them. I didn't think I should spend that much time printing, so I didn't want to do that. I'm here representing myself, although I've been an advocate and have been involved in this issue for a long time. I have a 44-year-old son who was disabled by a mosquito bite when he was six weeks old. He now has-- he had viral encephalitis and so it changed our lives and changed his. I actually have written testimony, but because time is short and because we're quoting statutes-- I hope I didn't hand you my papers. I probably did. Did I give you a separate individual sheet there? Well, that's OK, I can take it. This issue of the advance notice is a significant issue. I've worked for the Social Security Administration and they violated the Supreme Court rule; unknowingly, but they did. And when the rule changed, they had to go back and redo something like 500,000 decisions. And it cost a lot of money because of our failure to acknowledge the due process requirements of the, of

the Supreme Court decision of '70, Kelly vs. Goldberg [SIC]. The court ruled that there was a due process right and a change of entitlement requires an advance notice. The advance notice standard has now been ten days before its effective date, a minimum of ten days before its effective date. It can be longer. In the Social Security system, if you send the notice on the 1st, that notice can be effective within that ten-day advance period. I understand that the state is going to say that this bill makes a 30-day appeal period possible. It does not. The standards say you have ten days to appeal from the date of the notice. You don't get 30 days to appeal. The appeal language is very clear; it's ten days. So in that ten-day period, if you file an appeal, you can keep your benefits. And if you don't file within that ten-day period, then your benefits would cease during the appeal. The ten-day receipt date has to include mail time. Now the Social Security Administration, standard information and the federal statutes-- I've quoted the statutes in my material there-- federal code title CFR416.1336 states notice has to be received within ten days and states that is an assumed five-day mail time. The Social Security Administration's policy, which I have also listed in the material I provided, extends that five-day mail time for weekends and other issues that may come up that delay the mailing time. So the ten days can actually add-- the five-day mail time can actually be extended for weekends and delay of mail and so on. The decision here in the Supreme Court was a result of a suit between Mr. Kelly and Mr. Goldberg. And the result of that suit-- one of the arguments from the state of New York, who was part of the suit, said, well, this is going to be physically and administratively difficult. The Supreme Court said-- and I can paraphrase although it's in the material I've sent you-- well, you know, the state has an interest in making certain that its citizens receive correct and accurate payments and that, that interest overrides the fact that they might find this a little difficult. That's in the Supreme Court decision. It's listed in the material I provided. The, the other issue with this bill, with the Senator's bill, is the demand for adequate notice. My son received a notice that he was, he was subject to share of cost. The notice was dated 11 days before its effective date, received five days before its effective date, and contained no information about how they arrived at that decision. Simply said, based on our rules, you have their share of cost to buy. So I called the caseworker to say how come I didn't get a ten-day advance notice? And she, frankly, didn't know what I was talking about. She went to the supervisor and asked her and the supervisor said, well, we can't control the post office and the notice meets the state's notice for clarity. The notice does not meet anybody

else's notice for clarity. If you want to see a clear notice, you can look at other places. New Mexico, in 2014, had a, a suit filed, based on a consent agreement, challenging the fact that the state of New Mexico failed to improve their notice system. The result of that, that suit over the consent agreement was that the state of New Mexico agreed to rewrite all of their notices through the Department of Health and Human Services. I'm sorry, I may run over time a little bit. I'll try not to. When you deal with, with statutes and legislation, you have to keep-- you have to refer to them and that takes time. The current NAC that Nebraska uses to determine when notices have to be mailed says the notice has to be mailed ten days prior to its effective date. That's a violation of, of the federal law that I quoted earlier. And the federal law not only requires a five-day advance based on the Supreme Court hearing, federal law also assumes a five-day mail time, which we've already said it can actually be extended. So this bill would allow the notice to be received ten days in advance, but it doesn't extend the appeal time. You only get ten days from the date of the receipt of the notice in order to file the appeal. You still have to figure out what date the notice was received. So the argument that it adds 30 days to the appeal period, I think, is, is not accurate. And I-- also, federal statute mandates this requirement of ten-days advance notice. There is no federal statute that I'm aware of that mandates no more than ten days. I can't find one and maybe an attorney can read one for me that I can't read. But, you know, they'll have to show me that to, to make me believe it. The state is in violation of federal rule in NAC469 in that they will implement that decision without acknowledgement that it wasn't received prior to ten days. And that's guaranteed not to be received within ten days if it's only mailed ten days in advance. The physical impact of this, I think is minor. The only period of physical impact would be from the 1st or the 14th because any bill mailed using the five-day mail time standard-- any, any notice mailed after 15th would only be effective the second month after the, the date of the letter. I think I'm out of time, I'm sorry.

HOWARD: Yeah. Let's see if there are any questions from the committee. Are there questions? Well, we appreciate your robust amount of information and we're so sorry that you've had this experience.

PHILIP GRAY: And I-- again, I guess I would say you really need to read the federal statutes.

HOWARD: Thank you, Mr. Gray.

EDISON McDONALD: Hello, my name is Edison McDonald, E-d-i-s-o-n M-c-D-o-n-a-l-d, representing the Arc of Nebraska. We're here today in support of LB955 and want to thank Senator Walz for bringing this bill forward. This bill helps to increase the time for an adverse Medicaid notice from 10 to 30 days and clarifies what needs to be in the notice. In the Supreme Court decision of Kelly v. Goldberg [SIC], in 397 U.S. 254, it was determined that the beneficiary is entitled to a predetermination hearing before the decision is implemented and requires a due process notice be received prior to the implementation of the decisions. Normally, that decision is, is accepted to be ten days in advance of the decision and normally must account for reasonable mailing time. SSA and CMS allow for a standard five-days mailing time. The state does not have explicit instructions in either the NAC-- and I'd refer you to Section 469 NAC 1-004-- or instructions to caseworkers about providing for mailing time and/or advance notice. There is a calendar on the department's website, which does not provide for-- a schedule for mailing advance notices, but it is not well understood or generally followed when notices are issued. Normally, the notices about a change do not contain enough information about how the decision was reached and what information was used to be able to have an individual be ready to appeal it. It is not uncommon for notices to be received after the effective date when mailed the last ten days of the month and this does not allow for enough time for individuals to respond. We take a great many calls where an individual, parent, or provider who has received notice only a few days from or after when they were still allowed to appeal. Because they failed to account for mail time, as required under federal law, we have placed our federal Medicaid funding at risk. Frequently, this letter goes, initially, to the wrong person. This notice will, in an unclear fashion, say that they have lost benefits and reference a general section of statute or of the Nebraska Administrative Code. However, this won't clearly lay out what line, in particular, it applies to and how the individual no longer meets the requirements. Then they almost always have to research, contact, interview, and hire an attorney at a significant cost to help file an appeal. The other option is that they file an appeal without an attorney because the notice is unclear whether you can have an attorney. When you file without an attorney, frequently, the documents that are needed to be in the record for action in the courts are not included. The notice also attempts to scare off families by saying that they could make them pay back all the fees during their services. This can run in amounts above $10,000/month for some families, depending upon how long your appeal process is stalled, leaving a family in dread and limbo.

This is a commonsense law that should have little to no cost. I want to address the fiscal note that I think is an example of an exaggerated fiscal note. First, this will help to clarify the already complex world of disability law issues and help to decrease staff time on some of these contacts. I know, from my personal communication over a lot of these issues with the department, I'd, I'd love to see the fiscal impact of staff having to deal with my time. Second, this will help ensure that they're in-line with 20 CFR 416.1336 and eliminate our risk of losing federal funds. Third, this will help to ensure that we protect the department from easily lost court cases, as currently, one of the easiest ways to overturn these cases, as I've talked to a variety of attorneys, is to challenge the notice. Fourth, Medicaid is allowed to be more permissive than federal law; however, not less permissive, which the fiscal note indicates otherwise. Federal law does allow for greater appeals periods, however, not for smaller periods. This is a commonsense tool that we suggested in our waiver study as a low or no-cost tool to help remedy our faulty system. And I hope that you will support families who are in dire need and who are overloaded with confusing information and lack the time and clarity in information that they need in order to appeal and ensure the best care of their child. Thank you. Questions?

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

ARCH: Thank you. Just for clarifying--

EDISON McDONALD: Um-hum?

ARCH: --our last testifier said that this does not actually extend the 30-day period, doesn't extend the appeal process 30 days. And as I read, as I read the bill, it could be understood that the recipients still must file the appeal within ten days. Maybe somebody else after you can answer the question?

EDISON McDONALD: Yeah, that's not my reading.

ARCH: OK.

EDISON McDONALD: Later, I know Seamus Kelly, who's an attorney--

ARCH: OK.

EDISON McDONALD: --who works on these sorts of cases, will be speaking to this. But that is definitely not my reading of this.

ARCH: All right.

EDISON McDONALD: I think it does affect that, that period accurately.

ARCH: Thank you.

HOWARD: Other questions? Senator Cavanaugh.

CAVANAUGH: Thank you, Chairwoman. Thank you, Mr. McDonald, for being here today. So since they haven't testified yet, I have no idea if the department is testifying in support or opposition to this. So my comments will be in that vein or my questions will be in that vein, I should say. So the ten-day limit from the materials that you have provided--

EDISON McDONALD: Um-hum.

CAVANAUGH: --and just looking over the federal statute--

EDISON McDONALD: Yeah.

CAVANAUGH: --I don't-- and you, you noted a couple of sections to look at--

EDISON McDONALD: Um-hum.

CAVANAUGH: --there is nothing in there saying that it must be restricted to ten days.

EDISON McDONALD: No and the, the deal with how Medicaid and Medicaid waiver systems works is that we can always be more permissive. We can never be more restrictive.

CAVANAUGH: So the fiscal note assumes that we can't be more permissive?

EDISON McDONALD: Yeah and that's not correct. I've talked to CMS previously about this issue directly and they said that we are allowed to expand that.

CAVANAUGH: So I'm just going to telegraph a question--

EDISON McDONALD: Yeah.

CAVANAUGH: --for future testifiers that I would be interested to know if the department also had those conversations before getting to this fiscal note, so thank you.

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

ANDREA SKOLKIN: Good afternoon again and thank you, Chairwoman Howard and members and the Health and Human Services Committee and Senator Walz for introducing the bill. My name is Andrea Skolkin, A-n-d-r-e-a S-k-o-l-k-i-n, and I'm here today representing the Health Center Association of Nebraska and the seven health centers across the state, as well as being the CEO of One World in Omaha. And as I stated earlier for another bill, we provide comprehensive and culturally-appropriate healthcare to a very low-income population, including over 100,000 patients. And we are a critical safety net in Nebraska with about 70 percent of our patients being from racial and ethnic minorities and we are here today in strong support of LB955. As part of the comprehensive services that federally-qualified health centers offer, we employ 30 eligibility workers across the state to assist people enrolling in medical assistance programs and the insurance marketplace. These individuals are trained and certified application counselors and provided assistance to more than 69,000 Nebraskans in 2018, with our numbers being calculated right now as to totals. They work a lot in enrolling and helping people who have been disenrolled or any letter that comes to their house to help interpret what it means. They have very limited knowledge about the complex rules or what the application requires and the things that they have to do in the interim to remain qualified. Many of the documents that they receive are not at the health literacy level that the individuals are at and some are received in the wrong languages. That includes not just Spanish or English, but there are other languages spoken throughout the state. Oftentimes, they come to seek assistance from our staff and they might not have even opened the letter that they received, hearing so much about this ten day and five-day mailing period, because they just don't understand. This complexity is likely to only increase with the implementation of Heritage Health's new-- the waiver program and the Medicaid expansion population in addition to-- with the tiered benefit structure and the proposed waiver with additional reporting requirements which are, in our opinion, more requirements than many of the programs across the United States. So providing clarity to these decisions made for disenrollments as well as how the tiered benefit system moving from basic to primary, primary

to basic; getting them can be confusing and will get more confusing and making sure there's adequate time when people are enrolling or trying to appeal those determinations is crucial for transparency and allowing people the time to be able to appeal their rights. Similarly, in LB955, it's a step forward that they are-- they do try to make aware-- the beneficiary's enrollees-- of their rights to appeal the decision, which is very important because many people will get the letter. They're afraid. They don't know what it means and am I out and I-- I'm just not going to touch it. So for these reasons, we encourage your support of LB955 and thank you for your time. I'm happy to answer questions.

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

WILLIAMS: Thank you, Senator Howard, and thank you, Ms. Skolkin. And can you help me, from a practical standpoint-- you, you deal with people coming in and out of this situation.

ANDREA SKOLKIN: Um-hum.

WILLIAMS: I am troubled by the, the days that it takes in the mail and then the lack of that notice at the ten days. From a practical standpoint, though, if you have the mail time plus the ten days, more of the federal standard versus just flat going to 30 days, does that create a large enough window for recipients of the notice to take appropriate action to appeal, if necessary, to contact the right people to understand what they're doing or do they need an extended period beyond the ten days after receiving the notice?

ANDREA SKOLKIN: I would speak on behalf of One World and myself, I do not believe that is adequate time. When you look at many with-- not to stereotype, but the population, their understanding-- they're working maybe a couple of jobs, one car in the household, getting an appointment-- so if we have eight application counselors or even ten, those appointments are booked and people are coming constantly. Being able to get that appointment, have all the paperwork or have to go back home, get the paperwork, I think that more time is needed for the population to be able to appeal.

WILLIAMS: Thank you.

ANDREA SKOLKIN: Um-hum.

HOWARD: Any other questions? Seeing none, thank you for your testimony today. Our next proponent testifier for LB955. Good afternoon.

SARAH MARESH: Hi, Chairperson Howard and members of the Health and Human Services Committee. My name is Sarah Maresh and again, that's S-a-r-a-h M-a-r-e-s-h, and I am a staff attorney in the healthcare access program at Nebraska Appleseed, testifying on behalf of Appleseed. Again, we are a nonprofit legal advocacy organization that fights for justice and opportunity for all Nebraskans and one of our core issues is ensuring that all Nebraskans have access to quality, affordable healthcare. The current Medicaid notice system is plagued with issues that negatively impact beneficiaries' due process rights. Notices that provide vague, unhelpful descriptions of why actions are being taken, together with the slow receipt of notices, which leave little time for beneficiaries to appeal to retain their benefits, makes it difficult for beneficiaries to understand or challenge any benefit changes before being negatively impacted. We support LB955 because it makes needed changes to the Medicaid notice process that will provide beneficiaries with additional information and time that they need to make informed decisions about changes to this significant benefit. Our organization has been contacted by numerous individuals seeking help understanding their notices or information about their rights and responsibilities under various Department of Health and Human Services programs. Oftentimes, notices are vague and leave the beneficiary guessing about why actions have been made and where to turn to find out more information about such action. By requiring DHHS to include an explanation, reason, and an informational basis, including specific regulations or laws for the proposed action, this bill will provide beneficiaries with desperately-needed information about how and why decisions are being made about their benefits. We would encourage requiring DHHS to provide enough information so that a reasonable, a reasonable person reading the notice would be able to understand the factual basis for such change. Statutorily requiring the DHHS to provide information to beneficiaries on their right to appeal also ensures that beneficiaries are aware of impending deadlines and their right to challenge any inaccurate or missing information identified in the notice. We also support identifying personnel that the beneficiary can contact about such change. We would encourage requiring DHHS to identify the contact information of a specific person or persons within the DHHS with knowledge about this determination that the beneficiary can contact. We think this will help cut through the red tape that beneficiaries often encounter when they do not know who to contact within the agency. Extending the

deadline for beneficiaries to appeal to retain their benefits to 30 days after the notice of decision is mailed is also good policy. As others have testified, currently, beneficiaries may only have a matter of days by the time that they actually receive their notice in the mail to understand and to decide what to do about those benefit determinations before their appeal deadline to retain those benefits has expired. Providing beneficiaries more time to retain their benefits and appeal will allow beneficiaries to contact that identified DHHS employee and seek out resources that they may need to understand their notice, such as legal or interpretational services. And this will help beneficiaries maintain and make informed decisions about their benefits. Together, these statutory changes to the Medicaid notice requirements bolster the constitutional protections for Medicaid beneficiaries and will help ensure beneficiaries have the information and time to understand benefit changes. Therefore, Nebraska Appleseed supports this bill. I'm happy to answer any questions if you have any.

HOWARD: Thank you. Are there questions? All right, seeing none, thank you for your testimony--

SARAH MARESH: Thank you.

HOWARD: --today. Our next proponent testifier for LB955. Good afternoon.

SEAMUS KELLY: Good afternoon, Chair, members of the committee. My name is Seamus Kelly. That's spelled S-e-a-m-u-s, last name is Kelly, K-e-l-l-y. I am an attorney in private practice and my practice is really dedicated to trying to meet the needs of people with disabilities, their families, and caregivers. And through my work, I represent several clients who are dealing with these sorts of issues. I'm one of the, one of the few attorneys that people come to when they have these problems. In addition to being an attorney, I'm also a parent of children with disabilities and I have received these notices both on my own behalf, as a parent, and then reviewing them with my clients. And I wish-- I could not find the last notice I had that there was an adverse change to my daughter's services. I could not find it, I was hoping to include that for you so that if anyone can see-- if you've never seen what these notices look like, to understand really how minimally informative they are and how honestly frightening they are for a family to receive because families often-- people, whether they just-- they rely on these services. They're using these services for a reason; generally because there's a high need, a need

that people cannot afford to, to pay for through their general, you know, finances. And then all of sudden, you get a notice that says, oh, your services are being terminated, you have ten days to appeal. It's been said several times by people-- and I do agree with that-- that, you know, I think everyone is aware of the mail time and it, it-- people don't always check their mail and I agree with all of that. And that's one reason why I support the change and the addition to the timeline. But also, I think it's easy to overlook for-- just-- you know, I believe she said a reasonable person-- I like to use the, the grandmothers example rather than a reasonable person. If, if there was a typical grandma who got this letter, what would she think? And when people get these, they're terrified. They, they freeze up, they lock down, they get worried about I don't know what's going to happen. So it's-- many times, people will come to me like on the tenth day after they've gotten the letter and say, I finally decided I need to do something about this or I didn't know who to call, I didn't know what to do. I called around to some advocacy agencies and they gave me some names and we called around and it just-- it takes a while to get, to get those answers that you need. So, so that's primarily the, the extension of time. I wouldn't mention-- I don't think it extends the timeline for appeal. I think the law gives you a 90-days time to appeal anyway. It just extends the time from when the adverse action is taken back to that 30 days. But I think the Senator, when she introduced it and said that you can still appeal beyond the ten days-- even as it is now, it's just that you're no longer able to continue to receive services while that appeal is pending. But further on the notices themselves, they're very-- they say that you've been-- the state is going to take an adverse action. It talks about-- you have-- and it says the reason why-- there's a reason why this action was taken. And then it just cites some Nebraska administrative code and when you actually go to those codes, generally, they're just, like, the eligibility codes anyway. It doesn't actually say what was looked at, why your information was faulty. And a lot of times when I'm representing clients in these-- usually-- and they do appeal them. We don't know until we get the exhibits from the department about what information was lacking. And oftentimes, it's really just a matter of-- not that they don't have the right information that, that would make sure that they maintain eligibility, it's just that the families didn't know what information to submit. They didn't get the right information. So there are a lot of times that we're looking at this information, we're able to see why they were actually denied. And then we can submit that information and thankfully, several times, we're able to resolve these without a hearing and reestablish eligibility.

But if that information is in the notice that allows families to understand what information is lacking, that would be so much easier and avoid so much cost and hassle for both families and the state to, to start the appeals process, to get the state legal teams involved, and all of that. So I think that-- I went a little out of order from my letter, but it's in there too and most of that stuff is in there. But I do think it's important that this change is made to allow that, that those people who rely on these services are able to do that and to get the help that they need. And with that, I'm happy to answer any questions anyone would have.

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

WILLIAMS: Thank you, Senator Howard. And thank you, Mr. Kelly. Two really quick questions; you brought up the grandma waiting-- you know, kind of closing down and waiting till the tenth day. If we pass this legislation, will grandma just close down and wait until the 30th day?

SEAMUS KELLY: I, I don't think so. I think--

WILLIAMS: OK.

SEAMUS KELLY: Really what happens, I think, is that people get it and they sit on it about a week. I mean, realistically, I think you get bad news, you trying to figure out what you're going to do, and then you say, oh, my-- I've got to figure something out. I don't know what to do so I asked my friend or I asked someone who's at, you know, an advocacy group or something. I don't think it's that they would shut down just permanently, I think it's just anybody when you get bad news, it's hard to make a decision to act on it right away.

WILLIAMS: My, my second question; when, when you have been involved and you contact the department, do they have, readily available, the information that you need to determine why the-- why, why they're being terminated?

SEAMUS KELLY: I would imagine that they have the information available. The-- under the administrative appeals laws and the act, the-- they have--

WILLIAMS: My question--

SEAMUS KELLY: --to provide it. I don't give the exhibits until usually about five days, five to ten days before the hearing is scheduled. I believe they have the information, but usually, the process is then

the State, the department, they have a summary of why they took the decision. But a lot of times, even just knowing what information was missing allows me to say, oh, here, you don't have any information that shows this. Do you have that? Can we get that?

WILLIAMS: And I'm heading down the path-- and someone else, I'm sure, from the department can answer this-- is how, how-- what is the difficulty level of being able to provide that information in the notice? That's, that's my question. I don't know that you can answer that.

SEAMUS KELLY: Right, I don't--

WILLIAMS: --somebody else coming.

SEAMUS KELLY: Yeah. But I do think there needs to be some information, some help-- actual helpful information in the notice, which shares why, why you're there.

WILLIAMS: Thank you, Mr. Kelly.

SEAMUS KELLY: Absolutely.

HOWARD: All right. Any other questions? Seeing none, thank you--

SEAMUS KELLY: Thank you.

HOWARD: --for your testimony. Our next proponent testifier for LB955. Seeing none, is there anyone wishing to testify in opposition? Welcome back.

JEREMY BRUNSSEN: Good afternoon, Chairwoman Howard and members of the Health and Human Services Committee. My name is Jeremy Brunssen, J-e-r-e-m-y B-r-u-n-s-s-e-n, and I am the deputy director for finance and program integrity for the division of Medicaid long-term care within the Department of Health and Human Services. I am here to testify in opposition to LB955, which will change the time frame Medicaid beneficiaries can maintain their benefits for requesting a state fair hearing following a notice of action. LB955 also mandates that specific information be included in the notice of action. So I'm going to not read through my entire testimony, but I want to hint on a couple of things and I think there are probably some questions, so. So first, currently, the department does include all the information outlined in Section 3 of the proposed legislation on page 2, line 17 to 24, on all notices of action. This is mandated by the federal

Medicaid regulations found at the CFR. That's notated in a copy of the draft of the testimony that's provided. I think where I want to kind of jump to, then, is to talk about where this proposed bill, potentially-- is actually, potentially, more restrictive than federal Medicaid regulations that we wanted to point out just so that way, it was understood; one of the reasons-- really the primary reason why we're in opposition to this bill. So, for example, you know, federal Medicaid regulations, specifically state that the beneficiary may maintain services if they request a hearing before the date of action. And the date of action is defined in federal Medicaid regulations, at the CFR that's notated for you there, and defined as the intended date in which a termination, suspension, reduction, transfer, or a discharge becomes effective. So, for example, if DHHS were to send out a notice of action today, just-- so today, literally, today, January 29, discontinuing eligibility, the date of action would be March 1, 2020, based on federal timely notice requirements. Under the federal law, the beneficiary would have until the date of action, in this example, March 1, 2020, to request a state fair hearing and continue benefits during that period. Under LB955, however, the beneficiary would have until February 28, or 30 days after the notice is mailed so it's actually a bit more restrictive. Because of this, this discrepancy, the state would be, potentially, in violation of the federal law and would be implementing a more restrictive time frame than federal law allows. I would like to note that currently, this chapter of our regulations is under the process of updating the regs and going through the promulgation process and is in our final review with the department. Any questions?

HOWARD: I do. Because I, I am not sure if I understand. So we're not-- I'm not going to ask any questions about Section 3 because you're already doing it and that's not the issue, right?

JEREMY BRUNSSEN: So all of the, all of the requirements that were listed in the bill are, are actually already on the notice of action. So you know, I think-- what I've heard today is-- it's definitely feedback that we maybe need to take into consideration from beneficiaries, recipients around concerns about how the layout of the actual notice of action is provided. I think some of that-- we're open to the feedback in there. I think part of it is we have to make some technology changes in order to accommodate that. What I am-- what I do understand is that there is limited information on those as to why the action was taken, such as failure to provide required documentation or

over the income limit, but I'm not sure the level of detail beyond that is provided.

HOWARD: OK. So I want to ask about the state of action issue because I'm not sure, I'm not sure if I understand, sort of, what you're saying. So what's, so what's the difference between the ten days that we're working on and the 30 days that's proposed?

JEREMY BRUNSSEN: So in current Medicaid regs or historically, beneficiaries have had ten days since-- after the notice of action to contact the department to have continuous-- to maintain their eligibility while they're going through the appeal process. Recent-- in the last year or two-- I don't have the exact date. We can follow up with you on that-- Medicaid felt right for update it [SIC] and basically stated that beneficiaries have until the effective date of the action, up until that date, to maintain their eligibility while the appeal is going through the process. So because of the way we process and we treat eligibility and with capitated arrangements, just high level-- if a beneficiary receives a notice of action from us after the 20th of the month, for example, they actually get not only the rest of this month, but the following month before that is effective versus if it's prior to the 20th, it's effective the next month.

HOWARD: I-- so let me maybe-- because I'm really struggling with this and, and I--

JEREMY BRUNSSEN: OK.

HOWARD: --want to make sure I understand it. So is there a possibility that I could receive a letter today where the date of action is February 1st?

JEREMY BRUNSSEN: No.

HOWARD: No. OK and why is that?

JEREMY BRUNSSEN: Because we have to provide at least ten days notice and we-- because of-- we can't provide that ten days notice in, in a capitated-- in a managed care environment. We don't pay for a partial month, we only pay for a full month. So we can't cut you off after, say, the 20th of the month. We can't-- we have to cover the next following month because it would be in violation of the ten-day notice requirement. So if we, if we-- no, if we make a determination and

provide a notice of action, we can't make it effective on the 1st of February because it's not at least ten days out.

HOWARD: OK, I-- and so--

JEREMY BRUNSSEN: So we'd cover the entire next month.

HOWARD: What I'm hearing, though, is that sometimes people-- there's a difference between when the notice is mailed and when it's received. So could I receive it today and you would cut me off on February 1st?

JEREMY BRUNSSEN: I can't, I can't say for certain. I would have to rely on the experience that others are saying-- I can't say for certain when something gets postmarked and sent and when it's received. I can't answer that with confidence, though.

HOWARD: OK. Is there a possibility, though, that I could get a letter that you mailed on the 20th and I get it today and it's cutting off my coverage on February 1st?

JEREMY BRUNSSEN: I suppose-- anything's possible, so I don't want to say it's not possible.

HOWARD: OK, OK. Other questions? Senator Arch.

ARCH: I want to ask-- I want to go back and ask this question a little bit differently. Just for clarification, when does the ten days start; when you mail it or when they receive it?

JEREMY BRUNSSEN: So it's when the notice of action-- ten days from when we make the determination so when we, when we send it.

ARCH: When you send it; so when it's, when it's dropped in the mail. Now that may be a little different because you just said the date of determination. Do you, do you make the date of determination the day you send it?

JEREMY BRUNSSEN: No.

ARCH: OK, so you--

JEREMY BRUNSSEN: Well--

ARCH: --you may have some days there to--

JEREMY BRUNSSEN: I'm, I'm-- yeah, I want to make sure I'm not commingling concepts and words.

ARCH: Right. Please, please help.

JEREMY BRUNSSEN: So I think there's a difference being the date that the termination is made and the notice of action. The notice of action is essentially the effective date.

ARCH: Yes.

JEREMY BRUNSSEN: So reask your question and make sure I'm tracking.

ARCH: OK, so the ten days is-- it refers to what?

JEREMY BRUNSSEN: So we can't-- we cannot make-- the effective date of the notice of the action, we can't make that less than ten days from the date that we mailed a letter, that we make the determination.

ARCH: Those two are synonymous; mailing the letter and the date of determination?

JEREMY BRUNSSEN: Well, I'll have to follow up on the exact timing of it. I just can't speak-- but we can follow up on that.

ARCH: OK, but you can't make it less than ten days?

JEREMY BRUNSSEN: Right.

ARCH: So you used the example of the 20th of January, but if you were the 19th of January-- if you dropped that in the mail the 19th of January, then you are-- you would be within the ten days?

JEREMY BRUNSSEN: Right. You would be--

ARCH: You would be-- you could do it, but you're saying because of our managed care environment, that's not possible. You're going to, you're going to carry it through to the next month.

JEREMY BRUNSSEN: So it's actually the inverse. So if it's prior to the 20th, then it's effective on February 1st. If it's after the 20th or 20th or after, it's effective March 1st because it's not-- we haven't-- we wouldn't have ten days to provide them adequate notice.

ARCH: OK, thank you.

HOWARD: Other questions? Senator Cavanaugh.

CAVANAUGH: Thank you. You maybe saw me scrolling on my phone. I wasn't trying to be rude, I was trying to find the federal Medicaid regulation that you stated here. And, and perhaps you can provide a copy of what you're referring to because when I pull that up, I cannot find anything that talks about the notice and the ten-day notice.

JEREMY BRUNSSEN: I can, I can have our team follow up.

CAVANAUGH: That would be great, I think it would be--

JEREMY BRUNSSEN: Which specific one are you referencing just to--

CAVANAUGH: How about all of them? They all would be-- whatever you are, are specifically referencing within here, if you could send that to the committee, that would be very helpful. So since I can't do that, I'm going to turn to the fiscal note, which seems to be the crux of the issue here, reflecting that it is the department's understanding, based on the cited federal regulations, that if you change the ten-day notice, then we're no longer compliant with federal law, which means we would have to pay for any services covered from day 11 to day 30, is that accurate?

JEREMY BRUNSSEN: Well, I think it's, it's a bit more complicated than that. I think that-- well, our biggest concern is that the, the bill requiring a 30-day could actually potentially be more restrictive than what's required by federal law, so--

CAVANAUGH: So have you had a conversation with CMS about this?

JEREMY BRUNSSEN: I personally have not.

CAVANAUGH: Has-- before this your testimony was prepared, did somebody--

JEREMY BRUNSSEN: I can't say whether or not there was a conversation. I'm personally not aware of one.

CAVANAUGH: So, OK. I apologize, but you are testifying in opposition to this based on, on sharing departmental information to the committee about why the department is in opposition to this, but I don't, I don't understand why the department is in opposition to this if the department didn't do its due diligence to talk to the federal government to ensure that your opposition was valid. And you're not

able to speak to whether or not that due diligence was done, which is-- I'm going, going to speak for myself here-- very frustrating to have you here doing that. So in the future-- and perhaps you could follow up with the committee with that information because I think it's extremely important for us to know what due diligence was done to enact a $240,000 fiscal note, so I would appreciate that.

JEREMY BRUNSSEN: Thank you, noted.

CAVANAUGH: Thank you.

HOWARD: Senator Hansen.

B. HANSEN: Thank you. What happens if it was 15 days? Is that better than 30 days?

JEREMY BRUNSSEN: So I, I think this is where I run into the concern around the fact that-- potentially, that any defined specific date that we list could potentially conflict with the federal reg. So that's really our position. It's, it's-- I don't think that we oppose the idea of giving individuals additional time to appeal. That's not the department's position. We just want to make sure that what we do aligns with the federal reg. That's it, which is what we're doing currently in our promulgation process. That's really our position.

B. HANSEN: All right.

HOWARD: I, I-- one of the testifiers handed out the POMs for Social Security, the program operations manual, and it says providing the ten-day advance notice, it has to be mailed at least 15 days-- are you mailing them 15 days or are you mailing them ten days?

JEREMY BRUNSSEN: So I can't-- I'm not sure exactly which statute was referenced. I know there was some talk about 469. The section that impacts Medicaid is actually in, not in 469, it's in 477, so I don't know. I wouldn't be able to speak to it without getting copies and having our team have a chance to look at it.

HOWARD: Sure. Senator Arch. No. Senator Murman.

MURMAN: Yeah, just so I'm more clear on it, I haven't asked a question yet.

[LAUGHTER]

MURMAN: So say it was mailed-- the, the determination and the mailing took place January 19th. They may not get the notice until about the 25th, 26th. Would it take effect, then, February 1st?

JEREMY BRUNSSEN: Yes, sir.

MURMAN: So that's really only about five-days notice, the way I look at it. OK, thanks.

HOWARD: Can you also-- before I go to Senator Cavanaugh, can you also help me understand the, the fiscal note because I feel like I don't understand the cost associated with it?

JEREMY BRUNSSEN: I think that what I would like to do is follow up formally with you--

HOWARD: Oh, OK.

JEREMY BRUNSSEN: --in writing because I think it's a challenging issue and it's-- and I apologize, Senator Cavanaugh, we'll do our best to follow up and try to provide clarification around it.

HOWARD: OK, because-- I mean, I understand incapitated--

JEREMY BRUNSSEN: Yeah.

HOWARD: --payments. Like, I'm with you on that, but I'm just-- I'm not understanding the, the additional costs associated with the--

JEREMY BRUNSSEN: So our-- I can speak from the Medicaid position. I think our concern is more about aligning with federal regs than the fiscal because I think there's always some give and take, depending on, you know, how the-- and I'm-- and our, our position is relative to how the bill was written, you know? So I think, from our perspective, there are scenarios where we don't know what to expect in terms of how many people will actually activate and take action over a longer period or over more time than what's current day. But I think our concern is just aligning federal regs, but we'll follow up and provide some more information on the fiscal.

HOWARD: And then there was another question and I apologize, Senator Cavanaugh, it seems like the bare minimum is ten days and this is giving you 30. So I'm just-- I, I don't understand how it would be more restrictive.

JEREMY BRUNSSEN: Yeah, so the example, there would be-- literally, if we had a notice go out today, we would be, we would be saying in our state statute that you, you get-- you can-- it's 30 days, when in fact, based on the current federal Medicaid reg, it's based on the date of, of action, which is the effective date, which would be March 1st. So it could actually shorten that--

HOWARD: Oh.

JEREMY BRUNSSEN: --period for the beneficiary.

HOWARD: So it's really just a language change. The language needs to say 30 days from the date of action, as opposed to 30 days after the date of notice; isn't that the day of notice?

JEREMY BRUNSSEN: I think it's more aligning to the actual-- the federal language.

HOWARD: Didn't you say date of notice? I'm so sorry, you said date of action. So it needs to say date of action instead of date of notice on line 27?

JEREMY BRUNSSEN: So the-- basically, you must request the, the hearing before the date of action. So the date of action is defined as the date intended, in which the termination, dispense, reduction, transfer, or discharge becomes effective.

HOWARD: OK. So potentially, the drafters used the wrong language here on line 27 on the green copy?

JEREMY BRUNSSEN: I think there'd be an opportunity for us to have a conversation if there's a way we could--

HOWARD: OK.

JEREMY BRUNSSEN: --help with that.

HOWARD: OK. Thank you, thank you for that. Senator Cavanaugh.

CAVANAUGH: Thank you. So I, I wanted to take the opportunity, since we have you here to address what Ms. Maresh from Appleseed had mentioned about the notification and having a specific person or persons within DHHS with knowledge of the determination that the beneficiary may contact. And so I just wanted to, to put that to you. Is that

something that the department could consider doing, making these notices more informative?

JEREMY BRUNSSEN: So I'm happy to go back and talk with their eligibility policy teams and with our policy and regs teams that actually work on these day to day. I, I have no problem going back and asking what, what, what is possible.

CAVANAUGH: Would you be willing to work with some of the people who testified today? We had our federally-qualified health centers testifying and it, it sounded-- that they were indicating that they would find it helpful for their-- the people they serve to have more information on those notices as well. Would you be willing to, to work with them on that?

JEREMY BRUNSSEN: Yeah. I mean, I, I welcome any feedback. People can send me comments and we can follow up with them.

CAVANAUGH: OK and just want-- wanted to put into the record that you had 16-days notice on this piece of legislation, which is more notice than we give to the individuals impacted by this legislation. So when this was introduced on the 13th of January, did the department begin working with Senator Walz and her staff on their concerns with the language in this or is this the first time that this is being raised?

JEREMY BRUNSSEN: I-- you know, I'm not aware of any conversations that have happened with-- I'm not involved in every conversation, to be quite transparent with you. So I'm not aware, but-- and I can't say whether one happened or not.

CAVANAUGH: Thank you and I appreciate your flexibility on your first time in front of us.

JEREMY BRUNSSEN: Happy to be here.

HOWARD: All right, any final questions? Clear as mud? All right, thank you, Mr. Brunssen, for visiting with us today. Our next opponent testifier. Seeing none, is there anyone wishing to testify in a neutral capacity? Seeing none, Senator Walz you're welcome to come up and close. I'm going to read your letters--

WALZ: All right.

HOWARD: --into the record while you're coming up. Proponent letters include: Amy Behnke, the Health Center Association of Nebraska; Linda

Jensen, Nebraska Nurses Association; Joey Adler, Holland Children's Movement; Nick Faustman, American Cancer Society; Mary Sullivan, National Association of Social Workers, Nebraska Chapter; Sherri Jones, Nebraska Speech-Language-Hearing Association; Heath Boddy, Nebraska Health Care Association. There were no letters in opposition or neutral. Welcome back, Senator Walz.

WALZ: Thank you very much and thank you-- I just want to thank all the testifiers who came today. Again, LB955 intends to require the Department of Health and Human Services to provide further support and an explanation for any proposed action when eligibility of services are discontinued. And also, just to make sure that there's a 30-day notice to appeal that decision by the department. We would be very happy to work with the department on language to clarify expanding the timeline in an amendment if needed, if they feel it's important. What I feel is more important is adequate notice for individuals who are to be removed from Medicaid, as well as an explanation on why they were removed and how to appeal that process. So with that, I would answer or try to answer any questions, but I think what we need to do is work with the department on expanding a timeline in an amendment.

HOWARD: All right, any questions? Senator Cavanaugh.

CAVANAUGH: Thank you, Senator Walz. Next year, if we have a similar bill, would you bring the postmaster general with you?

WALZ: Yes.

[LAUGHTER]

CAVANAUGH: That would be helpful, thank you.

HOWARD: All right, seeing no other questions, thank you, Senator Walz. This will close the hearing for LB955 and we will open the hearing for LB956, Senator Walz's bill to provide duties for managed care organizations under the Medical Assistance Act. Welcome, Senator Walz.

WALZ: Thank you, Chairwoman Howard and members of the Health and Human Services Committee, the best committee. For the record, my name is Lynne Walz, L-y-n-n-e W-a-l-z, and I proudly represent Legislative District 15. Today I am here to introduce LB956, a bill to provide duties for managed care organizations regarding provider agreements. The core of this bill requires a managed care organization to notify a provider whenever there is a material change to a provider agreement

that is not otherwise clearly identified in the provider agreement that decreases the provider's payment or compensation or changes administrative procedures in a way that would significantly increase providers' administrative expenses. This legislation also sets out requirements for standard procedure MCO should adhere to in the notification process. Further details can be found in subsection 3. In this process, the bill dictates that the provider has the option to either accept or reject the proposed change. Should the provider accept the change, everything goes on as normal. Should they reject the material change, there is a time period of one month for the provider to submit a written protest to the MCO. Within 30 days after the receipt of the written objection, both parties should then meet in an attempt to reach an agreement. Should this negotiation effort fail, 30 more days are allowed for the parties to unwind their relationship. You may be asking yourself why do we need this? I can only share with you what I've heard from providers. A lot of them feel they are not being heard and their concerns are not being understood. There will be a number of people following me with more detailed and more personal experience than I-- than what I have. But I wanted to share with you a little bit about what I've been told. Right now, what the providers have is an online portal that houses all of the language regarding their agreement. To my knowledge, it can be changed at any time without notice. I have heard about circumstances where a provider will be receiving their reimbursement one day for a service and the next day they will apply for the same reimbursement and be rejected with no, no notification of the change. It will then be their responsibility to eat the cost of that service or procedure. I have also heard stories of an MCO not allowing a private provider to diagnose and treat an individual in the same day for a physical therapy procedure. While I understand they probably have some reason for their decision, this causes problems with the delay of care. If someone is in extreme back pain and they can't receive care for another couple days, this could exaggerate their injury. Again, I would just like to reiterate that there are people following me who could share more details regarding these stories or answer your questions. And I want to stress that this is not only a financial drain on our providers, but also a health issue for our Medicaid patients. Thank you and if you have any questions, I would be happy to try and answer them.

HOWARD: Thank you, Senator Walz. Are there questions? Seeing none, will you be staying for close?

WALZ: Yep.

HOWARD: OK. Our first proponent testifier for LB956.

GRACE KNOTT: Last time I was here I went way past the red, so I hope I don't do that this time. Senator Williams, I think you were the one that stopped me last time. Senator Howard and members of the Health and Human Services Committee, my name is Grace Knott, G-r-a-c-e K-n-o-t-t. I'm currently president of the Nebraska Chapter of the American Physical Therapy Association. I've been a physical therapist for the past 41 years. And I feel right now, and I really believe, that my profession is on the brink of collapse due to the administrative burden continually heaped upon my profession over the past several years, resulting in less time available to meet the needs of the patients we serve. I am in front of you today to express my support for LB956, fair and transparent contracting for Medicaid providers. As president of the Nebraska Physical Therapy Association, I have felt tremendous responsibility and burden to provide timely and effective communication to the over 1,300 members of our association regarding policy changes implemented by the three Medicaid managed care organizations. I have felt the burden was on me and not the MCOs to provide policy information for our members. For example, I was called in late July of last year by UnitedHealthcare Community Plan to give our association advance warning about a new authorization process that they were implementing on September 15. That was just six weeks away. I was happy to get the advanced warning, but felt it was up to me to get the information to the members. They gave me a very brief overview of the authorization process and told me about an upcoming educational session they were doing for contracted providers. This education was slated for late August, two weeks away from the implementation date. As the new authorization process was rolled out, we found out that the education was inadequate and many aspects of the policy were found out after therapists started getting denials for requested therapy services. I've had many association members call me and tell me the amount of administrative time that this new policy caused due to the short implementation timeline. One large facility in Omaha who treats many Medicaid beneficiaries informed me that they were spending 30 to 40 hours per week on just this new authorization process for UnitedHealthcare alone due to educating physicians about the new process, educating beneficiaries, calling UnitedHealthcare for clarification. Because of the short turnaround, over 20 patients in this facility have had significant delays receiving needed therapy services. The MCOs will tell you that they have provider protocols for

provider updates on policies and rely solely on this for communication. I'll tell you, healthcare providers are busy people and cannot spend time on the internet to watch for provider bulletins. I have a hard enough time going in there and reading it myself and disseminate information to where I work at. We need this bill passed so that we have a set policy for communication with adequate time to review and prepare for new policy changes. I want to say this is not just a problem with UnitedHealthcare Community Plan. We've had similar problems with other MCOs. Nebraska Total Care implemented a prior authorization policy in April of last year. Just overnight, denials of needed therapy services were rampant due to policy implementation of an essential health benefits mandate. They were interpreting numerous needed therapy service requests as nonessential health benefits. Advanced communication and education of a forthcoming policy change to healthcare providers should be mandated by our state to allow healthcare providers adequate time to review and determine the impact that policy change will have on their practice. When this does not occur, it can be devastating. Recent policy changes from the three MCOs cause pediatric therapy practices, who see a high percentage of Medicare beneficiaries that were hard hit when advanced communication does not happen, affecting access to care, stress, and increased administrative cost. Lastly, Heritage Health MCOs do not provide adequate education to the frontline employees when they do implement policies. During this last three years, so many times we have called the MCOs and called who we are supposed to for beneficiaries and they are telling us the wrong thing. And we were educating them regarding what the provider bulletins were saying. So this points to, also, an inadequate timeline that happens so often with policy changes. I strongly encourage you to advocate to advance this bill. This is needed to help the providers that are willing to provide care to our most vulnerable populations in the state to have effective, streamlined policies that can focus on providing skilled care and enhancing quality of life. Thank you for your time today.

HOWARD: Thank you. Are there--

GRACE KNOTT: Any questions?

HOWARD: Are there questions? All right, seeing none, thank you for your testimony today. Our next proponent testifier. Good afternoon.

JESSICA THOENE: Good afternoon. Hi, Senator Howard and members of the committee. My name is Jessica Thoene, J-e-s-s-i-c-a T-h-o-e-n-e. I am here today-- I'm a speech-language pathologist and owner of Alpha

Rehabilitation in Kearney. I'm testifying on behalf of the members of Nebraska's Speech-Language-Hearing Association. We are in favor of LB956. The Nebraska Speech-Language-Hearing Association represents speech-language pathologists, audiologists for the state of Nebraska, practicing in hospitals, private practice, and school districts. Alpha Rehabilitation is an outpatient clinic in Kearney and we serve adult and pediatric population with a range of orthopedic and neurological diagnosis. We contract to provide adult and pediatric services with various hospitals, nursing homes, and school districts. I've testified in front of you many times the last few years regarding the ongoing issues providers face with the managed care organizations in the state of Nebraska. Providers have to quickly adjust to unexpected changes in Nebraska Medicaid managed care plans for the past few years. MCOs have placed unreasonable demands on providers with no warning, have not engaged stakeholders and proposed changes to the plans, and have not been accountable when these changes result in delays or no service for patients and increase administrative burden and costs for providers. This bill will help ensure the providers are adequately notified in advance of the changes to the way we practice. This allows communication to occur on the presented changes and finally, the option to leave the provider network if a compromise has not been met. We can provide you with an example how with no warning, MCOs can implement an immediate change and the negative way it impacts providers. UnitedHealthcare enacted a double preauthorization for patients to receive physical, occupational, and speech therapy. This process was enacted without engaging providers to gather input on the implications that this may have to the providers. The time for enacting a system-wide change that affected providers, physicians, and patients was less than six weeks. The new requirements asked for physicians to request authorization for therapy services, which was not required in the past. Many times, it takes more than six weeks to get an appointment with a pediatrician or doctor for a well check, which then would delay therapy services. UnitedHealthcare was also requiring individual education plans from school systems. An IEP is put together by a school staff to allow children to access the educational environment and had no bearing on medical treatment. Speech-language pathologists have complied with the request, which is the following options: request and submit the IEP, submit a statement that a speech-language pathologist is unavailable to provide an IEP and verify that the child is receiving school-based services, submit attestation that the child is not receiving school services. And in spite of submitting this documentation, speech therapy clinics continue to receive denials for not having an IEP on file.

UnitedHealthcare asked providers to use a portal to submit authorization requests, but the portal has had so many issues and was not ready for use. UnitedHealthcare issued the providers a list of specific therapy codes that had to be used. However, the speech therapy code that they provided was not even listed on the Medicaid fee schedule and it was not even possible to submit an authorization request for these speech therapy services. Clinics across the state have experienced extreme delays in seeing patients; delays up to a month due to the unnecessary administrative burdens of this broken system. The biggest issue was that UnitedHealthcare staff was not properly educated or trained on how to implement the new system of requirements, which resulted in mass confusion to providers and physicians. How are providers supposed to figure out the rules when the representatives from the insurance companies don't know what the rules are? I could go on and on about the ways that this prior authorization process is not feasible. What was the outcome? Massive administrative burden cost to providers and medically-complex clients that did not receive service. There has been no impact on the MCOs except no reimbursement required to be issued until providers struggled to figure out how to jump through the hoops. Inconsistent and frequently changing rules is making it unfeasible to practice and provide therapy services in this state. The state of Nebraska can do better for the clients we serve and keep our providers in this state and network. We are blessed, in the state of Nebraska, to have providers that will stand up and fight for the right of the population that sometimes go unheard. LB956 would help us ensure that Nebraskans don't receive further delay in care and providers can continue to deliver the skilled care that we want to. We respectfully ask that you support this legislation and I would be happy to answer any questions.

HOWARD: Thank you.

JESSICA THOENE: Um-hum.

HOWARD: Are there questions? May I ask--

JESSICA THOENE: Sure.

HOWARD: If this legislation had been in place when these changes were being made by UnitedHealthcare, how would it have worked, then, in that instance?

JESSICA THOENE: I think it would have gave providers a lot, a lot longer to prepare for this change. And knowing that a child had to

have an appointment by a physician in order to continue services, we would have been able to provide that information to the patients and they would have been able to get in and the delays wouldn't have been able to happen. I think the, the bigger issue is that we haven't been able to have conversations and our feedback hasn't been heard. And so I think with this legislation, it would open the lines of communication more.

HOWARD: All right. Any other questions? Senator Williams.

WILLIAMS: Thank you, Chairwoman Howard, and thank you for being here. And that led me down the line that, that-- the legislation that is proposed creates these time periods and these windows in which to have conversations. But it also leads us down a path of saying, what if you don't have an agreement? You know, sitting down at the table and they say no and you say yes and we're there. And at the end of that, it appears to me that their, their suggested change goes into effect, but you're given an opportunity, then, to remove out of--

JESSICA THOENE: Out of the--

WILLIAMS: --that managed care organization--

JESSICA THOENE: Yeah.

WILLIAMS: --or whatever. What does that do to your patient--

JESSICA THOENE: Well, it's, it's--

WILLIAMS: --if they're carrying the UnitedHealthcare Plan or the Nebraska Total Care, you know, whatever?

JESSICA THOENE: Um-hum. I think that's the crisis we're in right now, is that there is a provider shortage. Due to all these constant changes, providers can't keep up and they can't afford the cost to figure out what the rules are to get paid so the provider network is decreasing. I see this as opening the lines of communication to hopefully have better conversations, that we keep those providers in network. But ultimately, it does give the provider a little bit of an out to be able to exit the contract if they don't feel like it's going to financially be able to be sustainable in a practice.

WILLIAMS: Thank you.

JESSICA THOENE: Um-hum.

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

JESSICA THOENE: Thank you.

HOWARD: Our next proponent testifier for LB956. Good afternoon.

MARY WALSH-STERUP: Good afternoon, Senator Howard and committee. Good afternoon, my name is Mary Walsh-Sterup, spelled M-a-r-y W-a-l-s-h-S-t-e-r-u-p, and I'm here on behalf of the Nebraska Occupational Therapy Association, speaking in support of LB956, fair and transparent contracting for medical providers. I have chosen to speak for NOTA as a representative because I'm a private practice owner. We have clinics in Lincoln, Grand Island, Aurora, Hastings, and Kearney markets. Since its inception of Heritage Health, the Medicaid managed care organizations chosen to provide quality healthcare to Nebraskans have implemented changes with little or no notification and without collaboration from any of the impacted disciplines. These policy changes, such as the recent preauthorization systems set in place by Nebraska Total Care and UnitedHealthcare plans, have resulted in our clients not receiving their medically-necessary occupational therapy services in a timely manner. And to give you a really good example of this-- is UnitedHealthcare-- they spoke about how they just suddenly threw out this preauthorization by the physician. This started in September of 2019. Just last week, we had a patient come into our office with a referral. We had to turn the patient away, tell him to go back to their physician, get the order from their physician to call into UnitedHealthcare. We contacted the physician's office. They had no idea, they'd never heard of it before. We had to educate the physician on it and to this date-- I checked this morning and this person has still not had the authorization to get their care and it's been over two weeks. This result of lack of notification training to the providers has resulted in a delay in care not only of this patient, but many patients across our organization and across our practice as Nebraska occupational therapists. Occupational therapists across the state have contacted us with multiple delays in care and concerns. A delay in occupational therapy services is incongruent with published evidence and best practice, which compromises the overall client outcomes. With the decline in outcomes due to the delay in services, patients will seek additional medical care, which will only cost more money and be more expensive options. The implementation of LB956 would provide accountability to the managed care organizations

to work collaboratively with providers to ensure implementation of policies that are attainable and work for the best interests of our recipients. It is also important to note the complexity and lack of training on the policy changes have led to increased administrative burden on occupational therapists and other providers across Nebraska. The significant increase in administrative burden is creating a challenge for clinics across Nebraska. For example, one small clinic that provides OT, PT, and speech therapy services had to hire a full-time employee just to manage their UnitedHealthcare Community Authorization Plans. Larger hospitals have created new departments solely dedicated to Medicaid authorizations. Medicaid services in Nebraska for occupational therapy are often provided below cost due to the low reimbursement and the increasing administrative burden. This model is not sustainable. This will force practitioners to make the difficult choice to stop providing therapy services to Medicaid recipients in Nebraska. And I'd just like to note here, too, that if you really look at the researching, if you follow things, therapy is really becoming cash pay because of policies like this. And who gets left out? The Medicaid recipients, if it becomes a cash pay industry. Advancing and passing LB956, which is budget neutral, improves communication, accountability, and potentially greatly reduces any delay in services that Medicare recipients are, are currently experiencing with the policy changes. We strongly encourage you to advance LB956, as it will ensure there is a fair and transparent process used by all Medicaid managed care organizations in their communication of policy changes. This would prevent any unnecessary delay in access to care for Nebraska's most vulnerable and allow our clinics to continue to deliver evidence-based, cost-effective therapy. I ask you to support LB956 and thank you for hearing my testimony today and I'm open to any questions.

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

CAVANAUGH: Thank you. Thank you for being here.

MARY WALSH-STERUP: Um-hum.

CAVANAUGH: So they are-- therapies that are covered are being denied is that--

MARY WALSH-STERUP: Yes.

CAVANAUGH: --am I understanding correctly?

MARY WALSH-STERUP: Yes.

CAVANAUGH: OK, so the state is paying our MCOs to cover individuals and those individuals should be covered for these services and those services are being denied. And that's why it's budget neutral because we, as a state, are already paying MCOs for the services or for the coverage?

MARY WALSH-STERUP: Yes, but that's, like-- the, the reason we're talking about this today is that we want to be notified--

CAVANAUGH: OK.

MARY WALSH-STERUP: --that there is going to be material changes in their policies and procedures--

CAVANAUGH: Sure.

MARY WALSH-STERUP: --to, to notify the providers ahead of time and not put the burden on the providers to figure it out on their own--

CAVANAUGH: Um-hum.

MARY WALSH-STERUP: --or to educate the physicians and the rest of the community on what their changes are.

CAVANAUGH: OK, thank you.

MARY WALSH-STERUP: Um-hum.

HOWARD: Senator Murman.

MURMAN: Thank you for coming in to testify, Mary.

MARY WALSH-STERUP: Uh-huh.

MURMAN: If I understand it correctly, then, the problem the providers have is that they don't have timely notice of changes and also they're not clear on what the changes are, is that--

MARY WALSH-STERUP: Correct. That's very accurate, yeah.

MURMAN: OK, thank you.

MARY WALSH-STERUP: Um-hum.

HOWARD: Senator Williams.

WILLIAMS: Thank you. You've been doing this for a while.

MARY WALSH-STERUP: Yes.

WILLIAMS: We've been in the Heritage Health situation for over two years now.

MARY WALSH-STERUP: Um-hum, um-hum.

WILLIAMS: How were you given notice of changes before we adopted Heritage Health?

MARY WALSH-STERUP: Well, I'm getting a little older so it's sometimes hard to remember those things.

WILLIAMS: You haven't reached my age yet.

[LAUGHTER]

MARY WALSH-STERUP: I think that's been a problem. It's just been an issue. Prior, it doesn't seem like there is as many of these just sudden changes, like, you do one way for a while and then boom, they change to do another way for a while, boom, they change it to another way. That's kind of what's going on the last few years, which has led to a lot of provider burnout, frustration, and quite frankly, lack of ability for providers to continue to see Medicaid patients.

WILLIAMS: OK and there's also a difference because you're dealing with three organizations now?

MARY WALSH-STERUP: Right and that was-- this was--

WILLIAMS: Have you personally reached out? I have had the opportunity to work with all three of the, the MCOs and their field people dealing--

MARY WALSH-STERUP: Um-hum.

WILLIAMS: --directly with a provider with a problem. Has-- have you and your people done that and it hasn't resulted in any positive change?

MARY WALSH-STERUP: Yes, actually. Several years ago, I came and testified here before this group. I reached out to-- at that time, it

was WellCare. And WellCare reached out to us, as a group, an organization, worked with us, walked through-- we were able to develop a plan that was good for the patient, ultimately good for-- you know, it was a win-win. We've done the same thing with Nebraska Total Care on occasions. We've been able to reach out to them and work with them. We've made attempts over the last six months to, to work with UnitedHealthcare. We've had a meeting with them. We had another meeting where they were all on the phone and then they canceled it and said they'd connect with us again and that hasn't happened yet. But I think it's just-- although we have reached out with them and worked with them, I think it's just that frustration level of here we go again, here we go again; you know, the same thing over again.

WILLIAMS: OK, thank you.

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

MARY WALSH-STERUP: Um-hum.

HOWARD: Our next proponent testifier for LB956. Good afternoon.

BRIDGET ASCHOFF: Hi, good afternoon. My name is Bridget Aschoff, B-r-i-d-g-e-t A-s-c-h-o-f-f. Thanks for having me again and for the opportunity to listen. So I am here as a parent regarding my daughter, Claire, who you heard of last year when I came to testify. And so in January of 2019, we received the devastating news that Claire was going to be kicked off of Medicaid due to the eligibility criteria for the A&D waiver. And speaking to the notices, we actually received three separate notices because they couldn't get their wording correct on why they wanted to deny her and to appeal within the ten days, we had to appeal with the first letter that we received, not the two subsequent letters that we received. And so we scrambled and appealed by the tenth day and then when we got our official denial in August, I opened that letter on August 3rd and she was found ineligible or they were actually kicking her off August 1st and it was dated July 31st. So when we're talking about dates, that's just an example of what some of our families are dealing with. So back to this. So we've been here, I guess, talking-- I've been down to Lincoln probably more times than I can count anymore. But Claire officially-- because the department decided to implement the waiver-to-waiver transfer, she was eligible for Medicaid officially on October 4th. So that's when we started filing for all of those services and our experience with DD Services has actually been really, really good. Our case-- our service

coordinator is awesome. She is on time. She responds, she cares. She's been phenomenal. But dealing with Medicaid has been a very different experience. So when we first filled out our paperwork, they actually denied Claire due to our income. So they did not read our file to look that she had already met the DD waiver qualifications. So we had to go back, get more information, resubmit paperwork. It took me over a week to get ahold of our caseworker at Medicaid because anytime that I call her, it goes directly to voicemail. It doesn't even ring. So I leave voicemails and they don't get returned to a point where I-- there were so many voicemails that you couldn't leave voicemails anymore. So then I just kept trying to call to get in touch with anyone that I possibly could. Eventually, I did get a hold of somebody who was able to help me-- reassure that we've got all of our paperwork to resubmit to get her on Medicaid. So we finally got Claire's Medicaid card in-- earlier this month, January, and they had put us on UnitedHealthcare. So I called our therapy office where Claire has been receiving therapies, OT, PT, and speech, to let them know that we had her card and she said oh no, we had everybody switch to WellCare during open enrollment because UnitedHealthcare has made some changes and they've made filing a nightmare. So I was actually informed that it took them-- they were on the phone for about three hours for one therapy session for one client with UnitedHealthcare. So now we start to panic because we were told that Claire's therapies from October 4th on were going to be covered and they would be covered by UnitedHealthcare. But how are we supposed to provide the documentation that they need if these therapies have already happened? So we decided that we're going to go ahead and switch to WellCare to make things simpler for our therapy provider. When I called Heritage Health to make that change, she told me she could not talk to me because Medicaid had listed Claire, our four-year-old daughter, as the head of our household. Let me tell you, she thinks she runs the house--

[LAUGHTER]

BRIDGET ASCHOFF: --just like most four year olds do, but she does not pay the bills. So she had to call Medicaid to have them change that so that she could talk to me. And then I had to call our therapy offices and Claire's medical team and make sure if we switched to WellCare, would that be a good option? Yada, yada, yada. So we did finally get her switched over. So she'll be on WellCare, officially, February 1, but everything from October through January is going to be dealt with by the UnitedHealthcare. So this is quite a mess and quite a fight. As a parent of a child with special needs, I already fight battles for

Claire that I don't even dream about for our other two typically-developing children. Every time I come down here, we are out hundreds of dollars because I'm not working so there's lost wages. My children are in daycare longer, that's an added expense. Claire is missing therapy today because I am here. So I'm just really frustrated with all of the hoops that we are having to jump through, lots of phone calls and messages that are unanswered and I'm just really frustrated. If, if Total Care and WellCare can provide the coverage that our kids need for their therapies, it doesn't really make sense why UnitedHealthcare is making things so difficult and adding another fight for us. So thank you.

HOWARD: Thank you and thank you for visiting with us again.

BRIDGET ASCHOFF: I didn't cry this time so that's good. [LAUGHTER]

HOWARD: All right. Are there any questions from the committee? Senator Cavanaugh.

CAVANAUGH: Thank you. Thanks for being here.

BRIDGET ASCHOFF: Yeah, my pleasure.

CAVANAUGH: So did Claire actually call and talk to them?

BRIDGET ASCHOFF: If Claire was verbal, I would help her call.

CAVANAUGH: OK. I was like-- I kind of wanted to see this transaction.

BRIDGET ASCHOFF: Right? They had to call Medicaid and I don't know what they all had to do. When we even got her-- when I called back, their documentation was still off with Medicaid. They had one document that said I was-- my husband and I are the head of the household and another one that said that she was. They were able to still switch us over, but I'm like, who puts a four year old as the head of the household?

CAVANAUGH: Well, thank you for coming in--

BRIDGET ASCHOFF: Yeah.

CAVANAUGH: --and continuing to keep us up to date on what's happening with Claire. It's, it's good to know that she's got a great advocate at home.

BRIDGET ASCHOFF: Thank you, I appreciate that.

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

BRIDGET ASCHOFF: Thank you.

HOWARD: Thank you for visiting with us.

BRIDGET ASCHOFF: Yes, good to see you guys.

HOWARD: All right. Our next proponent testifier for LB956. Good afternoon.

BRITTANY SCHUSTER: Good afternoon, Senator Howard and committee. My name is Brittany Schuster, B-r-i-t-t-a-n-y S-c-h-u-s-t-e-r. I live in Kearney with my husband and two boys. My youngest son, Paxton [PHONETIC], is almost 18 months old and he was born with spina bifida. A little background on him, he was born with the most severe form of spina bifida, myelomeningocele, which means part of his spinal cord was outside of his body in a fluid-filled sac when he was born. At 22 hours old, I put the life of my baby boy in the hands of a neurosurgeon and he was able to close the defect, but the nerve damage that was done in utero is irreversible. We applied for the AD waiver before we left the NICU when he was born and he was denied because he wasn't disabled enough yet. We appealed, but it was upheld. Sorry. This is the first time I've talked about him.

HOWARD: It's OK, take your time.

BRITTANY SCHUSTER: After his nine-month well check, we reapplied and this time, he was approved. As an occupational therapist myself, one, one of the benefits I was most excited about was the amount of therapy he would be able to get. He was automatically enrolled in WellCare when we got the waiver, but working in the therapy field, I knew that UHC was easier to work with and to get therapy visits. But September 2019, that changed. He was receiving PT, OT, and speech. His PT called UHC at the beginning of September to try and speed up the approval process. That day on the phone, the UHC rep approved PT for two times a week, but was not able to approve speech and OT and so there was a two-week lull in the services he got. Eventually, they did approve him for one time a week and 18 speech therapy units. So units are different with speech therapy because they usually only build one unit. But like speech has said before, if they don't approve the right

unit, then they can't get it. So he had all three therapies approved until November 15, 2019. He went the week following the 15th without therapy because it wasn't approved. They then approved him for speech therapy after they called and asked if he had a hearing test. And I verbally told the office manager, yes, his newborn hearing test, and that was good enough for them to approve speech at that point. So just my word, I guess they didn't need documentation, but PT and OT were still in the process of getting approved. On November 21, his PT called UHC again to see what she needed to do to assist with their approval. She was informed then that his pediatrician needed to get on the UHC portal and request authorization for new evals for PT and OT even though he had been seeing them all year. I had also called UHC during that time frame just to see if I could provide documentation or kind of, like, try and push it along and just maybe a re-eval to get some visits. And the rep I spoke to that day could not clearly tell me what they actually needed. She didn't know if a pediatrician authorization through the portal was needed or if they could re-eval and submit for more visits. She didn't know. So a week after the 21st, I think-- let's see-- the week after the 21st, I messaged his pediatrician to see if she needed any information from therapy or myself for the new evals and she just kind of asked where he goes and who he sees. Twelve days later, on December 9th, I followed up with her, and she had not been given approval. She had requested off for a new eval and UHC had not approved just her initial request for him to get new evaluations. The rest of the year, we just waited. On January 16th of this year, I took him to the doctor, and during that appointment a case manager at Children's in Kearney came and spoke with me. She told me that as of January 1, there was still no approval just to get the evals done, not even for additional treatment, just for him to be evaled. And we requested those in November. She also said that they had closed the case because when we were able to switch, we decided to go to WellCare. Whether or not it's better, I don't know, but I figured it couldn't get any worse. So, so he went over a month without PT and OT during a very crucial time in his development. He needs all three therapies two times a week to regress [SIC] towards living a productive life. The amount of time it's taking to get approval for evals then submit the signed evals and then wait to hear if treatment is approved is really impeding the health of individuals with UHC. Thank you.

HOWARD: Thank you. Are there questions? Seeing none, thank you--

BRITTANY SCHUSTER: Thank you.

HOWARD: --for visiting with us today. Our next proponent testifier for LB956.

MELISSA KIMMERLING: Hello, Senator Howard and members of the Health and Human Services Committee. My name is Melissa Kimmerling, M-e-l-i-s-s-a K-i-m-m-e-r-l-i-n-g, and I am also an occupational therapist in Nebraska and the policy chair of the Nebraska Occupational Therapy Association. I'm providing additional testimony in support of LB956 on behalf of all therapy services related to the broader national issue before us today and to also provide you some perspective on how this issue has been handled by our neighbors and peers. LB956, a budget-neutral bill, supports healthcare providers in having a set timeline and process when managed care organizations make material policy changes. Our organizations have heard from multiple practitioners and providers and families, as you have heard from today, across the state regarding frustrations and challenges with policy changes implemented by the managed care organizations that impact many of your constituents receiving healthcare services. LB956 would protect Medicaid recipients in Nebraska when pertinent changes occur, who could potentially lose coverage, and as you have seen, have lost coverage of those healthcare services without notice. This problem is not just affecting Nebraska. Recently, our fellow Americans in Kentucky passed legislation ensuring that each insurer offering a health benefit plan shall establish procedures for changing an existing agreement with a participating provider. That includes the requirement of a 90-day notice of the material change, a description of the material change, and notice of the opportunity for real-time collaboration with the participating provider. And they're even so specific to include the font, size, and type. That's Kentucky. Additionally, Louisiana has a clause within their managed care contract that ensures providers receive 30-calendar-day notice in writing of policy procedure changes and maintain a process to provide education and training for providers regarding any changes that may be implemented prior to the policy and procedure changes taking effect. And that's directly quoted from Louisiana. Furthermore, Ohio passed similar legislation and further defined that material change in greater clarity in order to provide for successful implementation of that passed legislation. We would highly recommend Nebraska consider similar clarity should this legislation move forward. In Maine, a carrier offering or renewing a health plan is required to notify a participating provider of a proposed amendment that would have

substantial impact to a provider agreement at least 60 days prior to the amendment's proposed effective date. After the 60-day notice period has expired, the amendment to a manual, policy, or procedure document becomes effective and binding on both the carrier and provider. Additional states with similar language that have been identified by my colleagues at the American Occupational Therapy Association include Minnesota and Washington. I've submitted written testimony on behalf of the Nebraska Occupational Therapy Association in addition, which provides further detail and specific links to each of the aforementioned regulations. I echo that of my esteemed colleagues in saying that it is our belief that LB956 will help ensure that all managed care organizations are held accountable to the same timeline and process for making any change to an already established contractual agreement with a provider, ultimately helping to ensure that Medicaid recipients continue to receive the care necessary to increase their independence, quality of life, and ability to return to the community to work, preventing any increase in disability, applications, or additional citizen taxation. We humbly request that you advance LB956 as this is an issue of urgency and it has a daily impact on Medicaid recipients until it is resolved. Thank you and I'm happy to answer any questions.

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

MELISSA KIMMERLING: Thank you very much.

HOWARD: Our next proponent testifier for LB956.

EDISON McDONALD: Hello, my name is Edison McDonald, E-d-i-s-o-n M-c-D-o-n-a-l-d, representing the Arc of Nebraska. I'll try and be brief because I'm back again, but I did want to come up and talk briefly about this. We are supportive. We've been working with a lot of families that have been dealing with these issues. What we've seen a whole bunch of is that families end up with really inconsistent care and especially the big issue that we've been talking to a lot of families about is with therapies. In order for therapy to work well, it's important to have consistency. And what a lot of families are running into is that they're trying to go and schedule something out. However, they don't know if it's going to be covered by then or not or then they're getting something that's postdated and it is postdated in a way that ends up making it so that they won't be able to get the, the appointment covered by the date they actually attend. This lack of clarity and lack of consistency is continuously causing issues for

families. And I think, you know, it affects the providers in a way that is directly impacting these families. I do want to thank UHC. I know that they've been working on trying to do some more outreach and are looking at trying to do some community events to talk about some of these issues. So I think that there's at least a little bit of good news in that direction. Thank you very much. Questions?

HOWARD: Thank you. Are there questions? Seeing none, thank you for your testimony today. Our next proponent testifier for LB956. Anyone else wishing to testify in support? Is there anyone wishing to testify in opposition to LB956? Good afternoon.

JAMES WATSON: Good afternoon, Senator Howard. My name is James Watson, J-a-m-e-s W-a-t-s-o-n, and I'm the executive director of the Nebraska Association of Medicaid Health Plans. Those plans include Nebraska Total Care, UnitedHealthcare Community Plan, and WellCare in Nebraska. I'm here to respectfully express our opposition to LB956 because we feel the bill is unnecessary and is redundant to existing provider contract language requirements. Initially, the MCO contracts are reviewed by the department at the time we respond to the RFP. And then after that, the contracts are submitted for approval during the rigorous review process. All the contracts that we have include language about notification and policy changes, changes to the agreement, and termination language. And in fact, the MCOs' contracts with the state of Nebraska require the MCOs to notify providers and members of an impending policy change a minimum of 45 calendar days prior to implementation. Administratively, the changes that are outlined in LB956 would require a contract amendment to every MCO provider contract in the state and that would be a significant cost and very time consuming to both the providers and MCOs. I'd also point out that the providers have a forum to discuss any of these changes in provider advisory administrative simplification committees, engaging with an MCO's provider relations representative, hosting on-site meetings with providers by the MCOs, and providers can voice their concerns to Medicaid long-term care. Since 1999, the state of Nebraska has had requirements for managed care plans, but they're in the insurance laws. Section 44-7106 provides that MCOs have to establish a mechanism by which participating providers are notified on an ongoing basis of the specific health services and the coverage. At the time we recruit and sign a provider, we have to notify them of their responsibilities and the benefits they provide, the administrative policies and programs. And interestingly, we are required to have 60-days written notice to each other, the MCO and the provider, before

we terminate the contract or clause. One of the more straightforward requirements is that the MCO has to establish procedures for resolving administrative payment or other disputes and the contracts have language on dispute resolution. I can't address the specifics of whatever policy was put in place, but it, it sounds like people are continuing to dialog about it and I would suggest that's the best thing to do. I don't know that an additional 90 days would help in that situation. It's something that people need to understand in order to understand that there has to be, you know, back and forth. And I, I believe that the MCOs are capable of providing that level of assistance. I can't rule out the possibility that they don't agree. And that's maybe where this is at, but I want to just point out, too, that the materiality definition here is key. And I'm not sure I understand it, but I, I believe-- I'm a recovering attorney. I should be able to do this, but it's-- basically, it focused on anything that reduces reimbursement or that costs administrative expenses to the providers. Then it's a material change. If it's, if it's something that goes their way, it's not a material change. And I would suggest that there's a lot of subjectivity in this definition as to what constitutes a material change and what isn't a material change. So I don't know that the bill is going to help that much. I'd be happy to do my best with any questions that you have.

HOWARD: Are there questions from the committee? Senator Cavanaugh.

CAVANAUGH: Thank you. Thank you, Mr. Watson, for being here. You-- and you kind of ending talking about the vagueness of the material change. But if I could direct you to the bill--

JAMES WATSON: Um-hum.

CAVANAUGH: --on page 2, line 6, it actually defines what a material change is.

JAMES WATSON: Right.

CAVANAUGH: So I, I think that's pretty prescribed as to what-- I mean what Senator Walz means by a material change and I just--

JAMES WATSON: What I was suggesting, Senator, was that it was subject to differing interpretations and, and unclear because it, it tends to define the materiality in terms of something that the occurrence and

timing of which is not otherwise clearly identified in the provider agreement. I mean--

CAVANAUGH: So you would like to see this more prescribed?

JAMES WATSON: Yes. I can't, I can't tell-- it seems very subjective to me, directed at a particular provider. And I don't think that's going to work.

CAVANAUGH: So more detail on what material changes would be desired from the MCOs perspective?

JAMES WATSON: If this bill is moved forward, yes.

CAVANAUGH: OK. And then-- but your point number two; you said that the MCOs' contracts with the state already includes language and that would require notifying providers of policy changes and I think you said that this would be costly. How--

JAMES WATSON: Oh, no, I'm sorry. I didn't mean to confuse you. I, I-- we have 45 days to notify them. The part that would be costly would be the fact that we have to amend all of our provider contracts.

CAVANAUGH: Right and how often do you amend-- currently amended your provider contracts?

JAMES WATSON: Pretty infrequently; I'd say less-- I-- and I mean, I'm generalizing, but I would say in the 1 to 2 percent range. I don't think that they get amended a lot.

CAVANAUGH: Not, not, like, on an annual basis?

JAMES WATSON: No, not unless there's a reason, which would be, like, a new regulation or something like that. But I don't-- there's nothing that I know of that would mandate them having to be amended every year.

CAVANAUGH: So I have, well, just a follow up to this--

HOWARD: Sure.

CAVANAUGH: So the 45-day minimum, is that in statute, is that documented, is that a regulation?

JAMES WATSON: It's in the contract that the MCOs have with MLTC.

CAVANAUGH: With MLTC?

JAMES WATSON: Um-hum.

CAVANAUGH: With the department?

JAMES WATSON: Yes.

CAVANAUGH: But not in the contract with the providers?

JAMES WATSON: No. There's language in the contracts with the providers about how you do an amendment. I don't believe they're all the same--

CAVANAUGH: Because--

JAMES WATSON: --but there is language in the contracts that talk about how you can amend contracts.

CAVANAUGH: Because it-- what I was hearing from providers today is that they're not getting the 45 day--

JAMES WATSON: Yeah, I, I don't know what was out on the portals, but that is where, traditionally, you would notify people of the coming change. It sounds like UnitedHealthcare reached out to one of the associations for some help in getting the word out, but I don't know when it happened. I just don't have details about it, Senator, and I apologize for that.

CAVANAUGH: And it's too cumbersome to give three-months notice on these material changes?

JAMES WATSON: Once you get past what is a material change, it's a long period of time; 90 days is a long period of time. The two parties can terminate the contract without cause in 60 days--

CAVANAUGH: OK.

JAMES WATSON: --according to Nebraska insurance laws. So, I mean, I, I think, I think the key in the problems they're talking about today is the, is the discussion and the understanding and not the prior notice. I don't know that that would have helped. If you don't agree, you have to talk about it and find a way to agree.

CAVANAUGH: OK. I would just say that I've had three children and three months is, is basically maternity leave and it goes by in a blink of an eye.

JAMES WATSON: [LAUGHTER]

CAVANAUGH: So I don't view it as a long period of time, but thank you.

HOWARD: I, I have a question. Does putting notices up on the portal, does that meet your notice requirement currently?

JAMES WATSON: I think it does--

HOWARD: OK.

JAMES WATSON: --as long as it meets the contract stipulations and I believe it would. I mean notice is notice.

HOWARD: Well, I mean, not necessarily, because often for, like, the department, in order to give notice on, like, say, an 1115 waiver, they had to do stakeholder meetings and public hearings and they had to post in a public place and they had to publish it. So your expectation is that your providers will check the website regularly when there are changes or will you send them an email?

JAMES WATSON: I think the provider relations representatives actually do both. I mean, I think they check, but they also reach out to them. I mean, it would make sense and that sounds like what happened here.

HOWARD: I've got a lot of shaking heads behind you, Mr. Watson--

[LAUGHTER]

HOWARD: So maybe you could follow up and, and see if, if-- when--

JAMES WATSON: Sure.

HOWARD: --they're giving notice, is it just posting it on the website or is it more than just posting it on the website?

JAMES WATSON: OK.

HOWARD: Is there an email or a phone call that goes along with it?

JAMES WATSON: Happy to do that.

HOWARD: OK, perfect. Senator Cavanaugh.

CAVANAUGH: Sorry, that leads me to a follow up on the 45-day versus the 90-day. I did see something about an orange envelope with attention: provider agreement amendment enclosed. That's on page 4, lines-- well, 1 through 3. And so it seems like the intention, here, is to make sure that providers are getting notified. That's the ultimate goal and I don't know how often I check websites. Again, I'm going to use my kids, but they go to public school in Omaha, to Westside, and there is a portal.

JAMES WATSON: Um-hum.

CAVANAUGH: I couldn't tell you what it says today on that portal. I don't know what was served for lunch, but sure, I could find it out if I want to look every single day. So is the expectation that the providers are checking the portal every single day to see if there's changes?

JAMES WATSON: I don't believe that's the exact expectation. I mean, that's what, in a perfect world, would be what would happen. But I know that's not practical. I also do think that the provider relations representatives reach out and attempt to make these things known. And I'm-- I-- you know, I don't know what happened in this situation, I really don't, but that's my understanding of how it works is that they try and make sure people know.

CAVANAUGH: So if this bill didn't have a 90-day number, if it had a different number of days then the-- there's nothing really stopping you from doing the orange envelope with the attention-- like making more of a concerted effort to notify providers of changes--

JAMES WATSON: No, there's nothing stopping us, no.

CAVANAUGH: --and that wouldn't require new agreements?

JAMES WATSON: The way this reads-- let's see-- "each managed care organization"-- this is in line 17 on page 2-- each managed care organization shall establish procedures for changing an existing agreement with the provider that include the requirements of this section. In a sense, the contracts already have amendment language in them. I think they would have to be changed based upon that particular paragraph because you have to include the requirements of this section and that's what I think is expensive.

CAVANAUGH: OK, so the providers don't seem to share that concern about that expense, at least not from what we heard today, correct?

JAMES WATSON: No and it's not their expense.

CAVANAUGH: Oh, thank you.

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

JAMES WATSON: Thank you and I will follow up as I've--

HOWARD: Thank you. Our next opponent testifier for LB956. Seeing none, is there anyone wishing to testify in a neutral capacity? Seeing none, while Senator Walz is coming up for closing, I will read the letters. Proponent letter: Monica Ortiz Kirby, Pediatric Therapy Center, Papillion; Jamie Summerfelt, Nebraska Home Care Association; Annette Dubas, Nebraska Association of Behavioral Health Organizations; Samantha Rezac, self; Kira Shapiro, self; Darcy Esau, self; Joni Cover, Nebraska Pharmacists Association; Heath Boddy, Nebraska Health Care Association; Todd Hlavaty, Nebraska Medical Association; Jennifer Acierno, LeadingAge Nebraska; Brook West, self; Dallas Nelson, self; Amy Tyler Krings, Leid Learning & Technology Center; Andy Hale and David Slattery from Nebraska Hospital Association; Emily Hill, self; Mary Walsh-Sterup, Nebraska Occupational Therapy Association; Taylyn Lawrence, self; Sydney Pendergrass, self; David McBride, Nebraska Optometric Association; Dylan Kuta, self; Molly Penner, self; Janel Mies and Melissa Kimmerling, Nebraska Occupational Therapy Association Inc. No opponent letters, no neutral letters. Welcome back, Senator Walz.

WALZ: Hello. Thank you, Chairwoman Howard. Well, there are certainly a lot of questions that I have that I wish I could ask, but I can't. Personally, I guess I, I am confused because, you know, apparently there is language in the contracts that say they already give a 45-day notice. I don't understand if there is that language, why that doesn't happen and what happens if you don't abide by that contract if you're not giving the 45 days? So I have a lot of questions as well. This legislation sets out to require that there is a 90-day notice of any material changes for the MCO, for the provider, any description of that material change, and a statement that the provider has an option to either accept or reject the proposed material change. It also provides for a process for appeal. We've heard a lot about the inconsistency in changes and rules from providers and families. And

please understand that I feel-- and I'm sure you feel-- the ability for providers to adapt to those changes really only helps the patient, the client, the customer. It's frustrating to not only listen to the provider and family testimony, it was also really disappointing for me to hear that frontline staff working directly for MCOs are not being educated and communicated with when it comes to working directly with the customer. It als--, you know, I think that we-- again, I think I've said this before, but I think we tend to forget that this is taxpayer money. And I, as a taxpayer, want to make sure that the very best service is being provided to the customer and that we are being accountable to recipients of healthcare in Nebraska. So with that, I guess I'm going to end my closing and ask if you have any questions.

HOWARD: OK. Are there questions? Seeing none, thank you, Senator Walz. This will close the hearing for LB956 and the committee will reconvene in my office in five minutes for our Exec Session.