PAUL HENDERSON: All right, we should be good.

HOWARD: OK. I don't see anything that says it's recording, but it is?

PAUL HENDERSON: It says recording on my end here, so.

HOWARD: That's the only one that matters. All right. Good morning and welcome to the Health and Human Services Committee via Zoom. 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. I'll call you out and we'll go in alphabetical order, starting with Senator Arch.

ARCH: Good morning, this is John Arch and I represent District 14: Papillion, La Vista, and Sarpy County.

HOWARD: Senator Hansen. Is he on the phone, maybe? Nope. OK, Senator Murman.

MURMAN: Hello, I'm Dave Murman, District 38, 7 counties in south central Nebraska: Clay, Webster, Nuckolls, Franklin, Kearney, Phelps, and southwest Buffalo County.

HOWARD: Senator Walz.

WALZ: Senator Walz, and I represent District 15, which is all of Dodge County.

HOWARD: Senator Williams.

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

HOWARD: And I skipped Senator Cavanaugh.

CAVANAUGH: That's OK, it's that Duchesne education. You should have gone to Marian. Senator Machaela Cavanaugh, District 6, west central Omaha, Douglas County.

HOWARD: And it looks like Senator Hansen joined us. Do you want to introduce yourself, Senator Hansen? You're muted.

B. HANSEN: Thank you. Sorry, just sat down for a second. I mentioned to Chairwoman Howard, I'll be in and out maybe a little bit because

I'm in between patients today, so. Senator Ben Hansen, District 16, Washington, Burt, and Cuming Counties.

HOWARD: Thank you. We've got a full attendance. This is great. All right. Also assisting the committee are our legal counsels, T.J. O'Neill and Paul Henderson. And Paul Henderson will be moderating the Zoom and working tech for us today. A few notes about our policies and procedures. These interim hearings are being recorded and they'll be posted on the Health and Human Services Committee's page through the Legislature's website. Please keep yourself muted unless you are testifying. There's an icon at the bottom of your Zoom window that looks like a microphone, which you can use to mute or unmute yourself. This morning we'll be hearing one interim study and we'll be taking them on the order listed on the agenda on the legislative calendar. If you're planning to testify today, please ensure the introducer of the interim study has your updated contact information, including name, email, and phone number. This will help us keep an accurate record of the hearing. If you 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. the day prior to the hearing. And all of those letters have already been emailed out to the committee. Any handout submitted by testifiers will also be included as part of the record as exhibits. Please provide a copy of your handout to the introducer of the interim study and a copy to our committee clerk, Sherry Shaffer. Her email address is sshaffer@leg.ne.gov. And will also be posted in the chat. Each testifier will have about five minutes to testify. When you begin, the timer will start. We may ask you to wrap up your testimony after the five minutes has passed. We're going to try a real analog system. If you have one minute left, T.J. is going to hold up a yellow card. T.J., can you hold up that yellow card so we can see it? We're going old school today for timing. When you testify, please begin your testimony by stating your name clearly. Then please spell both your first and last name. The hearing on each interim study will begin with the introducer's opening statement. After the opening statement, we'll hear other testimony, invited testimony today. The introducer of the bill will then be given the opportunity to make closing statements if they wish to do so. We do have a strict no prop policy in this committee. So even on Zoom, if your pets walk in, that's a prop. We don't want them there. Just kidding. We really actually do want them there. OK, before we get started for the hearing today, I want to note a few things. My office really weighed out the pros and cons of

holding our interims in person versus virtually and decided that being fully virtual would be safer and more convenient for many members and their testifiers without jeopardizing the important fact-finding role of committees in the Unicameral. This has put a huge burden on my staff, the Legislature's Technology Office and the Clerk's Office, and I want to make sure that they know that we're all very grateful for their efforts. I know it was a big lift. This committee is serving as the guinea pigs for the Legislature as we work out the kinks on virtual hearings. So I'll ask for your patience for any technology issues that come up. As noted in the hearing notice, we are recording the hearing and once we conclude it will be posted on the HHS area on the Legislature's website for folks to watch afterwards. Finally, I'd like to note for the record that part of the consideration for going virtual for our hearings this year was to ensure convenience for the Department of Health and Human Services and to ensure that every effort was made for them to attend three interim hearings in particular: Senator Morfeld's LR404 on Medicaid expansion, the HHS Committee's LR406 to discuss issues related to COVID-19, as well as the Committee's LR410 to discuss issues related to Saint Francis Ministries and their work in the child-- in child welfare in the Omaha area. The agency has refused to attend all three important hearings and shared a letter which outlines their reasons for not attending. While all members of the committee have a copy of this letter, I want to read into the record their specific reasons. First, they are working to finalize the DHHS portion of the Governor's budget for presentation to the Legislature early next year. Second, they are disbursing CARES Act emergency funding payments for state and local partners while ensuring appropriate federal accountability. And third, their team is in the midst of responding to the COVID-19 pandemic. Colleagues, in the 16 years that a Howard has served on the HHS committee, the agency has never once refused to come in. So our role as the elected representatives of the citizens and taxpayers of Nebraska and in particular our service on this committee means that we are guardians of the health and welfare of Nebraskans. But without the ability to speak to the agency we oversee, we are unable to truly do our jobs on behalf of the people we represent. The decision from this agency was in many ways unprecedented and unexpected since we worked cooperatively to schedule these hearings. And then I found out on Friday, late in the afternoon, that they would not be attending. I truly considered exercising this committee subpoena power, but given the time constraints of the holidays have chosen not to. And speaking with some of our colleagues about committee subpoena power, I want to

be clear about its use. I don't feel it's appropriate to use for legislation because bringing in the agency to support or oppose a bill when they aren't willing doesn't make sense. However, when the state is facing issues such as a new major program like Medicaid expansion or a global pandemic where over a thousand Nebraskans have died or embezzlement allegations with a contractor that works with Nebraska children and families, that's an appropriate time to exercise our constitutional duty, right, and responsibility to bring the agency in to speak with us. So in light of their absence, we're going to proceed a little bit differently than we normally do this morning. In order to make sure that everyone is on the same page with regards to what the agency is sharing with the committee, I'll have Senator Morfeld open on LR404. And then before we bring up his invited testifiers, I'll have my legal counsel read the information sheet provided by DHHS into the record. If there are questions from the committee, we'll draft a letter to the agency as follow-up. We will follow the same process as well for LR406 and LR410 next week. In closing, colleagues, DHHS's refusal to appear before us sets a dangerous precedent for our oversight role and truly sends a clear message to our constituents. I've said in the past that when you disrespect a senator or a colleague you are actually disrespecting the 40,000 people they represent as well as all Nebraskans that we serve. And that's exactly what's occurring today. With that, we'll begin today's interim hearing with LR404. Welcome, Senator Morfeld. You are welcome to open.

MORFELD: Thank you, Chairwoman, Chairwoman Howard, members of the Health and Human Services Committee. For the record, my name is Adam Morfeld. That's A-d-a-m M-o-r-f as in Frank -e-l-d, representing the "Fighting 46th" Legislative District, here today to introduce LR404, a study to report on the mechanics of the implementation of Medicaid expansion. I'm going to keep my remarks here pretty brief and then I'll probably listen in. I'm actually not feeling very well for the first time today. And unfortunately, my fiancee came down with COVID this last weekend. So I'm really glad that we're doing this virtually. This is my long way of saying that. So Nebraskans have overwhelmingly voted to expand Medicaid via the ballot initiative 427 on November of 2018. Almost after-- excuse me, after almost a two-year delay, enrollment began on August 1 with coverage beginning October 1, I believe. This resolution was introduced to get an update on how rollout is going. Today's testimony is intended to update the committee on the experiences, the strengths, and the challenges of the newly eligible enrollees and the organizations that serve them, plus

suggestions for making the program better. I'm also disappointed that the department did not take 15 to 30 minutes to come in and, and let us know and give us an update on perhaps one of the biggest changes in Medicaid in Nebraska in many decades. So with that being said, I'd be happy to answer any questions, but I'm more or less just looking forward to hearing from folks on the ground with how the rollout is going and what we can do better. Thank you.

HOWARD: Thank you, Senator Morfeld. I think we're just going to do hands. Does anybody have any questions for Senator Morfeld? Don't see any hands. All right, thank you. We'll first have T.J. O'Neill go and read the DHHS info sheet into the record.

T. J. O'NEILL: Good morning, members of the Health and Human Services Committee. My name is T.J. O'Neill, O-'-N-e-i-l-l, and I'm one of the legal counsels for the Health and Human Services Committee of the Nebraska Legislature. Chairwoman Howard has asked me to read into the record an information sheet sent to our office by the Department of Health and Human Services and which has been sent to the committee. The information sheet reads as follows: DHHS/Medicaid and Long-Term Care, MLTC, managed care entities, and community partners across the state collaborated to successfully launch the Heritage Health Adult, HHA, expansion program on October 1, 2020. Nebraskans who are eligible for coverage are now able to access these healthcare benefits. As of the 1st of December, 22,120 Nebraskans have been found eligible for coverage. Applications Processing: MLTC continues to provide a quick turnaround time of Medicaid applications after the launch of the HHA expansion. On average, it takes less than two weeks for eligibility staff to process an application since the department began accepting applications for expanded Medicaid on August 1. DHHS has been able to keep up this pace through increased staffing to the program. The Medicaid Eligibility Operations Unit hired and trained 69 new teammates to help with the launch of HHA. DHHS has 506 staff currently working on Medicaid eligibility, with 38 positions currently vacant and in the hiring process. To maintain low vacancy rates, DHHS has focused efforts on monitoring eligibility teammate experience and retention efforts, as well as employing strategies to source, hire, and onboard new teammates. Challenges: DHHS had to balance many priorities and overcome challenges while preparing for the launch of Medicaid expansion. One of the most notable challenges was responding to and working through the COVID-19 pandemic. The pandemic required that the department be more flexible and agile with work processes to ensure that operations meet the needs of our stakeholders. DHHS

successfully executed swift actions to mitigate challenges such as moving employee onboarding and training to a virtual environment, limiting in-person training class sizes, deploying limited work from home capability, augmenting in-person meetings and work with virtual platforms and technology, and flexing schedules and modifying work processes. Additionally, the Public Health Emergency, PHE, has put similar pressures on providers, managed care partners, and other stakeholders who were preparing for expansion as well. DHHS also acknowledges the impact that the pandemic has on Nebraskans and Medicaid beneficiaries. Similar to many other states, DHHS has not seen a significant increase in new applications for Medicaid as a result of the pandemic upon analyzing Medicaid application and enrollment rates throughout the PHE. However, DHHS is experiencing increased enrollment as a result of continuing coverage for individuals who have had a change of circumstance and would normally no longer meet eligibility requirements, except they remain enrolled as a result of PHE. Nebraska is receiving enhanced federal financial participation for keeping individuals on the Medicaid program through the PHE. The Medicaid program is managing through a leadership change during this time period as well. With the support of the executive leadership team at DHHS and the tremendous contributions of supervisors, unit administrators, and teammates at MLTC, this leadership change did not negatively impact the launch of Medicaid expansion on October 1. Public Awareness: MLTC created and executed on a plan to create public awareness and education for stakeholders across the state to prepare them for the launch of the expansion program. From July to September, Medicaid directly engaged approximately 1,600 individual stakeholders and over 400 organizations. Most of these engagements took place via online webinar platforms in order to observe social distancing guidelines. In addition to these direct engagements, Medicaid developed a variety of informational materials such as FAQs, factsheets, fliers, and more. Hard copies of these materials were made available at no cost to stakeholders upon request. DHHS continues providing updates and information on expansion through the public website and additional outreach through social media channels, through TV and radio, and on billboards across the state. Operational Success: DHHS managed the initial launch of Medicaid expansion successfully, planning for and executing initiatives to support an increased volume of calls and applications prior to and throughout the launch of the expanded program. CE-- DHHS CEO Dannette R. Smith has received positive feedback from community members regarding the expansion, specifically

noting that communication provided to the public was excellent. In addition to the aforementioned public awareness campaign, DHHS launched a call center to support questions and concerns regarding eligibility from Nebraskans statewide. In both August, when DHHS began accepting applications, and October after the official launch, the call center was staffed on weekends to accommodate alternative schedules. Individuals, particularly those within communities of color, reported satisfaction with both the timeliness of response and respectfulness with which they were treated by DHHS call center staff. And that is the end of the information sheet. Thank you.

HOWARD: Thank you, T.J. We'll now invite Molly McCleery from Nebraska Appleseed to share her testimony.

MOLLY McCLEERY: Thank you, Chairperson Howard, members of the committee. Before I get started, I do want to mention that there is a now intense construction happening like right next door to my house that just started right when we got on this call. So hopefully it does not come through on your end, but. My name is Molly McCleery. That's M-o-l-l-y M-c-C-l-e-e-r-y, and I'm the director of the Health Care Access Program at Nebraska Appleseed. I appreciate the opportunity to speak with you today. As you know, this has been a core priority for our organization now for almost eight years to ensure implementation of this program. I want to begin, I think a lot of times when we have these conversations, it goes to the policy issues and some of the logistical challenges that we'll be seeing. But to begin, I want to just really lift up the importance of the fact that 22,000 Nebraskans have gotten coverage in-- since October and have been able to seek out the healthcare that they need. Many of these folks have been waiting for years to be able to access healthcare and they're finally able to get that. And we're really looking forward to seeing the benefits this program can bring to both those individuals, their families, and then also to the community as a whole. I think the COVID pandemic has really demonstrated the importance of healthcare kind of across the board and not just for COVID treatment, but for underlying health conditions and then the behavioral health impacts of the pandemic that we'll be seeing in, you know, in the long term. There are a few pieces of implementation of the program that we wanted to bring to the committee's attention. These are reporting of enrollment data, the medical frailty process, and then elements of the waiver that pose challenges for enrollees. I'll let the providers who are here today kind of speak to the provider perspective, but I'm guessing some of the issues I'll mention in terms of enrollee challenges also will

align with some of the issues that they're seeing. As, as T.J. mentioned in the letter from the department, we've got around 22,000 Nebraskans enrolled after 4 months of enrollment. We have long estimated that 90,000 Nebraskans would be eligible. That's pre-COVID. I've seen estimates from national experts that anywhere from 10,000 to an additional 50,000 Nebraskans could be eligible as a result of economic challenges related to the pandemic. Nebraska has generally kind of weathered the pandemic in terms of unemployment better than other states. And so I think in terms of the increased Medicaid applications, we're, you know, not seeing quite as many. But I would not be surprised based on kind of looking at trends from other states and looking at trends from previous enrollment in Nebraska if we would see a bump in enrollment due to marketplace enrollment occurring right now where people go and they may have had marketplace insurance in the past, but now have Medicaid eligibility. And then also what we're seeing with enrollment in Medicaid with the pandemic is that there's generally a lag for a few months after a big spike in cases. And so in this wave that we're in, we may see another kind of bump in Medicaid enrollment in January. What would be helpful, I think, for tracking enrollment and to know if we're getting everyone that is eligible enrolled is increased transparency in public reporting on enrollment numbers. What we're getting is kind of limited information in news releases, and that doesn't include information around the number of applications total, the number of denials. It doesn't always include the number of medical frailty determinations or requests. And it would also be helpful to see demographic data, if possible, not protected health information, but just knowing increased information about who is enrolling. Are they using enrollment assistance? Where in the state are they located? This would help groups on the ground who are doing some of the outreach efforts to kind of fill in the gaps from the agency to know where those populations are and how to reach them to get them signed up. In terms of the medical frailty process, this is going to be challenging for consumers to navigate. If an enrollee is determined medically frail, they receive the prime benefits package and are exempt from the requirements of the waiver for either 12 or 36 months, depending on their condition. However, enrollees are enrolled in basic coverage until they're able to demonstrate eligibility for this status. What we're seeing with folks in the Medicaid expansion population, in particular, is that if they have not had access to healthcare prior to enrollment and expansion, they do not have access to medical records always to demonstrate that condition. And so there is a waiting period essentially for folks to be able to get those

prime benefits and that exemption until they can demonstrate it through accessing services now that they have coverage. There's also a lack of a regulatory framework to describe this process. The department has issued a couple sets of regulations and then due to the delay in the approval of the waiver, pulled back regulations and then just released a set for informal comment that was due yesterday. The regulatory framework in the set of regulations, which I'll say is seven pages to describe essentially this entire waiver, is not sufficient to outline the rights, responsibilities, and enrollees' due process, or the responsibility of the agency. There's no timeline for which the agency needs to make a determination of medical frailty status. It's unclear whether that is deemed an appealable determination where someone could file an administrative appeal. So theoretically, it should be an appealable determination, but there could be more clarity in outlining that process. The last thing I want to mention is just overall this waiver is incredibly complicated and burdensome. I know that this has been approved by the federal government and we're working to respond to consumer questions and provide materials to help explain how folks navigate it. But the number of requirements that individuals have to track on various different timelines is incredibly hard to follow. It's unclear whether at times it's the individual that's doing the reporting, the provider that's doing the reporting, the managed care organization that's doing the reporting. I think it's important to remember that Section 1115 waivers are designed to test hypotheses. And the-- in the waiver application, the department listed out a number of goals for this program, including improving health outcomes, improving the economic self-sufficiency of folks that are enrolled in this program. But it's important that we actually evaluate whether this sort of intense scheme actually leads to those results. At this point, what we're seeing is that nonexempt enrollees are currently locked out of dental, vision, and over-the-counter drug coverage until October of 2021, so a year from the start of enrollment with no way to earn those additional benefits because that structure is not in place. It's unclear to me how that is testing a hypothesis or supposed to lead to better health outcomes. And we're not even really talking about the work requirement piece yet, which is an additional layer of complexity for enrollees to navigate. So ultimately, this is a hugely beneficial and important program that we're undertaking. But in order to see the full benefits, we need to ensure that folks are getting signed up that are eligible, that we have oversight of the implementation process, especially with

an eye to the enrollee experience. So I'm happy to take any questions, but. Thank you.

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

ARCH: Thank you, thank you, Chairperson Howard. I do, I do have a question and, Molly, I don't know if you're the right person to ask this, but you, you talked about a bump in possible enrollment in January. I guess, I guess my question, and maybe you alluded to this in your testimony, but it is the people who are on the insurance exchange right now that are receiving subsidies for the purchasing of healthcare who now would qualify for Medicaid expansion. And would-- and are those, are those people going to shift over in January, I guess, is the question? If you're not, if you're not able to answer that question, perhaps a later testifier could ask-- could answer that. And is there an estimate as to what that number is?

MOLLY McCLEERY: So there's kind of two different things happening at the same time. So right now we're in open enrollment for the marketplace. Folks who are between 100 and 138 percent of the federal poverty level should have received a notice from the marketplace that is-- if they're currently enrolled in that coverage, asking them to update their information because they may now be eligible for Medicaid expansion. The marketplace will coordinate with the Medicaid agency. If the folks are eligible for Medicaid, they'll be shifted over and that will be shifted over as soon as that's processed. If they're eligible for marketplace coverage, they'll be able to choose a plan for the next plan year that would start in January. What I was mentioning in terms of a potential bump in Medicaid enrollment is if we look back to Medicaid enrollment numbers starting last March, what we're seeing is that health insurance is not the first thing that people are seeking out as a result of the pandemic. A number-- I think we thought that enrollment numbers would be higher faster. But what we're seeing is that folks are seeking out help for food assistance, housing, things like that first. And so the health insurance enrollment is coming a little bit later. So with each kind of wave in COVID, there's usually a bump in enrollment that's like two months out. So if we look back to kind of the fall wave, that might be January.

ARCH: OK.

MOLLY McCLEERY: This is purely kind of a speculative--

ARCH: Right.

MOLLY McCLEERY: --looking at trends, but that's what I've been told by the national experts.

ARCH: The first population that you were talking about that, that would discover in their, in their reenrollment on the exchange that would discover that they're now eligible for Medicaid, is there, is there an estimate on that number that you've seen?

MOLLY McCLEERY: I don't, I don't have that number.

ARCH: OK.

MOLLY McCLEERY: But I can look and see if there is an estimate. Yeah.

ARCH: OK. Because I, I have heard around 15,000 somewhere, somewhere in that range as a possibility, but, and maybe somebody later that's testifying would, would have that number. But anyway, thanks, thanks, Molly.

MOLLY McCLEERY: Yes.

HOWARD: Senator Cavanaugh.

CAVANAUGH: Thank you, Chairwoman Howard. Thank you, Miss McCleery, for being here and for your testimony. My questions are more directed to the department, but since they're not here, they arise out of your, your testimony. So I'm going to just give you my questions for the record. I don't think that you can actually answer them because you're not the department, but your testimony certainly raised these issues. And if the department were here, it would have been wonderful to have this information illuminated for all of us. Previous times that the department has come and given us a briefing on Medicaid expansion, they have shared significantly more information than our legal counsel read into the record. And in reviewing that letter, there is a lot of data missing, which you pointed out, too, in your testimony. For example, it would be very helpful to know the number of applications that they've received and the percent of denials that have happened and what is the main reason for those denials happening. I'd also like to know why it is taking a year for people who are in the nonexempt category to receive those enhanced benefits. Additionally, this has been a question, and perhaps I'm stealing thunder of future testifiers on here, but a big question this entire time has been who is in charge

of reporting all of these things? This waiver has required a significant layer, multiple layers of additional administration. And throughout this process, I have asked the department numerous times for clarification on who is in charge of administering this reporting. And we know that the healthcare providers do not want to be the ones to do that because that adds an additional cost and time for them and it's not covered. They're not compensated for either. So those are my questions. If you have answers, wonderful. Otherwise, I'll move on.

MOLLY McCLEERY: I, I don't have answers to a number of them. One piece I would clarify in terms of the eligibility for the prime-only benefits not being until October of 2021, the reason for that is that under the approved waiver it doesn't actually start until April, 2021. To start coverage in October, they move forward with two alternative benefit plans through state plan amendments. And those-- folks are sort of locked in to those depending on whether they are exempt based on pregnancy, medical frailty status, or be 19 and 20 years old. So that's-- and then starting in April, that's the first six months of reviewing whether folks meet the requirements. If they meet them, then they can start getting those enhanced benefits in October. But just the timeline ends up being that folks are without those benefits for a full year.

CAVANAUGH: So they have to be on the benefits for six months before they qualify for the enhanced benefits, but it takes an additional six months?

MOLLY McCLEERY: It takes-- the six-- there's a six-month review period starting in April to demonstrate eligibility for those enhanced benefits.

CAVANAUGH: OK. So if somebody were to enroll, say, in March, they could start that in April as well?

MOLLY McCLEERY: If they enrolled in March, they could start coverage whenever their application was-- or it, it would start in--

CAVANAUGH: I'm sorry, the six-month review of eligibility for the enhanced benefits. If you enrolled in March, you could start that in April, or do you have to wait another six months?

MOLLY McCLEERY: You would start the six months when-- if it's after April 1. There's just no reviewing the requirements until after April 1.

CAVANAUGH: OK.

MOLLY McCLEERY: It's just that folks who've enrolled now are without for--

CAVANAUGH: Right. So anyone, anyone who's enrolled from August 1 through April 1 has to wait until April 1 to start the six-month review?

MOLLY McCLEERY: Yes, yes.

CAVANAUGH: OK. And we changed our Medicaid program contrary to the statute that was voted on by the citizens in Nebraska that said that it had to be the same as the current Medicaid program. So we've changed our Medicaid program down to the prime program without the enhanced benefits, correct?

MOLLY McCLEERY: The prime program or the prime benefits package tracks the state plan benefits that all other kind of full scope benefit-- benefits packages in--

CAVANAUGH: I guess we're, we're in the basic then. Sorry, I maybe said the wrong one.

MOLLY McCLEERY: Basic is the plan that does not occur-- does not include prime or the quote, unquote, prime [INAUDIBLE] benefits. So that doesn't include dental, vision, or over-the-counter drugs. Dental, vision, and over-the-counter drugs are part of our state plan benefits package that other populations receive. So like parent, caretaker, relatives, seniors, folks in other categories.

CAVANAUGH: But our overall Medicaid program now is starting in October 1 is basic and those categories are moved up to prime based on being in those categories. Correct?

MOLLY McCLEERY: This is just the expansion group [INAUDIBLE]

CAVANAUGH: Oh, so that's against the statute.

MOLLY McCLEERY: The fourth subsection of the statute does say that no additional barriers or burdens can be placed on the expansion group in-- compared to other Medicaid populations.

CAVANAUGH: And that the, that the benefits offered have to be the same.

MOLLY McCLEERY: Yeah, no additional barriers or burdens on, on services. Yes.

CAVANAUGH: Right. So we're, we're violating the statute currently.

MOLLY McCLEERY: That's been our position. And we've noted that in our testimony in, in regards to the regulations, is that in order to comply with the statute, it would need to be not placing burdens on this population.

CAVANAUGH: Well, gosh, it sure would be nice to hear from the department on why we're violating statute. Thank you.

HOWARD: OK. Are there other questions from the committee? All right. Seeing none, thank you, Miss McCleery, for visiting with us today.

MOLLY McCLEERY: Thank you.

HOWARD: Next up is Amy Behnke from the Health Center Association of Nebraska.

AMY BEHNKE: All right, good morning, everyone. Again, thank you, Chairwoman Howard and members of the Health and Human Services Committee. My name is Amy Behnke, that's A-m-y B-e-h-n-k-e, and I'm the CEO at Health Center Association of Nebraska. I'm here today on behalf of Nebraska's 7 federally qualified health centers and the 115,000 patients they serve annually. We'd like to thank Senator Morfeld for introducing LR404 and the ongoing discussion around the smooth implementation of Medicaid expansion. Nebraska's health centers provide primary medical, dental, behavioral health care, as well as enabling services like transportation and translation to all, regardless of insurance status or ability to pay. Ninety percent of our patients are at or below 200 percent of poverty; 67 percent are of a racial or ethnic minority; and nearly 50 percent of health center patients are uninsured. Uninsured and underinsured patients contribute to the cost of their care based on a sliding fee scale. Health centers are the safety net providers in the state. In 2019, health centers

provided services to approximately 12 percent of the total Medicaid population and 34 percent of the total uninsured population in Nebraska. We have experience with both the Medicaid program and with the populations likely to qualify under, under expanded Medicaid. Since applications for Medicaid expansion opened in August, health center outreach and enrollment staff have assisted 2,215 individuals in applying for expansion coverage. They are actively educating patients on the availability of expansion as well as the benefit structure. While COVID originally limited in-person assistance, outreach and enrollment staff were able to assist clients over the phone with their verbal consent. To date, we haven't noted any specific barriers in that enrollment process, in that basic enrollment process. We do, however, continue to have concerns with the tiered benefit structure, particularly the lack of access to dental services and basic coverage. Lack of oral health coverage will likely have a negative effect on the health of enrollees in basic coverage. Lack of dental services is likely to impede goals of improving care for chronic conditions and create barriers to creating integrated care models. FQHCs in particular integrate dental services as part of a focus on the health of the whole person. In addition, dental services often serve as an important employment support as dental diseases are associated with missed days of work. Likewise, vision services are important for treating the whole health of a person, as well as supporting activities that promote work and higher wage earnings. Finally, over-the-counter medication is an important benefit for enrollees, especially due to the low-income status of the expansion population. Over-the-counter medication is often an important element of managing chronic diseases. For example, aspirin therapy for those with ischemic vascular disease is a common treatment option. Over 1,000 patients at Nebraska health centers alone received aspirin therapy last year. Finally, the implementation of the 1115 waiver components related to personal responsibility and wellness requirements raise concerns as to how individuals will be educated on those program requirements. Experiences in other states with similar waivers have shown that individuals are largely unaware of the minutia of Medicaid program requirements. Experiences in Arkansas, with much more publicized waiver and more punitive measures, found no change in waiver participant behavior in employment. We're also concerned that the new waiver requirements will significantly increase the amount of paperwork needed to complete an application. And so among a population with low health literacy, this can create significant additional barriers to application processes that some may already find onerous.

I would also say from a provider perspective there remains a lot of confusion as, as Molly stated previously, as to who will be responsible for which portions of implementing those requirements. And that's something that we're trying to work through to make sure that we're properly educating our providers on that. By having two different coverage levels, the waiver will lead to a significant amount of churn between programs, especially once work requirements are implemented. Interruptions in coverage, especially dental coverage, could create serious issues relating to continuity and quality of care, while simultaneously increasing administrative burden on providers. Confusion about benefits as well as shifting benefits makes ensuring that patients have coverage is administer-- it will be administratively difficult. Now more than ever, we need to ensure that we're doing all that we can to ensure access to critical health services. The COVID-19 crisis has magnified the racial and economic disparities that hinder access to healthcare. It has become abundantly clear that community focused, culturally appropriate responses are needed to adequately address ongoing disparities. We must also ensure that we are removing barriers to accessing healthcare, not multiplying them through program requirements. We remain committed to working with you, the depart-- and the department to ensure that eligible individuals are successfully enrolled in Medicaid expansion and are able to access and utilize the benefits of the program. And with that, I'll say thank you and I'm happy to answer any questions you may have.

HOWARD: Thank you, Ms. Behnke. Are there questions? I actually have just two. One is I'm curious about how the federally qualified health centers are messaging around the dental tier, because I know that dental in particular is something that the FQHCs really take the lead on for vulnerable populations. But how are you sort of teaching this population how to get into that next tier in order to ensure that they have coverage for dental in particular?

AMY BEHNKE: Right. So, so that's something that I would say is in process, particularly because the waiver itself and those requirements won't be implemented until April. So we know that we kind of have between now and April to start to work on educating individuals and providers. In the meantime, it's kind of administratively on the back end. It's making sure that the health centers understand that even if somebody has basic coverage that they may still have to be on a sliding fee scale over on the dental side because they don't have health insurance coverage for dental services.

HOWARD: And then for the, the medications issue, is there any support from like your 503B program, your pharmacy program, to help with over-the-counter if they're not eligible for this benefit?

AMY BEHNKE: That's that's a great question. There are a lot of requirements around how 340B can be used. And it's incredibly complex, particularly when it comes to, to Medicaid and Medicaid managed care. But that's part of how health centers use those savings through that pharmacy program, is that they can offer some discounted medications and services to their health center patients who otherwise can't afford access.

HOWARD: Thank you. Are there any other questions for Ms. Behnke? All right, seeing none, thank you for visiting with us today.

AMY BEHNKE: Thank you.

HOWARD: Next up is Annette Dubas from the Nebraska Association of Behavioral Health Organizations.

ANNETTE DUBAS: Good morning, Senator Howard and members of the Health and Human Services Committee. My name is Annette Dubas, A-n-n-e-t-t-e D-u-b-a-s and I am the executive director for the Nebraska Association of Behavioral Health Organizations. We represent 49 behavioral health organizations, consumer groups, and regional behavioral health authorities across our state. We'd like to especially thank Senator Morfeld for introducing LR404 and to this committee for holding this hearing during these most trying and challenging times. If there ever was a time for public input, it is now. So thank you so much for your leadership on this. The Nebraska Association of Behavioral Health Organizations supported the successful ballot initiative that led to Medicaid expansion for our state. We firmly believe that providing individuals with the means to access behavioral healthcare is important to their overall health and well-being. We believe Medicaid expansion will bring people to mental health and substance use disorder services that have not had that access before. And we know, especially due to COVID, that the demand for services is only going to increase as we go forward. And, you know, once we get through the, the physical aspect of the health emergency, the mental health demands will definitely still be there. While we support Medicaid expansion, one of our main concerns relates to the funding that was shifted from the Division of Behavioral Health to Medicaid in anticipation of new enrollees and individuals who previously received services through DBH

now qualifying for Medicaid. During the previous biennium, DBH shifted $4.3 million from their budget to Medicaid to cover expansion individuals. And because of that, regions reduced their contracts with providers accordingly. What we know is that to date we are not seeing enrollment numbers anywhere close to the 90,000 projection, and we are not sure how many of the new enrollees will need mental health and substance use disorder services leading to a budget transfer far higher than needed. For financial accuracy and transparency, we need to make sure that those receiving mental health and substance use disorder services are tracked as they move from DBH to Medicaid. For division budgeting purposes, we need to ensure the regional system is not experiencing budget cuts based on inaccurate projections. We need to make sure that we can track how and where that $4.3 million is being used and any-- as we go forward and any additional money that would typically have been in the division going to Medicaid. The regions are an especially important part of the payer mix and meet the behavioral needs of many individuals. Taking that amount of money from the regions while the number of individuals they serve isn't reduced to the degree originally projected will have an impact on access to services at a time when mental health and substance use disorder services are more critical than ever, as I mentioned, due to COVID. The Division of Behavioral Health is a behavioral health system that allows for flexibility to meet an individual's specific needs, while Medicaid is a payer which has far more regulation and eligibility requirements. It's important that we have a transparent tracking system and we are placing the appropriate amount of funding where the people are being served. We worried that with a lag time in reporting utilization, people could fall through the cracks or experience a disruption in their treatment. Behavioral health is unique in the Medicaid expansion world because we rely so heavily on public payers. They are a major part of our funding mix, numbers upwards of 60 percent or higher, with behavioral health coming-- funding coming from public payers. So because of that, this just reinforces the need for tracking and transparency to ensure that public funds are used where and when they are needed, so that we're meeting the, the needs of, of individuals in a timely fashion. I will also go on to say that I agree wholeheartedly with the testimony from Molly and, and Amy as far as the reporting requirements, tracking the, the ability for these individuals to receive those enhanced rates. You know, my members are already underwater with administrative requirements as it is. Their resources are, are finite. They're stretched to the max. So adding any more additional reporting requirements wouldn't, wouldn't be something

that they would embrace warmly. So we appreciate the comments made by the FQHCs and Appleseed as well. So, again, I would like to thank you for your time and attention to this and would be happy to answer any questions if I'm able.

HOWARD: Thank you, Senator Dubas. Are there questions? I have one relative to the regions, and you might not be able to answer it, but do you know the specific services-- when they had to do the reduction, what specific services were impacted by the regions modifying their contracts?

ANNETTE DUBAS: I couldn't tell you that specifically. I would-- I would assume that each region would be a little bit different based on the types of services that each region provides. And so, you know, they would have to go in individually. I'd be happy to try to get more information about that for you, Senator, and get that to you as soon as possible.

HOWARD: Thank you. All right, any other questions? OK, seeing none, that was our last testifier for this morning, Senator Morfeld had waived closing. But we're going to send him some good healing energy because it sounds like both he and Rachel aren't feeling too great. And then I will see everybody at 1:30 this afternoon for Senator Arch's telehealth. That's going to be a little bit more of a marathon. So we'll see everybody then. OK?

CAVANAUGH: Senator Arch and Senator Howard, I'm going to be late to that. I have a meeting that's at 1:00, so--

HOWARD: Perfect.

CAVANAUGH: --I'll be there.

ARCH: You can view-- you can view the entire recording later, Senator.

CAVANAUGH: I'm very interested in telehealth, so I don't want to miss it.

HOWARD: All right, everybody, later. Thank you so much.