

Transcript Prepared by Clerk of the Legislature Transcribers Office
Health and Human Services Committee February 10, 2022

ARCH: Good afternoon. Welcome to the Health and Human Services Committee. My name is John Arch. I represent the 14th Legislative District in Sarpy County and I serve as Chair of the HHS Committee. I'd like to invite the members of the committee to introduce themselves, starting on my right with Senator Murman.

MURMAN: Hello, I'm Senator Dave Murman from District 38, and I represent seven whole counties and part of an eighth in line along the southern border in southern Nebraska.

WALZ: My name is Lynne Walz. I represent Legislative District 15, which is all of Dodge County and Valley.

WILLIAMS: Matt Williams from Gothenburg, Legislative District 36.

M. CAVANAUGH: Machaela Cavanaugh, District 6, Omaha, Douglas County.

ARCH: Also assisting the committee is one of our legal counsels, T.J. O'Neill; our committee clerk, Geri Williams; and our committee page, Rolf. A few notes about our policies and procedures. First, please turn off or silence your cell phones. This afternoon, we will be hearing three bills and we will be taking them in the order listed on the agenda outside the room. 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 the opportunity to make closing statements if they wish to do so. For those of you who are planning to testify, you will find green testifier sheets on the table near the entrance of the hearing room. Please fill one out. Hand it to one of the pages when you come up to testify. This will help us keep an accurate record of the hearing. When you come up to testify, please begin by stating your name clearly into the microphone, then please spell both your first and last name. We 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. When the light turns red, it is time to end your testimony. We will ask you to wrap up your final thoughts. If you wish to appear on the committee statement as having a position on one of the bills before us today, you must testify. If you simply want to be part of the official record of the hearing, you may submit written comments for the record online via the Chamber Viewer page for each bill. These comments must be submitted prior to noon on the workday before the hearing in order to be included in the official record. Additionally, there is a white sign-in sheet at the entrance where you

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may leave your name and position on the bills before us today. With that, we will begin today's hearing with LB698. Welcome, Senator Kolterman.

KOLTERMAN: Good afternoon and thank you, Senator Arch-- Chairman Arch and members of the Health and Human Services Committee. My name is Senator Mark Kolterman, M-a-r-k K-o-l-t-e-r-m-a-n, and I represent District 24 in the Nebraska Legislature. Today, I'm here to introduce LB698, a proposal directing Nebraska Medicaid to cover diabetes patient access to continuous glucose monitors, also known as CGMs. Continuous glucose monitors allow individuals with diabetes to track their glucose levels at regular intervals throughout the day and night generating readings every five minutes, and help patients with diabetes more accurately dose insulin. According to the American Diabetes Association, CGMs are recognized as a standard of medical care for effective diabetes treatment for those patients on insulin therapy. All commercial insurance plans, Medicare and over 45 state Medicaid programs provide access to CGMs. Nebraska is just one of five states at where Medicaid does not provide any type of coverage for CGMs. Patients with better management of their diabetes have better outcomes, a higher quality of life, and costs significantly less to the state. Without proper care, diabetes patients are at increased risk of blindness, limb amputation, kidney failure, and heart disease. Hospitalizations are expensive and risks are heightened because of COVID-19. Diabetes-related COVID complications account for 30 percent of all coronavirus hospital admissions and represent the second leading cause of pandemic deaths. Real-time CGM systems have been proven to improve glucose control through reductions in A1C and time spent in hypoglycemia, which is an individual's-- is when an individual's blood sugar is too low. The alerts, the alarms, and share feature of real CGM systems help address hypo-- hypoglycemia, especially overnight, and are extremely important in saving lives and saving money with reduced hospitalizations. Studies indicate that CGMs decrease diabetes-related hospital admissions by up to 76 percent. Want to read that again. Studies indicate that CGMs decrease diabetic-- diabetes-related hospital admissions by up to 76 percent. The cost of CGMs continues to go down with systems costing around \$1,300 per year on average. These systems replace the need for finger sticks, so the incremental cost per patient who elects to make the change is really only about \$88. But the cost savings are tremendous. Numerous published studies definitely correlate CGM use to reduced hospitalizations, with average savings of \$3,800 for each avoided hypoglycemia hospitalization and \$8,500 for each avoided hospitalization for, for diabetic ketoacidosis, which is a potentially fatal condition resulting from a patient's extremely high blood sugar

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levels. I've handed out a letter which you should have already received from a variety of healthcare and patient groups in support of this legislation, including the Nebraska Hospital Association, the Nebraska Medical Association, Nebraska Academy of PAs, Nebraska Academy of Nutrition and Dietetics, and numerous diabetes patient groups. Thank you for your consideration and support of LB698 as we work to protect Nebraskans with diabetes and to ensure that all Nebraskans with diabetes have access to life-saving technologies. On a little bit more personal note, I would just let you know that I'm a diabetic. I, I have not had to use this type of a machine yet. But I will tell you that since people found out that I'm carrying this bill, one of my college-- colleagues, Dr. Robert Hilkemann, signed on to the bill because in his practice, he's had to do a lot of amputations of toes and fingers and things of that nature due to diabetes. He said he'd do whatever he could to help get this bill across the finish line. In addition to that, one of my other colleagues, Senator McCollister, just got one of these machines, and he said it's, it's an eye opener. It's really worked for him and he's happy that he got it and it's doing the job that it was intended to do. It's alerting him and educating him on the ups and downs of his blood sugar levels. So with that, I would try to answer any questions for you. Don't make them too technical, because those people are behind me. Thank you.

ARCH: Thank you. Are there any questions? Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thank you, Senator Kolterman. I honestly didn't know that this wasn't covered. Did you find this out because you have diabetes, or how did you find out that this wasn't covered under Medicaid?

KOLTERMAN: I was asked to carry the bill and was told that it was not covered by Medicaid and it was their intent to try and get it covered.

M. CAVANAUGH: OK.

KOLTERMAN: Medicaid-- the, the people at Medicaid are very much aware of the bill today, and I, I can't tell you whether they're supportive or not, but I don't, I don't--

M. CAVANAUGH: They'll let us know. I'm sure.

KOLTERMAN: Yeah.

M. CAVANAUGH: OK, thank you.

KOLTERMAN: You're welcome.

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ARCH: I, I have one question. My understanding is there is at least one of our MCOs that currently do provide continuous glucose monitoring. Do you know if all three do-- I say voluntarily, not in, not in statute?

KOLTERMAN: I, I don't know the answer to that. I do know that in the RFP, it's being talked about to include this for, for, for the future.

ARCH: You say they did in the, in the new RFP?

KOLTERMAN: They're-- it's being talked about--

ARCH: As being discussed.

KOLTERMAN: --as a potential on the new RFP.

ARCH: OK. All right.

KOLTERMAN: Is what I've been told.

ARCH: OK, great. Thank you. Any other questions? Seeing none, thank you.

KOLTERMAN: Yes.

ARCH: First proponent. Welcome.

KARA MEINKE BAEHR: Thank you. Chairman Arch and members of the committee, my name is Dr. Kara Meinke Baehr, K-a-r-a M-e-i-n-k-e B-a-e-h-r. I am an endocrinologist here in Lincoln, testifying in support of LB698 on behalf of the Nebraska Medical Association. I would like to thank Senator Kolterman for introducing the bill to require Medicaid coverage of continuous glucose monitors. As an endocrinologist, I specialized in the diagnosis and treatment of hormone-related conditions. I have extensive experience working with patients with diabetes and considerable knowledge of the tremendous benefits of CGM. Continuous glucose monitors, also known as CGM or sensors, are devices that monitor glucose every five minutes through a tiny sensor electrode that is inserted under the skin using an automatic applicator, then a transmitter wirelessly sends the glucose data to a separate monitor or directly to a smartphone app. Seeing glucose in real-time can make-- can help make informed decisions to better balance food, physical activity, or dose insulin. The CGM is worn usually on the abdomen or the arm and last 7 to 14 days and then is replaced again at home. The CGM is always recording data, even during sleeping, showering, or exercising. At endocrine appointments, I download the CGM and review the data and trends with my patients. I

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like to describe previous finger-stick glucose values as looking at the pictures in a story. I can see what the glucose was at a single moment. But I cannot assess if the glucose was potentially rising too quickly or dropping dangerously low. Also, it is very difficult for patients to poke their finger six to ten times each day to make insulin-dosing decisions at meals, during exercise, or before bedtime. On the other hand, having a CGM report to review with my patient is closer to like watching the movie. We can assess trends and see what the patient's glucose was doing 24/7 on the downloaded data. This is essentially equivalent to 288 continuous data points of glucose in one day. There have been countless aha moments where my patients are surprised at how quickly significant hypoglycemia happened after eating certain foods or how fast their glucose dropped with exercise. CGM has made the difference in the quality of life of so many of my patients. One example is my patient, Heather [PHONETIC]. She is now in her late 20s and was diagnosed with Type 1 diabetes in her early adolescence. Heather is also autistic and nonverbal. Her parents are her caregivers. Her blood sugars have always been variable, and even small amounts of insulin could cause her blood sugar to plummet. Her parents had to call 911 several times when she was unresponsive and severely hypoglycemic with a low glucose. At the time, her parents were waking up almost every one to two hours to check Heather's glucose to ensure it was in a safe range. Starting her on a CGM several years ago was completely life changing. The CGM continuously measures Heather's glucose, and her parents check the app on their phone or smartwatch to monitor them. They also are sent an alarm if her glucose is rising or dropping too quickly. I remember vividly how emotionally happy and thankful her parents were after starting the CGM. Her mother said it was the first time she felt like she could sleep through the night in 15 years. Heather has also not had a single 911 call for severe hypoglycemia since that time. Continuous glucose monitoring also makes sense from a cost standpoint. CGM costs approximately \$1,300, and this is only around \$90 more expensive per year than finger sticks. Meanwhile, one trip to the emergency room due to severe low blood sugars or a hospitalization due to diabetic ketoacidosis from high blood sugars, cost thousands of dollars more than the CGM. Studies also show that CGM decrease diabetes-related hospital admissions by approximately 75 percent. CGM is also the current standard of care in diabetes treatment for monitoring glucose levels. Many studies have been done to show meaningful improvements in diabetes outcomes after starting CGM therapy. There is more than \$1,000 cost savings for every 1 percent reduction in Hemoglobin A1C. Daily in my endocrine practice, my patients rave about what a difference CGM has made in their quality of life and in their diabetes control. For these reasons, the Nebraska Medical Association would

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respectfully request your support and advancement of LB698. Thank you for your time, and I'm happy to answer any questions.

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

WILLIAMS: Thank you, Chairman Arch. And thank you, Doctor, for being here. Couple of quick questions.

KARA MEINKE BAEHR: Sure.

WILLIAMS: I'm, I'm sure I know the answer to the first one. The accuracy is the same as a finger stick and this?

KARA MEINKE BAEHR: Yes.

WILLIAMS: No difference in accuracy?

KARA MEINKE BAEHR: Yes, it's been-- CGMs are approved to make dosing decisions.

WILLIAMS: Would you talk a little about the alarms that can be set with this? And as I understand it, there could be multiple places that those alarms could go.

KARA MEINKE BAEHR: The alarms are very important. They can go to the patient or other people. Usually around five people can have access to the alarm. So parents, other spouses, if people are traveling, school nurses is another big one. And so yes, it can be to the patient and to other people to help them.

WILLIAMS: Senator Kolterman, in his opening, mentioned, and, and you also mentioned the cost of about \$1,300. And Senator Kolterman, I think, mentioned that that cost had been coming down.

KARA MEINKE BAEHR: Correct.

WILLIAMS: You have any ideas about-- it wouldn't have to come down very much for you to eat up that \$90 difference.

KARA MEINKE BAEHR: Exactly, there almost would be the same cost soon.

WILLIAMS: OK, thank you.

ARCH: Questions? Senator Walz.

WALZ: I don't really have a question, I don't think. But first of all, thank you for--

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KARA MEINKE BAEHR: Thank you.

WALZ: --your testimony, that really helped bring a lot of situations into light. And I would imagine that, you know, just having the ability to look at those trends and able to prevent trips to the hospital is just a game changer for people. So--

KARA MEINKE BAEHR: Exactly.

WALZ: --I just wanted to say thank you. It really, really helped.

KARA MEINKE BAEHR: Thank you.

ARCH: Other questions? I, I have a couple.

KARA MEINKE BAEHR: Absolutely.

ARCH: In, in reading the fiscal note-- thank you for that information on the \$90 because that's not included in, in this fiscal note that I can find. But is this-- is-- do other states-- let me back up-- is-- should this be used for every diabetic patient? Is there targeting? Is there more, you should use it, but it's not necessary for you? How, how do you respond to that?

KARA MEINKE BAEHR: I would say the standard of care would definitely be with patients who are on insulin. Now do I have patients that are not on insulin and on other medications that use them and provide-- and no tremendous benefit? Absolutely. But the idea that you can dose insulin off them and how your blood sugars change so much with food, exercise, and those things, I would say first would be insulin treatment.

ARCH: So, so if we were to do this and it would be available to the patients, it's still a doctor's order.

KARA MEINKE BAEHR: Absolutely. It's a prescription.

ARCH: So-- and a, and a physician may not necessarily order it for every diabetic patient.

KARA MEINKE BAEHR: Absolutely.

ARCH: Are there supplies required with this in addition to the device itself?

KARA MEINKE BAEHR: It depends on the different model. There's three different CGMs on the market right now. And some have a separate

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sensor part, the electrode and then the transmitter part. Some it's all in one device and is together where it's one prescription. There's also some people, which is more rare now, use the receiver or the reader that they can see their data. That cost is waived if they're using a smartphone app, which is always free.

ARCH: OK. All right, thank you. Any other questions? Thank you for your testimony.

KARA MEINKE BAEHR: Thank you very much.

ARCH: Thank you for coming today. Very helpful. Next proponent.

KATHLEEN TONKIN: Morning, Senator Arch and members of the committee. My name is Kathleen Tonkin, K-a-t-h-l-e-e-n T-o-n-k-i-n, and I'm testifying in support of LB698 on behalf of the Nebraska Academy of Physician Assistants. As a practicing physician assistant, I have seen firsthand improved blood sugar management in patients who use CGMs over finger sticks alone. Being able to see 300-plus blood sugar values a day, as well as trends, provide so much more information than six to eight blood sugar finger sticks a day. Detecting low blood sugars before they're critical can prevent emergency department visits, seizures, and death. Better blood sugar management and correction of hypoglycemia decreases a patient's risk of end organ damage, such as renal failure, blindness, and amputation, which can save the state money managing these long-term complications. My daughter was diagnosed with Type 1 diabetes when she was two. We didn't get a CGM until she was four as the technology was pretty new then, but the benefits of the device were seen immediately. Being able to see arrows up or down and treat her blood sugar accordingly has saved us many emergencies and scary times. The CGM also allows me to sleep as opposed to being up every night at midnight and 3:00 a.m. to check blood sugars. I still deal, deal with sleep deprivation as I was up at 4:30 this morning treating a blood sugar. But without the CGM, I probably wouldn't be able to work like I do. Now that Reagan [PHONETIC] is 11, the CGM gives her independence and confidence to manage her blood sugars when she's away from me. T1D can be very intimidating for friends and other parents. Having a CGM helps reassure other parents that when Reagan is in their care, there's always a safety net that she won't have any unknown urgent lows when she's with them. Since I brought it with me, she's not going off right now. But as Dr. Baehr commented, people can follow. So if I want to be a helicopter parent, this is what her blood sugar is right now when she's at school. So the, the nurses follow those, other people can follow those. When she does sleepovers, I'm able to see her blood sugars when she's away and be able to help manage that and help other

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parents when she's with them. For children under 18, Medicaid does have some CGM coverage now, but often that is required with multiple authorizations, which is time that providers have to spend advocating for our patients to get these devices covered. Everyone with Type 1 on insulin or even Type 2s with-- on insulin therapy could benefit from these devices. We also encourage Medicaid to appropriately cover the devices so that patients are able to fill these prescriptions and not be denied coverage because they're not covered at the cost of what the device is. I thank you for serving on this committee and for your consideration on this bill. If you have any questions, I'd be happy to answer those.

ARCH: Thank you for your testimony. Questions?

WALZ: I have a quick question.

ARCH: Sure.

WALZ: Thank you. Thank you for coming today.

KATHLEEN TONKIN: Yeah.

WALZ: Appreciate it. You, you just mentioned that it takes time to get approval. Can you-- do you have an idea how much time that approval takes?

KATHLEEN TONKIN: It probably depends based on your insurance coverage. I know even ours on private insurance, you know, it still requires a prior authorization. Some of those require you to submit blood sugar, some don't for the length of time, but generally the providers still have to advocate to get those covered. And sometimes that can be a, a long battle when the patients need those devices.

WALZ: Thank you.

ARCH: Other questions? I, I just have one. Is there an annual cost for the family for, for a monitor?

KATHLEEN TONKIN: Just what would be within your, your insurance and your deductibles. I mean, we pay our out-of-pocket costs. You know, the, the phone and the app and things are, are free. But--

ARCH: But I mean, do you have to replace this monitor occasionally?

KATHLEEN TONKIN: Her sensor is replaced every ten days. The transmitter on it, the battery life is good for about three months, so that's replaced every three months.

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ARCH: OK, but otherwise the device itself, that--

KATHLEEN TONKIN: That essentially is the device. The transmitter, you still have to replace then within the, the app that's on her phone, you have to put in the new serial number and then it syncs to the phone.

ARCH: When there's a new transmitter.

KATHLEEN TONKIN: Yeah, and then when you put the-- yeah, each time you do a new sensor, there's a, a warm-up period for that sensor.

ARCH: All right. Thank you. Any other questions? Seeing none, thank you very much for your testimony.

KATHLEEN TONKIN: Thank you.

ARCH: Next proponent. Welcome.

CHRISTIE ABDUL-GREENE: Thank you. Good afternoon, Chairman Arch and members of the Health and Human Services Committee. And to Senator Kolterman, thank you for bringing this bill forward. My name is Christie Abdul-Greene, C-h-r-i-s-t-i-e, Abdul, A-b-d-u-l, hyphen Greene, G-r-e-e-n-e. I like to make it complicated. So I'm here as a social worker and as the division manager of patient centered care and value based care for CHI Health Clinics. CHI Health is a regional health network that consists of 20 hospitals, 2 stand-alone behavioral health centers, and more than 150 employed physician practices in Iowa, Minnesota, Nebraska, and North Dakota. We employ about 1,600--16,000 people. The data that I'm going to share with you today is specific to Nebraska and Iowa. So we currently provide care to 20,419 patients with diabetes. Not all of those patients have Type 1 diabetes or insulin dependent. Those are patients aged 18 to 75, and that's in Nebraska and Iowa. Eight percent of those patients have Medicaid. So that comes out to 1,577 patients that we're taking care of within CHI Health and primary care. We know that, as the previous testifiers, testifiers have shared, that having diabetes and if not in control can be very debilitating and very scary. So I want to just paint a scenario for you, and I think this is a very true scenario for a lot of our patients on Medicaid. So imagine this: You're a parent, you have two children, you work in a factory or food service setting and you use public transportation. You also have a diagnosis of diabetes that you're struggling to manage and control. Your fingertips are sore and your boss gets upset when you have to stop work to check your blood sugars. Your healthcare providers keep telling you that all the consequences of not managing your diabetes and you're scared. You know

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it's important, but you just honestly can't keep up. Working to maintain housing is all you can focus on right now. Unlike other patients, you do not have access to, to a tool that could be a game changer for your diabetes. It could help you and your healthcare provider know when you are having ups and downs so that you can make changes in your diet and your insulin regimen. This would be very helpful as you know you don't feel well and you're afraid of renal failure as your family care provider has mentioned that your labs are not looking so good and you don't know what to do. That's a very real scenario that plays over and over with our patients who have Medicaid and don't have access to a tool like this. So when we look at our patients at CHI Health, we see that our data is very similar to national trends. We also see a significant disparity in our outcomes for diabetes. So there's a 9 percent disparity between patients with Medicaid, our patients, compared to those with commercial insurance, as far as their controlled A1C, and there's actually a 17 percent disparity between Medicaid and Medicare patients. All of those Medicare and commercial patients have access to the CGM tool. So we see that outcomes are worse where we don't have access to this tool in Medicaid patients. LB698, as introduced by Senator Kolterman, represents a great opportunity to reduce these inequities and healthcare disparities by providing coverage for this CGM tool. As stated before, the tool can improve clinical and quality outcomes, improve quality of life, which as a social worker I think is probably one of the most important things that we can do, reduce healthcare costs, as again been shared, and support broader efforts by the state Medicaid agencies to address structural health inequities. I have some additional data, but you have the testimony that I can read that shares, you know, all of the healthcare cost savings that have been shown in multiple research. There's a recent [INAUDIBLE] paper that I also noted in the testimony that was just completed in January 2022 that has more than you ever wanted to know about CGMs and why they're important to our patients. So with that, I really thank you on behalf of CHI Health, our providers, and really on behalf of the 1,577 Medicaid patients that currently don't have access to this and ask that you please support this bill.

ARCH: Thank you.

CHRISTIE ABDUL-GREENE: Questions?

ARCH: Are there any questions? I just have one question.

CHRISTIE ABDUL-GREENE: OK.

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ARCH: Do you, do you have any personal experience with any, any of our MCOs currently providing them?

CHRISTIE ABDUL-GREENE: Yeah, I actually-- this got brought up in one of my many emails. I think the Wellcare, is maybe not Wellcare anymore, I believe that one of them is covering the CGMs.

ARCH: OK.

CHRISTIE ABDUL-GREENE: And I'm, I'm not 100 percent,--

ARCH: OK.

CHRISTIE ABDUL-GREENE: --but I believe they are.

ARCH: All right. OK, well, thank you very much for your--

CHRISTIE ABDUL-GREENE: Thank you.

ARCH: --testimony. Next proponent.

LILLIA CHERKASSKIY: Chairman--

ARCH: Good afternoon.

LILLIA CHERKASSKIY: Hello. Chairman Arch and members of the Health and Human Services Committee, my name is Dr. Lillia Cherkasskiy, L-i-l-l-i-a C-h-e-r-k-a-s-s-k-i-y, and I would like to also express my support for LB698. I am currently a resident physician in the Creighton University Department of Family and Community Medicine, located in Omaha, Nebraska. I serve both as an inpatient physician at the CHI Health Bergan Mercy Hospital and as an outpatient family medicine physician at the University Campus Clinic located in north downtown. I serve a diverse community of Nebraskans, including college students, refugees, and underserved low-income communities. Approximately 25 of my patients-- 25 percent of my patients have Type 1 or Type 2 diabetes. Both of these diseases are characterized by uncontrolled blood sugars. Both diseases also have genetic and environmental determinants and are rising in prevalence throughout the country and in the Midwest, in particular. As blood sugar levels rise, the body either becomes unable to produce the insulin necessary to regulate these sugars, or the body becomes resistant to the effects of the insulin it can produce. As a result, major organs will often sustain severe damage and even fail. When major organs fail, lives are forever altered, mortality increases, and healthcare spending increases exponentially. Patients with kidney failure from diabetes are placed on dialysis, usually go on disability permanently, and

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their life expectancy drops from whatever it was before dialysis to three to five years. Imagine this happening to a 40- or 50-year-old with a job, mortgage, children, hobbies, who could have otherwise expected to live another 40 years. This is unfortunately not a rare scenario for my diabetic patients who are unable to control their blood sugars. Uncontrolled sugars also lead to nerve and blood vessel damage, which can cause severe pain and increase susceptibility to infection. This scenario can lead to limb amputation if the infection reaches the bone. Again, this is not uncommon, and I take care of multiple patients in the hospital and clinic every week with leg amputations due to diabetes. Finally, uncontrolled sugars can damage the blood vessels in the eyes, causing blindness. All of these consequences of uncontrolled diabetes that I've described are preventable. With the technology available to us, a motivated patient matched with a caring doctor should be able to avoid going on dialysis, having a limb amputated, or going blind. Patients with diabetes should be dying of something else, not their diabetes. LB698 proposes to cover continuous blood sugar monitoring devices for patients with Medicaid. With these devices, patients are not required to stick themselves with needles six to eight times per day, as we discussed, to bring us inferior data compared to what the devices can do. Some patients are able to stick themselves six to eight times a day and, and provide us this data. But unfortunately, the majority of my patients are not because they have low-health literacy and they work multiple low-paying jobs where they can't take a break to perform a sterile needle stick whenever needed. Investing in a continuous blood sugar monitor that my patients could wear would very likely improve diabetes control, prevent life-altering complications and death, and help bring the care of our most vulnerable patients up to the standard for the healthiest patients in our country, all while saving money that would have been spent addressing their complications. Thank you.

ARCH: Thank you. Are there questions? I have one, Ms. Cherkasskiy.

LILLIA CHERKASSKIY: OK.

ARCH: Do you ever, do you ever use continuous glucose monitoring for Type 2?

LILLIA CHERKASSKIY: We do sometimes, and it's for Type 2 diabetic patients who are having a lot of trouble. So it's not-- it's for people who were not able to have adequate control with just the finger sticks and who have had to go on insulin. And sometimes we're even able to initially use insulin when they're first diagnosed and we need

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the monitors and then with time, get them under good control and then we don't need the monitor anymore. So it's very helpful that way.

ARCH: OK. Thank you.

LILLIA CHERKASSKIY: Um-hum.

ARCH: Any other questions? Seeing none, thank you very much. Next proponent.

CHRIS DUNN: Good afternoon, my name is Chris Dunn, C-h-r-i-s D-u-n-n. We've heard some incredibly powerful testimony from some healthcare providers, but I'm here to talk to you as a mom. Thank you for allowing to share-- allowing me to share my story and thank you for considering this very important piece of legislation. This issue became my reality in 2006, when my then two-year-old son, Nolan [PHONETIC], was diagnosed with Type 1 diabetes. Unfortunately, lightning struck twice for our family as my four-year-old daughter, Patsy [PHONETIC], was also diagnosed a few years later. Type 1 diabetes is an autoimmune disease in which the body does not produce insulin, which is a hormone that is required to survive. People with Type 1 diabetes either have to inject or infuse insulin and diligently monitor their blood sugar around the clock. In the first nine years of our journey with Type 1 diabetes, we did not have access to the technology that we're discussing today. In order to keep our children safe and healthy, we had to monitor their blood sugar around the clock. To accomplish this, we had to poke their little fingers and use a blood glucose meter to check their blood sugar. We literally did this every two to three hours, 24 hours a day. A reality with Type 1 diabetes is what we in the community commonly call "dead-in-bed syndrome." This is when someone with Type 1 diabetes has a hypoglycemic event while they are sleeping. When this happens, this can become fatal. As a parent, this is our greatest fear. This meant that we set alarms for midnight and 3:00 a.m. every single night, and we would sneak into their bedrooms to poke their little fingers to check their blood sugar. If they were low, we would have to wake them up to consume some fast-acting sugar to bring their sugar up. I would then have to stay awake to recheck their blood sugar 15 to 20 minutes after they are treated to ensure that their blood sugar rose to a safe level. If their blood sugar was still low, we would repeat the cycle sometimes for hours. During these years, I was walking around in a state of complete exhaustion all the time. The most frightening experience-- excuse me, would be if I slept through my alarm, which unfortunately was not uncommon because I was so exhausted. I would wake with a start an hour or so after my alarm first started going off, my heart would race, and my stomach would drop. I would literally

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jump out of bed and run to their bedrooms and place my hand on their chest to make sure they were breathing. And then I would start poking fingers. Can you imagine the toll this took on my mental health? Thankfully, nine years into our life with Type 1 diabetes, our insurance approved both of my children for the CGM. Using this technology completely changed our lives. My children wear the small sensor that you've heard about today, which takes that blood sugar reading every five minutes. It transmits that blood sugar via Bluetooth to their cell phones, which sends that number to the cloud, which in turn sends that blood sugar reading to my phone and to the Apple Watch that I wear. We literally have real-time blood sugar numbers at our fingertips 24 hours a day. Not only does the CGM technology give us a current reading, but it also shows us the direction that the blood sugar is heading. If they're heading low, we can intervene before they actually get low. If they are trending high, then we can [INAUDIBLE] additional insulin to prevent dangerous high blood sugar levels. Simply put, it helps to keep their numbers in range, which will prevent long-term complications in the future that you've heard about today. The CGM also gave us the gift of sleep. We no longer set alarms at midnight and 3:00 a.m. every night as the CGM will alarm if their blood sugar is low or high and wake us up only when necessary. A few years ago, I was actually in Washington, D.C., preparing to meet with members of Congress about this very issue, CGM access. The night before I went on my hill visit, I was awakened in the middle of the night by the CGM alarm. Keep in mind, I was in Washington, D.C., and my children were at home in Nebraska. My son's blood sugar was 50 with a double-down arrow. A blood sugar under 70 is dangerous. He was 50 and trending even lower very quickly. I was able to call my husband and wake him up so that he could get my son some fast-acting sugar very quickly. The CGM technology literally saved his life that night. I have many other stories about the CGM and how it has prevented other close calls for our family over the years. I cannot imagine going back to life without this technology. All families affected by Type 1 diabetes should have access to this life-changing and life-saving technology. Thank you for letting me share my story.

ARCH: Thank you for your testimony. Are there questions? Seeing none-- Oh,--

WILLIAMS: I do.

ARCH: --Senator Williams.

WILLIAMS: Thank you, Chairman Arch. Thank you for being here.

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CHRIS DUNN: Yes.

WILLIAMS: You mentioned that you were finally able to get approved for commercial insurance.

CHRIS DUNN: Yes.

WILLIAMS: Is that private insurance or through an employer of yours or your husband's?

CHRIS DUNN: It's employer insurance. Yes.

WILLIAMS: Can you, can you tell our committee the, the issue, was it time-consuming to go through that process or--

CHRIS DUNN: At that point in time, it had not been the standard of care, and so it, it took some additional approvals to get that passed. Now at this point in time because it is the standard of care, we don't have to go through so much difficulty to get it approved through commercial insurance any longer.

WILLIAMS: So from your perspective, it's currently available through commercial insurance?

CHRIS DUNN: Yes, it's not difficult through commercial insurance. At least from my experience, it-- it's approved. Yes.

WILLIAMS: Thank you.

CHRIS DUNN: OK. Any other questions?

ARCH: Thank you. Are there any other questions? Seeing none, thank you very much--

CHRIS DUNN: Thank you.

ARCH: --for your testimony. Next proponent.

JENNIFER MCGILL: Good afternoon. Chairman and members of the committee, thank you very much for taking the time to hear such an important piece of legislation today and thank you to everyone else who's making their voice heard on this issue. My name is Jennifer McGill, J-e-n-n-i-f-e-r M-c-G-i-l-l. I'm a registered nurse and certified diabetes educator at Virta Health. I have lived with Type 1 diabetes for 32 years. Prior to my current position, I proudly worked at OneWorld Community Health Centers for nearly four years. It broke my heart to see Medicaid patients with Type 1 diabetes who were in and

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out of the hospital but were denied continuous glucose monitors because they were adults. On the other hand, it thrills me to see my patients bring their blood sugars into a normal range thanks to their continuous glucose monitors or CGMs. The constant graph they see on their CGMs, shows the immediate response of blood sugar due to food, exercise, and other factors. Impossible to do when you're only doing finger-stick checking. I have been using a Dexcom every day for eight years. It has allowed me to improve my A1C or average blood sugar. The problem with relying on A1C to determine management of blood sugar is that it doesn't give us the full picture of day-to-day fluctuations in blood sugar. Only the average. The CGMs offer analysis of time and range, which is the true predictor of health and management of blood sugar. For example, one person with an A1C of 6.5 percent might have a rollercoaster blood sugar between the 30s, much too low, and the 300s, much too high. And another might have a very tight range of 70 to 140. But without the blood sugar data, it's anybody's guess as to what the A1C means, especially for patients on insulin. Most insurance companies cover one to four test strips a day, depending on diagnosis and medications. But what happens in between meals and overnight? When we're asleep, we're unconscious to the symptoms of low or high blood sugar. Too many patients have died in their sleep due to hypoglycemia unawareness. Many patients will purposefully allow their blood sugar to remain dangerously high in order to avoid death, favoring a slow journey towards terrible complications from high blood sugar over the terrifying possibility of dying suddenly due to low blood sugar. The CGM alarms prevent this by alerting the patient when the blood sugar goes out of range, allowing them to treat accordingly in time. I know that my CGM has saved my life on many occasions and saved me from innumerable out-of-range blood sugars that sap my energy, productivity, and mood. It has allowed me more freedom and peace of mind to live a normal, healthy life. Every patient with diabetes deserves that sense of calm and confidence. Thank you.

ARCH: Thank you for your testimony. Are there any questions? Seeing none, thank you very much.

JENNIFER MCGILL: Thank you.

ARCH: Next proponent. Is there anyone else that would like to speak as a proponent? Is there anyone that would like to speak in opposition to the bill? Is there anyone that would like to speak in a neutral capacity? Seeing none, Senator Kolterman, you're welcome to close. As you're coming up, I would mention that we received 14 letters in-- as proponent for this bill, no opponents, and no neutral. You may close.

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KOLTERMAN: Thank you, Senator Arch. First and foremost, I think I'd like to thank the dedicated parents and healthcare professionals that are here that trusted me to carry this bill. There's some key numbers I want you to think about. Number one, between \$88 and \$90 a year is what we're talking about from more cost, and that's already being paid out. But on the flip side of that, if you're hospitalized with hypoglycemia, \$3,800 is what it could cost you. And, and even worse, if you have diabetic ketoacidosis, that's \$8,500. Those are, those are real numbers. So the real issue here is, do you want to pay me now or do you want to pay a whole lot more later? That's a real question. We can save a lot of money for the state of Nebraska and our Medicaid patients. And in addition to that, we can save a lot of lives and keep people healthier by allowing this to go forward. So with that, I'll answer any questions you might have.

ARCH: Thank you. Senator Williams.

WILLIAMS: Thank you, Chairman Arch. And thank you, Senator Kolterman. I talked before when I asked a question about private insurance. With your experience, does most private insurance cover this?

KOLTERMAN: They do now. And, and again, I think it boils down to the, the provider has to make a case for it in, in some cases. But yes, they do provide the coverage.

WILLIAMS: How about Medicare?

KOLTERMAN: I can't answer that.

WILLIAMS: OK.

KOLTERMAN: I, I would, I would assume they would again.

WILLIAMS: Thank you.

ARCH: Other questions? Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thank you, Senator Kolterman. I want to follow up on more questions on the fiscal note. So after hearing the testimony about the \$1,300 and the \$90. Is it your understanding in the fiscal note, are they taking into consideration the individuals that currently use the, the finger prick and those costs versus--

KOLTERMAN: I'll be honest with you, I haven't looked at the fiscal note.

M. CAVANAUGH: OK. Tyler, will you follow up with me?

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KOLTERMAN: I think I-- I mean, we try to answer your questions, but I think we've made a very strong case for the fact that this is really going to be cost neutral and even save the state a lot money.

M. CAVANAUGH: That's what I'm kind-- that's what I was getting at is that it looks like from my perspective and I, since they didn't come in, I don't know if that's what they were intending, but it, it does look like they're doing it purely based on the costs, not the, not the replacement.

KOLTERMAN: Not the savings.

M. CAVANAUGH: Yeah.

KOLTERMAN: Yeah, we'll, we'll look into that for you.

M. CAVANAUGH: OK. I think, yeah, that would be helpful. So thank you.

ARCH: Any other questions? Seeing none, thank you very much.

KOLTERMAN: Thank you.

ARCH: That will close the hearing for LB698. We will now, we will now open the hearing for LB895. Senator Walz.

WALZ: Thank you. Good afternoon, Chairman Arch and members of the Health and Human Services Committee. My name is Lynne Walz, L-y-n-n-e W-a-l-z, and I proudly represent District 15, and I'm here to present LB895. LB895 requires the MCO's prior authorization process be more transparent, more consistent, and more timely. Currently, my understanding is that Medicaid patients seeking chiropractic, physical therapy, occupational therapy, or speech language pathology services are being denied authorization, and it's unclear to providers as to why they would be denied this coverage. So they're just not giving any reasons why, or it's taking a long time to get a reason why. I'm also hearing that it's taking up to two weeks for patients to receive a response from managed care organizations to let them know if they will be denied or if the claim will be modified. Excuse me. In addition, I have concern for patients that have been involved in life-altering accidents not receiving treatment based solely on the wait for authorization for managed care organizations. I should be clear that there are some MCOs that are already following this procedure, but this bill would make sure that current and future contracted managed care organizations are all on the same page of transparency and timeliness. In, in anticipation of the new RFP, we're just trying to ensure that whatever managed care organization the state contracts

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with now and in the future are all going to be held to the same standards and are meeting the needs-- more importantly, meeting the needs of the patients. If we start at Section 2 of the bill, we are asking that managed care organizations use evidence-based clinical guidelines, and we are also asking organizations to make available, make available their guidelines on their website so all providers can comply. Moving to subsection (2), we're asking that people who are approving, modifying, or denying claims be healthcare professionals or the same discipline. We want to make sure that the people making these decisions understand the necessity for the type of care the patient is seeking. In subsection (3), we address the process for a patient seeking care for an accident. And to expedite that process, we are asking that there is not a requirement for prior authorization for up to 12 initial treatment sessions. It is important that a patient seeking care from a chiropractor, physical therapist, occupational therapist, or speech-language pathologist, pathologist due to a life-altering accident receives immediate care. In subsection (4), we are asking for timely payment by managed care organizations not to exceed 15 business days. This is outlined in the rules that managed care organizations should already be following. Subsection (6) requires a 48-hour response by managed care organizations to deny or modify a prior authorization request. What I've heard from providers is that it is imperative to make the next appointment-- and I completely agree with this because once you leave the office, it's hard to get your appointment, but to make the next appointment while the patient is in the office. That means that it's all the more important to make sure that they are ready for authorization as soon as possible. Additionally, I've been working with the Nebraska Medical Association on an amendment to this section, which I have handed out to the committee. They've just asked that we make it clear that 48-hour time frame does not apply to clinicians, but only to therapy providers. Finally, subsection (6) [SIC], we are asking for an expedited review when the medical necessity warrants an immediate response. Again, ensuring timely responses for patients that urgent-- that urgently need care. This bill ensures that we are giving equal care to Medicaid patients across the board, regardless of which managed care organization they happen to use. The intention of this bill is to promote, is to promote quality of care, decrease patient cost, and create a better outcome for patients. The bottom line is that there is just one thing-- if there's one thing that we can do now to address the problems we are hearing from patients and providers, this bill is extremely necessary if we want to ensure consistent and equal coverage for Nebraskans. With that, I would be happy to answer any questions, but I also know that there are people behind me who can. Thank you.

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ARCH: Thank you, Senator Walz. Any questions? Seeing none, thank you very much. First proponent.

BRIAN BRUNKEN: Good afternoon, Senator Arch and members of the Health and Human Services Committee. My name is Brian Brunken, B-r-i-a-n B-r-u-n-k-e-n. I'm the chairperson for the Practice Management Committee of the Nebraska Chapter of the American Physical Therapy Association. I also own a small private practice in Millard west area of Omaha. I'm here today in support of LB895. Thank you, Senator Walz. I represent the 1,300 members of our chapter that serve Medicaid beneficiaries, especially in rural and urban areas. I also have the honor of being a member of clinical advisory boards for all three managed care organizations within Heritage Health. We appreciate the opportunity to work with these MCOs, and many times we have reached compromises. Again, as Senator Walz said, we want uniformity across all three MCOs, though. Some of these agreements also are not in writing. Some of them are verbal. So once again hopefully this bill would solidify things. Briefly, this is a process by which a patient completes PT, the patient sees their physician, receives a referral for PT. Usually, that'll state 2 to 3 times a week for 4 weeks, 8 to 12 visits. Then the patient is evaluated in the clinic or home setting and sometimes via telehealth now with the pandemic. Following this evaluation, the PT sets his or her plan of care. Next, the MCOs require the pre-authorization submission of both client and therapist information that was gleaned from the evaluation. This is so the MCO may approve therapeutic interventions. They use proprietary algorithms to determine if the therapy is medically necessary. Often, the initial authorization derived from the algorithm or other methodology within the MCO does not grant sufficient visits to achieve the patient's goals. This results in multiple submissions of the pre-authorization process. If it's not completed, you do not get paid. LB895 is not intended to increase costs for the MCOs or for Nebraska taxpayers. However, it is intended to reduce administrative burden associated with this pre-authorization process, to achieve transparency from the MCOs and their sources for their algorithms, to allow therapists to provide care for 12 visits without pre-authorization, and finally, to reduce the amount of time, currently up to 14 days, that Senator Walz stated that the MCOs are allowed to render a decision. This delay violates the fact that better therapy adherence is noted when the patient, as she said, schedules their follow-up visit right there on their first appointment. This results in less anxiety, better outcomes, and fewer overall visits. Furthermore, following surgery, research supports early access to therapy, which allows for increased function, better therapy adherence, and, and, again, better outcomes. Delaying physical therapy potentially increases the likelihood of an

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opioid addiction, which we know is a big problem in our country. PT has the potential to decrease opioid addiction by 10 percent. Just a one-day supply of an opioid increases the chance of addiction by 6 percent. Early PT for low back pain has been shown to decrease medical costs downstream, MRI, shots, those kind of things, surgery, by over \$2,700. We appreciate the need for pre-authorizations for such things as major surgery or maybe experimental medications. However, in our case, it causes a lot of downtime in the clinic, and we don't get to treat patients as much as we'd like. There was a study done, administrative costs account for one-quarter to one-third of healthcare spending in the United States. Of course, this far exceeds other countries. Twelve visits were selected as the average number of visits, and this was derived from a company called FOTO. They do outcome registry for PT, so they looked at over seven million patient episodes as their basis. Forgive me for assuming, but I would assume that at least half of the cases could be taken care of in this manner without pre-authorization. In other words, under 12 visits. Nebraska Medicaid already has visit limitations, therefore, adding further authorizations only adds a significant burden, all at my expense or other providers' expense. Today, treating the patient is the easy part as we fight for authorization to see the patient, complete the treatment, and the fight on the back end to attain payment. This is not sustainable long term, and Nebraskans are not receiving the timely care that they need. I strongly encourage your support for this bill, allowing 12 visits without pre-authorizations. This will allow again Nebraskans the necessary care without delay, without interruption, create uniformity across all MCOs, and will decrease the administrative burden placed on us at our cost. Thank you, and I'll entertain any questions.

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

WILLIAMS: Thank you, Chairman Arch. And thank you, Mr. Brunken, for being here. You work with all three of the MCOs--

BRIAN BRUNKEN: Yes.

WILLIAMS: --through, through your practice. Am, am I correct in stating that some of these, there's not consistency between the three MCOs?

BRIAN BRUNKEN: Correct. I didn't want to kind of bore you with those details, but my plan of care might match the physicians' plan of care. For instance, we talked about three times a week for four weeks, so it will be 12 visits. My, my plan might be less than that, might be a little bit more than that. But when you go ahead and then complete

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this prior authorization process, which we've been told an experienced authorization professional can do it in four to five minutes. I am 51 years old, it takes me 20 minutes to do it. But-- well, you might give eight visits, you might get four visits. Then you come back after just four visits, say, if you had a total knee or rotator cuff repair. I see you Monday, Wednesday, Friday, and on Monday, we're doing it all over again and it just gets exhausting. And their studies have shown-- they've shared their data with us that they end up giving us 12 to 25 visits, depending on the type of diagnosis anyway, so.

WILLIAMS: OK.

BRIAN BRUNKEN: And we've, we've talked to-- sorry for interrupting, we've, we've talked to other, like, there's a hospital system in Omaha that's actually hired at least three employees just to do authorizations only. I know there's some people behind me that can speak to that as well that are other private practitioners. Thank you.

WILLIAMS: There are, as I understand it, four different disciplines: chiropractic, physical therapy, occupational therapy, and speech-language pathology that are, that are covered with this. I would assume in some cases there are people needing more than one of these disciplines.

BRIAN BRUNKEN: Correct.

WILLIAMS: And so if we follow this, then each one of those would get 12 visits correctly pre-authorized.

BRIAN BRUNKEN: The way I understand it, yes, that is in its current state.

WILLIAMS: OK. Any additional questions? Seeing none,--

BRIAN BRUNKEN: Thank you very much.

WILLIAMS: --thank you for your testimony.

BRIAN BRUNKEN: Thank you.

WILLIAMS: Invite the next proponent. Good afternoon and welcome.

CANDICE MULLENDORE: Good afternoon. Need my glasses. Thank you-- oh, Senator Arch left, but thank the rest of you for the opportunity to testify today in support of LB895. My name is Candice Mullendore, C-a-n-d-i-c-e M-u-l-l-e-n-d-o-r-e. I'm an occupational therapist, as well as a private practice owner of a pediatric outpatient clinic in

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Papillion, Nebraska, that serves children and youth with disabilities for occupational, physical, and speech-language therapy services. I'm here today representing the Nebraska Speech-Language-Hearing Association, as well as my private practice. As Brian mentioned, since the inception of Heritage Health, the managed-- Medicaid managed care organizations chosen to provide quality health to Nebraskans, have implemented a variety of prior authorization processes that have resulted in our clients not receiving their medically necessary therapy services in a timely manner. As a provider as well as a therapist, I have experienced the many iterations of Medicaid managed care organizations and their various authorization processes in the past five years. The intent behind LB895 is to simplify the authorization process and to ensure that providers can provide Medicaid recipients quality care in a timely manner. In the past five years, the administrative demand for meeting each MCO's requirements for authorization has become unsustainable. Medicaid recipients are 25 percent of my practice as patients. My practice had to hire an additional 1.5 full-time equivalent of administrative personnel to handle only the Medicaid MCOs. That cost is over \$65,000 annually for my practice. This is a cost that some clinics may not be able to absorb and choose to no longer serve those recipients. This could decrease in access and care across our state. Speech therapists often see patients for swallowing disorders. When a speech therapist evaluates a patient with a swallowing disorder, it's often a deficit that they need immediate therapy to prevent further complications such as aspiration. If you aspirate food that you are eating, it could result in a medical complication which sometimes requires hospitalization. If a patient cannot access therapy due to a delay in receiving an authorization, we are putting that patient at significant risk for an unnecessary medical complication. I'm here to tell you a story of a pediatric patient that two speech-language therapists treated. This pediatric patient, we'll call her Michelle, had a stroke, which is a really rare occurrence in a child. The stroke affected Michelle's ability to safely swallow foods and liquids. She was at risk for aspiration and was placed on a modified diet, which means a speech therapist was working on the patient's ability to swallow a certain type of food safely. During her stay at an inpatient rehabilitation facility, Michelle and her parents working with their speech-language pathologists have been able to provide Michelle with enough nutrition by mouth to prevent the placement of a gastric tube, which provides nutritional support for patients with swallowing challenges. Upon discharge from the inpatient rehab facility, Michelle was going to receive continued speech therapy at an outpatient practice. The outpatient practice submitted for an authorization and due to a long response time, the new authorization was not in place

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prior to Michelle's discharge home. This left Michelle and her parents in a precarious position. Michelle was going to go without speech therapy due to a 16-business day gap between her inpatient and outpatient therapy, which was almost three weeks in regular days. During this gap in care, Michelle lost many of her swallowing skills that had she progressed to in her inpatient therapy. She was losing weight and was at risk for placement of a nasogastric tube. The negative impact of waiting for an authorization on Michelle and her family was unnecessary, disheartening, and frankly, put Michelle in a position to possibly have a medical complication, which would result in a higher cost for the MCO. The physical and emotional stress that Michelle and her family endured during this gap in care was immeasurable. Imagine if you were Michelle's parents watching her struggle to eat-- sorry, this gets emotional because I can picture this, and losing the skills that you worked so hard to improve while you're in inpatient rehab. Imagine worrying every day that you put your daughter on the scale she was losing pounds. Imagine worrying that she could aspirate and become very ill. Imagine that stress as a parent. Now imagine with the implementation of LB895, that stress won't happen for any of these parents. Imagine a seamless transition from inpatient to outpatient rehab and the incredible gains that a patient like Michelle could make. Imagine how you, Senators, can make a difference for all these families through LB895. Fortunately, through intensive outpatient therapy after receiving the authorization, Michelle was able to regain her swallow skills. Michelle is only one story, and I wonder how many other patients like Michelle are out there that did not receive timely therapy that resulted in negative outcome. Imagine the collective impact we can have on Nebraskans when the situation occurs many times a day across our state. A delay in therapy services is incongruent with published evidence and best practice, which compromises overall patient outcomes. With a decline in outcomes due to the delay in service, the Medicaid recipient may access the Medicaid-- the medical system more which could increase the overall cost of healthcare. The implementation of LB895 would provide parameters for authorizations to the Medicaid, Medicaid managed care organizations to approve therapy quickly and will work in the best interest of Nebraskans. Thank you, and I'll take any questions.

WILLIAMS: Thank you. Are there questions? I have a question.

CANDICE MULLENDORE: Um-hum.

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WILLIAMS: In your practice, you deal with Medicare patients, those that have private insurance and those that you're dealing with the MCO with Medicaid?

CANDICE MULLENDORE: Yeah, I don't accept Medicare because I'm pediatrics, but I have, I have commercial insurance, government--

WILLIAMS: What is the pre-authorization requirements generally with the private insurance?

CANDICE MULLENDORE: Generally, there is no pre-authorization for most private insurers. You-- when the patient signs up for their healthcare, they're given a certain number of visits a year. So, for example, 60, and so they would know that they have 60 visits. You have to prove possibly medical necessity if they come for a retrospective review. But in general, the patient is allotted a certain number of visits for the year, and then you work with the family to figure out how they want to use those visits.

WILLIAMS: OK. Any additional questions? Seeing none, thank you for your testimony.

CANDICE MULLENDORE: Thank you, Senators.

WILLIAMS: Invite the next proponent. Good afternoon and welcome.

NICK PAYNE: Good afternoon, Senator Williams and members of the Health and Human Services Committee. For the record, my name is Dr. Nick Payne, N-i-c-k P-a-y-n-e, executive director of the Nebraska Chiropractic Physicians Association, testifying in support of LB895. Medicaid beneficiaries across the state of Nebraska have access to conservative care provided by doctors of chiropractic, as well as our colleagues in physical therapy, occupational therapy, and speech therapy. Pre-authorization is a widely used procedure in the Nebraska Medicaid system, yet it often leads to delays in medically necessary care, as well as increases in administrative burdens. Doctors of chiropractic have a unique process when we are interacting with the pre-authorization system in Medicaid. While some of the therapy services that we provide to our patients require pre-authorization, the main mode of treatment we have, the chiropractic adjustment, is not included inside of that process. Our association members reporting that the prior auth system requires long waits on the telephone to obtain prior authorization or multiple phone calls back to the MCO to follow up on online submissions, which are supposed to speed up the process. It doesn't seem to work as well as intended. Oftentimes, care is denied or a very limited number are approved. This could be two to

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three visits, potentially. This care is not adequate to take care of the patient's condition or really even get to the point where we have appreciable improvement. Then you have to start that pre-authorization process all over again. And it is definitely an inefficient and costly process. The current pre-authorization process has created a system that allows Medicaid beneficiaries to receive a small percentage of the care that may be recommended by their healthcare practitioner. A portion of LB895 requires the beneficiaries be allowed 12 initial therapy visits prior to authorization. This time frame allows for some consistency in treatment and some progress towards measurable clinical goals. The chairman of the AMA Board of Trustees, Dr. Mukkamala, has stated: We're seeing people suffer more while we're waiting days or weeks to do what we know needs to be done. It affects our morale and how we practice and it frustrates our patients. I believe the statement by Dr. Mukkamala represents our current situation with the pre-authorization process. In Nebraska, we currently have an environment that allows roadblocks to be placed between the Medicaid beneficiary and conservative care. This is in stark contrast to what the research tells us. We know from the research that's out there that conservative care is the initial mode of treatment results in better outcomes for patients and lower overall healthcare cost. In reality, the prior authorization process will likely increase the costs of the Medicaid program whenever a patient is forced to leave a conservative care environment and seek treatment from more invasive and more costly procedures. The NCPA is supportive of LB895 beyond the impact to doctors of chiropractic. Our conservative care colleagues are facing even greater challenges that are negatively impacting patient care. Collaborating on this bill clearly has shown us the adverse impact of the current prior authorization system. It is flawed and cumbersome delivery of care. Change is necessary to ensure that medically necessary, high-quality, cost-effective care is delivered. I want to thank Senator Walz for introducing this bill, and the NCPA ask the members of this committee to advance LB895 to General File for further consideration. I'd be happy to entertain any questions.

WILLIAMS: Thank you, Dr. Payne. Are there questions? I-- I'm going to ask you the same question I asked the last testifier about comparing Medicare and private insurance to what you see with the MCOs and Medicaid.

NICK PAYNE: So for Medicare, there is no pre-authorization for any chiropractic services. The majority, there's only a select few commercial payers that have any level of pre-authorization, and that's a very, very small percentage here in Nebraska. And then, of course, Medicaid, like I said, we are a little unique. So the adjustment that,

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that we provide is not what we are pre-authorizing, but it would be any other service, any other therapy services that we provide, such as electrical stimulation, therapeutic exercise, neuromuscular education, things that we're doing to help assist that patient and progress them through treatment quicker to get that better end result in a more timely fashion.

WILLIAMS: Thank you. Additional questions? Seeing none, thank you for your testimony.

NICK PAYNE: Thank you.

WILLIAMS: Invite the next proponent. Welcome and thank you for being here.

MARY WALSH-STERUP: Thank you, Senators, for taking the time to hear us today. I'm here to support LB895. I'm currently a partner with Central Nebraska Rehabilitation Services. My name is Mary Walsh-Sterup, W-a-l-s-h hyphen S-t-e-r-u-p. I'm an occupational therapist and I'm going to support-- speak on supporting LB895 for the Nebraska Occupational Therapy Association, as well as a private practitioner. I currently practice-- we have 14 outpatient clinics in Lincoln, Kearney, Grand Island, as well as several rural communities. Medical necessary therapy should be a consideration and collaboration between the physician and the patient, and is carefully thought out as the physician prescribes that therapy. As a provider of therapy services, I've witnessed delays and interruption in care on a regular basis over the past five years due to the authorization processes implemented by the current MCOs. We have worked with all four of the MCOs, there's three, Wellcare used to be here, and worked with them and addressed their authorization processes. It's those processes that have brought me to this committee prior to speak on the, the difficulties that we have had. The significant amount of administrative burden that has pushed onto the provider makes it long-term unsustainable. But more importantly, what it's doing to the patient and my colleagues here have really talked about the administrative burden and how it's affected all of us. So I would-- what I really like to emphasize today is to give you some real life stories about how this has affected patients. We are a fairly large provider. We provide PT, OT, and speech services. And so literally, when I asked my team for examples, I probably had 100 examples that I could have easily shared with you. First, is a patient that had shoulder surgery. She was referred to therapy, the doctor ordered 3 times a week for 12 weeks. We submitted authorization and we received eight and we had to submit for an additional authorization. Three weeks later, we received three visits. Then submitted for an additional authorization two weeks later and

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received six additional visits. We had 17 total visits provided. We did seek an additional authorization and it was denied, they wanted the patient to wait a period of time before resuming any additional therapy. So we ended up having 17 total visits provided. Each one of those authorizations took the-- our clinicians about 20 minutes to complete. The patient returned to the physician one month later and had significant increases in shoulder tightness and advanced adhesive capsulitis and was referred for additional services. And so we had to start the whole process all over again. Another patient had a shoulder injury. We completed the evaluation at that time, started early active range of motion. The patient was submitted for authorization, 14 days later we received the authorization. The patient attended their second appointment for therapy 16 days after their initial evaluation. This was a significant delay in the patient's care. The patient presented with significant tightness and limited range of motion. Perfect example of delay in medically prescribed therapy, resulting in increased complications for the patient. C.T. was a patient that was referred for neck pain and severe headaches. An evaluation was completed and we had to put the patient on hold until we received the authorization. During the period of the hold time, the patient contacted our office and asked about therapy. We had to continue to tell her that she was on hold. Authorization was received 12 days later. Further attempts to call the patient found that the patient's phone was no longer in working order. We then attempted to try to find their contact, their emergency contact, to see if we can locate the patient to get them scheduled for their treatments. We were unable to locate the patient, and we had to send back to the physician a letter indicating that we were unable to provide the prescribed medically treatment due to delays in care with the authorization process. D.K. is a student athlete who sustained an ACL strain and his home was in northern part of Nebraska, and it was almost 60 miles that he came into our clinic. We had to complete the evaluation and we felt like because of the instability in his knee and knowing that he was going to be going back to performing sports that we wanted to get him started on treatments right away. He called for an immediate authorization and we were told by the authorization clerk that, nope, 14 days was what they were allowed and don't expect to get anything for 14 days. So we had to deal with, do we do the right thing by the patient and go ahead and treat the patient knowing that we're not supposed to by the MCO or do the right thing by the MCO and not treat the patient? Here was a kid who was an athlete, was going to return to sports and could have sustained a significant injury to his knee. Our therapist was very concerned about him and we did go ahead and treat this patient anyway. These are just a few examples of real life stories of how the authorization process has limited our ability to

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treat our patients effectively and in a good manner of time. So thank you.

WILLIAMS: Thank you for your testimony.

MARY WALSH-STERUP: The red light comes on fast.

WILLIAMS: We-- you know, five minutes goes faster when Senator Arch isn't here.

MARY WALSH-STERUP: Oh.

WILLIAMS: We, we speed that up. Geri does that over there. Are the examples that you're citing here, all examples that we're dealing with MCOs?

MARY WALSH-STERUP: Correct. Yes.

WILLIAMS: I wanted to be sure that I understood that. Other questions?

MARY WALSH-STERUP: Questions?

WILLIAMS: Seeing none, thank you--

MARY WALSH-STERUP: Yeah.

WILLIAMS: --for your testimony. Invite the next proponent. Welcome, Mr. McDonald.

EDISON McDONALD: Hello, my name is Edison McDonald, E-d-i-s-o-n M-c-D-o-n-a-l-d. I'm the executive director for the Arc of Nebraska. We advocate for people with intellectual and developmental disabilities. We're here in support today of LB895 because many of our members have struggled with the lack of clarity and the bounce back and forth from providers to MCOs. This has created a number of expensive issues and delays or denial of care, as we've heard in previous stories. This prevents individuals from getting the care that MCOs are supposed to be providing. This is an issue that we regularly deal with, and we've seen some key spikes in denials or delays. Typically, for some families we've worked with, this requires a bounce back and forth between doctors, chiropractors, physical therapists, occupational therapists, speech therapists, and managed care organizations that are confusing and frustrating. This requires a huge increase of time from families who have to spend an inordinate amount of time and effort on calls and filling out excessive paperwork. For some families, this ends up being days out of their week. This also makes it more difficult for those providers to maintain profit

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margins. So many begin to want to shift away from those clients. While this undoubtedly won't fix all of the issues with prior authorizations, we believe that this bill is a significant step in the right direction. We hope once this passes, to track this issue further and better determine what other changes are necessary. And I just wanted to share, you know, I've really seen this issue over the last few years, and it always seems to come and go in waves. We have one kind of change within a certain MCO's process in terms of how they deal with these issues. And then all of a sudden, I get all sorts of calls in from families who are dealing with this. But there's one in particular where we had a huge spike and I had a number of families who met with me and talked with me about this issue. And I heard these stories about these individuals who they wanted to go to therapy. But for our individuals, making sure they have consistency in their life, consistency in how they get their therapy, consistency in their week and their schedule is very important to address their disability and their needs. And so really ensuring that we have that consistency and that we eliminate the yoyo process back and forth is so important because, ultimately, for so many of these families, if they go and, you know, have the prior authorization for a couple of sessions and then they don't know if they're going to, it really just kind of leaves them stuck between a rock and a hard place. And a lot of times it's almost more logical to just say, let's not go ahead and do this for some of those families. And with that, any questions?

WILLIAMS: Are there questions? Seeing none, thank you for your testimony. Invite the next proponent. Good afternoon and welcome.

AMBER WOODS: Good afternoon, Senators. My name is Amber Woods, A-m-b-e-r W-o-o-d-s. I am the revenue manager for CenterPointe and we are a behavioral health organization operating in Lincoln and Omaha. I'm here today representing CenterPointe and the Nebraska Association of Behavioral Health Organizations, who also represents numerous behavioral health providers, hospitals, regional behavioral health authorities, and consumers throughout the state. I thank you for the opportunity to, to testify in support of LB895 and to speak toward including behavioral health in this bill. Like many of the chiropractic, physical therapy, occupational therapy, and speech pathology services in Nebraska, behavioral health providers shoulder vast administrative burden that accompanies contracting with Medicaid providers. You've just heard several proponents speak about the issues that you're having-- that they're having, and behavioral health providers and organizations experience the same issues with the lack of transparency, incongruous processes, and erratic communication when requesting authorization-- excuse me, requesting authorizations for

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services. At CenterPointe, we utilize evidence-based practices and each offer program to treat individuals with behavioral health disorders. However, when requesting authorizations for these services for managed care payers, we are often denied and deferred. The reasons for denial vary. We have received authorization denials stating individuals no longer meet medical necessity because they showed a modicum of progress, our supplied clinical data is suddenly insufficient, a managed care physician's subjective understanding of what meets the clinical criteria is used to determine service eligibility. Authorization deferments can persist for months and are typically caused by errors of the payer. When following up on authorization requests, we are told that the initial paperwork was not received despite us having fax confirmations to the contrary. We're given authorizations that are issued to the wrong services, or we're given a partial approval, which grants authorizations for only three to seven days for long-term care programs. These tactics exemplify the need for consistency in service authorizations. One of the most significant issues we experience in authorization denial for our long-term treatment programs is the denial for the, the individual's second month. In our co-occurring residential treatment facility, that rate-- that happens about 35 percent of the time. The average length of stay for similar programs throughout the state is six to nine months. Yet, we fight for initial auths and appeal denials for auths one month, and we do this on a daily basis. Our Community Support Program suffers with this issue as well. Although this program is economical in cost, it offers our individuals the most stability over time, and it prevents the need for higher levels of care. Yet in the last 12 months, we've lost over \$36,000 to inexplicable, inexplicable authorization denials for this service. As a nonprofit organization, there is considerable financial burden on billing staff who spend months chasing payments for clean claims. One managed care organization that we contract with has held onto payment for authorized services for 461 days, despite numerous attempts on my part to resolve the issue. To date, we are owed \$265,000 for services that were denied for no authorization when, in fact, an auth was in place. So oversight to ensure claims are paid correctly and within 15 business days from receipt eases not only the burden on contracted agencies, but on our individuals and service who often receive convoluted letters about these incorrect denials. Our client population is vulnerable and the undue stress of believing they now owe medical bills topping out in the thousands causes them unnecessary harm. Managed care organizations need to be held accountable for and transparent with their authorization processes. The provision that managed care organizations expedite review of the authorization requests and use evidence-based clinical guidelines consistent with

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professional standards would ensure frivolous authorization denials are a thing of the past. It would reduce administrative time spent drafting appeals and scheduling state fair hearings that are suddenly canceled when the managed care organizations reevaluate the submitted clinical data and the provisions outlined in LB895 would allow specialized providers to focus on delivering quality care rather than the impending battle for authorization and payment from managed care organizations. By including behavioral health in LB895, you will enable behavioral health providers the same assurances and financial protections resulting from these standardized and consistent authorization processes. I thank you for your time and welcome any questions you may have.

WILLIAMS: Thank you, Ms. Woods. Are there questions? Senator Murman.

MURMAN: Thank you for testifying. I guess I didn't follow your figures on the, the monetary figures on your losses. Were those for providing care that wasn't authorized and, and so you didn't get reimbursed?

AMBER WOODS: Yes.

MURMAN: Thank you.

AMBER WOODS: Yes. And for care that we had attempted multiple times to get authorization for.

MURMAN: Thank you.

AMBER WOODS: Um-hum.

WILLIAMS: Additional questions? Seeing none, thank you for your testimony. Invite the next proponent. Welcome, Mr. Schrodt.

DEXTER SCHRODT: Vice Chair Williams, members of the Health and Human Services Committee, my name is Dexter Schrodt, D-e-x-t-e-r S-c-h-r-o-d-t. I'm vice president of advocacy for the Nebraska Medical Association here to testify in support of LB895. As you all know, I'm not a healthcare provider, so I can't add much more than what you've heard. I will say in my time at the NMA, I've, I've heard complaints about every single one of these issues, so I will say it was nice to see this bill and see what this bill is attempting to do. And especially Senator Williams, you mentioned the, the 12 visits, and while it is reserved for the therapy services in there, as you heard from Ms. Walsh-Sterup, every time that comes back, that comes back to the physician office. So then that creates more work than for our physicians and their offices having to then send it back to the MCO to

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get it back on to therapy. So it does help us in that regard. And most of all, I would like to thank Senator Walz and her LA, Amanda, for working with us on the amendment that you had passed around. That amendment, I'll just explain briefly. Our physician members reviewed that, the 48-hour window gave them a little heartburn because if it's not turned around in those 48 hours, for physicians anyway, it then results in automatic denial, which then creates more work for the physician office and the MCO. So an extra 24 hours on there would, you know, meet the time frame that our offices would like to see not be to crunched there, but still have a requirement in place while still allowing therapy services to have the time frame that meets their needs. And with that, I ask for the committee's support.

WILLIAMS: Are there any questions? Seeing none, thank you--

DEXTER SCHRODT: Thanks.

WILLIAMS: --for your testimony. Invite the next proponent. Is there anyone else here to speak in support? If not, we'll move to opponents. Invite any opponents. Good afternoon and welcome.

JAMES WATSON: Good afternoon, Senator. My name is James Watson. It's 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 Healthy Blue Nebraska. I thank you for the opportunity to testify before you. I'm here to respectfully express the association's opposition to the introduced version of LB895. We oppose the introduced version of LB895, in large part because the Medicaid and Long-Term Care agency has announced that it will be procuring new contracts in 2022. The current version actually was done in 2015. The first version was done in 1996, so this is sort of a-- it's a routine happening that an agency will reissue RFPs to gain improvements. From listening to the testimony and also from conversations with our membership, it seems very clear that what is needed is data to find out really what's going on. MLTC has every dataset from every MCO across the board, and what we would expect is when the issue is looked at by MLTC, they would look at their data, drill down, figure out what is exactly happening, and address those issues in the prior authorization process. But if you do it by contract as opposed to statute, it allows for a lot more detail and flexibility by MLTC. And even as they go along during the term of the contract, they can amend it and the MCOs will look at it and almost always comply, so they have flexibility to provide oversight on a consistent basis and use data when they do so. The current contracts, as I said, were led in, in 2015, and they do provide a comprehensive regulatory framework for managed care

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organizations to provide services. In fact, they're over 2,000 pages long. With new agreements in mind though, MLTC conducted listening sessions throughout January 2022. There were five locations across Nebraska. Two virtual sessions were also held, and we know from looking at the results that the LB895 proponents took advantage of the opportunity, as did the Nebraska Association of Medicaid Health Plans. The second concern that we have is that LB895 would require disclosure of algorithms, which are proprietary. I want to state that the health plans don't have opposition to providing guidelines. That is different than an algorithm. An algorithm is like a checklist, which is used as a decision aid in many industries to safeguard against mistakes, safely guide a path forward. In healthcare, health professionals are now using these same strategies, using proprietary algorithms with artificial intelligence systems to guide the development of approval criteria. MCOs are, in fact, required to be transparent with the criteria that is used in evaluating requests for authorization as required by Nebraska law and the contracts with MLTC. Adding the disclosure of proprietary algorithms should not be necessary. Relatedly, in developing its principles on artificial intelligence applicable to insurance companies, the National Association of Insurance Commissioners discarded the concept of requiring insurers to disclose their algorithms to state insurance regulators. They stated that for the purpose of improving the public's confidence in, in intelligence, the actor should submit to transparency and make responsible disclosures of what's underneath. The proactive disclosures include revealing the kind of data being used, the purpose of the data, and the artificial intelligence system and consequences for all stakeholders. We also believe that the prior authorization exemption for 12 visits is indeed excessive. It's conceivable that a minimal number of visits without prior authorization would be desirable with certain, but not all, therapists and chiropractors. Insurers' programs that grant prior authorization exemptions work by very carefully selecting the providers eligible for these programs. Generally, the provider has to be under contract with an insurer for a certain amount of time meeting established quality goals. With regard to specialty review and reviewer turnaround time, the criteria for an initial approval is developed by MCOs based upon updated clinical information, which provides sufficient guidance to reviewers. NAMHP does not believe it's necessary for a same specialty review initially, although specialty input can be furnished in an appeal as required by NCQA. Mr. Chairman with your permission, I just have a couple more comments.

ARCH: Please, but summarize, if you will.

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JAMES WATSON: Yes I will. Lastly, NAMHP believes that any turnaround time for reviews should be guided by the member's medical needs. The clock should not begin to run until all needed information is submitted rather than automatically when the request for prior authorization is made as listed in LB895. We would urge that the NCQA standard of 72 hours, in fact, be followed, and all the MCOs are NCQA accredited by requirement of MLTC. And with that, I conclude my testimony. And if you have any questions, I'm happy to entertain them.

ARCH: Thank you. Are there questions from the committee? Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thank you for being here.

JAMES WATSON: You're welcome.

M. CAVANAUGH: So the algorithms are proprietary, and I was reviewing the language on that. I'm not going to speak for Senator Walz, but the way that I read it, it seems like the intention is to create, create some transparency in the decision-making process for how you're deciding or to approve or not approve these.

JAMES WATSON: Um-hum.

M. CAVANAUGH: So is there some middle ground there on how to create more transparency--

JAMES WATSON: Sure.

M. CAVANAUGH: --in the decision-making process?

JAMES WATSON: The MCOs are available and willing to provide the clinical guidelines, which actually drive the decision-making. We are just objecting to the idea of algorithms which we use to analyze the data to provide the pathway and are purely internal because we don't think they're necessary. But the guidelines, absolutely, it's required by the NCQA as far as I'm concerned.

M. CAVANAUGH: So what I was hearing from earlier testimony, and I, I believe even from Senator Walz's opening, is that sometimes these things, these requests are being denied and there's no explanation. And so if we had transparency on what the basis of the decision-making was, I think that might have been solving for it. But again, I'm not trying to speak for Senator Walz here. I'm just asking my questions.

JAMES WATSON: Sure.

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M. CAVANAUGH: But is there-- why are you explaining-- why are the MCOs not explaining why they are denying the claims?

JAMES WATSON: There should be a rationale given at the time of denial by someone with sufficient clinical expertise to do it. I don't know the facts of the particular situation that they're talking about. I do know that each of the three MCOs has met with the proponents in various capacities, whether it's by an association or by visiting a practice. All three of them have tried to put their hands around this for their companies. There isn't anywhere where the data across all three MCOs exists other than with MLTC because we're prohibited by antitrust considerations for sharing data between us. And it just doesn't happen. But MLTC has the data and we file it with them. And I think if they study it, they will find some things that they can do. I can't guarantee that. But as far as I know, it's not been done that way with data.

M. CAVANAUGH: OK. I have additional questions.

ARCH: Yes.

M. CAVANAUGH: OK.

ARCH: Please.

M. CAVANAUGH: So to the 72 hours, you said that, that the standard of 72 hours should be followed.

JAMES WATSON: Should be. I mean, it's an NCQA standard.

M. CAVANAUGH: OK.

JAMES WATSON: For a standard inquiry.

M. CAVANAUGH: So I guess if it should be followed, then why is there an issue with putting that in too as a requirement?

JAMES WATSON: Into the bill?

M. CAVANAUGH: Yes.

JAMES WATSON: Oh, I, I don't know. Senator, my comments are directed at the green copy of the bill. That's what we had available.

M. CAVANAUGH: OK.

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JAMES WATSON: If there's efforts to, to rewrite things or something like that, we're not aware of the 48.

M. CAVANAUGH: OK, so, I'm sorry. So you were, you were referring to the 48 hours.

JAMES WATSON: I was. Yes.

M. CAVANAUGH: OK, I apologize. I didn't catch that part there. OK, so but you're not opposed to 72 hours being amended?

JAMES WATSON: For a standard request.

M. CAVANAUGH: For a standard request.

JAMES WATSON: I still don't like the idea of it being in a legislative bill because that's-- really, I, I think it's MLTC's program and they're studying it and we ought to let them do that. It can only result in an improved program.

M. CAVANAUGH: From a legislative side of things, we're just trying to put guardrails in our procurement process--

JAMES WATSON: Of course. I understand.

M. CAVANAUGH: --as much as we can.

JAMES WATSON: I understand.

M. CAVANAUGH: So thank you.

JAMES WATSON: Yes.

ARCH: Other questions? Senator Williams.

WILLIAMS: Thank you, Chairman Arch. And, and thank you, Mr. Watson. A couple of times in your testimony, you use the term, you're opposed to the introduced version--

JAMES WATSON: That's correct.

WILLIAMS: --of, of the bill and, and talking about the fact that the RFP is coming out--

JAMES WATSON: Yes.

WILLIAMS: --this spring and getting to that. And this, this committee has been very involved with wondering about this procurement process

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and that issue. In fact, that's where Senator Arch has been testifying this afternoon outside of here. Would, would you be opposed from, from the MCO's standpoint, if the RFP included the language primarily of Senator Walz's bill? Do you think that's something that you would be-- generally, the, the MCOs would be opposed to?

JAMES WATSON: If the RFP contained it? It would mean that the MLTC people had made a decision to do it that way. And that does make some sense in terms of it is their money, it's the state taxpayers' money. However, they decide to do it when they, when, when they put language in an RFP, it becomes public, carrier's bid on it. And it's usually a very extensive document. But as we say, if, if that's what MLTC decides, then people bidding are going to have to deal with it, and live with it.

WILLIAMS: I understand your, your concern about the proprietary nature of the algorithms. For those of us that have sat in these seats since Heritage Health was rolled out, one of the things that we consistently battle on the part of, of providers and their clients are the differences or inconsistencies between coverages and that.

JAMES WATSON: Right.

WILLIAMS: Is it fair to assume that the-- even though you cannot and would not disclose the algorithms that the algorithms for each of the three MCOs would arrive at the same result for a provider request?

JAMES WATSON: I couldn't say that because I'm not sure how internally the MCOs are using algorithms. I mean, they are internal tools.

WILLIAMS: And you see how that answer gives us pain--

JAMES WATSON: Of course.

WILLIAMS: --because we're asking our constituency's providers to deal with three MCOs and this one does it this way, this one--

JAMES WATSON: Yeah.

WILLIAMS: --and that--

JAMES WATSON: I think there's a great opportunity--

WILLIAMS: We would all like to see more consistency. Thank you.

JAMES WATSON: You're welcome.

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ARCH: Other questions? Seeing none, thank you very much for your testimony.

JAMES WATSON: Thank you. Appreciate it.

ARCH: Next opponent for LB895. Is there anyone that would like to testify in a neutral capacity for LB895? Seeing none, Senator Walz, you're welcome to close. As you're coming up, I would let everyone know that we received seven proponent letters for LB895, no opponents, and no neutral letters.

WALZ: Thank you, Chairman Arch. I just wanted to emphasize again just how important this is. We were trying to make sure that patients receive equal, consistent, and timely coverage for much needed treatments. And again, LB895 intention is not, you know, just looking at specific managed care organizations and [INAUDIBLE]. That's not the intent. We just want to make sure that when DHHS does their next RFP, RFP process, that it's a smooth transition for patients and providers. I think that a couple of days ago we, we saw a quote from the Health Center Association of Nebraska, and they submitted a comment that said: Gaining approval often takes multiple follow-up phone calls and additional requested documentation, and seems to lack consistency from patient to patient and between managed care organizations. So most importantly, these delays and inconsistencies result in delayed treatment for patients, which can exas-- exasperate medical conditions. I wanted to-- and now I can't read my notes. Amber Woods, who came to testify here for CenterPointe, you know, made a really good point about the behavioral aspect of this. And I think that it is something that we also need to be looking at because we all know that behavioral health is vital to, you know, the people, our constituents. And I, I think it's also something that we need to be discussing in the future when we, when we have these conversations. I know that providers and MCOs have met. They met several times to come to an agreement on how we can assure consistent and timely care and coverage for our constituents and, and patients. And I was hoping that a proposal would be brought and agreed upon prior to today's hearing. And I'm still hoping actually that something can happen in the near future and that it also, you know, that we have conversations regarding behavioral health. It's always better when we can find solutions together. I mean, just-- let's work together, let's find a solution, because that just makes it much more quicker to provide quality care to the people that we serve. So thank you for taking the time to listen and to all those who came to testify today. I'd be happy to answer any other questions.

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ARCH: Thank you. Any other questions? Seeing none, thank you for trying to come to agreement--

WALZ: You're welcome.

ARCH: --on some of these things. With that, we will close LB895. We will now open the hearing for LB857, and Senator Day, you are welcome to open.

DAY: Thank you, Chairman Arch and good afternoon members of the Health and Human Services Committee. My name is Jen Day. That's J-e-n D-a-y, and I very proudly represent Legislative District 49 in Sarpy County. I am here today to introduce LB857, which makes it easier to enroll eligible children in healthcare coverage, enabling them access to essential care like annual wellness checks and doctor's visits in the case of illness. LB857 will use the express lane option to automatically enroll eligible children who are receiving Supplemental Nutrition Assistance Program, or SNAP benefits, in Medicaid or the Children's Health Insurance Program, or CHIP, healthcare coverage. When kids access-- when kids have access to health insurance through Medicaid and CHIP, the positive impacts are evident in that child's life and their family and in the community. Kids with health insurance receive more regular, age-appropriate treatments and preventative care. Families with insured children are more financially secure and economically productive. Ensuring kids have health insurance also supports our state's hospitals and providers by reducing the cost of uncompensated care and providing effective and efficient coverage to kids who need it. Today, many Nebraska children remain uninsured. In 2019, Nebraska had the 11th lowest participation rate among children who are eligible for Medicaid and CHIP as compared to other states. As of 2020, Nebraska ranked 31st in the nation in Medicaid, CHIP eligible children participating in the program. The express lane option, as described in LB857, provides an opportunity to capture some of the children who are currently falling through the healthcare coverage cracks and quickly get them access to healthcare. LB857 will allow children who are receiving SNAP benefits to automatically be enrolled, redetermined or renewed as eligible for Medicaid or CHIP coverage. This streamlined process is referred to as express lane eligibility and allows the Medicaid and CHIP programs to use eligibility information from other programs to make automatic eligibility decisions and enrollments in coverage for children. SNAP was chosen as a required express lane program in LB857 because SNAP has lower-income thresholds than CHIP and some Medicaid programs. This means that Nebraska kids receiving SNAP benefits are generally income eligible for Medicaid or CHIP. Additionally, SNAP, Medicaid, and CHIP

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applications collect overlapping information from enrollees. While SNAP will be a great express lane program, LB857 also recognizes that the Department of Health and Human Services has discretion to designate other programs as an express lane to health coverage. Not only will LB857 insure more kids who qualify are enrolled in the health insurance they need, it would also make sure the process is more efficient for families and for Nebraska Department of Health and Human Services. Because SNAP will be an express lane program, families who qualify for SNAP benefits will not need to submit additional paperwork to qualify for or renew Medicaid or CHIP for their children. This eliminates unnecessary burdens for families. It also allows DHHS to more efficiently make determinations and cut administration-- administrative costs. This bill also directs DHHS to maximize federal Medicaid funding, which may be available to cover significant costs associated with the changes required by this bill. For example, federal funding is available as a 75 percent match for IT operations and a 90 percent match for IT development in the development of a eligibility and enrollment system. Fourteen other states have implemented express lane eligibility successfully and reaped the benefits, including our neighbors South Dakota and Iowa. Moreover, in 2016, the Inspector General of Health and Human Services issued a report evaluating the 14 states that have adopted express lane eligibility and found that these states saw reduced administrative burden and cost savings. Furthermore, they found that although some states encountered initial barriers when they implemented express lane eligibility such as information sharing, these issues were overcome by every state that implemented express lane eligibility. While our state's Health and Human Services is opposed to LB857, I believe they are capable enough to match the performance of other states and troubleshoot any initial issues. In addition to the administrative cost savings, it's also worth considering the long-term outlook of what this change does and what Medicaid provides for children. It funds regular well-child visits. It helps kids get vaccinated for things like polio, measles, and influenza and provides access to physician's visits in the case of illness. A fiscal note can't show the lifelong benefits when each child gets the care they need at the time they need it and has the opportunity to grow into a healthy adult. LB857 puts Nebraska kids on the express lane to healthcare coverage and fast tracks administrative costs savings for our state. I urge the committee to support and advance LB857 and would be happy, happy to answer any questions you have.

ARCH: Thank you. Are there questions from the committee? Seeing none, thank you very much. We'll now ask for the first proponent of LB857.

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KELSEY ARENDS: Good afternoon, Chair Arch and members of the Health and Human Services Committee. My name is Kelsey Arends. That's K-e-l-s-e-y A-r-e-n-d-s, and I'm the Health Care Access Program staff attorney at Nebraska Appleseed. I'm testifying on behalf of Nebraska Appleseed today. I am testifying in support of LB857 because it will connect Nebraska children to the health insurance they need, reduce barriers to healthcare coverage for families, and promote administrative efficiency. Some Nebraska children are missing out on the health insurance coverage they need. Our state has one of the lowest child participation rates in Medicaid and the Children's Health Insurance Program, or CHIP, as compared to other states. In 2019, only ten other states had lower rates among eligible children. When kids go without health insurance, they miss out on necessary checkups and preventative care, and their families often face burdensome healthcare costs. Today, families must submit multiple applications and separate renewal paperwork in order to enroll in and maintain benefits like Medicaid, CHIP, and the Supplemental Nutrition Assistance Program, or SNAP. These burdensome and often complicated processes can prevent families from efficiently enrolling in benefits in the first place or cause problems at renewal. Often, when households lose benefits at renewal, the family is still low income and must quickly jump through hoops to reapply and reinstate their benefits. Even short gaps in coverage, sometimes called churn, can lead to a decline in health, harm to child development, and higher hospitalization rates. Churn also means that DHHS must expend time and resources processing repeat applications and reenrolling families that churn off and back on to benefits. LB857 presents an opportunity to address our current coverage gaps for Nebraska kids, make it easier for Nebraska families to access the health coverage they need, and promote administrative efficiency. This bill requires DHHS to use data collected from households receiving SNAP benefits to automatically enroll, redetermine, or renew eligibility for children in Medicaid or CHIP. This option is called the express lane eligibility option, or ELE. ELE allows Medicaid or CHIP to rely on income eligibility findings, as well as other eligibility findings from SNAP even though the programs use different income calculations or other eligibility methodologies. The result is a more streamlined system for Nebraska families and for Nebraska DHHS. SNAP is a great express lane program for multiple reasons. First, SNAP and Medicaid or CHIP programs require similar information from applicants, including who is in the household, citizenship or immigration status, and income. Second, the income eligibility thresholds for SNAP are lower than the income eligibility thresholds for CHIP and categories of Medicaid. This means that generally children receiving SNAP benefits are financially eligible for Medicaid or CHIP. Finally, while SNAP is a required express lane

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program under LB857, the bill recognizes that DHHS has discretion to add other permitted programs as well. The ELE option can increase enrollment and retention of eligible children in health insurance by automatically enrolling or renewing appropriate healthcare coverage for kids who already receive SNAP without requiring duplicative paperwork. States that have used ELE also report cost savings and reduce administrative burdens by using this cross-program data. LB857 requires DHHS to submit a state plan amendment to the Medicaid and CHIP state plans for approval from the federal government in order to implement ELE. We anticipate that there would be significant federal funding available to implement ELE. The program as described in LB857 will likely qualify for a 90 percent federal match for IT development and 75 percent federal match for IT operations. The current fiscal note on this bill only reflects a 50 percent match. We anticipate that the actual state costs would be significantly lower. This federal money is available to invest in Nebraska children through LB857. Because LB857 will make it simpler for Nebraska children to get enrolled in the healthcare coverage they need, reduce burdens on Nebraska families, and streamline administrative processes, Nebraska Appleseed supports this bill. I'd be happy to answer any questions.

ARCH: Thank you. Are there any questions? Senator Walz.

WALZ: Thank you. Can you just explain a little bit more about what you said with the 50 percent reduction in--

KELSEY ARENDS: Sure, in the federal match?

WALZ: Yeah.

KELSEY ARENDS: Yes. So right now, the fiscal note anticipates a 50 percent federal match for all the system changes that would be required to share data across the programs. Right now, there's an available 90 percent federal match for those initial developments of those data-sharing programs and a 75 percent match for ongoing operations. So that would be pretty significant.

WALZ: That would be great. Thanks.

KELSEY ARENDS: Yeah.

ARCH: Thank you. Any other questions? I have one.

KELSEY ARENDS: Sure.

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ARCH: Do you happen to know is there a, is there a verification process required? I mean, you-- yes, you've got information, it's SNAP, but is there a, is there a verification process, reconciliation process required?

KELSEY ARENDS: Sure. So what I can say is that both Medicaid data and SNAP data are verified by DHHS when families apply for and start to receive benefits. So that's another reason that SNAP is a great program because DHHS is already verifying all of the eligibility information when families apply for SNAP so that it's, it's verified data to begin with so then it can go to the Medicaid program or the CHIP program. One distinction, one piece of the puzzle that doesn't just get automatically crossed off the list is citizenship verification. So there are Medicaid requirements that there's a document verification for citizenship or immigration status. This bill doesn't do anything to change that rule. DHHS will still need to have those same document verifications, but many other data points for eligibility would be automatic at initial enrollment and renewal or redetermination, which would be a huge benefit.

ARCH: Thank you. Any other questions? Senator Murman.

MURMAN: Yes, thanks for testifying. I think there is a-- still a Department of Education policy that if a, a school district is below a certain level of poverty, everyone is eligible for SNAP. All the kids are eligible for SNAP. Would that, would that cause any problems?

KELSEY ARENDS: So I'm not sure about that. I--

MURMAN: Actually, I may have that confused. I think that's free and reduced lunch. I just thought of that so--

KELSEY ARENDS: That's fine.

MURMAN: --no problem.

KELSEY ARENDS: And some other states have used free and reduced lunch as an express lane option. So if DHHS was interested in using that data from school lunch programs, they could add that as an express lane option, too.

MURMAN: Thank you.

KELSEY ARENDS: Um-hum.

ARCH: Do you know when-- while there's not an express lane per se, do you know that when SNAP or other social programs are offered that

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there is not already the information regarding other possible programs they could qualify for?

KELSEY ARENDS: I can't speak to any information DHHS might be providing families as they enroll in SNAP, for example, whether they say, oh, you might be eligible for Medicaid, I'm not sure about that. What I do know is that right now today families have to submit multiple applications and separate renewal processes.

ARCH: So what, what, what my memory is triggered is in a conversation with the department that, that they have been working on the development of some software where there is a single point of access for, for getting the information on the various programs that, that would be available depending upon income level. So maybe somebody else could testify to something.

KELSEY ARENDS: I, I would respond to that if that's OK. We would be very interested to see a consolidated application portal. That sounds great. Express lane still has been shown in other states to provide really significant cost savings for states that have implemented, even if it's only at renewal or redetermination. So even if applications are streamlined, there's still a great opportunity to save costs and save burdens on families at redetermination and renewal.

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

KELSEY ARENDS: Thank you.

ARCH: Next proponent for LB857.

KENNY McMORRIS: We may need to look at that as another policy here in, in relation to a proxy for poverty. Senator Arch, members of the Health and Human Services Committee, my name is Kenny, K-e-n-n-y, McMorris, M-c-M-o-r-r-i-s. I have the pleasure of serving as the chief executive officer for Charles Drew Health Center in north Omaha. I'm also testifying on behalf of the Health Center Association of Nebraska and the seven Federally Qualified Health Centers in our state. Health centers serve over 107,000 patients annually across the state of Nebraska. FQHCs see patients regardless of their insurance status or their ability to pay, and are an essential safety net provider within our state. In 2020, over 30 percent of uninsured Nebraskans received care at an FQHC, as well as 12 percent of all Medicaid enrollees. LB857 would implement express lane eligibility for children enrolled in Medicaid or CHIP. This option has existed in states since 2009 and allow states to use eligibility information from one, one program,

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such as SNAP for enrollment in Medicaid and/or CHIP. This streamlines the enrollment process, reducing the amount of paperwork and administrative burden on both enrollees and the department. Along with comprehensive primary care, Nebraska Federally Qualified Health Centers provide enrollment assistance. Health centers employ enabling support personnel, including federally funded navigators and certified application counselors who help Nebraskans sign up for Marketplace plans, Medicaid coverage, and economic assistance programs like SNAP. Enrolling in Medicaid can be a challenging process for anyone, especially those with low-health literacy or who speak languages other than English. The current paperwork required by Medicaid creates a substantial burden for many individuals. Forms are often confusing or unclear and require significant additional documentation, which many patients do not have on hand. This often requires multiple trips to the health center to work with assisters, which can be a significant barrier to those without reliable transportation. These problems are further exacerbated for individuals with limited English proficiency. We have experienced materials or translation being provided in the wrong languages. For example, in Korean, when a patient speaks Karen. These barriers make it significantly harder for individuals to get enrolled in health coverage. Streamlining the process for enrolling in Medicaid for children will help kids get enrolled in coverage and keep that coverage. A significant portion of disenrollments from coverage are due to paperwork issues. Keeping kids enrolled in Medicaid is vital to their overall health and wellness. Children enrolled in Medicaid are more likely to have a usual source of primary care, access needed healthcare services in a timely manner, and are able to afford the much needed medications. Ensuring children have easy access to Medicaid benefits they're entitled to is a good investment for the health and future of young Nebraskans. Thank you again, Senator Day, for introducing this bill, members of the committee, and we encourage you to advance LB857 to General File. I'll be happy to take any questions.

ARCH: Thank you for your testimony. Any questions? Seeing none, thank you very much. Next proponent for LB857.

KENNY McMORRIS: Work on that free and reduced lunch.

EDISON McDONALD: Hello again. My name's Edison McDonald, E-d-i-s-o-n M-c-D-o-n-a-l-d. I'm the executive director for the Arc of Nebraska. We advocate for people with intellectual and developmental disabilities. We're here today in support of LB857 because our members have far too much paperwork to fill out and far too many programs to

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understand. This helps to simplify and speed up the pathway to services for many of our members. We frequently have calls to our office and our chapters, spend an inordinate amount of time walking families through the basics of these programs, especially SNAP, LIHEAP, Medicaid. In particular this year-- each year I do an annual survey and I try and do about 100 one-on-one meetings to really get a good feel for where our members are at. And this has been an issue that I've seen a significant increase in interest this year. I think the, the big thing is that especially having our members be physically in an office or interacting with folks for those who have sensory issues in particular can be problematic. So we've been working on doing more trainings around how to go and apply for these programs. But I think this really helps to just kind of speed up and clarify the process. I think the bigger benefit here than just the initial eligibility determinations will likely be the express lane eligibility for redeterminations, automatic enrollment, and automatic renewables for eligible children. This will significantly decrease the amount of time families and organizations like ours will have to spend helping families to navigate the complexities of Medicaid determinations and especially those redeterminations. I always find it interesting that fiscal notes never take into account the decreased time they will have to spend walking families through issues like these and decreased time talking to organizations like ours. Looking at the department's fiscal note, it looks like these are mostly one-time expenditures that will have significant long-term benefits, and it seems like an excellent use of ARPA funds to help us take a step that has been needed previously, but COVID has exacerbated. We urge your support of LB857. Any questions?

ARCH: Thank you. Are there any questions? Seeing none, thank you very much. Next proponent.

AUBREY MANCUSO: Good afternoon, Senator Arch, members of the committee. My name is Aubrey Mancuso, A-u-b-r-e-y M-a-n-c-u-s-o. I'm here on behalf of Voices for Children in Nebraska, and I'm also submitting testimony on behalf of the Nebraska Child Health and Education Alliance, of which we are a member. After being here for three days, I also just noticed that the word Nebraska is misspelled on the testifier form, the green sheet, so just a heads up on that before I get into my testimony here today. Consistent access to healthcare for kids is a critical component of healthy development. Voices for Children supports LB857 because it can help more kids access health insurance. The most recent estimates from the U.S. Census show that the children who lack health insurance in Nebraska, about 57 percent of them are likely eligible for state health

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insurance, but not enrolled. Further, data tracking health insurance coverage for families during the COVID pandemic has shown increased volatility in access to coverage, especially for families with the lowest income. In the last quarter of 2021, for example, 22 percent of very low-income families, those making less than \$25,000 annually lacked access to health insurance. Over the past decade, states across the country have adopted innovations to make it easier for children to enroll in and access healthcare. This is based on the wide recognition that the preventative benefits of consistent pediatric care help not only individuals, but can also have a positive impact on healthcare systems and costs. We know that when kids receive vaccines and well-checks, more serious issues can sometimes be prevented. In addition, the screenings embedded in most pediatric practices can help identify developmental issues that can benefit from early interventions. Data from our Medicaid program in Nebraska show that while children make up almost 67 percent of those enrolled, they account for only 27 percent of the program costs. This demonstrates that insuring children is relatively affordable, and it yields larger benefits for both individuals and our healthcare system. LB857 also creates greater administrative efficiency through information sharing. Health insurance access is critical for kids and LB857 will help more children in this regard and we would urge the committee to advance the bill. Thank you.

ARCH: Thank you for your testimony. Are there any questions? Seeing none, thank you very much. Next proponent for LB857. Welcome.

REBECCA FIRESTONE: Good afternoon, Chairman Arch and members of the Health and Human Services Committee. My name is Rebecca Firestone, R-e-b-e-c-c-a F-i-r-e-s-t-o-n-e, and I'm the director-- the executive director of OpenSky Policy Institute. We're here to testify today in support of LB857 because reducing lapses in Medicaid and CHIP coverage would not only help ensure consistent access to children's healthcare, but also save the state money by reducing administrative costs. Medicaid and CHIP enrollees must renew their eligibility every 12 months. This renewal process often results in eligible enrollees losing benefits when required paperwork is not submitted to the state or the state is slow to process it. Seventy-two percent of lapses in Medicaid and CHIP benefits are due to a failure to successfully complete the redetermination process. Lapses in Medicaid and CHIP can be detrimental in numerous ways. Can result in delayed care and negative health outcomes, which also have social and economic costs for children, their families, and the state. Additionally, each shift in and out of coverage creates costs to the state, which has to process new applications and reapplications. One study estimates that

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the administrative cost of just one person's lapse in Medicaid coverage cost is between \$500 to \$600, whether a child or an adult. So according to an OpenSky analysis, this means that Nebraska has accumulated between \$3.6 and \$5.4 million in excessive administrative costs due to disenrollment and reenrollment processing in 2019 alone. Thus, the savings and administrative costs that would result from LB857 would more than offset the cost outlined in the bill's fiscal notes. LB857 helps address the lapses in Medicaid and CHIP coverage and unnecessary administrative costs caused by burdensome paperwork by allowing Nebraska to use SNAP eligibility to verify Medicaid and CHIP eligibility. SNAP is well-suited to assist in determination of Medicaid and CHIP eligibility, as 92 percent of children enrolled in SNAP in Nebraska are enrolled in Medicaid or CHIP. LB857 could therefore ease the burden on families from having to provide the same information to multiple agencies and reduce the potential of coverage lapsing. Several other states have adopted express lane eligibility as well, and research indicates that these states have also seen a decrease in the number of uninsured children. We therefore support LB857 and would encourage the committee to advance it to the floor. Thank you for your time and I'm happy to answer any questions.

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

REBECCA FIRESTONE: Thank you.

ARCH: Next supporter for-- proponent for LB857.

EFREN GARCIA: Good afternoon, everybody. My name is Efren Garcia. It is spelled E-f-r-e-n G-a-r-c-i-a. I'm a program specialist with the department-- with the Family and Community Well-Being Department for the Latino Center of the Midlands. It is a nonprofit in south Omaha. I'm here to testify for-- on behalf of LB857. Thank you, Senator Jen Day, for introducing this bill. For those of you who may not know, the Latino Center engages with a variety of youth in our community. Programs such as Pathways to Success, Healthy Kids Club, and Siembra Nebraska Internship Program strive to uplift the quality of life and opportunity for our Latino youth. The majority of our youth come from low-income backgrounds and rely on SNAP. Many of our families are also non-English speakers. LB857 would help eliminate additional barriers and time to access affordable healthcare. This would help families like mine. I'm a-- I'm the first in my family to graduate from college, and I'm grateful for the opportunity to work for this organization and represent families like mine that would benefit from programs like this. Latinos are the fast-- are the fastest growing population in the U.S. However, poverty and food insecurity impacts

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them higher than other groups. In particular, those under the age of 18. According to an analysis by the Center on Budget and Policy Priorities, about one in four Latino children live under the poverty line. Additionally, one in five Latino households with children were found food insecure in the year of 2016. Latino children also disproportionately receive CHIP and Medicaid coverage. In another study, it was found that coverage for CHIP and Medicaid for all U.S. children are one in three. But for Latino youth, it's over half. So this goes to show the importance of CHIP and Medicaid coverage, and I believe that allowing removing these barriers will allow easier access. Additionally, there are illnesses that impact the Latino community much more, such as diabetes, cervical cancer, and liver disease. According to the CDC actually, it is, it is considered that over half of Latino/Hispanic adults will develop Type 2 diabetes in their lifetime. And to bring up an interesting point, in Nebraska, Latino youth actually represent the highest-- the Latinos in Nebraska represent the youngest population-- the biggest, youngest population group. It was found that in among, among Nebraskan Latino students, obesity rates among them are 30 percent, and that's-- and the national average is 23 percent. So by allowing access to healthcare at a young age, we can prevent future illnesses such as Type 2 diabetes. I work with a variety of kids. I work with the Healthy Kids Club, ages 4 to 14. I teach them about nutrition, so prevention is a big thing, and I feel like this bill will do a lot for that. So I ask you all if you care about public health, economic growth, social justice and health equity, you should support this bill. I ask you to consider communities like mine when deciding on whether to support this bill. Thank you.

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

EFREN GARCIA: Thank you.

ARCH: Next proponent for LB857. Seeing none, do we have any opponents for LB857?

KEVIN BAGLEY: Good afternoon.

ARCH: Good afternoon.

KEVIN BAGLEY: I feel like I'm in the seat in opposition more than I'd like sometimes. Probably more than you all would like as well. Good afternoon, Chairman Arch, members of the Health and Human Services Committee. My name is Kevin Bagley, K-e-v-i-n B-a-g-l-e-y. I'm the director of the Division of Medicaid and Long-Term Care within the

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Department of Health and Human Services. I'm here to testify in opposition to LB857, which would require our department to implement express lane eligibility for Medicaid utilizing findings from the SNAP program. The purpose behind express lane eligibility, as has been very eloquently stated by previous testifiers, is to streamline the member experience when applying for services. It achieves this by allowing states to rely on findings from other programs' eligibility determinations to facilitate enrollment. However, the regulations behind ELE place significant administrative controls on how the data is shared, as well as on how applications are processed in order to ensure member privacy and eligibility determination accuracy. Currently, our eligibility data indicates that roughly 94 percent of all children enrolled in our SNAP program are also concurrently enrolled in Medicaid. And I think that's an important statistic for us to think about as we talk about this. There are very few children in our program, relatively speaking, where we don't already have that eligibility matching. The additional requirements that we were talking about that come through ELE really put more red tape into an already onerous process by potentially adding additional time and data elements to the process. It would also require system changes that would be unlikely to produce significantly different results. A spot check of the roughly 4,000 children currently in the state eligible for SNAP that are not eligible for Medicaid indicated in most cases, families simply had not applied. And so because of that, we didn't have sufficient information to make an eligibility determination. In a lot of cases, we found through some research-- well, there was, there was a comment earlier that 14 states currently leverage express lane eligibility. That was true at one point. Currently, there are 7, 7 of those 14 states have discontinued that process. Part of the reason that we have found was related to an OIG audit in 2016 at the federal level that noted that potentially 11 percent of the children found eligible through that process may have actually been ineligible. We want to ensure that we're not creating an additional burden for ourselves down the road where we would have to do additional audits and, and work through that process there. During my tenure as Medicaid director, I've spent considerable time meeting with members and providers to better understand their experiences with our program, including this last month, a statewide listening tour. I've heard loud and clear, as you all have from many proponents for this bill just moments ago, that it's important for us to work to improve their experience in application processing and submission. To that end, we've been working to build a new application portal called iServe Nebraska that will allow potentially eligible individuals or their representatives to apply for multiple programs all at once, leveraging common, common data elements in those applications in order to improve

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and streamline their experience. I'm excited to share that we plan to roll out the iServe portal in April of this year. We plan to monitor our members experiences using that tool to identify how it can be enhanced in the future for continued improvement to their application experience. Recognizing the unique opportunity we have as a state to leverage funds available through the one-time coronavirus state fiscal recovery funds to make improvements to our systems and programs, we would encourage this committee to look for other opportunities that may be more effective. I thank you all for your time today and yield to any questions.

ARCH: Thank you. Are there questions? I, I, I got--

KEVIN BAGLEY: Please.

ARCH: --could you talk a little bit more about this iServe portal? I mean, is this truly an application or is this just information to apply?

KEVIN BAGLEY: So it's, it's an application. What it would actually do is be a web portal whereby we would ask questions about what people are interested in applying for. So if they're interested in applying for SNAP, if they're interested in applying for Medicaid, and I'll pick those two because those are the two we've been talking about, we would go through in the back end of this tool and identify what are those common data elements I need? I need name and address for both of those. I don't need to ask that twice. And so we asked that once and we store that data and leverage it against what is required in the back end to process those individual applications. But we don't have someone fill out these onerous applications each time duplicating that data. So it's a first step. I don't think it solves the world's problems in terms of the onerous nature of these applications, but I do think it's an important first step in streamlining that experience for our members.

ARCH: Whether it's, whether it's the, the express lane or this system, are-- is eligibility determination still separate?

KEVIN BAGLEY: It is.

ARCH: It's a, it's a common application. But just because you're eligible for SNAP, does not automatically mean you're eligible for Medicaid.

KEVIN BAGLEY: That's right. Now with express lane eligibility, there's some opportunity to-- for states to leverage a determination made in

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one area or another. But the rules surrounding whether or not that determination is made accurately don't change, which is really part of what that OIG audit finding was related to. If we are simply-- I, I apologize if this comes off flippantly, if we're simply taking someone's word on SNAP and making some assumptions about their Medicaid eligibility or vice versa, we may be missing some important data that's required for an accurate determination. And if that's the case, six months down the road if there's an audit, the state or even the individual may be on the hook for that cost, which we don't think is the appropriate way to take either. So I think our concern is really we want to make sure we're making accurate determinations upfront.

ARCH: And, and whether it's iServe or express lane redetermination wouldn't be affected by either one of those.

KEVIN BAGLEY: You know, I, I don't think so. And the reason why is that 94 percent match that we currently have. If that were a, a much more disparate number, if we had 70 percent, we might save-- we may save considerable amount of time on those renewals. But ultimately, the renewal determination process would be the same. And so we're still going to be making the same number of determinations. I would add SNAP, I believe, reviews theirs every six months, whereas generally with Medicaid, we only do it every year.

ARCH: OK. Thank you.

WALZ: I do have a question--

ARCH: Senator Walz.

WALZ: --as he was talking. So as talking about the, the federal funds that are available, why would we not utilize the federal funds for this program? Or is there an opportunity to utilize funds for the program that you're talking about as opposed to the program that Senator Day's introduced?

KEVIN BAGLEY: Yeah, and that's a great question. I, I think an opportunity exists to use those, those ARPA dollars here that are mentioned in the bill, the coronavirus recovery dollars mentioned in the bill for iServe-type projects and we are using considerable federal funds right now on that iServe project. Generally, that's for the Medicaid-related portions at least matched at 90 percent federal funds. The clarification, I would add there was some discussion around in the fiscal note, we mentioned 50 percent versus what might otherwise be a 90 percent or a 75 percent federal match. The reason

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for that is these particular dollars through that coronavirus state relief act are only matchable at 50 percent federal funds. If it were state General Fund that we were leveraging, we might be able to get that 75 percent or 90 percent match.

WALZ: Are those funds-- will they also be matched to maintain the system?

KEVIN BAGLEY: So in this case, I believe these are one-time dollars.

WALZ: I meant--

KEVIN BAGLEY: Go ahead. Sorry.

WALZ: Aren't these matched-- isn't, isn't there a match through federal funds?

KEVIN BAGLEY: Yeah.

WALZ: OK.

KEVIN BAGLEY: Yes. So that 75 percent is generally for the maintenance and operations. Again, that assumes we're leveraging state General Fund as the state match. If we're using these funds for a match, then it's limited to 50 percent in the, the federal guidance that came with these.

WALZ: OK, and then I'm going to ask another-- can I ask another question?

ARCH: Sure. You may ask another question.

WALZ: Thank you. Just in your mind, and I know this is kind of putting you in a, a tough spot, but I'm just curious, what are the benefits of the program that you're talking about, the pros and cons of the program you're talking about for people and our state and the pros and cons of the program that Senator Day is talking about people and for the state?

KEVIN BAGLEY: So I think, I think the overarching goal for both proposals here is, is really the same, and that is to facilitate a more streamlined process for people to apply for services. And I think what I've heard from members and providers across the state is I've got input. And what I'm hearing here and would love to have some more conversations with folks after as well. But the overarching goal is the same. I think the pros to the iServe system that we've, we've talked about here are it's on the cusp of implementation. So timing is

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on our side there. In addition, we've put considerable resources already into that development. This express lane eligibility would create some significant changes that would postpone the implementation of iServe. And I think at this point, we don't know that we would see a lot of benefit because nearly all of the children that are eligible for SNAP are also eligible for Medicaid. So, so what we're seeing is, for the most part, if you're applying and are becoming eligible for SNAP, you are applying and becoming eligible for Medicaid. There's some disconnect there, and I think that's worth looking into and, and addressing. I think this level of overhaul would inject a lot of red tape into the system that would be trying to address a much smaller issue.

WALZ: I have one more--

ARCH: Please.

WALZ: --quick question. And I'm just trying to--

KEVIN BAGLEY: Please.

WALZ: --I'm just trying to understand. One of the things that you said-- where is my-- one of the things that you talked about is as people go on to this portal, they're asked questions and what kinds of things are you interested in? So that's-- I mean to me, interested and applying are two different things. So you find out what they're interested in and then they have to go-- like, what happens after you find out what they're interested in?

KEVIN BAGLEY: So I, I probably should phrase that a little bit better in fairness. What we're asking them is, is what are your needs?

WALZ: OK.

KEVIN BAGLEY: You know, do you have some food insecurity? Do you, do you have some unmet medical needs? Do you currently not have coverage? These kind of questions to help us kind of guide them toward what do you need to apply for? We can also ask them directly, what are you applying for? And they can let us know right off the bat as well. But that guide to kind of help them identify what they might need to apply for is, is also something we think is helpful.

WALZ: That is it.

ARCH: OK. Any other questions? Well, first of all, thank you for taking the initiative to develop iServe.

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KEVIN BAGLEY: Thank you.

ARCH: Sounds like a good program. We're anxious to see the results and see what happens with that. Regardless of this bill, that's, that's great that you're doing that.

KEVIN BAGLEY: Thank you.

ARCH: Thank you for your testimony. Any opponents-- any other opponents for LB857? Anybody like to testify in a neutral capacity for LB857? Seeing none, Senator Day, you may come up. And as you're coming, let me get the, the list. We received, we received seven letters in as proponents for this bill, no opponents, and none neutral. You may close.

DAY: Thank you again for your attentiveness this afternoon on this bill and I appreciate all the testifiers, even Director Bagley, even though we don't agree on this bill, I appreciate everybody being here today. Just a couple of things that I wanted to mention. Again, there is the federal dollar match of 90 percent if we were to utilize this type of program to develop a program that would eliminate multiple applications, which I don't-- maybe I don't quite understand the iServe program yet, but it sounds like there's still multiple applications involved. And if we're not implementing a program that eliminates multiple applications we're not actually streamlining it for the members in the end, which is ultimately the issue, right? And I speak as someone who-- I've, I've mentioned my financial-- my family's financial status from years ago, and my family did qualify for SNAP and Medicaid and as a, as a-- I feel like intelligent, college-graduated adult who owned her own business. I was very capable of filling out those applications and going through it, but it was a huge pain in the butt to continuously do it, and there was definitely times where we missed out. My son missed out on coverage because there would be a lapse in coverage between the time where, you know, we would-- we had to do it yearly and I know that's a whole other issue, but the process is not easy, even for someone like myself. And so I think that's what we're trying-- that's the problem we're trying to solve. And I think Director Bagley has the same perspective. That's a huge issue here. And additionally, you know, if we still have kids who are low income enough that they qualify for SNAP and they don't-- they qualify for, for Medicaid and they don't have healthcare coverage, regardless of if that's 5 kids or 5,000 kids, that's really problematic. You know, health insurance, especially for kids, is a way to provide preventative care, as Mr. Garcia mentioned. And if we're-- if kids are missing out on that simply because of, as CEO McMorris mentioned, paperwork, we are not doing our job as a Legislature and as

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a state to make sure that we're getting our kids that it's our job to take care of all the things that they need. So I'm happy to answer any questions that you have.

ARCH: Thank you. Are there any questions? Seeing none, thank you very much.

DAY: Thank you.

ARCH: This will close the hearing on LB857, and this will close the committee hearings for the day.