[]

DON PEDERSON: Since we're on somewhat of a limited time, I think it's appropriate for us to start now. There is one person who will be here and will join us as we're in progress. But let me make introductions first though. At my far left is Pam Perry; next to her on her right is Gayle-Ann Douglas; next to her is Cory Shaw. At the far end is Steve Martin; and the Vice Chair is Kathy Campbell; and myself. We're expecting Linda Ollis to be here and she's a vital member of this committee. She's...in fact, I think she's walking in the door as we speak. This is Linda Ollis that's coming in. We've changed the format a bit for this particular hearing. There are three reports, as you know. And as I mentioned earlier, if you want to have a copy of the report, it's up here in the front in one of these brown chairs. There are three of them there, so if you wish, you can just have one. It seemed to us that as we were going through previous hearings we spent an inordinate amount of time looking at a PowerPoint presentation when we already have the material. So met last week with Vivianne Chaumont, the director for the Medicaid program, and we agreed that this would be a better use of our time. Instead of doing a PowerPoint presentation, which they were in the throws of completing at that time, we would have her present to us the matters that are contained in each of the three reports in a summary sort of fashion. And that that would give us the opportunity to ask questions from the council as it's being presented. I think rather than wait until it's all over with in each one of them, it's more appropriate to ask the question at the time that it's being presented so we can all remember what the question was. And then I think that we will have time when the hearing is concluded for public comment. I would call your attention to two facts that I think that we need to bear in mind. This committee is called the task force to reform Medicaid, which in general terms considers not expansion of Medicaid, but it considers as much as we can do to contract Medicaid and still provide the services for our citizens. So it's a twofold purpose, and it's a difficult job with DHHS to evaluate these various programs recognizing that at some point there is going to be someone that's to be adversely affected by a dollar amount or whatever else. But we have to look at the total picture and then the department will have to make

recommendations and then we go forward with it. We've been working on this for several years as a council with sometimes different members of the council now being here that were not here at the time we initially started. But we started with this idea. It was a program that was initiated by the Legislature asking us to realize that we could not sustain the growth in Medicaid that was taking place and that we should do what we can to see if we can lower those costs of Medicaid and in some way preserve the solvency of the program for the state. So it's a big burden and it's a heavy responsibility, frankly, to do that. But the council is very conscientious and trying very hard to look at both sides of the issue of the services and the costs. So I would ask if Vivianne Chaumont would come forward and make a presentation to us at this time. Thank you, Vivianne. []

VIVIANNE CHAUMONT: (Exhibit 1) Good morning. I'm Vivianne Chaumont. I'm director of the Division of Medicaid and Long-Term Care in the Department of Health and Human Services. I'd like to thank you all for your time. I know you're all busy people. I think this is an important task, an important committee. I thank you all for time of being here. And I want to thank Senator Pederson for meeting with me last week and agreeing that I do not have to go through a painful PowerPoint presentation, which I much prefer to have more of a conversation with you folks than do that. From the list of questions that some of you had submitted, it's pretty clear that you've all read the report. So that's a good thing and we'll just start. Today I'll be presenting three reports: the Medicaid Reform Biennial Report; the Medicaid alternative benefit structure recommendations report from Mercer, which was a Medicaid reform report--recommendation was to have this report done; and then the Medicaid medical insurance for workers with disabilities report. As Senator Pederson stated, I'm just going to go through some of the report highlights as I see them. If there are things that you think are highlights that I don't mention--and the fact that I don't mention doesn't mean that the item isn't important, it just means that we have limited time--please feel free to ask about any of that. So I'm going to give you the report highlights. Then I'm going to talk about the major changes in the program since the last report, current projects that

we're working on, recommendations that we have, questions and any discussion that you want to have. Some of you had submitted previous lists of questions. Where appropriate, I'll try to work those in during my presentation, but if I don't work them in, we'll get them in at the end. So the highlights. I think the highlights of the biennial report is that we had total increases in eligibles that were less than 1 percent. That was a surprise. That was lower than what we had expected. One of the questions was I think the largest percentage of growth was in adults in the Aid to Dependent Children's program. And the question was, has an analysis been done to determine the drivers behind the 9.5 percent increase. And I think the year before it was 17 percent, but we don't know why there's a 9.5 percent increase. We can't figure that out. Although, you know, we might think that that's adults with children, that it might be an unemployment issue. That's... []

DON PEDERSON: Vivianne, may I ask a question... []

VIVIANNE CHAUMONT: Um-hum. []

SENATOR PEDERSON: ...at this early stage? You mention that there's a reduction in numbers. But in looking at the Mercer report, they say: Project overview, the state of Nebraska budget continues to expand in numbers, eligibles continue to grow. I didn't understand that. []

VIVIANNE CHAUMONT: Well, it's not going down. It's increased, but it's increased at a lower rate than we thought it was going to increase. The program is fairly flat at this time, but it is not decreasing. Vendor expenditures went up about 4 percent from '07 to '08. The average cost per eligible increased about 3.5 percent, and the services that increased as a share of total Medicaid budget were the managed care capitation, home and community-based service waivers, and home health services. They increased as a share of the total, and you would expect that because as we move to cost contained, managed care is a big part of that. And as we move to de-institutionalize people and

move them to the community, you would expect that home and community-based services and home health, which is nursing delivered in the home, would increase as we move people from an institutional setting. There was a question about managed care and do we know how the managed care organization is allocating its dollars. Based on reports that they file with the Department of Insurance, they state that they spend 85 percent of their capitated revenue on medical services and 12 percent on administrative costs. I assume the other 3 percent is profit. Fifteen eighty-five blend in that is allowed by federal law and it's kind of a standard. When we set rates, we actually assume 88 percent of the revenue will go to medical and 12 percent will go to administration and profit. So I'll be talking to the actuaries about why the difference in those numbers. []

CORY SHAW: Vivianne, a question. I was interested just in terms of the relative use of resources by the MCO compared to the rest of the patient population that might be eligible for that program, but stay outside of it. Have they provided us or can we get access today to see that they've been successful in avoiding costs in one particular area or another or... []

VIVIANNE CHAUMONT: I don't have information to that detail, but I do have information about the success of managed care, both for the...and I that a little bit later, I could jump to it now if you would prefer. []

CORY SHAW: That's fine. []

VIVIANNE CHAUMONT: Which? []

CORY SHAW: You want to go ahead and talk a little focus on it now? []

VIVIANNE CHAUMONT: Oh, do it now? Sure. []

CORY SHAW: And maybe before you get to the success factor, you mention that the rate or that the investment in the MCO had gone up. I think my map was right about a 20 percent increase over last year. Did the enrollees go up? []

VIVIANNE CHAUMONT: Yeah. Let's talk about that. And I gave an extra handout which is there. The net payments, when you look at the net payments when you look at the net payments, you know, $88 million versus $72 million, are pretty deceiving because of the time that we pay the capitation. So there are months where there are...I mean, I'm sorry, there are years where there are 13 months paid in a year, and '08 was one of those, and there are years when there's 12 months paid in a year, and there's even one year in which 11 months was paid in a year. So you can't really look. It's not a 20 percent. It's been pretty steady, although it's been growing. There was also a blip in the data in that 1,000 Medicaid births were paid in a year that wasn't the year that they were in fact incurred. So they look really high for that. I think it's 2008, they look really high. But if you look at the handout, you will see that it shows a 1.11 percent increase in rates over the time frame, and a 1.64 percent increase in enrollment. And if you look at those two percentage increases, those are very comparable to the rate increases and to the enrollment increases in the fee for service program. So I think that's a better way to look at the data. As far as the success of the program, we think it is a successful program. We have analyzed what the average per-member, per-month cost is for...and Mr. Shaw, I'm glad you mention that. The rest of the sentences in that paragraph somehow were deleted in the editing. []

CORY SHAW: Yeah. I figured as much. That's all right. []

VIVIANNE CHAUMONT: And we corrected...yeah, I'm so sorry. When we submit a final report we will take care of that and several other errors in the report. But the managed care organization average per-member, per-month cost is $206.42. I believe this is FY '07. The average PCCM cost, which is the primary care case management program which is a managed care program or it's an administrative services organization, but the

organization is not at risk. That is a $208.70. So you see there's a savings for the MCO. And then the fee for service population, we compared the contiguous counties because mandator managed care Nebraska is Lancaster-Sarpy-Douglas. So basically the Omaha-Lincoln area. But we're thinking with a growth that's going on now that the contiguous counties to those areas are pretty comparable as far as their costs. And their costs are per-member, per-month is $211.18. So we do believe managed care is saving the state of Nebraska money. []

CORY SHAW: I'm sorry, I didn't catch the first... []

VIVIANNE CHAUMONT: At risk managed care is saving the state of Nebraska. []

CORY SHAW: So what was the at risk number again? []

VIVIANNE CHAUMONT: Two oh six point four two. []

CORY SHAW: So it's $206 versus $208 versus $211, is that right? []

VIVIANNE CHAUMONT: Yeah. []

CORY SHAW: Okay. []

VIVIANNE CHAUMONT: Um-hum. []

STEVE MARTIN: Excuse me, I have a follow-on question to that. I didn't see data that risk adjusted those populations either by age or by actual case type, by the type of case care. Is the department doing risk adjustment among those populations? []

VIVIANNE CHAUMONT: The department...my understanding is that we're not risk adjusting our rates at this time. The background... []

STEVE MARTIN: No, no, no. I didn't mean risk adjusting rates, just risk adjusting populations because in the urban markets, there is some degree of selection. []

VIVIANNE CHAUMONT: Um-hum. []

STEVE MARTIN: So typically, traditionally MCOs tend to attract lower risk populations because they're not as self-aware of the need for specialty care and those things. And those who know they need a specialist of some kind or at higher risk populations... []

VIVIANNE CHAUMONT: Um-hum. []

STEVE MARTIN: ...tend not to attract. Do we have at least on a case adjusted risk...so we can compare what's the net risk going in of the population to the MCO, age and case rate risk... []

VIVIANNE CHAUMONT: Yeah. []

STEVE MARTIN: ...versus the population going into the MCO? []

VIVIANNE CHAUMONT: There is a lot of background material to this number. This is the summary data. So the... []

STEVE MARTIN: So that might be able to get provided. I think that would be good because even just age adjusting, the population says a great deal, but also case adjusting the populations by, you know, percentage, acuity, or morbidity adjustments by the number of hospitalizations or a variety...there's a variety of toolsets to do that, would be I think useful in the net analysis to the committee to understand the savings. []

VIVIANNE CHAUMONT: Uh-huh. Well, there's someone who understands the data

much better than I that if you're interested could come at some point and present to you. []

CORY SHAW: Now I'd agree with Steve. Certainly if we're going to assert that that technique has been successful at changing the slope of the line of growth, then we probably need to make sure that we're relying upon data that's been appropriately analyzed, at least in the council well. Yup. []

STEVE MARTIN: Yeah. I'll point the finger at my industry. We tend to declare success sometimes. And in the under 65, 10 percent of population can create 70 percent of the total net risk for claims. So 1 percent shift of that 10 percent is significant in net cost. And so just that analysis of that 1 percent would be key to showing...to at least the committee looking forward on how much net savings could that have. I certainly wouldn't want it to error on the side of more profits to our industry. (Laugh) I wouldn't be doing my duties to this committee. []

VIVIANNE CHAUMONT: Okay. Well, if you would like another presentation on that I'd be happy to have someone be here in order to go through that with you. Let's see... []

DON PEDERSON: Maybe you could do it by a subsequent written report. []

VIVIANNE CHAUMONT: Sure, yeah. []

DON PEDERSON: Let's do it that way, and then if there's a question, we can inquire of you. []

VIVIANNE CHAUMONT: Um-hum. Perfect. I think we actually did a report and presented it nationally, so I think we have the data. Okay. On the labor services that we said had been increasing, there was a question about whether or not we had data available for how the spending is allocated in the waiver services. And you'll have two

handouts there that say exactly what the waiver services that are being paid for in the aged and disabled waiver and in the developmental disabilities waivers. Another question was whether hospital costs for traumatic brain injury patients are accrued under the in patient hospital category or waiver services. And patient hospital costs are never a waiver serve, they're a state plan mandatory benefit. So they are not under the TBI waiver. The only services under the traumatic brain injury waiver are the services provided by QLI for assisted living. And we only have one provider that's currently doing that waiver and would welcome any others if they would come to the table. []

CORY SHAW: That was my question then. I used that as an example. I just wasn't clear if the category of enrollee had all of their expenses attributed to that category or if it was just (inaudible). That's helpful to understand. Yeah. []

VIVIANNE CHAUMONT: Yeah. I understand. No. The waiver services are just those that are under the waiver, that are only provided under the waiver. And so you'll have a waiver client with in patient hospital, with drugs, with physicians, with everything else, and that would be in the acute line. []

CORY SHAW: Gotcha. []

KATHY CAMPBELL: There was another question close to that in terms of the average eligible person, it's on page 10. The average monthly eligible persons by category is updated. The actual Medicaid case load was lower than expected, and I think Cory also asked this question. Do we know why those were...or why they were lower than the projections? []

VIVIANNE CHAUMONT: You know, they use a variety of projection tools to estimate, say "guesstimate" what the growth is going to be, and it was just lower. Then I think that Nebraska has been lucky so far in the economic downturn that we've had. We haven't seen the economic downturn that other states have seen. And so it was just a matter of

estimating it higher than what we thought. The one that surprised me was the decrease in the aged because you hear about all the baby boomers coming. And I think they're still coming. I think they're just not here yet. So you know, the projections could, you know, something tanks in the economy, tomorrow those projections could go out the window. []

KATHY CAMPBELL: I would guess that most of us looked at that question because if there was something from that estimate that one could trend out to say, okay, over the course of the next 5, 10, 15 years will we see a trending differently. I think that's what we've tried to watch here is that long-term trending, and that's why the interest in that question. []

VIVIANNE CHAUMONT: Um-hum. When we developed the biennium budget, we revise trends in enrollment as well as in rates. And so we do do that, but two years out, so. []

CORY SHAW: I mean, the report notes that really the one quantifiable change that's talked about is that the actual case load for 2007 and 2008 were lower than expected. And my question was, does that account for all of the projected savings or are we relying upon...I mean, there's two other factors here, one of which really, really don't have a lot of control over... []

VIVIANNE CHAUMONT: Um-hum. []

CORY SHAW: ...which is the CMS expenditure per capita projections which obviously change from year to year. []

VIVIANNE CHAUMONT: Um-hum. []

CORY SHAW: But I don't think there's that much variability in those frankly. So I'm encouraged, but I guess I'm skeptical as to what's driving it if it's something that we're

doing or if it's we're changing some assumptions about the future that have changed our estimated gap or if this temporary dip in enrollment, which as you point out could change next week given what's going on nationally with the economy. []

VIVIANNE CHAUMONT: Okay. Let me just clarify, it's not a dip in enrollment, it's a flattening. []

CORY SHAW: Not a...flattening. Thank you. []

VIVIANNE CHAUMONT: It's not rising at the rate that we thought it was going to rise. It is rising. It's just not rising as...you know, I mean when you look at the big numbers, it's fairly flat. But it's still a 1 percent increase. And I can jump ahead to that. You know, we did see a decrease in the gap that had been talked about from a 2005 report to the 2025 report of $785 million. This has been decreased. The 2008 report has a $368 million gap. That's still substantial money, that's not couch change there. You know, that's...but the analysis is that it is driven by lower case load and a slowing of the growth in cost per Medicaid eligible as well. []

STEVE MARTIN: Do you...I'm wondering whether some of it is an attributed phenomena of Part D, that's kept a number of seniors from applying... []

VIVIANNE CHAUMONT: And some...absolutely. Um-hum. []

STEVE MARTIN: ...because the absence of Part D I think was a major accelerant in the number of over 65 who were pushed into a financial position to apply. Whereas... []

VIVIANNE CHAUMONT: Exactly. []

STEVE MARTIN: ...Part D has created a safety net that I think when the original budgets, when I remember the first projections we saw... []

VIVIANNE CHAUMONT: Um-hum. []

STEVE MARTIN: ...those budgets were based on just literally an extraction only of the current spend rate of the department... []

VIVIANNE CHAUMONT: Um-hum. []

STEVE MARTIN: ...not a detraction of the potential new enrollees in the over 65 that would have come on because of the needs drug coverage driving them to an economic eligibility level, the lack of any drug coverage and the need for coverage of pharmaceuticals. So it seems to me like that might be the most logical decelerant. []

VIVIANNE CHAUMONT: Um-hum. []

STEVE MARTIN: And over time, you know, that still doesn't take away. Drugs are still one of the...because we're still paying a supplemental price to that, we're still the... []

VIVIANNE CHAUMONT: Right, and I mean the slow in the growth and the cost for Medicaid clients, for each Medicaid client, you cannot ignore the impact of Part D. That has a huge impact. We were...the pharmacy budget was increasing in double digits, and in the upcoming biennial budget we're projecting a 6 percent increase in pharmacy. I mean that's less than half of what the, you know, what the growth had been in the past. So that's certainly some of it, but you also can't ignore the reduced costs and the institutionalizing folks and in encouraging, you know, community services as opposed to institutional services, not just in long-term care services, but in behavioral health and other areas, so. Going to have to jump around and not repeat myself here. Nursing facilities in hospitals saw a decrease as a share of the total Medicaid budget, which is exactly what you would be expecting and what we would be searching for. I think that is pretty clear to everyone that community care, both on the physical health side and the

long-term care side and the behavioral health side, is less expensive. Pharmacy, I think we already talked about. And you notice in the chart that it's the only service expenditure to decrease, and it decreased substantially. And that is without a doubt Part D. []

CORY SHAW: And did that include, the numbers we show here include the net effect of the federal clawback provision? []

VIVIANNE CHAUMONT: Okay. And I was told there's no such thing as a net effect to the clawback. The clawback is calculated somewhere else. But what it does show is that even with the clawback, the growth in pharmaceuticals expenditures is dropping dramatically, and again, it's Part D. []

CORY SHAW: I just remember early on in our deliberations there was discussion about the fact that the effect net would actually be potentially it'd cost us more money. Even though we were going to lose the drug expense... []

VIVIANNE CHAUMONT: Right. []

CORY SHAW: ...the feds were going to come back in and take enough federal funding away that it was actually going to turn it upsidedown for us. []

VIVIANNE CHAUMONT: Right. In Colorado...I was in Colorado when Part D started coming in, and the way that CMS and the federal government had the clawback calculations, at first the states actually would have subsidized Medicare program more than they are currently subsidizing the Medicare program by paying for a clawback, which is the first time that--I'll get on my soapbox--that a federal program is being paid in part for, a totally federal program being paid in part by the states. Okay. I'll back off of that. Let's see, so we talked about...I think we covered all of that. Okay. So that's kind of the highlights of that report. I was going to...of the data part of that report, I was going to

move into major changes since the '06 report, if that's okay. []

CORY SHAW: I had a couple of other questions that I had asked and wanted to just get some clarification on it. On page 9 in table three it talks about biennial budget rate increases that are funded and it lists different categories, hospitals, practitioners, and there's some facilities, etcetera. Are those changes in payment per unit of service or...I assume they are because the aggregate change was different than the number described here. []

VIVIANNE CHAUMONT: Yeah. []

CORY SHAW: Okay. []

VIVIANNE CHAUMONT: You know, I have all you questions worked in, but obviously not in the same areas. []

CORY SHAW: Okay. That's all right. I just wanted...I thought you were going to... []

VIVIANNE CHAUMONT: And that's fine, not a problem. That is the chart on page 9 only the budgeted rate increases that were adopted by the Unicameral. []

CORY SHAW: Okay. []

VIVIANNE CHAUMONT: So the other numbers would include utilization and enrollment, as well as the rate. All right. Now, there's no report that mentions any of this, but I cannot give a report of what's going on in the Medicaid program without saying that we are building a new Medicaid management information system. The contract was signed in June of '08, and it should be completed 7-1-11. And that is just a huge project that hopefully once it's done we will have much more flexibility in making changes, payment changes, in paying faster and better and the flexibility to change the program and be

able to pay through the MMIS is going to be wonderful. So is a huge change that has happened since the last report. So as far as that the report contains an updated status of every single project that was in that Medicaid reform report. And I'm just going to talk about...highlight some of the major ones. One of them is the covered services, and I gave you a handout that's the green and blue one. This was in the 2005 Medicaid reform report, the department was told to align for adults, align optional services with those of private dental health and vision insurance contracts, and we did that. In determining which ones to do after that report came out, the Legislature took a budget reduction. So the money that we were supposed to save from making those changes was already taken out of the budget. What we did was we compared other states Medicaid coverage. And you will see that is a report that you have, we also compare with the BlueCross state employee plan because it was said to align to private insurers. We implemented those changes July 1, '08 and they're for adults only. They limit: dental services to $1,000 a year; therapies which are occupational therapy, physical therapy, and speech therapy to 60 visits a year; hearing aids a pair every four years; glasses a pair every two years; and chiropractors 12 visits a year. And so that happened July 1, '08. []

KATHY CAMPBELL: Vivianne, can I just ask a quick question? []

VIVIANNE CHAUMONT: Sure. []

KATHY CAMPBELL: Of all these that have been out, the one that has the most questions to me has been on the dental services. Are we doing any tracking to know...I mean, I would assume some of the times we get people who have such severe problems because they haven't been in a regular dental prevention checkups twice a year. So the $1,000 then would go quite quickly if you had a root canal or something else. Is there some way the we mitigate that if there's a very unique situation? []

VIVIANNE CHAUMONT: No. There are no exceptions. []

KATHY CAMPBELL: Okay. []

VIVIANNE CHAUMONT: And look at the dental, I think it's the cover sheet. The large majority of states don't cover adult dental at all. And a lot of them...and there's many of them who cover it at $1,000 a year or less. So it does have an impact. Any time you cut, reduce a benefit, it has an impact. There's always going to be somebody who is using it that you're going to effect. []

CORY SHAW: I guess the interesting thing I question is I understand the otherwise healthy adult maybe not getting dental coverage (inaudible) the world we're in that with some of our disabled population it would seem like maybe categorically there would be ways to provide coverage without...and again, I don't have any idea the expense...I have been asked the question by some about what happens with that population given the fact that they may have unique needs that kind of border on... []

VIVIANNE CHAUMONT: Um-hum, um-hum. []

CORY SHAW: ...medical needs because once their oral health deteriorates, you get to the point where you start creating other problems for them that cost the system money, so. []

VIVIANNE CHAUMONT: That's correct. But if it's a medical need, an issue of infection, then, you know, you address that issue as a medical issue and not as a dental issue. []

CORY SHAW: The point is it would have been prevented had you had... []

VIVIANNE CHAUMONT: And you know I think what's going to happen is that there are going to be cases where you might have done, you know, a root canal and you were going to do an extraction instead. You were going to do different...you know, there's

going to be choices to make. But you know as the dentists constantly tell me how low their rates are in the state of Nebraska, $1,000 should go pretty far, so. []

KATHY CAMPBELL: I think the concern has been that unusual situation as Cory has talked about, and from a lot of people who don't have a dental home it's the same as they don't have a primary health care home. Those are just problems in the system that we have to deal with and that's why the question I think have been coming. []

VIVIANNE CHAUMONT: Right, and we have heard a lot of input on the dental, as well as the therapies, mostly on the dental from dentists. But yeah. Okay. Pharmacy was another driver. We talked about, you know, what is the biggest thing driving the pharmacy costs down. But we've also done some things with...we have a drug utilization review board that reviews every single new drug. Every single new drug does on prior authorization when it comes out, and then it's reviewed by the DUR board. When it's been out for six months and the board can take off the prior authorization, leave on the prior authorization, change the prior authorization, do different things. And to date we have over, since that program was started, we have over 100...the DUR board has reviewed over 100 drugs. And then we had also a prescriber education program that we worked with on Nebraska Medical Association for prescriber education regarding behavioral health drugs aimed at children under I think it's the age of five--it's on there, I think it's five--who are on antipsychotics and other behavioral health medicines, people who are on more than three behavioral health medicines. And it's been an educational letter out to providers regarding that, and are going to I believe step up our processes on that as well as when we do that, I would like to contract with an evaluator to see if in fact those strategies work and if they work in the long term as opposed to you know a little bump or a little decrease, you know, and they get the letter and then back to...so we'll be working on that. Long-term care services obviously was a big driver of costs. We have increased home and community-based services slots and we have started the money follows the person program, which is a program where we have folks, transition coordinators out trying to move people who want to move from nursing facilities and

from ICF/MRs into the community and providing them special services to do that. And that started recently. []

DON PEDERSON: Vivianne? []

VIVIANNE CHAUMONT: Yes. []

DON PEDERSON: I see where Nebraska is 1 of 31 states that's selected for this home and community-based waiver service where they can...if they're in a care home and they want to get out of the care home, they can apply to do that. But is that working at all? []

VIVIANNE CHAUMONT: Um, are you... []

DON PEDERSON: It's on page 18 of your report, the home and community-based waiver service. I think it was a federal program that... []

VIVIANNE CHAUMONT: Oh, Nebraska is one of 31 states who got the money follows the person grant that we're talking about. It took an inordinate amount of time to get that approved by CMS, but that's the program I was talking about that we've just started. And yes, I know that we have moved I think a couple of people from ICF/MRs and into the community and are in the process of working to get other people out. []

DON PEDERSON: Just as observation, I don't see how that's ever going to work really because by the time somebody gets into a care home and they've been there for a period of time, they rely upon the care home. But then secondly, in order to get there, they've liquidated all of their property and so, you know, where to they go? []

VIVIANNE CHAUMONT: The biggest issue in money follows the person is getting housing for the person. Although there are people who, with the right services, would go

back with family. There are people who, you know, who do have homes still. And so...yeah, I think our strategy should focus on the discharge and not letting them go into a nursing home in the first place and making sure that people before they make those choices know exactly what's available in the community. []

DON PEDERSON: And I think we've talked about improving the assessment of people and determining at some point before they go into a nursing home whether or not they could get along on services aside from the nursing home. []

VIVIANNE CHAUMONT: Well, and we have revised the tool and are going to be implementing the new tool hopefully by the end of this calendar year. But the evaluation that's done to see whether Medicaid will pay for a nursing home is the exact same evaluation about whether or not that you know it's...in order to go into a home in community-based services, you have to meet the nursing facility level of care. So it's the same tool. And I think the trick is to get people advised to do that. And it's interesting because if someone is more expensive in the community than they are in a nursing home, we need to steer them toward the nursing home. But if in fact they cheaper in the community than they are in a nursing home because nursing home is a mandatory required service, they have the right to choose the more expensive level of care because nursing facilities is a required Medicaid services, whereas HCBS is an optional Medicaid service. And you have to provide the choice for someone who is cheaper in the community to go into a nursing home. I think education is a large part of it. I think that working with hospitals in discharge planning is also going to be key to making sure that people know before they make that because you're absolutely right, Senator. Once they're in a nursing home...and it's just hard for people to move, but once they're in, you know a lot of times it means that they have liquidated so it's harder, definitely. []

KATHY CAMPBELL: I think one of the questions that I've been asked in this program is what happens or are we projecting and evaluating what happens after that fifth year and they moved? You've now got them moved out and they're there for five years and the

program lasts that long, but then what? And so I'm assuming that we're building in some kind of an analysis system what we will do for people at the end of that period. []

VIVIANNE CHAUMONT: The services will not change. So once they come out of the nursing home and go into the community, those services are your standard HCBS services that we have in the waiver. And you know, unless we change the waiver, they'll be there five years or whatever. The grant, the five years is that CMS is paying the state an enhanced match for the services when they come out. So they'll be, you know, there will be some extra money there assuming that...you know, for the services. But the services themselves...so what will go away is the transition coordinators. And in five years we can see how that has worked, and if it's a cost-effective program to have, we can take a look at it and you know, and determine. But the actual service itself, that's not affected by the five year. []

DON PEDERSON: Vivianne, in that same regard, have we made changes or improved the assessment of people before they go into homes? []

VIVIANNE CHAUMONT: Well, like I said, we are revising the tool and I think that that tool will be more effective in helping determining what care they need and whether or not they can be safely served in the community. So that's the new tool that will be implemented hopefully by the end of this year with regs to go with it. []

DON PEDERSON: Thank you. []

VIVIANNE CHAUMONT: Someone had asked about, I think Mr. Shaw had asked about the own your future, an LTC partnership which are two programs we are trying to educated people and have private insurance available. As to the own your future, we don't have any data as to what any impact that was. That was to educate people about their choices. And as to the LTC partnership, that was with the Department of Insurance and they have told us that they have 22 insurers signed up; 22 insurers between them

have 40 different policies. And they don't have the data on how many policies have been sold, but they have the anecdotal that there is much less demand than was expected, so. And I think that's been pretty standard in all the states. []

STEVE MARTIN: I think it's very possible over time, I mean, people don't realize it's only the first wave of the baby boom now that's just entering retirement. And as the middle of that boom, that's where the assets are. The people will probably elect to protect and we're seeing more uptake as employers in the age 50 population that's buying into either group or individual employer sponsored programs. So it may be a decade before we begin to see the uptake. []

CORY SHAW: And that was actually going to be my question was had...and I don't remember the detail of the program, but I thought it was mostly oriented and had focused on individuals. And I wonder if there isn't some value in giving some consideration to the state working with employers to educate them about the possibility of offering a benefit, whether or not the employer contributes anything to the cost of that premium. But certainly the more that you can imbed into that employment relationship where those folks have those assets who are likely to want to protect them, I think we might see greater uptake going forward over the next decade, which I agree with Steve. []

STEVE MARTIN: Yeah, I think states could provide some incentive. I'd like the director to comment. But I think there's been little done in the group long-term care format and its subsequent conversion. I think there's little known there. But you know a lot of employers still have group disability, but when an employee hits age 40 to age 50, they tend to start opting out of that. That's ideal, but I think we need to look at maybe even some different directional incentives, maybe not necessarily through program, but through other employer incentives that might actually help in a cost cut in another side of the state budget. But until we have that, I don't' think we see a lot of those group policies out there that are very good now in terms of their conversion capacity when the

employee retires. []

VIVIANNE CHAUMONT: Okay. The next area is utilization control basically. I call it that. We have an enhanced care coordination program. That was one of the recommendations in the Medicaid reform report. We signed a contract and...I'm trying to think when...I think it's September 1 that program went. I says on there, I didn't write that down. Sorry. It's a voluntary program. What that means is the way it works is we have a contractor. The department gives the contractor lists of folks who have incurred $50,000 or more dollars in expenditures in the last 12 months. And then the contractor goes through those lists and the claims and determines who they're going to target. And then they could call the client and say, you know, will you work with us. It's totally voluntary, will you work with us to see if we can, you know, improve your quality of care as well as reduce costs. So it does not include clients in the MCO because the MCO is supposed to be doing that already. And it's in MCO's interest to do that. So we don't need to go there. If the client is in the PCCM, we will take them out of the PCCM and put them in the enhanced care coordination program. It is a statewide program, so it's available to everyone and we are just getting started. I believe that a letter either just went out or is about to go out to providers and clients telling them about the program. []

STEVE MARTIN: Is there a reason $50,000 was selected as the watermark versus maybe clinical predictors or is that some of the experience like the Minnesota-Wisconsin program, is that why that was... []

VIVIANNE CHAUMONT: I think that high care...that yeah, it's high cost folks that are being targeted and we picked $50,000. []

CORY SHAW: Maybe just a follow up on that. Is there the possibility of to expanding that to people who may have not yet incurred $50,000 but may have a predisposing condition or conditions that would suggest that if they haven't, their ticking time bomb might...maybe that's where Steve was going. []

STEVE MARTIN: Yeah. The predictive model is what I... []

VIVIANNE CHAUMONT: Um-hum, yeah. I think that those are all great ideas and that right now I just want to start the program and see if it does anything at all, and then we can you know amended it as we learn some lessons and see how it's working, so. []

STEVE MARTIN: Does the staff have any of the predictive modeling analytic tools available to them or those not in the budget at present? Will you take the diagnostic and procedural data and the toolsets predict the future expenditure based on those earlier...those usually tend to run... []

VIVIANNE CHAUMONT: We are not currently doing that. []

STEVE MARTIN: Okay. So those currently aren't budgeted is what I'm assuming. []

CORY SHAW: And I guess the point is that U.S...I suspect U.S. Care Management may have some of that capability and... []

VIVIANNE CHAUMONT: Exactly. []

STEVE MARTIN: You would assume so. []

CORY SHAW: ...engaging them in that discussion rather than after the $50,000 has been incurred, maybe starting to do with something a little prospective might be able to... []

VIVIANNE CHAUMONT: Right. I think that they'll look at the $50,000, and then they run the analytics to see where the savings are going to be and, you know, where hopefully an impact can be made and they'll be doing that. You know, maybe at some point we

shift away from the $50,000 to something else, but this is how we're starting it. []

CORY SHAW: Yeah. []

VIVIANNE CHAUMONT: Okay. High-risk pregnant teen program, we contracted. We put out and RFP. We contracted with a--can't remember--four contractors and sent the contract to CMS. So we had been working with CMS on the program and we were advised by CMS that there would be no federal financial participation for the program because it lacked comparability, statewideness, and choice. So without FFP, we terminated the program. Any questions on that? On behavioral health we issued a new contract effective July 1, '08 which is something that actually we are very excited about. It's the first time that...what we did was the division of children and family, as I'm sure you're aware, has a lot of you know behavioral health costs. The division of behavioral health obviously has behavioral health costs. And then Medicaid of course is the granddaddy of them all as far as the money is concerned. We issued a joint RFP, all three divisions together to still have three separate contracts because you know the funding needs to be kept clean. And we are on the Medicaid side previously the administrative services organization focused its prior authorization and management on 24-hour care, and they are adding outpatient care to that focuses as well. So I think for the first time as a child particularly goes through the different systems, we will have one organization that can track them and I think that the thought is that there will hopefully be some cost savings there. But I think the biggest driver is that it will improve the quality of care and the management of the care of children in the system. Okay. So those are the highlights. If anybody has any questions about any of the other projects in there we can take those now. []

STEVE MARTIN: Just since you mentioned it earlier. On the new system, is that being funded by the higher match rate, is that...that's I know has been typical. []

VIVIANNE CHAUMONT: I missed the first part of your question. I'm so sorry. []

STEVE MARTIN: You brought up in the beginning of your comments on the new system... []

VIVIANNE CHAUMONT: Oh, the MMIS. []

STEVE MARTIN: Yeah. Could you comment on the cost associated with that and is that at a different match? []

VIVIANNE CHAUMONT: Yes. What do they call it...I can't remember that. There's two letters, I can't remember what they are. But the building of it, the design and the development. I think that's it, design and development is a 90-10 match. []

STEVE MARTIN: Ninety, ten. []

VIVIANNE CHAUMONT: So the federal government pays $9, we pay $1. And it's still very expensive. []

KATHY CAMPBELL: In the report on page 21 you talk about the technical assistance to develop community health centers, which I think are just terrific. I mean, I think they go along with community-based services. One of the questions I had as I read the update here, Vivianne, is how many do you think we need in the state? I mean you're working on lots of fronts and I think they're good. But how many ultimately do you think we need? []

VIVIANNE CHAUMONT: I really don't know. []

KATHY CAMPBELL: Is it going to be based more on the number of clients that we have in a regional area, do you think? What is the criteria that you're using in terms of knowing where to go in this state? []

VIVIANNE CHAUMONT: You know, I think that this project has basically finished. The Office of Rural Health and the Division of Public Health was involved in that. I know we just...I think there's one new FQHC coming up, and that's the only one that I'm aware of. []

KATHY CAMPBELL: Okay. So we're sort of in a watch period to see how those numbers grow. But you wouldn't be adverse for applying for more if we could determine where they might be needed? []

VIVIANNE CHAUMONT: If n FQ sprouts up somewhere we will pay, you know, we will pay their claims when they submit them. []

KATHY CAMPBELL: Okay. []

CORY SHAW: Could we talk a little bit about page 15 which is a table of program budget and expenditures and the budget for this next year? []

VIVIANNE CHAUMONT: Um-hum. []

CORY SHAW: I have a general question first and to remind maybe the council as to how the numbers are displayed. Are these numbers the total spend regardless of source, meaning that some portion of the spend in aggregate that we're talking about here is federally funded versus some of it's state funded? []

VIVIANNE CHAUMONT: Yes. []

CORY SHAW: Okay. []

VIVIANNE CHAUMONT: Unless it says "General Fund" or "federal fund," the Medicaid

request for $1.6 billion is total funds. And it should SCHIP as total funds. []

CORY SHAW: Okay. So as we go down the list then of the projected savings...and again, I don't want to diminish any savings whatever, whether it's $1 or $5. But the numbers that are laid out here in terms of savings include both the state share and the federal share or... []

VIVIANNE CHAUMONT: No. It says "the following General Fund reduction." []

CORY SHAW: Okay. All right. That's what I... []

VIVIANNE CHAUMONT: So the numbers in the box are just the General Fund. So two and a half times is the total because it's 60-40. []

CORY SHAW: Okay. And is that true of each of these line items? Each of these line items is matched the same way? []

VIVIANNE CHAUMONT: Yes. Um-hum. []

CORY SHAW: So the dollar impact to nursing homes, for instance, is really $1.4 million? []

VIVIANNE CHAUMONT: Yes, $1.5 million. []

CORY SHAW: Okay. And that's true of each of these as we go down the list. So working for a large physician group I'll draw my attention to the big number. (Laugh) So what we're saying is that physicians across the state of Nebraska based on this proposed budget change, we reduce total physician spending which goes back to the $154 million by about $12 million according to this budget proposal? []

VIVIANNE CHAUMONT: Ten million, two and a half times. []

CORY SHAW: Okay. I'm sorry. So about 5 or 6 percent of our total spend on physician. []

VIVIANNE CHAUMONT: Well, no because if you'll look at that, you'll see that it's for 2011. And what I didn't' clarify in this report that we will clarify when we do the final report is that there is a 1 percent rate increase put in for all Medicaid providers in '10 and '11. You know, so the base will have grown by 1 percent in...you know, plus that's just the rate. We talked about you know the base grows depending on... []

CORY SHAW: Sure, trend. []

VIVIANNE CHAUMONT: ...you know, all of that stuff. But I didn't mention in the report that there's a 1 percent...the budget contains a 1 percent provider increase in '10 and '11. So the nursing home rate increase, for instance, would be $1.5 million. If you calculate the nursing home, the '09 budget or the '08 budget and what we spent in '08, then it will increase because it's a cost based you know reimbursement system and it will increase as a result of the provider increase. So the base will be higher by the time you get to FY '11. But if you just looked at FY '08, you're talking about a .48 percent increase, so less than half a percent is the cut, the proposed. []

STEVE MARTIN: I think since we're talking about these and part of the role of this committee is making sure we are doing all we can to protect both the beneficiary and the taxpayer both. You know, you can't but help but go down the listing. I think we have to be reminded the we're not always protecting the taxpayer because when we move programs where the hospital's at a critical access, we move from...and I'm not pointing fault, I'm just pointing a reality. When you move from 100 percent payment of cost to 90 percent or when we shift downward sizeable and public programs, the remaining public pays the differential, perhaps not so much in long-term care in that the cash paying

customer pays that. But the rest of the marketplace who's buying private coverage for insurance pays for that. And the single biggest predictor to the private market of their trend is what we call the Medicare and Medicaid cost shift. And so that just means that many more children who then whose families don't choose coverage. And so it is a delicate balance. I certainly can't be critical here. But I think we have to recognize that there will be a day of reckoning of this. There's a place we can't go anymore at some point in time. []

CORY SHAW: And I think the other issue that I think we ought to have to understand as a state from an economic standpoint is that you're leaving as a result of these reductions. And again, I understand our mission here. But you're leaving federal dollars on the table that won't wind up in Nebraska, that won't wind up being paid out to Nebraska citizens, which won't be used by Nebraska citizens to buy groceries and gasoline and cars and farm implements, whatever the case may be. And I think that's an important...again, beyond the scope of this committee, this council. But it's at a critical consideration because you're producing the amount of take on the federal government into this state and that's going to have an impact. I mean, it'll impact in the ways that Steve described. The other impact it's going to have I suspect when you take this much money out of the physicians system, which if you look at the hospitals and physicians account for about a third, maybe a little bit more of total Medicaid spending. And yet the majority of the cuts we're talking about are falling to hospitals and physicians. And again, everyone needs to understand where I work and what I do so I'm disclosing that. But it's an issue that we have to recognize it's going to effect potentially access at some point for this population. []

KATHY CAMPBELL: Well, I think that the critical question that we asked earlier was, you know, whether we were seeing enough of a trend to say that we're still on that climb even though we've narrowed the gap. And there are some groups in Nebraska who believe that we really aren't at the critical stage that we are and that we aren't going to trend out to that and it's not growing as much. And so to make some of these cuts may

be very difficult if that trend is not there. And I think that's... []

VIVIANNE CHAUMONT: And if that trend is there and you don't take things, then you're really going to have some serious issues with the financial sustainability of this program in five years, and you may have to take way more drastic cuts. []

KATHY CAMPBELL: Oh, I understand that. I mean we've... []

VIVIANNE CHAUMONT: So yeah, it's a balance. []

KATHY CAMPBELL: That issue is just exactly what Steve has talked about has been a weight that this reform council has talked about since the beginning. []

STEVE MARTIN: Yeah. My comment is I don't disagree with the Director's comment. I think you have to take where you can take it. I think what happens is we will overrun it and have negative consequences no matter what. If we don't take them, we will have massive negative consequences. As we do take them, we will still hit a point where the negative consequences bite us in another way. You know, part of this dilemma is structured in there's fundamental reforms that we probably have to take to the whole system, not just one state. []

VIVIANNE CHAUMONT: If anyone has any ideas of how to get $9 million in General Fund savings in 2011, I would be delighted to hear them. []

STEVE MARTIN: Do you find it damper because of the pressure your department is under to cut, do you find that that it seems it does dampen the aggressiveness we can take in new programs. I mean, in other words we kind of have to start them with what we've got, see how they work, and then tweak them as we go. We can't be maybe as aggressive as we'd like to be. I'm hearing that a little bit like as we're ramping on the broader risk management program in a long-term care. You know, we don't' have the

front end analytics, etcetera, so we start at a point. It doesn't seem like we start some preventive programs, and I think this is universal to all Medicaids. I'm just asking for your thoughts that if there's areas that we can take maybe a little more financial risk up front for a greater return in the back end. It seems we ramp these up a little cautiously. And I don't know, maybe we don't have the evidence to be a little more aggressive on certain programs. []

VIVIANNE CHAUMONT: I think on the...I think you're talking about the enhanced care coordination program. []

STEVE MARTIN: That's one. I think it's in other areas, and all those areas where we might try to capture that audience to make better choices up front, you know. We're always in that dilemma too in our business. But I just was curious if there's any of those things where you or staff thought that, boy, if we had a little more money up front we could be a little more aggressive. []

VIVIANNE CHAUMONT: I think the enhanced care coordination is funded; that isn't an issue. I think the...you know, we built the program to, you know, based on what some other states were doing, to try to get a program up and running as quickly as possible because we were behind the eight ball by the time we started the program. So now we will see you know what fruits there are to that. The education of you know people into long-term care is, you know, I mean that's an ongoing battle basically to get people the information. I mean we have senior care options. Those are contracts that are run by the state agencies on aging. They advise seniors on, you know, where to go. I personally think that we need to focus more on discharge planning. We submitted a grant application that would have given us some money to work with the hospitals in doing some discharge planning, and we didn't get that grant. I think that some of the thoughts and ideas that we had in putting that grant together are things that we need to just go ahead and try to follow up on. Right now I will tell you that on the MMIS building, the MMIS is a huge drain on my resources. []

LINDA OLLIS: We all experienced that in IT. (Laughter) Can I just ask, I know that you're going to be referring to some other recommendations a little bit later. But with all of the attention that is being paid to pharmaceuticals and I don't see anything really addressing drug cost or anything as a part of any of these measures. Is that because you've got that somewhere else in the proposal? []

VIVIANNE CHAUMONT: Now, you know what? It could be that we got...yes, it's somewhere else. But let's talk about it now. []

LINDA OLLIS: Okay. I was going to say because I think you got some, you know, other proposals in DME and pharmaceuticals. But this just doesn't (inaudible) Cory seems to really emphasize only the institutional providers. That was my... []

VIVIANNE CHAUMONT: Right. One of the recommendations that was in the Medicaid reform plan was for the department to take a look at preferred drug lists and joining a purchasing pool. It doesn't reduce what you pay out for pharmaceuticals, it increases the rebates that you get from manufacturers. And Mercer did a report for that that came out last summer...oh, this summer just went by fast, last spring I guess it was. Anyway, and that report recommended that we do a PDL and do a purchase pool. There was a bill passed by the Unicameral this last year requiring the department to do a PDL and looking into joining a purchase pool. So that is a big influence in pharmaceuticals that's hopefully going to, you know, slow that again, that rate of growth and the cost of that. That is already...the savings from that is already in the budget because of the bill. So that's why there aren't things on top of that. But you know we excluded three classes of drugs from the requirement to be in the preferred drugs list, which amount to I think it was $57 million. So you know I think that we should go back and reconsider once we get the PDL going putting those drugs back in because we are decreasing the savings that are possible from the PDL and the purchase pool dramatically by keeping those drugs out. []

STEVE MARTIN: Mr. Chairman, can I return back? you made a comment that stuck with me and it's got me a little bit concerned. []

VIVIANNE CHAUMONT: Um-hum. []

STEVE MARTIN: You've brought a number of new ideas to the department, and I think one of the problems we've suffered with as we've been conservative in trying new things. But on the other hand, we've sometimes waited and we've lost out on funding nationally. We lost out a lot of waiver because we waited, and now that's pretty much gone. You made a statement that the 10 percent, our investment in the MMIS, is significant drain. Would there be a way that that should be considered as a set aside? In other words, where at least the Legislature may need to be engaged to. That's a long-term investment. And if it's going to cut short the ability to do short-term programs that might accelerate also our long-term savings, it's a concern. In my business we do that kind of trade out; we have to set aside that reserve. We don't take it. The organizations that take it out of revenue stream end up suffering their ability to compete and their ability to do new and innovative things suffers much more. So you have to plan a number of years and set that aside as a special reserve because I think you imply when that's complete it should have a real cost savings in both data it derives the ability to pay claims at lower rates faster, interface with more MCO-type entities, etcetera. So wouldn't it be better for that to be a set aside, not to be a budgetary drain? []

VIVIANNE CHAUMONT: Okay. Let me clarify what I said as far as... []

STEVE MARTIN: Okay. []

VIVIANNE CHAUMONT: ...that is concerned. That project has been funded by the Legislature and is funded separately by the Legislature, the MMIS project. I think the drain that I was talking about is staff. []

STEVE MARTIN: Well, that's what I...I'm getting at that too. []

VIVIANNE CHAUMONT: And I think that, you know, we are going to be able to have seven staff that have gone over to work full time on the MMIS. We do have the ability to back fill some of those positions. So we will be doing that. But in the mean time as you particularly start building, doing requirements, validation, and things like that, people who are not full time over the MMIS, still a large part of their time is going to be. And so that's the drain that I mean on people that are working really hard. []

STEVE MARTIN: I appreciate that. Thank you. []

CORY SHAW: Maybe just one follow up then. []

SENATOR PEDERSON: Go ahead. []

CORY SHAW: Again, it's piggyback on the previous discussion about federal funding and then Steve's point about what we're doing, the leveraging, and maybe you were going to get to this again. I'm getting out of order for you. I apologize. []

VIVIANNE CHAUMONT: That's all right. []

CORY SHAW: Was that you noted there had been some changes potentially in looking at drawing down additional federal funding matches through some administrative programs, but we really didn't' discuss any changes. Are we at a point where we feel like we've fully leveraged all those opportunities statewide, both administratively and clinically? Certainly if there are opportunities in the department to make investments for which there aren't obvious sources of funding, that would be one potential use of additional monies. Are we at a point now in your opinion where we've maximized that opportunity? []

VIVIANNE CHAUMONT: Right. I think that we have maximized the leverage that we can have with the General Funds that we have. []

CORY SHAW: But there's opportunity potentially with other funds maybe? []

VIVIANNE CHAUMONT: Pardon me? []

CORY SHAW: Are there...with General Funds we've maximized the...I mean, I know we've done some creative things with INE and GME. Are there other opportunities along those lines that we might be able to pursue? []

VIVIANNE CHAUMONT: I think that there might be, so long as General Funds aren't involved. []

CORY SHAW: Okay. []

VIVIANNE CHAUMONT: Okay. Current projects, some of the current things we're working on. One of them is the use of technology. We have gone to provider communications, all electronic. We are moving to 100 percent electronic fund transfer, meaning that we pay providers directly through an EFT process. And we are also moving to electronic claims submission so that we try to get all of our claims electronically--it's faster, it's more accurate, and it's just less labor intensive. To do that, there are some providers that...the nursing homes have been working really hard with us to try to get their providers to electronically fund transfer. Part of the problem, I would say the biggest part of the problem is an issue with our MMIS, our old MMIS. And so until we get the new MMIS in, we will not be able to hit the 100 percent electronic claim submission, but I think that's what Mr. Martin's talking about that at some point once that is built, there are going to be some administrative savings there just because it's going to be a better system. We are also working on sending out a Medicaid card, much like I

have to...I want it to look like the BlueCross/BlueShield card you'll be happy to know. But you know like a card that you get that doesn't say, you know...currently we sent out a...every month we send out an 8 and a half by 11 piece of paper. To a family, this card would just have everybody listed on it. The provider would still need to check to make sure that the person is eligible, which they can do on the web or on the phone or any number of other ways of doing it. But is would save just handling, postage, paper, trees. I think it's a good idea. Acute care rates is area that we have been working on. We have just awarded I think or just announced the award of a hospital rate study to Navigant Consulting. They will be reviewing hospital rates, outliers, DRGs. The system has not been rebased in quite some time. We also want them to look at any opportunities that we have to increase DSH funding so long as it doesn't involve General Funds like I was talking to Mr. Shaw about. So that will get started soon. We are doing never... []

LINDA OLLIS: Can you just give me a little more idea on that is that...how long that study is expected to take? And do you have and idea of the fee accepted bid, what the value of that was? []

VIVIANNE CHAUMONT: I don't. Oh, wait a sec. I don't know why... []

LINDA OLLIS: I don't want you to...you can... []

VIVIANNE CHAUMONT: I don't know why $144,000 comes into my head. But I don't know why, so... []

LINDA OLLIS: Numbers people remember numbers, so. Okay. []

VIVIANNE CHAUMONT: Yeah. I'm a lawyer, two numbers, that much, so. I'm sorry I don't remember and I don't know how long it's going to be, at least six months, the project. And we will be setting up some meetings with hospitals throughout the state to get their ideas and... []

LINDA OLLIS: Or maybe the Hospital Association. []

VIVIANNE CHAUMONT: Um-hum. And working with Mr. Bird back there. So yeah, we will be doing that. Never events, Medicare just came out with a rule because of our never event us an event that never should have happened in a hospital like leaving a sponge in somebody or somebody falls out of bed and hurts themselves beyond what they were in there for. I think I may be oversimplifying those, but I think those are the type things that people can understand. There's other things... []

LINDA OLLIS: Yeah. But they say...there was (inaudible)... []

VIVIANNE CHAUMONT: ...infections, things like that. []

LINDA OLLIS: So are you looking at the original kind of like 12 never events or are you talking... []

VIVIANNE CHAUMONT: What we are going to do is strictly follow the Medicare for hospitals only and if Medicare doesn't pay for it, we will not pay for it. That's about the only thing that our MMIS system can handle. At some point we, you know, will have to look to see if we want to do something that is just Medicaid or to expand it beyond hospitals. But currently we are just going to apply the Medicare methodology. So if Medicare doesn't pay for it, Medicaid will not pay for it. I don't know what kind of budget impact that's going to have in any way, shape or form. But that's what we're doing now. We have tried to make our program more transparent and more user-friendly. That's my understanding that we had rates posted on the Web site, and instead of having like you know we pay $35.28 for this, we would have some formula up there instead of the numbers. We are moving to have numbers so that people can just look and see exactly to try to make that a little more user-friendly. We've also on the acute care side tried to align some rates. We tried to increase the primary care rates for physicians as opposed

to increasing some of the other rates. So focusing rate increases where we believe we need them to be focused to provide better access to our clients. We've also done that with the behavioral health rates. In long-term care, there's a project that we're working on that we're going to start working on as soon as I'm able to hire somebody, and it's in the process. It's not being held up because of money, it's just you know hiring. And that is the PACE program, Program for All-Inclusive Care for the Elderly. I think this is the type of program that...what it is, is the PACE provider, a contractor, is responsible for providing all of the care for a particular client. The client chooses whether or not they want to participate in the PACE program. We don't make anyone do it. I come from Colorado where the Denver area has an incredible PACE program that's been very, very successful and they're expanding it in other areas of the state. They're expanding it throughout the United States. What happens is the provider gets a capitation from Medicare for all the acute care things if, it's a Medicare person, from Medicaid for all the long-term care things, costs. And then that provider manages all of the care. So the acute care as well as the long-term care, which is very different than what we have with the PCCM program or the MCO program; they manage the entire care of the client. And if the client goes into the hospital, it's a risk program that provider is responsible for it. If they go into a nursing home, they're responsible for it. So a provider usually has it certainly in their best interests to try to keep people at home, try to keep them healthy. And it's I think...even if it doesn't save any money, I think it's a good other choice to have for our long-term care clients, and we think it also can save money. So that's PACE. The nursing facility study we're doing a study of nursing facility rates similar to what we're doing with hospitals. And that was recently awarded to Myers&Stauffer, an accounting firm from Topeka. And that is going to be I think about a year in the works, and they are going to look at, are there better ways to reimburse nursing homes. Care management in the PCCM program, we are eliminating referrals from where currently you go to your doctor, your PCP, and if you want to go to an orthopedist, you need to go to your PCP and then they give you a referral to your orthopedist. So that we end up paying for the PCP and then for the orthopedist as well. PCPs told me that they very, very seldom say, no; they just sign the referrals. So you end up paying for two visits. We

will be watching to see, you know, any increases in the line. But I think that most private insurers have gotten away from that. And when you see people who make, you know, money going healthcare get away from something that was supposed to be a cost savings, that's kind of a hint that perhaps it wasn't saving any money. So we're going to try that for a while and see how that works. I think... []

LINDA OLLIS: Can I ask just based on what you know about the program and the number of physician providers that are, you know, Medicaid participants. Do you feel like you have adequate specialist coverage to handle that? I know that sometimes it's the relationship between physicians that keeps those referrals strong. I mean, do you feel that... []

VIVIANNE CHAUMONT: You know, I don't think there's an area in Nebraska or probably in the United States that has an overabundance of physicians in the specialists. I think that we certainly could use a lot more, especially in Lincoln, Lancaster County. I don't think it's such an issue in the Omaha area. We're also looking at contracting to do radiology management, which would be a prior authorization for the high end radiology MRI/CT scans. Nebraska has a very high utilization rate compared to other states. So we are going to look at contracting that out. And then...oh, there's where I had pharmacy, in the PDL and purchasing pool. So we already talked about that. Any questions? []

KATHY CAMPBELL: I just have one last one on the report. On page 24, on item 9, you talk about in the report that you're looking at contracting with a transportation broker. One of the questions I'd have there is have we tried tying into and will the broker look at the world transit system that already exists? And you know, I'd hate to see us you know develop a parallel system that might be working. And I know in some places it works more effectively than others, but just wanted to mention that. []

VIVIANNE CHAUMONT: Yeah, and you're absolutely right. I'll start with that one. I'm

going to now move to talking about the Mercer report which has recommendations and transportation brokerage, one of those in there. So I'll start with that one. The recommendation is to hire a broker to arrange transportation services statewide. I have some experience with transportation brokers, and one of the things that they do is in the different areas look at what infrastructure is there and try to utilize that infrastructure, not replace it, but utilize it. And then fill in with contractors or with their own transportation where there are areas missing. So that would definitely be part of that. I think Kansas and Missouri I think both have the same kind of, you know, mix of very rural and then very urban areas, and they both run successful transportation brokers. So I think it's something that we need to look at. We would need to do a much more due diligence on the expected costs and other things. But it's a project that I think is worth following up on. Okay. So I'll go back then to the Mercer report. You saw that they talk about, which was initially what the report was to focus on the defined contribution versus defined benefit. And just briefly, the defined benefit is what we have now where if you're eligible, you get a defined set of established benefits that you're eligible for. Another model is the defined contribution program where you get a fixed amount of per individual, depending on their eligibility category and their on needs and things like that. And so the benefits that each individual has varies by individual and can vary from year to year. The recommendation in the Mercer report as you can see is that it's to take a wait-and-see approach, see how other states are doing. It's unclear in Florida, for instance, it's unclear whether that's saving money, costing money, providing better care, providing worse care. I think depending on who you ask, you get a different answer. Other states have smaller programs that, you know, along those lines that they're doing. So we need to...the recommendation, and I think it's one that we're comfortable with is it sit back on that a bit and see how other states do. And then on the practical side, the current MMIS can't support a defined contribution program anyway. So even if we didn't think it was a good idea to wait and see, we don't have a choice at this point. But there's some interesting things going on in other states that we need to keep our eyes on. Another recommendation in the Mercer report has to do with behavioral health. We currently have an administrative services organization, and they receive a per-member,

per-month payment for administrative services, but the state is the one who pays the bills. And the state is at risk for all of the costs of the services. The recommendation is to move to an MCO model for behavioral health, on contractor statewide. And in that model, the MCO would do the administrative services and would be at risk for the services. The cost savings like in any other managed care come from shifting costs from 24-hour care to a lesser level of care. They would do prior authorization utilization review. The Mercer report indicates that there is savings to be done there. The other good thing I think about managed care in the behavioral health setting is that the managed care company can develop and pay for services that the state wouldn't otherwise have. You know, the peer support services, what I have seen in the states that I have seen that are fully capitated, peer support services, things like club houses, even employment, they can pay for care in an IMD where the State Department couldn't pay for care in an institution for mental disease. So that is one of the recommendations in the Mercer report. In long-term care, they talk about PACE, which I think that we are set to start on. I think that's a good program. They also talk about managed Medicaid long-term care. Numerous states are moving to managed care in their long-term care programs, and there is many ways to do it. I know Arizona where I was recently a few years ago, went to ALTCS they call it, and it's fully managed care for their long-term care. The Medicaid director there says it has worked very well. Different companies have different products for that. So that was their recommendation. On acute care, currently as we talked about, we have mandatory managed care in three counties. It's the PCCM model and the MCO model. They recommend going to full risk capitated. So to MCO model in the three counties, and they...because they believe that there are cost saving there. And they... []

KATHY CAMPBELL: Are you going to go back to these one by one for comments or questions, or did... []

VIVIANNE CHAUMONT: Well, I'm hoping that you'll just interrupt. []

KATHY CAMPBELL: Okay, okay. Good, good. []

VIVIANNE CHAUMONT: So I will just be quiet, and you have a question, obviously. (Laugh) []

KATHY CAMPBELL: Let me go back to the managed care, and the only thing...on the mental health and behavioral health, and I think you're aware that we have a problem that still is, although private sector has stepped in, in Omaha, for example, that it is far from being resolved, and that we have Medicare holding providers responsible for the lack of services being provided in the state. If you don't know that, it's been percolating over the past 18 months, I would say. And I think looking at a managed care process outside of looking at the number of providers and the adequacy of the number of providers that you can push to an outpatient basis--in other words, we're talking about take people...we keep people in our emergency rooms because there are no outpatient services, and literally treat patients in our emergency room (inaudible). And so I think it would be not a very wise idea to leap into this before you look at the adequacy of the providers. And if that's part of the study, then that's great, and it should be. []

VIVIANNE CHAUMONT: That would be part of a study that would look at a rate structure and what's available. But I also think that what we have to talk about there is that there's going to be the need for some providers who currently are providing 24-hour care to shift to community care, because there won't be as much of a need for the 24-hour care facility. I understand that there are issues, but I think it's worth studying, definitely. []

KATHY CAMPBELL: As long as that is a part of it and the current providers are included, because I think that a lot of the unmet needs are really camouflaged. I mean, we just aren't aware of them. []

STEVE MARTIN: Yeah, I think we're lacking, if I'm not incorrect, both the...I mean, we

don't have the acute care. That's also waiting lists now in many situations. So the...we really have more demand than we do have infrastructure in a lot of spots in the state (inaudible). How do we stimulate more infrastructure without stimulating it is a serious, serious problem we have to resolve. []

CORY SHAW: And I guess I was going add the same comment with respect to the statewide deployment of the managed care model, is that we can talk about financing, but if we don't have the delivery system in place to actually make it work,...we can change the way it's financed, but you'll still get the same outcomes, I think. So I think on both Recommendation 1 and 4, a serious evaluation of the delivery system is needed to go along with the consideration of how you're going to structure the financing, because we could create something wonderful from a financing standpoint, but if there's no one out there to provide the service or no willing provider to provide the service, or whatever the case may be, it won't work. []

VIVIANNE CHAUMONT: As far as the acute care, the recommendation is to go full risk in the three counties, and then to do the PCCM model, basically, statewide. And there may or may not be MCOs available to those statewide. But that would be the PCCM model more. []

KATHY CAMPBELL: (Inaudible) since we do have that experience in the Douglas, Sarpy--we're missing one county,... []

VIVIANNE CHAUMONT: Lancaster. []

KATHY CAMPBELL: ...Lancaster, thank you, it would be good to pull that group together, perhaps, before and make certain the whole system believes that this is a workable system, because I know that we talk about a reimbursement level of, you know, 75 percent of cost or whatever, is kind of what we're expecting. We're probably running more like 60 percent of our cost being covered, and not being held to the same

prompt pay requirements creates a big problem for us, as well, because they're extremely extended payment systems. []

VIVIANNE CHAUMONT: I understand that there are problems along those lines, and I'm assured that they are being worked on. But you know, it would be nice to have some competition in the state and be able to draw, you know, MCOs that compete against each other, which would be the best. []

KATHY CAMPBELL: But once again, not on the basis of just extending the payments, to say, yeah. (Laugh) []

VIVIANNE CHAUMONT: Well, no. You know, providing the care that's necessary in a timely fashion, you know, paying to providers. But I'm more than (inaudible), so. So we already talked about transportation. Durable medical equipment--they talk about competitive bidding to supply DME, and I don't know if any of you are familiar that Medicare was set to go on this grand scheme to competitively bid the DME, and that was supposed to save the Medicare program a lot of money. And I heard a presentation from them about that, and it seemed like they made things a little more complicated than they needed to--imagine that! But that program has been put on hold. I think one of the main issues with the Medicare will be one of the issues that we have with Medicaid, and that is, you know, where there are a lot of providers in the urban areas, it works out pretty well. In the more rural areas, it may work less well, and then there's the issue of putting small providers, you know, potentially out of business. So that's one of the recommendations. It would have to be really looked at very carefully. On the other hand, I think DME is a very fast-rising area of Medicaid expenditure throughout, and so I think that we do need to try to do something about DME. Dental services--their recommendation is to investigate an administrative services organization to prior authorize and do utilization review, but without better data they don't know if this would cost money or save money. So obviously that one we would have to take a very serious look at. []

CORY SHAW: So the assumption there is that it's not so much that the state's system, the claims system, is inadequate or that we gain something incrementally by adding providers to the system, because an ASO organization might be more effective. It is that there is a question about whether or not maybe we're seeing some consumption of resources that might be avoided if we did a little more utilization review. Is that kind of the premise? []

VIVIANNE CHAUMONT: Well, I think that what they say is utilization management may lead to services. I think there's also a concern that, you know,...a concern would be that if an ASO is able to expand a network, that will in fact cost more money. So is there enough in utilization management to offset potential for increased access? After 21 years of working in Medicaid, I'm still looking for an easy issue. (Laughter) So if any of you know of one, please let me know right away. Benefit changes--they also talk about...so they talked about the defined contribution. I think we've talked about that. They talk about increased copayments for adults and copays and premiums by income. And then they talk about other benefit issues that we need to take a look at, DME again. Even if we don't go to a competitively bid supplier, there's issues that need to be addressed there. Home health is also growing very quickly. Assisted living--they talk about emergency room...avoiding emergency room, increasing the program integrity activities, and then avoidable inpatient costs. So that pretty much, I think, takes care of that report, so. []

DON PEDERSON: Quarter of twelve. Aren't we glad we didn't do a PowerPoint? (Laugh) May I ask a question? You just received this Mercer report October 1. What is the expectation of your use of the Mercer report? What's the next step in connection with that report? Do you... []

VIVIANNE CHAUMONT: This is one that I believe you folks are to give us input, and then we will do a final report, I think, where we will say we're going to look at this, we're

going to, you know,... []

CORY SHAW: On page five it says that we've got to have a final report by December 1, so we've got a 60-day... []

DON PEDERSON: Yeah. So you've got to come back with your recommendations before December 1 in connection with the Mercer report; is that... []

VIVIANNE CHAUMONT: Right. We'll have to do a final Mercer report by then, which is I think the same issue with the biennial report. A final is due December 1, as well. []

DON PEDERSON: Unless you wanted to, I don't think it's necessary to go through that biennial report that you've got, the third report. []

VIVIANNE CHAUMONT: The 30 point? You don't want me to go through it? Okay. []

DON PEDERSON: What do you think? []

CORY SHAW: Which one is that? []

_____: The buy-in program. []

DON PEDERSON: The buy-in program? []

CORY SHAW: Oh. I didn't get a chance to look at that, so I didn't do my homework. []

DON PEDERSON: You can just briefly mention the buy-in program, if anybody has a question about it. []

VIVIANNE CHAUMONT: Okay. LB928 required the department to develop

recommendations. We currently have a program, MIWD. It's known as medical insurance for workers with disabilities; has about 100 participants. The way we determine eligibility, it's very complicated so I'm get going to try to...the way we determine eligibility is by looking at the federal benefit rate of $637 a month, whereas Medicaid eligibility, to become eligible for Medicaid you look at an amount of $867 a month. So you have the situation where someone can be eligible for Medicaid but not eligible for the MIWD. And basically it's a program for disabled persons to buy into the Medicaid program and work. So they pay a premium. Depending on how much money they're making, the premium, you know, varies. []

DON PEDERSON: This results from an effort to try and get people, if they wish, to get back into gainful employment and then buy in (inaudible) Medicaid. []

VIVIANNE CHAUMONT: Exactly, exactly. []

DON PEDERSON: And some of those...I thought it was interesting to observe that they'll go forward, and then they'll, for whatever reason, become disqualified from it. And it creates a mechanical problem to keep them in the program. []

VIVIANNE CHAUMONT: Right. One of the other options that's out there is a medically improved category, to have a medically improved category. And that's one of the issues, particularly of people with behavioral health issues. They go on their medications, they're able to work, they're able to contribute. Then they get knocked off the program because now they're not disabled anymore, and then they can't afford their medicine. And so it's a cycle with that. So the three options are to increase the disregard from $637 to $867, like we talked about, to recognize the medically improved category which, by the way, the feds still have not passed regulations on, even though it's pretty old legislation. And so the states are kind of in a bind as to building a program that they don't know, CMS could come and say, you did it wrong and so we're not paying for that. Unfortunately, we are unable to come up with any data that guarantees that any change

to the program will not increase Medicaid costs. The data that we have we are unable to know how many people, you know, went off the Medicaid program because of work, or came on the...we just don't have the data. So we're unable to estimate the cost impact, and therefore, because Medicaid reform is not to expand, our recommendation is to leave the program as is. []

DON PEDERSON: Any further questions for Vivianne? It's kind of like being on the witness stand for half a day, isn't it? (Laugh) Thank you for your report. []

VIVIANNE CHAUMONT: All right. Thank you. []

DON PEDERSON: Now if I don't do this now I'll forget it completely, but we had minutes of the last meeting. Is there someone that moves to approve those minutes? []

KATHY CAMPBELL: Mr. Chairman, I would move to approve, with the deletion of the second sentence. Either Senator Pederson called the meeting to order or I did. I do not think both of us did. I think that was just a carryover from the month before. []

DON PEDERSON: When I wasn't there. []

KATHY CAMPBELL: When you were not there. []

DON PEDERSON: Yes. []

KATHY CAMPBELL: So if we delete that sentence, I'd move approval. []

STEVE MARTIN: Second. []

DON PEDERSON: All in favor say aye. Opposed? Okay. Well, those minutes are approved now. Now we have the opportunity to hear from any of you who would like to

be speaking with us, and I would ask that you limit your time, because we are limited in time. Limit it to five minutes, so Mark, if you want to sign in. Just thought we might see you. []

MARK INTERMILL: Yeah. And I will not use the five minutes. My name is Mark Intermill. I'm the associate state director for AARP here in Nebraska, and I just wanted to offer a couple of comments about the recommendations from the Mercer report. But before I do that I need to say that I am among those who don't believe that the trends point to an unsustainable Medicaid program. We've been tracking Medicaid spending for a number of years, comparing it to state revenues; and over the past six years, revenues have grown at a rate that's twice the rate of growth for Medicaid. So I just wanted to make you aware of that, as well. The two areas that we were interested in in the Mercer report were long-term care and transportation, and I will say that we firmly support the recommendations as they relate to the PACE program. That is an excellent program, and it's one that I've wanted to see established in Nebraska for a long time. I think the challenge is whether or not we have enough individuals who are both eligible for Medicaid, Medicare, and have nursing facility level of care to make the program work. But I think it's worth giving it a try. With regard to Medicaid managed long-term care, I'm more skeptical. What we have seen over the last few years is a reduction in the number of persons who are over the age of 65 who are using Medicaid. In nursing facilities we've seen the number, the average daily census, drop from 7,137 in FY 2000 to 6,462--that's a 9.5 percent reduction over a seven-year period. I think what we have is working, and what we have is a system of using area agencies of aging to manage in-home, long-term care services through the waiver. I would also agree that the senior care options program has been of benefit. That's a Medicaid preadmission screening program for Medicaid-eligible individuals going into a nursing home. What we don't have in that program is preadmission screening for the non-Medicaid eligible. So what has often happened is that a person enters a nursing home not being eligible for Medicaid and with a matter of months becomes eligible, and they're already in the nursing home. So that may be something for this group to consider, is to look at expanding that

preadmission screening program to include those who are not eligible at the time of admission. In essence I think with regards to Medicaid managed long-term care, I don't think we have a problem that requires that level of a solution. So I would recommend that that be something that we pass on at this point in time. Transportation--the broker system, I think, is an excellent idea. AARP has been working with a coalition that is of transportation providers that we've just been working on for a few months. What we have found is that there is a need for better coordination of transportation services, and that's what we're working on, trying to get those transportation service providers, if they're going from St. Paul to Grand Island, to pick up somebody in Carroll on the way, and that's not happening right now. So we see the Medicaid brokerage system as a way to make that happen, if Medicaid is engaged and if they're demanding coordination that could help the process of the entire public transportation system in Nebraska. So that essentially is what I wanted to bring to you today. We like PACE, we like transportation brokers. We're not too thrilled about Medicaid managed long-term care, and we're not sure there's a sustainability problem. []

DON PEDERSON: Thank you, Mark. Any questions for Mark? You probably noticed in the draft report that there are 10 percent increases in the slots available for the waiver program for Medicaid. I don't think they're being used currently, but at least it's available, and a better assessment might limit the number, in that respect. []

MARK INTERMILL: And for my...what I'm hearing, particularly from the area agencies on aging in rural Nebraska is that they may be approaching the point where the Medicaid waiver market is saturated. I don't think that's the case in Omaha. I don't think it's necessarily the case in Lincoln. As I see it, we've gone from 17,000 nursing home residents in 1994 to 13,000 today. If we were at the national average, we would have 9,000; so there is room, I think, for additional savings in Medicaid. We just need to make sure we get the slots at the right places. []

DON PEDERSON: Thank you, Mark. Appreciate your report. Anyone else? Would you

sign in, please, or have you? []

KATHY HOELL: I did. []

DON PEDERSON: Thank you. []

KATHY HOELL: Senator Pederson and members of the Reform Council, my name is Kathy Hoell, H-o-e-l-l. I'm the executive director of the Nebraska Statewide Independent Living Council. SILC is a nonprofit organization that is mandated (inaudible) back to 1973, as amended in 1992. So for three years SILC has been advocating for changes in the current Medicaid Insurance for Workers with Disabilities program, or as we fondly refer to it, the Medicaid buy-in. The recommendations has never applied to people that were not already on Medicaid. Our recommendation has always been to incorporate the flexibility of the '99 Ticket-to-Work program, while avoiding the pitfalls of the earlier balanced budget act of 1997. According to the department's (inaudible) report, the BBA allows states to provide Medicaid to working individuals with disabilities who would otherwise be eligible. It does not mandate it. The state could simply include the requirement that a person be already on Medicaid to be eligible for the enhanced buy-in. No additional people would be eligible, despite anything you've been told. People who are not on Medicaid would not qualify for the buy-in, period, end of sentence. Our recommendation is to include people who would be deemed medically improved and to increase the assets and income levels as allowed on Ticket-to-Work but not to offer Medicaid to individuals who aren't already on Medicaid. The department is using convoluted logic, in our opinion. According to them, more people using the Medicaid buy-in program would mean more people on Medicaid. In reality, it's the same number of people that are on Medicaid. (Inaudible) the department has not provided a comprehensive analysis. It has not provided information which the Medicaid Reform Council and the Legislature need to make informed decisions on the people with disabilities who start to return to work. They have not considered the impact of enhanced buy-in on people with disabilities...impact of becoming gainfully employed

and reducing their dependency on the state. While it may be true that some people would be leaving the Medicaid rolls at a slower rate by going to work, you cannot assume that all would be able to work. I'll give you an example. Senator Pederson, imagine you were on Medicaid because of a disability. Say you had cerebral palsy and you were offered a full-time job at $12.50 an hour, which is about $2,100 a month. Who would turn that down? So you accept the job. You would immediately become ineligible for Medicaid, including the buy-in. If your employer offered insurance, you would immediately begin paying a premium of $100-$200 a month, leaving about $1,900 to pay for housing, utilities, phone, transportation, and everything else you needed, plus any healthcare that's going to come up. And before your insurance kicks in, which is usually about three to six months, but if your CP is a preexisting condition, the way a lot of policies work your preexisting condition doesn't get covered for anywhere from a year to two years, depending on the policy. And then it doesn't cover things like personal assistance services at work or at home, and durable medical equipment or medical transportation, speech therapy, or physical therapy, all of which you might need in order to take the job in the first place. So what do you do? You're forced to remain unemployed, you're forced to stay on Medicaid, you're forced to do whatever you need to do in order to take care of yourself. Increased participation on the buy-in would benefit everyone. Thank you for your time and consideration. If you have any other questions, I'd be glad to try to answer them. []

DON PEDERSON: Any questions for Ms. Hoell? I think you pointed out a lot of the concerns we have about that buy-in program, yes. Thank you for your testimony. Are there any others that wish to speak? I see you've signed in. []

LINDA JENSEN: Yes, I have--right there. Okay. My name is Linda Jensen, L-i-n-d-a J-e-n-s-e-n. I am president of the board of directors for NAMI Nebraska, which is the National Alliance on Mental Illness. We are the largest organization of consumers, family members, and providers in Nebraska and the U.S., concerned with seriously mentally ill. This week is Mental Illness Awareness Week, and how coincidental that we

are also celebrating the passing of mental health insurance parity. I don't know how many of you know, it's part of the bail-in, bail-out--whatever it is--bill. []

DON PEDERSON: A number of things are in that bill that we didn't even know about. (Laugh) []

LINDA JENSEN: Well, there's one good piece. (Laugh) I don't know about the rest. I don't understand all that, rather, but that's one good piece. And so we hope that that will result in less people needing to have Medicaid pay their healthcare bills for behavioral health services eventually, you know, because now they will be covered under their own insurance, if they have insurance. So as people develop mental illnesses...unfortunately, we haven't found a cure, so we can't prevent...in a lot of times we can't prevent. My own son developed schizophrenia when he was 20. There was no way, you know, we could have prevented that, unfortunately, a chemical imbalance. So anyway, I share the concerns that several of you raised about placing behavioral health under managed care. You are aware of the disaster that we had when it was under managed care a few years ago, and Richard Young Hospital was closed and several other hospitals were closed. St. Joe's was closed. So we really need to take a hard look at that proposal. You know, Lasting Hope is open now and there is some infrastructure being put in place. Thanks to the behavioral health reform, there's more community infrastructure, but it's still fledgling. It's still very vulnerable, and you know, I'd just hate to see any services go away, because you all know what has happened. And you know, we see more people in prisons, unfortunately, who have mental health issues. Some of that they're blaming on the fact that we don't have as many beds available at the regional centers. I don't know the exact cause of everything. So I do hope that you will look at that proposal with caution. I'm a professor of nursing by profession and I teach healthcare delivery, so I do understand the concerns of rising costs of Medicaid. And I would agree that sometimes there are unnecessary expenditures. Now I don't know about in behavioral health as much as, you know, physical health and the whole total picture, but we do definitely need a better focus on wellness and preventive care and

preventing complications. And so please try to include those types of things in any of the contracts. You know, if you can have people learning to exercise and eat better, or stress reduction, you know, all those different things, that could help people stay more well. I also share Kathy's concerns with the recommendation on Medicaid for workers with disabilities, because we have many people in our organization and our friends who have like a severe mental illness such as schizophrenia, bipolar, depression, and yet it can be controlled with medications, and also some peer support, some extra support. And they can take jobs so they can be "medically improved." But if they lose their coverage...now it may be a little better, since maybe they'll have health insurance, mental health insurance coverage through their job. But still, if they lose that coverage...because it's pretty expensive. My son's bills would probably be $1,000 a month at least, just for his medications; medication, and I should say, oh, all the blood tests you have to have, and all the follow up, you know, medical care. So anyway, I thank you all for your service on this committee, and just, you know, the cautions. And we would...I know there would be possibly advisory committees for when you set up those contracts. We certainly want to be involved in those, because hopefully we can prevent some of the disasters that happened before. Thank you. []

DON PEDERSON: Thank you. Any questions? Thank you. Any others? []

JENNIFER CARTER: (Exhibit 3) Good afternoon. Now I guess...my name is Jennifer Carter. I'm the director of the Health Care Access program at Nebraska Appleseed. I'm also their registered lobbyist. And for those of you who don't know, Appleseed is a nonprofit, nonpartisan that advocates on behalf of low-income Nebraskans, children in the foster care system, and new immigrants. I just had a few comments to make on mainly the alternative benefits report; although first, I would say we believe, as Mark does, based on the analysis, that Medicaid is not growing in quite the way we thought it was in 2005. And actually our main concern then and now is that a lot of the recommendations were based on the idea that Medicaid was growing at 12 percent, because they looked back 20 years, in which the S-CHIP was created, there were

changes in long-term care. There was no correction for those anomalies. And so there was, I think, a greater sense of urgency than needed to be. That doesn't mean that we shouldn't be looking at these programs to have them run more efficiently, save money. We would agree with that. But I think what it does mean is we have a little bit more time to try to get this right, that the sky is not falling in quite the way we thought it was. We're not outpacing the state's revenue growth at this point, and so let's take the time to make the right choices. And I also really appreciated Mr. Martin and Mr. Shaw's comments about the cost shift, not only leaving federal dollars on the table, which I think has an economic impact in the state, but when you do cost shift to the private sector, that matters. And we really, Appleseed would really appreciate if we could have a conversation that was broader about, where does it make sense to spend our money, for Nebraska taxpayers? Because it doesn't necessarily...you know, I know nobody likes to spend money in Medicaid--I mean, we do, sometimes, because we think it works. But you know, maybe that's the place we need to spend it, because it will be more expensive somewhere else. And how can we spend it most efficiently, to benefit the beneficiaries in the best way, and also not run up costs that aren't necessary to the state? And so we would actually hope that you would consider that as part of something that you could speak to as a council when you're advising the HHS Committee, and encourage them to take that broader view, as well, so that we're not just looking at Medicaid's bottom line but what's really best for the state overall. And so that's an overriding point that we wanted to make. But separately, our two main areas were moving to the full risk managed care. I mean, we appreciate and recognize that managed care is happening all over the country in Medicaid, and that when done well and done right, it can work. But we have some concerns that weren't addressed in the Mercer report about how this is going to happen. What are we going to contract for? Is it going to be for the full benefits due under Medicaid? Because in some states they've set up contracts where they didn't contract for all the benefits and the state is on the hook for the rest of the benefits, and you've got sort of a fractured system going on. What is the mechanism for oversight? Because I think we hear regularly that sometimes it's really difficult, and the state maybe has not been as strong at oversight in several areas,

and so I'd be also concerned about that as we went forward. We, of course, would also agree that you need to have at least more than one managed care organization, not only bidding on this, but I think working there, so that folks, if one is doing a really bad job, have an opportunity to go somewhere else and we can recognize what's happening in the market. Also, how are we going to ensure access to quality care--not only access, but also access to quality care, and making sure there are enough providers? One of our biggest concerns was why we haven't taken more of a look, as several states have done, at strengthening our primary care case management systems. I have a little...North Carolina is winning awards, saving millions of dollars, with a primary care case management system, which maybe you're working...having work in conjunction with managed care. But they've got a lot more providers on board, providers are happier, they're saving lots of money because they have these coordinated care centers where the providers are getting a lot of feedback on, are people using their prescriptions? Somebody is centrally dealing with that person's care, so we're not duplicating efforts and duplicating tests. And they've had great success there. Illinois, I believe, has also moved in that direction, and they're seeing a lot of savings. So we would like to see the council and HHS consider moving maybe more in that direction in conjunction with managed care, rather than full-risk managed care. I think the fundamental difference to me, in part, is orientation. If you're doing primary care case management, your focus is on what is right for this beneficiary. How do I get them the most efficient care, preventative care, and get savings in that way? If you're a managed care organization, your focus is the bottom line a little bit more, and you've got a profit incentive. And so not that...again, as Director Chaumont said, you know, hopefully that's their incentive, too, is to make sure that you're getting the preventative care and the care coordination that you need to save money. But I think when your real focus is the bottom line, there are going to be times where folks are not getting services that would save us money down the line and again avoid that cost shift. And so that's why we would really like to see somebody taking a look at strengthening our primary care case management system. And we sort of agree it would be great if we could expand that to the state, to the whole state, from the three counties that it's currently in. And actually,

there wasn't a huge indication in the Mercer report, to me, as to what the difference would be in savings between an MCO and a PCCM. And I know in the biennial report it looks like maybe $2, but we don't...you know, oftentimes it's self-selecting. We're talking about healthier groups, and I think the PCCM would be working with everybody, so that you might have a little better help there, and less administrative costs, because you're not paying the MCO as much money. So we would really appreciate folks looking at that. And then really, another concern is have is cost sharing and the copays and the premiums, particularly if the intent is to apply this to the Kids Connection program, which is the only program over 150 percent of the federal poverty level, but I know we were also talking about populations with no...where you don't look at the parents' income, which is, I think, the Katie Beckett program, so we're a little confused as to who we're talking about here. But generally speaking, this is not the greatest cost-saving strategy. It's more of a cost-shifting strategy, again, to the private market. You see a lot of...as we discussed a little bit last year, you see a lot of delayed care, drops in enrollment, which we think doesn't really...it's not, overall, going to be helpful. And there's another report I have here. Arizona recently...actually, I believe it's 2006, when they were looking at cost sharing. It's a very interesting study, that the administrative costs would outweigh the savings in imposing copayments and premiums in their program. And in part they recognize over and over that for the state as a whole, this could be problematic if people are delaying care and we've got more expensive care down the line. And not only that, but I think the biggest concern for them and for us with that, by law you cannot charge copays and premiums above 5 percent of the family's income. And how are we going to monitor that? And that's where the real administrative burden comes in, and that's, I think, where they were concerned about the cost in Arizona. Whether this new MMIS system will do that or not well enough, we don't know. We are highly concerned about the shoebox theory and that the family should keep track of their own receipts. On what? The private market rate, or the Medicaid reimbursement rate? How do they know? And it's the state's burden not to charge that, and I don't know that they can legally shift that burden to the families to come in and have to prove the 5 percent. So I mean, above all we really don't want to see the

shoebox system happening if we do copays, and so our other concern is why there is a recommendation for next year, it seems, or in the biennial report, to move to copays and premiums when the Mercer report seems to acknowledge we don't have the capacity right now to monitor this appropriately. Other than that, we agree with HHS and with Mercer that we need to wait and see on defined contribution. We have many concerns about defined contribution that I won't waste your time with now, for waiting and seeing. But we hope...I think there would be a lot of concerns moving in that direction. And the only other thing I would say is on the dental. I appreciated the conversation about the dental caps and coverage, and I will say we have an intake line, and we've heard from both dentists and patients. And I think it's going beyond the folks who just have an emergent situation that's going above $1,000, where they could end up in the emergency room and treat that as a medical cost, which again, we don't know if that's the most efficient way to run your system. But separately, most dentists, which we can appreciate, are concerned about being on the hook for anything that would cost over $1,000, and they're making folks sign statements that they will cover any costs above $1,000, and it's hard to totally anticipate where your costs are. So we're hearing that a lot of people are foregoing the preventative care, even though that care might cost less than $1,000, because they're not sure what's happening down the road. It's a root canal now, but what do they need after. And so we still have some really serious concerns. And as Mercer recognizes, a lot of states are doing more with their dental programs, because they recognize how important it is to overall health and cost savings, and that way keeping it out of your medical costs. So those are our thoughts, and we'd be happy...we work with a coalition of folks that I think in the past, you know, we've submitted responses to this group. And actually we were very pleased as a coalition to see that HHS has actually thought about and tried to implement several of the recommendations that we made long ago in 2005, like the preferred drug list, the HCBS waiver, counter detailing on drugs. All of that we really appreciate. We would like to also offer a written response, but it was a very quick turnaround time, so we couldn't quite do that appropriately. But I didn't know if you expected to have another hearing, if there's a time in a couple of weeks out or anything that would be more helpful than not for a

written response. So if you have any thoughts of that; otherwise, we would just try to turn it around, I guess, as quickly as possible. But if you had any ideas, we'd appreciate it. []

DON PEDERSON: We haven't talked about that. []

JENNIFER CARTER: Okay. Well, maybe we'll just aim for a couple of weeks from now. []

DON PEDERSON: Would you furnish copies of your reports to Vivianne Chaumont, so that she can have that information for the report? []

JENNIFER CARTER: Oh, sure. I have extras, yeah. []

DON PEDERSON: Any other questions for Jennifer? []

JENNIFER CARTER: Do you want me...can I just leave this here? Or do you want me to pass them out to you guys? []

DON PEDERSON: You can submit them...you have enough for us, too? []

JENNIFER CARTER: I do, yeah. []

DON PEDERSON: Oh, okay. That would be fine. []

JENNIFER CARTER: Well, not the room, but you know (inaudible). []

DON PEDERSON: Sure. We'd be glad to see them. Thank you. []

JENNIFER CARTER: Okay, thanks. []

MARY ANGUS: (Exhibit 2) I assure you that my presentation is quite a bit shorter than a lot of the previous ones. Good day, Senator Pederson and members of the Medicaid Reform Council. My name is Mary Angus, M-a-r-y A-n-g-u-s. I'm the registered lobbyist for the Arc of Nebraska. The Arc is a support and advocacy agency which is statewide and an affiliate of the Arc of the United States. We work with people with developmental disabilities. We live by the core values of mission and principles of the Arc of the United States--people first, democracy, vision, leadership, community participation, diversity, integrity, and excellence. And yes, that's a lot to live up to. The steps that you take as you work to reform Medicaid have an incredible impact on the lives of people with developmental disabilities. Two years ago with your help, and Director Chaumont mentioned this earlier, Nebraska was granted a demonstration project to move people out of institutions. Using Money Follows the Person, Nebraska will move 200 people with developmental disabilities out of intermediate care facilities and nursing homes. Medicaid has been integral to the provision of services for people with developmental disabilities, both in institutions and in the community. Currently, the cost per person, for instance, at Beatrice State Developmental Center, by department reports, is approximately $200,000 a year. Those same people, on an average, would be using approximately half of that in the community. The Arc of Nebraska supports the statements of the Nebraska Statewide Independent Living Council, and previous testimony of the Nebraska Advocacy Services, both before this council and in front of the Health and Human Services Committee of the Legislature. People with developmental disabilities want the opportunity to move into the community, to stay into the community, and to work in the community. Many of the services they need to do that can only be provided under Medicaid. As you've heard, private insurance does not cover many of these services. Please keep that in mind as you ensure the sustainability of Medicaid. In addition, I'd like to comment that I was pleased to hear some of the comments that Director Chaumont had about the wait-and-see type thing and the questions that you have all asked, in terms of other impacts. It's been very, very difficult to be able to tease out some of the other impacts that have been mentioned previously.

Just one piece on the Money Follows the Person project. I'm on that steering committee for another organization, and at the last meeting we were told that approximately six people have been moved out of different institutions under that program. As Director Chaumont mentioned, it took a long time to get approval for what was our protocol for that program. Also what she mentioned to you is very important, and that is that are state is using the same waiver system as we are using for others who are already in the community or out of an institution. So those services would not be decreased afterwards. We are using the enhanced match for that first year after transition, and being able to use transition specialists. So I'm really pleased to be able to report that. I think as you go forth with your recommendations it's important to remember that as you may cut services, you may also be cutting the possibility of people with developmental disabilities to remain in the community and living with the caps that may be in the future provided, and that it would be very important to look at what those other states, and I appreciate that wait-and-see attitude that we've been shown. Thank you for your service to the people of Nebraska, and I'd be happy to answer any questions. []

DON PEDERSON: Thank you, Mary. You and your organization do a wonderful job. []

MARY ANGUS: Thank you very much. We work really hard to. []

DON PEDERSON: Are there any other questions for Mary? []

MARY ANGUS: Thank you very much. []

DON PEDERSON: Thank you. []

MARY ANGUS: And I left a copy of the... []

DON PEDERSON: Good. Thank you. Is there anyone else that would like to speak? []

J.ROCK JOHNSON: I want to thank the council for your dedication and your time and the talents that you bring to this important work. My name is J.Rock Johnson, J-o-h-n-s-o-n. Director Chaumont made an excellent point in the example about securing funding for discharge planning. We do not leverage our fiscal opportunities or sometimes even know about them, because we are not organized in a fashion that would enable us to get that information. What we need is a single point of contact. This single point of contact within the state structure would promote accountability and transparency, and improvement in the quality of services for the people of Nebraska. This has been suggested many times, and I think the need still exists and is even greater now, when we have to make the very best work that we can out of the least that we may have. I also have not heard or read, and perhaps this is a gap in my understanding, but I've heard discussion about 1915I and 1915J, as being mechanisms within the Medicaid structure that are not waivers, that are options within the state, and that have to do with self-determination. And it seems to me that's one of the things that is a theme that's running through the work, as people being able to bring their skills and take advantage of new thinking and opportunities that are out there. As to the Workers with Disabilities coverage, that the division was unable to come up with any data does not preclude a pilot program; that CMS has not yet released guidelines nor have they done so in the last ten years for medically improved coverage does not preclude a pilot program. If the criterion for Medicaid's bottom line is to cut rather than get people who can and want to work and have at least a ten-year work history back to work, then we're missing an opportunity. Nebraska needs workers, motivated workers. That should motivate the state. It is possible to know the cost of everything and the value of nothing. A pilot program would generate data and help people who want to work get back to work, and give us information we need to make ongoing decisions. Thank you. []

DON PEDERSON: Thank you. Any questions of J.Rock? If not, thank you very much. Are there any others that wish to speak? If not, I will close the public portion of the hearing. We as a council need to talk just a little bit about what is our next step. []