[]

KATHY CAMPBELL: Good morning. I'm Kathy Campbell and I will convene the meeting of the Medicaid Reform Council. Senator Pederson sends his regrets that he cannot be here today. He had knee surgery last week, and it was a scope, and he's doing very well. And he had planned, typical Senator Pederson, had planned to be at the Missouri football game right after his surgery, but the doctor had other ideas. And he is getting along well. But I think the idea of not being able to kind of prop his foot up...but he's doing just really well and sends his best regards to everybody on the Reform Council. With that information in hand, and we also have several other people who could not be here today, so I think we have the full compliment of the panel that will be sitting today. I will go ahead and ask for an approval of the agenda as printed and sent out. []

_____: So move. []

KATHY CAMPBELL: Is there a second? []

_____: I'll second. []

KATHY CAMPBELL: There's a motion and a second. All those in favor, please say aye. Opposed same. The agenda is approved. The minutes of the March 14, 2007 meeting were mailed out or sent electronically to us, I guess. Are there any corrections or changes that you want to make? I would like to make one change on them. I believe that I was absent. Now, I'd like to say that I have the best of memories here, (laugh) but I believe that I was ill that day and called Senator Pederson. So we need to show me as absent from that. With that correction or change, is there a motion to approve the minutes? []

_____: So move. []

KATHY CAMPBELL: Is there a second? []

_____: I'll second. []

KATHY CAMPBELL: There's a motion and a second to approve the minutes, as amended, for March 14, 2007. All those in favor say aye. Opposed same. All right, we'll get into the meat of the meeting here. The fourth item on our agenda is the presentation of the Medicaid report. Vivianne is here with some staff members. And we are delighted to welcome her to, I think, is this your first meeting with us? []

VIVIANNE CHAUMONT: It certainly is. []

KATHY CAMPBELL: Well, we are delighted to have you with us. I should say for the panel, Senator Pederson had a great idea. And he suggested that we have lunch with Vivianne so we could kind of introduce ourselves and talk a little bit about the report. And we had a great lunch and we were very excited about the ideas that were coming forward. []

VIVIANNE CHAUMONT: Thank you. []

KATHY CAMPBELL: (Laughter) Does anyone know how to adjust the chairs here? That usually happens to me. You want to try that one? I don't know how to adjust the chairs here. That must where they have... []

VIVIANNE CHAUMONT: You know what it is, this is a lot lower, that's...that's what it is. []

KATHY CAMPBELL: Oh, I thought maybe that was just a special chair they had for witnesses,... []

PAT SNYDER: They do, they want them lower. (Laughter) []

KATHY CAMPBELL: ...for the testimony they want to make sure... []

VIVIANNE CHAUMONT: I'd be happy to rest my chin on the table. Not a problem. Thank you very much. It's my pleasure to be here today at my first meeting. And I've had the pleasure of meeting some of you, but not all of you. So I would love to get the opportunity to meet you all individually at a later time. We're going to get right to the CHIP report, which Deb Scherer is going to present. Before we get started on that report, I just want everyone to be real clear that what we are presenting is what the report says. And we're just going to go through basically the report. And that is not the administration's position on any one of the options or on, you know, what to do with the CHIP program at this time. We haven't had those discussions. So right now we're just presenting to you what the report says []

KATHY CAMPBELL: Can you all hear her in the back? I know some of you...probably need to...it's on, they probably just...they make it really difficult--a low chair, high mike. But if you cannot hear in the back, feel free to move forward or to raise your hand, because we do want to be able to have everyone hear. Oh, Jeff has gotten a new chair for you. Boy, that's going to be a lot better. Ah, it's the Goldilocks chair. (Laughter) []

VIVIANNE CHAUMONT: Thank you. Really, just right. (Laugh) All right. So we're just going to get...what I had said earlier was, for anybody that didn't hear it, that we are only reporting on what the report says, and the administration has not...we have not really sat down to discuss any of the options in the report and where we're going forward. We want to present the report to you, get your input, get public input, and then go from there. So without much further adieu, I'd like to introduce Deb Scherer. Deb is the unit manager of the operations unit at the department, and she is the person in charge of the CHIP program, and has been for years. And Deb...so, Deb. []

DEB SCHERER: (Exhibit 1) Not that many years, but since the inception of the State Childrens Health Insurance Program, which was authorized by Congress back in 1997 with the authorization of Title XXI of the Social Security Act. And that's when Congress provided funds for the states to provide healthcare coverage for children in the states that were in incomes...in families with income levels above the Medicaid income guidelines but that were uninsured. And states were given the options to develop programs under three different models, one would be Medicaid expansion. And under those models then the states followed the eligibility rules and the guidelines of the Title XIX program of Medicaid or separate CHIP programs, which then the state could use additional flexibility in eligibility and assigning benefits and have a separate CHIP program or Childrens Health Insurance Program or they could have a combination program, and they could have some children that would be in Medicaid expansion and some children that could be in an SCHIP. September 1 of 1998, following LB1064, Nebraska implemented the Kids Connection program which is our Medicaid expansion program that covers children living in families up to 185 percent of the poverty level, and those are children who were age 18 and under, from birth to age 18. So we'll go ahead, with that little bit of background and try to figure out what I need to do here. Get started. So the report that has...that's being presented to you today, why do we have this report? The department has developed the Medicaid Reform Report. And with the Medicaid Reform Report we looked at different options and looked at what the trends have been for the childrens healthcare coverage. We also, under Medicaid reform, are looking to ensure long-term savings and stability in the program, including the Title XXI or CHIP program. And also this report is required by state statute under LB1248 which was passed in the Ninety-Ninth Legislature, Second Session which was in 2006. Our current Nebraska model for our Title XXI or our CHIP program has all the benefits of the Medicaid program for all the children that are in the CHIP program. We use the same delivery services for those services which means that they see the same doctors, they go to the same hospitals, they're all in the same network. Those clients that live in Douglas, Sarpy and Lancaster County are enrolled in the managed care plans. Everything is the same as far as delivery of service. We use the Medicaid fee schedule

for paying the claims that are submitted for their services. It is an entitlement program because it's a Medicaid expansion which means if someone applies and they quality, they meet the income guidelines and the other eligibility guidelines, they are enrolled in the program where they are found to be eligible, they're entitled for eligibility. We do have federal funding available for our Medicaid expansion program after our CHIP allotment, federal allotment is exhausted. So we get a certain amount of money for our CHIP program every year from the federal government. If we happen to exhaust all of that, like we did this year, then we can go from our enhanced CHIP match to our Medicaid match which is a lower match rate than the CHIP match rate. But we still do receive some federal match rate under our Medicaid expansion. The limitations of our current model being a Medicaid expansion is that we don't have any flexibility of benefits. The children that are enrolled in the CHIP program are required to receive all the same benefits as the children that are enrolled in the Medicaid program. There is no cost sharing that's allowed for children that are age 18 and under or very limited cost sharing for children. It does not allow children who have health insurance to be covered under the CHIP program and that's a Title XXI regulation. And we are not allowed by have enrollment caps because it...or waiting list because it is an entitlement program. So if they are found eligible we do need to provide them with health services or enroll them in the program. And the benefits that are provided do not mirror those of the commercial market. Can't quite figure out how to... []

CORY SHAW: Deb, can I ask you just a question... []

DEB SCHERER: Sure. []

CORY SHAW: ...on that statement? When you say that the benefits don't mirror the commercial market and I think we kind of talked a little bit about this before, but can you just expand a little bit on that in terms of what...I mean, obviously the cost sharing piece is different than the commercial market. But in terms of benefit coverage the things that are covered services what are we talking about in terms of substantive variations? []

DEB SCHERER: Some of the things that are required are like the...what we call the EPSDT benefit package, Early Periodic Screening, Diagnostic and Testing, which are preventative healthcare services which covers, you know, the physical exams at a certain age group, the immunizations and those kind of things. And if something is identified we're required by law to make sure that treatment is covered. []

CORY SHAW: And again most commercial benefit plans cover those but maybe not...with no cost sharing. []

DEB SCHERER: Right. []

CORY SHAW: So that's why I just wanted... []

DEB SCHERER: Right and not to the same degree that the Medicaid program does. []

CORY SHAW: Okay. []

DEB SCHERER: We also have, you know, we have a pretty extensive Medicaid program... []

CORY SHAW: Um-hum. []

DEB SCHERER: ...without a lot of limitations... []

CORY SHAW: I understand that. []

DEB SCHERER: ...on the benefits. []

CORY SHAW: Okay. []

DEB SCHERER: Okay. With the report there were three options that Mercer provided to us. And I guess I didn't mention that our contractor was Mercer Health and Benefits. They were the contractor that put this option report together for us. And the first option is Medicaid expansion CHIP program combined with a health insurance premium payment plan. And a health insurance premium payment plan, in Nebraska we call that a HIP program. And what a health insurance premium payment plan is for families that have access to other health insurance, either a private insurance plan or a group insurance plan, the state does a cost-effectiveness test to see if it's more cost-effective for us to pay their insurance premium. And if it's more cost-effective for us to pay their insurance premium than just to put them on the CHIP program then we would pay their insurance premium. We would receive the Medicaid match for paying that insurance premium at a 60-40 rate. So we would get, not the CHIP match, but the Medicaid match at 60-40 for payment of the insurance premium. And the family would maintain that insurance plan, that private health insurance, the group plan or the private health insurance that they've purchased, have access to that insurance. The insurance then becomes primary for payment on the claims for the child. And then Medicaid pays any balance that is due up to the Medicaid fee schedule. Okay? So that's what a HIP program is, is we pay the premiums, the insurance is maintained. The insurance company is then primary to Medicaid and we pay any balances due after the insurance pays up to the Medicaid rate. With this...yes, sorry. []

PAM PERRY : I had a question. I wonder, I presume then that services that are covered are what is allowed through that private health insurance program then right? []

DEB SCHERER: That's right for the insurance company they pay on the benefits that are in their package. But because this is a Medicaid expansion the child would also receive all of the services that are in the Medicaid benefit package. So they would get those services as wrap-around services is what we call them, to their Medicaid benefits. []

PAM PERRY: Okay. []

DEB SCHERER: Because it's a Medicaid benefit package which is the next point. They still get all of those additional services so they would still get dental services and vision services and all of those additional services that are currently in the Medicaid benefit package. Okay? This allows children with CHIP to maintain private insurance with Medicaid funding for the match for the premium and also with funding for match for payment of their claims. This allows for administrative simplicity because we already have a HIP program that we use for some high cost individuals. Most of those are adults and medically handicapped children. We do not have CHIP children in that program. We would have to change our state plan to add the CHIP children. But it does increase the administration to do coordination of benefits with the private health insurance. The main benefits of this option are the administrative simplicity, that it is still a Medicaid look-alike, that it encourages private health insurance and it discourages families from dropping their health insurance coverage. They do need to meet that cost-effectiveness test though and that it can be approved by CMS within a specific amount of time. Okay. The impact of this option is that an estimated up to an additional 6,000 children could be enrolled in this option with the HIP, the health insurance premium program plan. That estimates includes children that we would actually go through the income eligibility to determine if they are Title XXI eligible but they would actually be found to be Title XIX eligible because under our federal guidelines we do need to do what's called enroll and screen or screen and enroll, which we actually look to see if they are Title XXI eligible but they are found to actually be Title XIX eligible. And children that are in a family, because of our eligibility, may be...some children may be Title XXI eligible and some children Title XIX eligible. So it includes both XIX and XXI. The state's General Fund share could decrease by $190,000 with this option. []

CORY SHAW: Deb, can I...question? []

DEB SCHERER: Sure. []

CORY SHAW: And this is actually a question that's a consistency question. In the three options in the executive summary, I want to make sure that we're talking about the same thing. In options B and C we refer to the number of children that is being covered as 291,000 and 281,000 in the summary. And I assume that's member months, not actually kids, because there's not that many kids in Nebraska. []

DEB SCHERER: Right, it is. []

CORY SHAW: So is this 6,000 really 6,000 months of...member months or is it 6,000 new kids? Because... []

DEB SCHERER: It's kids. []

CORY SHAW: ...6,000 member...okay. So you...this program would then expand by almost 25 percent the number of kids? []

DEB SCHERER: Right and that is in Title XIX and in Title XXI. []

CORY SHAW: Okay. []

DEB SCHERER: That's not only in the CHIP program, that is in Medicaid and CHIP. []

CORY SHAW: And then in the other two options where we're talking about numbers those are member months numbers which are...I mean, we have to do the math and... []

DEB SCHERER: Right. []

CORY SHAW: ...divide those by 12 to understand the comparability between... []

DEB SCHERER: It's not apples to apples. []

CORY SHAW: Okay, I just wanted to make sure. Thanks. []

KATHY CAMPBELL: Deb, when we get there, have you converted those? []

DEB SCHERER: I have not converted those. []

KATHY CAMPBELL: Okay. []

CORY SHAW: We can do it, we can do it real quick. []

KATHY CAMPBELL: Cory is going to work on that while we're... []

DEB SCHERER: Good, Cory. Do you need a calculator? (Laughter) []

CORY SHAW: I'll do it for you (inaudible) calculator while all you guys are talking. []

KATHY CAMPBELL: We do have calculators over here. []

DEB SCHERER: Good. Okay. Option B, Option B also expands on a Medicaid expansion program. And this plan is a Medicaid expansion with modified benefits and it starts out with a basic benefit package which would have a physical health services plan which would be similar to a plan perhaps like the state employees health plan. And then it would have a plus package that would have additional benefits which could be something like dental and vision services and then an enhanced package that could have the behavioral health services or the mental health, substance abuse services. So it would actually have like three levels of packages--a basic, a plus and then an enhanced. And along with that it would also have that health insurance premium

payment plan. So for families that had access to employer coverage or private health insurance we would do that cost-effectiveness test for them to keep their insurance. This allows for modified benefit packages but the EPSDT services are still required under this because it is a Medicaid expansion. It does allow the CHIP children to maintain their private health insurance with the Medicaid funding being drawn into the state. It does allow for cost sharing because there would be premiums and there would also be some copayments depending on which plan they chose. So if they got into a more extensive plan there would be higher cost sharing. If they went for the basic plan there would be less cost sharing, less premiums. If they wanted the plus plan there would be more premiums, most cost sharing. If they wanted the enhanced plan there would be more premiums, additional copayments, additional cost sharing, so depending on which plan the family felt met their needs. It would be administratively more complicated to select people...to have people select which plan they wanted into. We're administratively more complicated for a system to get those claims paid for the right people based on which plan they selected. It's possible to mirror commercial markets for the benefits so we could use benchmark plans, we could use benchmark look-alike plans or we could use secretary-approved plans for this type of an option. The main benefits of this option is that it is more flexible in the benefits, that we don't have to use strictly the Medicaid benefit package, that we can reduce the benefits and we can then make those benefits meet the needs of the clients that we're serving. So if they don't need that full benefit package of the Medicaid plan they are getting the services and selecting the services that they need. And then they are paying the premiums and the cost sharing for those services that they are actually needing. It does allow for premiums and cost sharing for the families to actually participate in paying part of the cost for the services that they are utilizing. And it does encourage private health insurance through that health insurance premium payment option. []

KATHY CAMPBELL: Any questions on B? One question, Deb, and it might have been and I missed it. But if a family has a child that has higher needs and so they would need a plus package or an enhanced package but they couldn't pay that premium, does this

adjust for that? []

DEB SCHERER: There was an option in here that the state could do a waiver based on high- risk so that we could actually do an assessment. And if there was a high-risk child we could waive the premiums to get those high-risk children into the appropriate packages. []

KATHY CAMPBELL: Okay. []

CORY SHAW: Okay. And again conceptually from a plus perspective where you're talking about our vision, dental and then some enhanced mental health benefits. []

DEB SCHERER: Um-hum. []

CORY SHAW: Those are the three basically that you're talking about. []

DEB SCHERER: That's kind of... []

CORY SHAW: What the basic package would look... []

DEB SCHERER: Right, yeah. And you know, we...when we kind of conceptualize these, when we talked about them just initially there was no hammering out what those packages would look like. []

CORY SHAW: Sure. []

DEB SCHERER: We just, you know, these are kind of the things that most insurance plans don't include the dental and the vision and the mental health is very minimum. So... []

CORY SHAW: What are the prices? []

DEB SCHERER: that's where we started with. The impact of this is that enrollment could decrease a half to 4 percent because of the selection of the packages and the premiums and the cost sharing. The potential saving could be $2.2 million to the state General Fund for Option B1 which was the moderate premiums and no point of service cost sharing and up to $5.1 million to the state General Fund for Option B2 which was the higher premiums and the most cost sharing. Option C is what many states have done and that's the stand alone State Childrens Health Insurance Program. This is not an entitlement program. This is a program that the states have the most flexibility with. The benefit plans in the SCHIP programs many times mirror commercial health care markets. States have the options to use the Medicaid benefit plans, to use a benchmark benefit plan, to use a benchmark look-alike benefit plan or to use a secretary-approved plan for their benefit package in an SCHIP. It typically uses private insurers and commercial payments rates but it does not that. The state can run these and the state can also use the Medicaid fee for service rates. The federal managed care requirements are not applicable in the SCHIP programs. They are administratively more complex because there are a few more reporting requirements within the SCHIP programs to make sure that there is not crowd-out, that people are not dropping insurance to come in and that kind of thing. You know, there's a few more federal requirements when you have an SCHIP program over an MCHIP program because it is not an entitlement. The main benefits of an SCHIP program is that it does allow the maximum flexibility in benefits so that you can pretty much determine what your benefit plan is going to look like in an SCHIP. It does allow an enrollment cap so you can determine the number of children that's going to be the maximum you can enroll in your program. It can mirror the commercial market so you can have your benefits that look like the largest insurer in your state where your employer...your state employee benefit plan. It does allow for waiting lists if families drop private health insurance coverage to get on your CHIP program. And it does allow the state to limit the General Fund contribution so that you know exactly how much you're going to be putting towards your

SCHIP program. And it does allow larger cost sharing by the family than the Medicaid expansion programs. The impact for the SCHIP program is that enrollment could drop 4 to 9 percent depending on the premiums and the cost sharing that's established in the plan. The increase in the state General Fund could be $3.3 million under Option C1 which was outlined in the report as no cost sharing and moderate premiums. And the state General Fund could decrease by $175,000 under Option C2 which was higher premiums and point-of-service cost sharing. The next steps after this report is that comments from the Medicaid Reform Council are due to the department November 1 and then a final report will be provided back to the council, the HHS Legislative Committee and the Governor by the department on December 1, 2007. []

PAT SNYDER: I have a question, actually I have two. []

DEB SCHERER: Sure, Pat. []

PAT SNYDER: The first one is, in your opinion as the director, administrator of the program since its inception, which of these three options would best serve the children of this state? []

DEB SCHERER: Well, Pat, I don't have an opinion. (Laughter) []

PAT SNYDER: That's well said for a bureaucrat. (Laughter) And in your opinion, which one would be the most beneficial to our state financially? []

DEB SCHERER: I think that that's really up for the public to comment on the options that are out there and to evaluate for the Medicaid Reform Council and the Legislative Committee and the public to comment on the options that were laid out there and to give feedback back to the department. []

PAT SNYDER: Thank you. []

VIVIANNE CHAUMONT : Did you want to ask me the same question, Pat, or not? []

PAT SNYDER: I will. Yes, I'll ask the first question first. []

VIVIANNE CHAUMONT: And the first question was which one? Benefits the children... []

PAT SNYDER: Which option benefits the children of Nebraska the most? []

VIVIANNE CHAUMONT: And my honest answer to that question is I don't know at this time because we really do need to go back and study this some more. But I think that whatever option guarantees the best financial stability in the long run benefits the children in Nebraska the most. And we don't know at this time which of those options that would be. And really it's the same answer for the state of Nebraska. I think whatever option, whatever way to run the program that can best guarantee the financial stability of the program so that the program can be sustained, not just now but in the future, is the best for both the state and the children in Nebraska. And at this time I don't know which one of those that is. []

CORY SHAW: So I want to make sure I understand. I'm simple. So here's what I take away from the options and see if I've got it. Option A, we don't really save any money but we're able to increase the number of kids that are covered by the program by up to 25 percent, that's a rough estimate. []

VIVIANNE CHAUMONT : Can I stop you there? []

CORY SHAW: Okay. []

VIVIANNE CHAUMONT : I think that when you read the report you need to note that the

6,000, you know, it says up to 6,000 additional children, first of all, some of those would be covered under the Medicaid program, the Title XIX program anyway. They would just come in to get evaluated and it would turn out they're not eligible for CHIP but they would be eligible for Medicaid. So those are children which should already be covered. []

CORY SHAW: Right...be covered. []

VIVIANNE CHAUMONT : The other part of the 6,000, which I find the more troubling part of the 6,000, is that they are children who currently have health insurance and therefore are not eligible for CHIP under our current program but would be eligible for CHIP under this program which allows CHIP children to come in. []

CORY SHAW: Yep, right. []

VIVIANNE CHAUMONT : And so... []

CORY SHAW: And I don't disagree. The reality is that a 25 percent increase in coverage may not be a good thing. []

VIVIANNE CHAUMONT: Um-hum. []

CORY SHAW: But what's laid out here is that there is a potential for a 25 percent increase in the number of kids in the program. Where they come from may be a combination of kids... []

VIVIANNE CHAUMONT: Um-hum. []

CORY SHAW: ..who are uninsured who we'd like to get in, kids who are currently insured and we'd prefer stay right where there at and folks that should be in Medicaid...

[]

VIVIANNE CHAUMONT: Right. []

CORY SHAW: ...but haven't just gone through the process. And Option B, the savings is potentially between zero, because I assume if there's no enrollment change there really isn't going to be any savings and $2.1 million in General Fund money. And we will lose, in terms of coverage, anywhere between none and 400 kids. Again just kind of boiling it down to bullet points. Am I right about that? []

VIVIANNE CHAUMONT : Umm, you are right about that. I think that the...you said there would be no enrollment change so that the savings could be zero. I don't think that's quite correct because if you'll recall that option includes cost sharing and premiums so there would be some increase, some increase. It also includes the addition of the HIP program to CHIP. And you know, I have some serious concerns about the HIP program as it's described and as the cost-savings are attributed to it in this report because in order to be eligible under the HIP program you have to do a cost-benefit analysis. And for instance, we pay under a managed care rate for kids it's something like $75 a month. So if your health insurance is higher than $75 a month you will never be found to meet the cost-benefit analysis. So my opinion is that the numbers that are attributed...and the report keeps saying this would be a really aggressive HIP program. My opinion is that a lot of the savings that are attributed to HIP under these particular options are not in the slightest bit realistic. []

CORY SHAW: Okay. So do you think just on that point then will we go back and try and come up with a realistic estimate of what we think the HIP...are we going to ask Mercer to do that or are you guys going to do that from a staff stand... []

VIVIANNE CHAUMONT: Those are next up to discuss. []

CORY SHAW: Okay, all right. Okay. So then my...I'm glad I'm doing it this way because you're helping us get a better understanding of what you guys know that may not be captured completely in the report. So then the last option, which I find really interesting because I'm interested to hear your insight, is Option C could result in a $3.3 million increase in General Fund expenditures or $175,000 decrease, depending upon where all the different variables fall at. And we again, based on what is summarized here, could lose between 1,000 and 2,000 kids out of the program. Is that...so expand on that. []

VIVIANNE CHAUMONT: I find those numbers, without, you know, having done a lot of analysis and we just got this ourselves, I find those numbers pretty troubling as well. I think as far as the enrollment drop is concerned I think that states that operate on CHIP programs have found that when you add a premium and when you add cost sharing enrollment goes down. The higher the premium the higher the cost sharing, you know, big surprise, enrollment goes even further down. So that's I think the issue with the enrollment dropping. As far as the increase in the state General Fund the report assumes that we would...that the state would use commercial...good commercial rates. []

CORY SHAW: Right. []

VIVIANNE CHAUMONT: There's no requirement for the state to use commercial rates. We currently operate the CHIP program in a managed care situation with shared vantage using Medicaid rates. So I think that's an option that needs to be explored. There is more...there probably is more administration, although there would be savings because if you were to do it, if you were to do the CHIP program with total managed care you would save, you know, for instance you would save all your administrative costs related to claims payment because the managed care company does that for you. But you know, you have to manage the contract, you have to write the contract, you have to do separate waivers, a separate plan. So I'm not going to tell you there's not

increased administrative costs. I don't think there's a $3.3 million increase in administrative costs. I would be shocked. []

CORY SHAW: Shocked, yeah. []

KATHY CAMPBELL: But it would appear in Option C that you could have an increased cost to the state General Fund. Would that be fair to say? What the total is may not be known but Option 3 tends to look like it could cost the state General Fund more money. Would that be accurate? []

VIVIANNE CHAUMONT : You know I'm not sure of that and here is why, I come from Colorado and Colorado operates a separate CHIP program. I was the Medicaid director in Colorado so because the CHIP program is a separate program the Medicaid program wasn't under me, it was a separate program in the same department. And the financial analysis that was always done at the department was that CHIP was...that CHIP took care of children cheaper than Medicaid took care of children. And we were encouraged to try to become more like our CHIP colleagues down the hall (laugh) than the other way around. So I really don't know, Kathy. []

CORY SHAW: But in some respects that stands to reason if you think that your most medically needy kids are never going to be in CHIP for the most part because their families are rendered destitute by the consumption of resources for their child or children. So I mean, to a certain extent I guess it would be interesting to know if you were to peel out maybe they did this in Colorado, you peel out the kids that you know are going to be in the traditional Medicaid program and compare, you know, doing mom's and babies, healthy mom's and babies in Medicaid versus the CHIP program. And were the differences substantial in Colorado? []

VIVIANNE CHAUMONT : Yeah. They did all kinds of studies because Colorado was putting together...and I left before it went to the Legislature, but was putting together a

proposal to do an 1115 waiver where they would have expanded...they would have really kind of made it one program. And you know, there were some things that they were going to do. And so they did a lot of data analysis related to the costs of Medicaid children versus the cost of CHIP children. And you know, in order to evaluate they had to evaluate whether you were talking apples and oranges. And they basically found that, and this is true in the Medicaid program, I mean the large majority of kids in Medicaid in Colorado and in CHIP in Colorado look just like the large majority of kids in the general population, which mercifully is healthy, low-cost kids. The first two years are the expensive years because you know you go through all the shots and you know vaccinations. But after that you know kids are...as a parent I shouldn't say this but at least on that level they're relatively cheap (laugh) compared to other Medicaid populations (laughter). Let me clarify that. []

KATHY CAMPBELL: That message keeps coming through loud and clear. Questions, other questions that you want to ask on that... []

CORY SHAW: Well, I guess just to follow on that because then the other logical primary differentiation is the flexibility around benefits and the fact that...I don't know the detail, but clearly the dental, vision benefits in particular are far more generous or not far, but more generous in the Medicaid program than they are in typical commercial programs simply because they are separate benefits. I mean at my employer I purchase a separate vision and a separate dental plan and it's separate from the medical plan. So in that sense they are separate and the Medicaid program tends to be more expensive. In terms of the wellness services that are provided for children in particular, at least you know our experience as a healthcare provider, the Medicaid plan covers the same things that most commercial insurers cover but the cost sharing is much different. In other words, you know for Medicaid obviously you don't pay for anything out of pocket when you come get a wellness check or anything for that matter, but under a traditional health insurance plan you might have coverage for wellness, but it's all part of your annual coinsurance and deductible requirements and so they are covered. And I think

that's an important thing for us to distinguish between because a lot of people get nervous when they hear basic or limited benefits or different benefits. What you're really talking about is the same basic benefit package that you have in Medicaid, X vision and dental. And what you're talking about is different cost sharing requirements for both the premium that you might pay monthly and for what comes out of your pocket when you go get your annual immunizations for your kids or your 3-, 6-, 9-, 12-, 15-, 18-month checkup. Those are all typically covered to an extent by private insurance, but they are not covered at 100 percent, you have to pay something out of pocket. And typically it folds into your annual deductible and coinsurance. []

VIVIANNE CHAUMONT : That's true but you can set up the program to have, you know, the premium certainly would be there, but you could set up the program to have different copays or no copays... []

CORY SHAW: For those kinds of things. []

VIVIANNE CHAUMONT : ...you could set up the program to have no copays for preventive care. []

CORY SHAW: Right. []

KATHY CAMPBELL: Does the Colorado program have cost sharing? []

VIVIANNE CHAUMONT : Yes. []

KATHY CAMPBELL: And premiums? []

VIVIANNE CHAUMONT: Yes and there's certain amount of administrative costs that come in with, you know, collecting the premiums and following up and all of that kind of thing. And the structure of the premium was changed after a couple of years of running

the program and I can't remember how it was, but it was to encourage enrollment and to ease administrative burden. So there is a premium and I believe it was...depended on the income as well of the family. []

PAT SNYDER: It was a sliding fee scale? []

VIVIANNE CHAUMONT : Yeah, it was sliding. Thank you. Yeah. And the copays may have been as well. I didn't run the program so I don't remember its detail. []

KATHY CAMPBELL: You'd make the assumption, we'd probably all make the assumption that it was a sliding fee scale from the... []

VIVIANNE CHAUMONT : Yes. []

KATHY CAMPBELL: Okay. You had a follow-up, Pat? []

PAT SNYDER: Yeah. My follow-up question is a question for your follow-up. You've referred that you've got to go onto a second level of analysis. How are you going to keep the Reform Council appraised of where the department is at with your analysis of this report? Are you planning on sending us information or making additional information available to us as you go through that analytical evaluation? []

VIVIANNE CHAUMONT : I think that the plan was to revise our report and give a final report December 1. []

KATHY CAMPBELL : I just have to say from Pat's question though I think it's difficult for us to...I mean we can comment on what we've got here, but listening to the description today there's a lot of additional work that you want to put into this to analyze where you are between options A, B or C. So therefore it's harder for us to make comment by these deadlines, unless we have something back from you, is that where you're going,

before that final report because we'd be just...I mean, we'd be making observations. And many people today are probably going to testify what they have here, but will they have or will we have another opportunity to provide some input knowing what the final...what you're choosing to do? And I don't know whether we then have another opportunity after December 1 to comment on that? []

PAT SNYDER: I'm wondering if as a council we could elect to either consensus or do a vote and request we have a preliminary report prior to say two or three or four weeks out prior to the December 1 final report, so we have an opportunity to at least have a reasonable understanding of where this program is going. And then would at least have a little bit of an educational opportunity to make a good recommendation. []

CORY SHAW: I would ask at least at a minimum we get back together some time the middle of November and just, even if the final report that you're planning to submit on December 1 isn't completed, that we'd have a chance to look at it. And the only reason I say that is as much as I'm interested personally, I got a lot of people that are asking me, so what are you guys doing about this? And you know so it's sort of that accountability thing which there may be an issue about what we're really expected to be doing here. But the fact is people want us to have some input and are asking us, I know at least me individually, to provide some perspective. So I'd like to suggest or request that we do something in the middle of November at least. []

VIVIANNE CHAUMONT : The middle of November to come back and have a meeting and kind of talk about where we are? []

CORY SHAW: Yeah. []

KATHY CAMPBELL : Would that be feasible? Do you think given your time table, that way prior to December 1 we'd have some idea and I'm assuming that the final recommendation may take bits and pieces from the different options that you're looking,

depending upon what the numbers tell you. Deb is nodding. I mean I'm assuming that you are just purely looking at A or B or C. But there may be...you may finally come out with Option D which is... []

VIVIANNE CHAUMONT : Right, correct. []

KATHY CAMPBELL : ...based on what we see here in our figures and what we've learned from this report. So the idea for this group to at least have an opportunity to see what D looks like or may look like would be helpful I think. []

PAM PERRY : It sounds like in the mean time we have a responsibility to (inaudible) comments. And I wonder if those might be in the form of questions and in addition to the questions that you'll be searching out, you know, additional information for and then concerns? I mean if we could even just outline those, any concerns or questions that we have at this point in time that might be helpful. []

PAT SNYDER: One of the things that...and I have to say you answered my question very accurately because you left me with the message that you are concerned that in the long-run we put in a program that is sustainable. And I think with all of the Medicaid programs that's the approach we have to take, otherwise we will have disaster as they've had in many of the other states. But in saying that it would also bode well for us if we all had that understanding of what went into that thought process. So I just commend you that you are moving forward in what I feel is a very reasonable way. []

VIVIANNE CHAUMONT : Well, thank you. You know what I'm not clear on as I'm hearing your comments about further input, what I'm not clear on I guess it wasn't my understanding that on December 1...that by December 1 we would file a report that says we are going to do A, plus B, minus C(3), you know, that we were going to set forth what we are going to do. I thought that...my understanding was that we were going to finalize the report with the different options. We might say you know, yeah, this is an

option, we're concerned about this, we don't you know, redo the numbers. But that by December 1 we were not going to be committing ourselves to we are going to do B(2). I don't remember which one B(2) is so no one get excited, (laugh) but you know what I mean. My understanding was that we would have a final report about the different options by December 1. That's...that's... []

KATHY CAMPBELL: Jeff, can you...we have at the bottom of the agenda and I'm assuming that there are copies for the audience, but at the bottom of the agenda is the statute. And I have read it several times myself. So, Jeff, could you enlighten us as to what the expectation is by December 1? []

JEFF SANTEMA: I think maybe going to the first point of are you precluded from making any other comments past that November 1 time line. I think that was intended just to give some rather immediate feedback to the department so that they could collect that input and incorporate it into their final report. That doesn't mean that the council can't meet again in November, talk about it some more. The department can...the council has a great deal of flexibility in that respect. In terms of what the expectation is for the final report I think Vivianne is correct, that it isn't necessarily that the state is committing to one of those options by that date. But I think what I heard members of the council saying is, particularly I think Cory was saying this, we'd really like to know though what your future progress is going to be, what your actions steps are going to be after you get the report and you further analyze it and make decisions based on the report that you've gotten. I think the report says that Mercer is going to do also write the final report for you. So you still have the contract with them to do the final as well. []

CORY SHAW: And that's due December 1,... []

JEFF SANTEMA: Right. []

CORY SHAW: ...that final report, so really you have another 30 days beyond the

November 1 date to submit the final report. So it sounds like maybe we at least have, in my mind, two more sessions where we're (a) hearing what your thoughts are after you've had a chance to provide your perspective on the document that you've been given, the preliminary document from Mercer. We get to hear that perspective. And then as we work over the final, you know, 45 days leading up to December 1 where we're obligated to put our stamp on a final report, that we've had a chance before that to talk about it with you and.... []

JEFF SANTEMA: I think the reason the statute says November 1 is... []

GAYLE-ANN DOUGLAS: Am I correct that the department is going to make a recommendation, but it will take legislative action to do it? Or is this an executive department decision? []

JEFF SANTEMA: I don't think it necessarily is going to have to require legislation. []

GAYLE-ANN DOUGLAS : Okay, that's what I thought. []

JEFF SANTEMA: Something may, but I don't think it's necessary. []

GAYLE-ANN DOUGLAS: Okay, okay, that's what I wanted to know. I didn't...I mean...that's micromanagement, I understand, but I just... []

PAM PERRY : That relates to a question I had though, too. If we needed to keep to a particular time line as far as some kind of final recommendations prior to the legislative session (inaudible). []

CORY SHAW: Statute requires that we have a final report December 1, I mean that's the only thing that we're statutorily required to do. []

PAM PERRY : Right. But I was thinking as far as narrowing you know a direction to pursue. []

KATHY CAMPBELL: And I do agree with Jeff. I think that the council can continue to provide comment and questions as we dialogue with the department. I think it's...the timing of the meetings depends upon as you begin getting some of your recommendations together, what is the best timing to meet with us to hear those? And that's what you two are asking the question, which is perhaps not you want some time to think about this, other than to know...I think that I would...I, personally, would like to get together as close to the time as you feel you've got your maybe not final analysis but some things that have become more clear to you in looking at the reports. So I think we are talking some time in November. []

JEFF SANTEMA: And, Kathy, would the council like to have additional input into the report that would reflect what the department intends to do with those various recommendations? For example, a description of further analysis they're going to give or what they're going to do with it after? Are those kinds of things... []

KATHY CAMPBELL: If I'm hearing my colleagues correctly, the answer to that is yes. I mean at least to be able to make comment and to say, yes, we think you're on the right track or we've still got some questions or this doesn't seem to gel together with what we had envisioned when we put the initial report together. Am I reflecting your comments correctly? Pat, does that reflect your... []

PAT SNYDER: Yeah. []

KATHY CAMPBELL: So perhaps what we do is not today set another day to meet, but allow the department to look at their time table and then you come back with some alternate times that we could set a meeting. Would that be acceptable to everybody? Because it's arbitrary to set a date not knowing how you want to structure your analysis.

[]

VIVIANNE CHAUMONT : That's a good idea. []

KATHY CAMPBELL: Is that helpful? []

VIVIANNE CHAUMONT: Yeah, I think that would be real helpful. And I can tell you that what we would shoot for is to try to get together mid-November... []

KATHY CAMPBELL: Okay. []

VIVIANNE CHAUMONT: ...so we have a month to... []

CORY SHAW: Just one other quick question and maybe others...what's...given these options we've laid out, what's the effect of what's going on in Washington? I mean, and how much influence is that going to have? I assume significant, but how does it effect each one of these options? Do we know yet? Do we not know? []

VIVIANNE CHAUMONT : Well, if the CHIP program gets reauthorized then we continue on our merry way with options. If the CHIP program does not get reauthorized in any way, shape or form then we have a totally different discussion. []

CORY SHAW: Sure. But in terms of the scope of the program, on the one extreme you have one group of people saying it ought to be this and on the other...I mean, does our program work regardless...let's assume it's reauthorized. And given sort of what we've heard out of Washington in terms of the sort of relative ranges of whether that reauthorization might take place, are the options that are on the table right now functional regardless of which option gets...or where we end up on that continuum, so long as the program is reauthorized, period? []

VIVIANNE CHAUMONT : Yes. []

CORY SHAW: Okay. []

KATHY CAMPBELL: We're just going to look at a calendar real quick here. I think if your discussion is to be mid-November, then we perhaps need to provide to Jeff our availability for the Friday before Thanksgiving or the Monday or Tuesday of that week. That's about mid-November. I think if we're going to go after Thanksgiving then that's the last week in November and that really doesn't help the department at all. So we are talking probably Friday the 16 or Monday the 19 or Tuesday the 20. So maybe if you could all just send to Jeff or Jeff put out a memo and say which of these work. And we also consult with the department, see if we can find a time to have a follow-up meeting. And the only item on that agenda, as I see it, that day is an updated report. So that the public knows that today we're going to hear some additional information. But at least they would know that that would be the only item on our agenda. Is that okay with everybody? And if you know your calendars today and can leave them with Jeff, that would be great. But that allows the department to kind of look at their calendar, too. []

VIVIANNE CHAUMONT : Right. And staff is telling me the earlier the better. []

KATHY CAMPBELL: The earlier the better? []

VIVIANNE CHAUMONT: So the 16th is better than the...but... []

GAYLE-ANN DOUGLAS: Well, and when you get to Monday and Tuesday before Thanksgiving that's going to be kind of (inaudible). []

KATHY CAMPBELL: So do you want to move it up and give her an alternate date for that Thursday and Friday? []

VIVIANNE CHAUMONT : 15th and 16th would probably be good. []

KATHY CAMPBELL : Okay, let's do that. Let's provide to Jeff our calendars for the 15th and the 16th, what would...and the department can check. And we'll, as soon as possible, then try to confirm that date so we know. And anybody else who wants to... []

DEB SCHERER: Can I clarify then what will be on the agenda? []

KATHY CAMPBELL: The only thing will be the Medicaid/CHIP program. We won't add any...because I know that Vivianne is probably going to talk about where we are. We have the Medicaid reform update, which is the total overview program, but this would be the only item, unless we come upon something (laugh). []

VIVIANNE CHAUMONT : Just say no. []

KATHY CAMPBELL: No, don't say nothing. Never. Thank you, Deb, very much for that. If we're finished with that item on the agenda, we'll move to five, which is the overall update. []

VIVIANNE CHAUMONT : I don't know why Deb ditched me? (Laugh) []

KATHY CAMPBELL: She scurried back there pretty quick. []

VIVIANNE CHAUMONT: I know, she moved back there really quickly, didn't she? When Senator Pederson and Kathy and I had lunch they talked to me about some of the changes that have happened over at the Department of Health and Human Services. And so I just want to briefly give you an update on the reorganization. I'm sure all of you are familiar with the fact that in the last legislative session the Department of Health and Human Services was reorganized from a system to a department. The new organization has six divisions: the Division of Medicaid and Long-Term Care, the Division of

Behavioral Health, Children and Family, Developmental Disabilities, Public Health and Veterans Affairs. And so I am the head of the Division of Medicaid and Long-Term Care. And then as part of the reorganization after my appointment we did some reorganization within the division and that's the org chart that you have before you. Basically, I reorganized the division into an acute care side and a long-term care side and that's what you see in the first chart. In the acute, when you go onto the second chart, the acute care programs are organized into four units. The first unit is the Medicaid Claims Unit and probably the only unit that didn't receive any further reorganization. And those are the people that make sure that providers get paid. So they have a somewhat important function. Right, Pat? Then we have the Operations Unit which was kind of all the little leftovers and that's the unit that Deb heads and that has the CHIP program in it, it has what I tell Deb, it has the only part of the Medicaid program where money comes in as opposed to money going out and that would be estate recovery, third party liability, things like that, program integrity. The third unit is Physical Health Services. We didn't quite know what to call it because it has a variety of things in it, but it's basically the practitioners and the providers. So we have, you know, the dental program, disability determinations is kind of an odd thing in there and that's the determinations that are made to determine whether people are disabled under SSI standards and therefore eligible for the Medicaid program, hospitals, acute surgical centers is what ASC stands for, I'm pretty sure, practitioners, physicians, therapists. And then the physical side of managed care, which is currently a program that we run the PCP program, primary care physician program that we run as a PCCM, and then the shared vantage, which is managed care program that is run by United. Then we have Behavioral Health Pharmacy and Ancillary Services, so everything that didn't fit into the Physical Health Services, you know, we put over on the other side. And it actually made some sense because behavioral health is over there, behavioral health has strong ties to the pharmacy program, that is probably the biggest expenditure in pharmacy is for behavioral health drugs. It also has the...we moved the managed care. We have an ASO. We operate Behavioral Health under an ASO agreement, which is currently Magellan, and so the managed care part of Behavioral Health is actually with the

program part of Behavioral Health now. DME and supplies, pharmacy and then transportation. On the other side of the department Renee came. Seemed like there was a bit of a disconnect between having community based services and some special programs and the rest of the Medicaid program. And (inaudible) community based services is a Medicaid program. And so what we thought we would do in this section is divide it into so really long-term care has the continuum of long-term care services from community services all the way through nursing facility through hospice. So that's all together now. And those services are basically divided into Waiver Services, which is the special services under home and community based waivers. And we have several waivers in there: the aged and disabled waiver, an autism waiver which was adopted in the last legislative session that we are working to implement and develop. The developmental disabilities waiver, let me just be real clear, is a Medicaid program but the waiver itself is administered by the Developmental Disabilities Division. But we need to have some oversight of that because it's Medicaid funds. The early intervention waiver, which is a waiver for young children, and then the Katie Beckett program, which is just really an eligibility category of Medicaid, and the traumatic brain injury waiver. So those are the waiver programs, and then we have the long-term care. Those are for specialized populations, that's the difference between a waiver and then the next section which is state plan service, which is a service that all Medicaid clients are entitled to. And those are, you know, hospice, private duty nursing, home health, the ICF/MRs, which are intermediate care facilities for the mentally retarded, nursing facilities, and personal assistance services, which are services delivered in the home. And money follows the person that I hope to talk about when I do the update on the Reform Council update. So Safety and Independence Supports Unit are all special, mostly state-funded speciality programs for different populations. But they also do the respite network and operate the social services block grant, which is some Title XX funding; and in there is also adult protective services. Adult protective services are delivered by people at the...I'm sorry, I'm still a Coloradoan in some areas, the service centers out in the, you know, the different areas of Nebraska. Not the triple AAAs, you know the field offices []

PAT SNYDER: The Medicaid field offices, yeah, in the counties, yeah. []

VIVIANNE CHAUMONT : Thank you. I forget. Aren't they called service? []

JEFF SANTEMA: Service areas. []

VIVIANNE CHAUMONT : That's it. Thank you. But the program is, you know, the policy and the administration of it is at the state department. And then the last but not least unit is the Unit on Aging and that's who has the triple As, and in Nebraska has the Ombudsman program and all of the aging programs with nutrition services, and transportation, legal services. They have a myriad of programs that are under the Aging administration. So that's the new organization that went into effect. And so far, I think, it's working okay. Are there any questions on that? Then we'll move onto an update on the Nebraska Medicaid Reform Strategies. Senator Pederson and Kathy indicated that this format had been used before and that you all liked it. So we went ahead and kept it. I wish I hadn't made the print so small. But I think there are several that I want to highlight and then you can ask me questions about any and all of them that you would like. The first one is at the very top of the page and that's the report that we were asked to do just to get some recommendations about defined benefit arrangements. And there are some states that have done defined benefits where as opposed to defined contribution you have defined or it's the other way around, defined...right. So what we've done is we've already gotten one report and that basically went through different options that some states have. And the report was pretty much, I felt, about the Florida...emphasized the Florida program. They have done a huge redo of their Medicaid program. But it also went to different options on how a state can expand benefits, expand eligibility and the different options for running programs in a way to expand eligibility, expand benefits, maintain things the way they are and cost control. So we got a preliminary report and we are in the process of asking for the final report that will come to the Medicaid Council basically asking them...telling them that our guidelines

are for a program that maintains stability and is financially feasible in the future. So those are the programs that they should focus on. The fourth one down, which is the state program for CHIP, and that's the report that we got today. We had a report that, one right underneath that one, is a parental buy-in special programs. And those recommendations were developed and provided to the Medicaid Council and to the Legislature, I believe, in December of '06 and that called for establishment for seeking a waiver to establish cost sharing for some of the programs where children are made eligible without regard to their parent's income. The prior authorization of new brand name drugs, which is the one right underneath that, we have established a drug utilization review committee and we have a contract for that. And they review new drugs as they come in and recommend whether or not the drugs should be prior authorized or if there are any restrictions that should be put on the drugs. And we are...I've asked staff to look at what they've done and see if they can come up with estimates of whether there have been any savings as a result of those activities. The one right underneath that is a needs assessment tool for continuum of long-term care services. And we are working on an in-home tool to assess long-term care, the need for long-term care services and we're also coordinating where the money follows the person in order to do that. And I think if it's okay, I would like to stop and talk about the money follows the person grant, which is not really a grant, because most of the time grants come with a check attached to them and this one did not. But it is an opportunity for some higher match and the program is to look for...to transition people in ICF/MRs or nursing facilities who have been in those facilities for two years or more to transition them to a community setting. So to see what people can be served in a community setting for, you know, less cost and if that's their preference for quality of life issues for them. We will not be moving anyone that does not want to move. We will be looking for people who are interested in making the transition. And involves then making sure that they have the appropriate services that they require in the community and that they have the supports that they need in the community. The grant says that the goal is to move 900 people. I think that's a good goal. (Laugh) I don't know how doable it is, but that's what we're going to be for. We were a little behind on getting the grant implemented, but we

have now hired a money follows the person grant coordinator, his name is Bill Ray (phonetic) and he has a lot of enthusiasm and a very good background, I think, to get this done. And we will be having a stakeholder meeting on October 30 and putting together an operational plan, which needs to be approved by CMS prior to moving people from the institutional setting to a community setting. So we are going to be working and asking to work with a variety of providers, a variety of advocacy groups and stakeholders to get this done. The incentive, the financial incentive from the grant is that we'll get a higher match for a year for the services that they get. So there is some money there. But I think the actual incentive is to provide people the choice to be able to live where they, you know, where they want to live and to be able to provide the services that they need in that setting. So as well as a quality of life issue for the particular individual, it's also...it can also be less expensive for the state to have people in a community than an institutional setting. So that's the Money Follows the Person Grant we're very excited about getting to work on that. The other one that I wanted to mention then was the right underneath that which is looking at a rate setting methodology throughout the continuum of long-term care. So looking at how we do rate setting from the community level all the way through the institutional levels, which in this case would be nursing facilities, because hospice rates are set, they're pretty prescribed by the federal government how we do those, but to assure consistency throughout that and to look again, I shouldn't say again, to look at how we set rates throughout that continuum of care. What we are hoping to do is issue an RFP to have someone take a look at that and give recommendations. Any questions or any other specific ones that you would... []

KATHY CAMPBELL: Does the council have any questions on any one of strategies that they want to talk about? It would seem to me that at some point, once we get through the CHIP program, that we may want to set in the first quarter of the year just a time for us to kind of review these, since we got them today, and take a look at them and see which ones we might want to go back. Because it's really hard, I think, today to just say which ones we want to do. Is that...is everybody agreeable with that? I think that would

be a lot easier for the department if we kind of knew which ones we wanted to talk about in the future. []

VIVIANNE CHAUMONT: That would be real helpful and also if at the time that we had that conversation if we got an idea of what your priorities were and give you an idea of what our priorities are. I think that would also be very helpful. And in talking about priorities, I want to just mention a few other things that, if there are no more questions about this, that the department is working on, that just might take a bit of our time in the next few years, and that is the department is in the middle of procuring a new MMIS system, which is a system that pays for claims. That is an absolutely huge endeavor. I've gone through several procurements in several states. And they are always quite enjoyable and a lot, a lot of work. And in the states that I've been involved in, in the past, we've actually had an outside contractor who did the system. The twist in Nebraska is that, as I'm sure you know, we operate our own MMIS system and we'll continue to operate our MMIS system. A contractor, we hope, will be coming in to build a new one that we will then operate. While we are in the process of building a new one, with assistance of current staff, we need to be operating the one that we are doing. So I sort of talk about, you know, rowing the boat while the boat is...keeping the boat afloat even as it's being built. So that is really going to take a lot of staff time in the next years. So I think it's really important then to focus our attention on the things that we really believe will improve the Medicaid program, will provide cost-savings, will provide better care, because we are going to be very busy with the other things. Another issue that we are working on this year is the reprocurement of our managed care contract. We haven't reprocured the managed care contract, physical health managed care contract since, I think staff told me this morning, 1999. And we're going to reprocure that. And hopefully, the plan is for a July 1, '08 new contract date. We are also looking to reprocure the behavioral health contract, which is an ASO at this point, again for July 1, '08. And I'm looking to see what changes need to be made to the PCCM, which is the primary care...the PCP program as well with the thought of determining whether we need to reprocure that one or what changes we want to make to that program. So on top of

these, those are just some other little issues we're working on. []

KATHY CAMPBELL: Those are very large. Questions from the council? Perhaps what we could do is take this list and send some comments to Jeff by the end of the year and see if we've got some agreement among us as to what we might want to hear in the first quarter. If, Jeff, you'd be willing to do that for us. []

JEFF SANTEMA: Yes, ma'am. []

KATHY CAMPBELL: Okay. Any questions? Any other topics that you'd like discussed before we go to public comment? Okay, thank you very much. []

VIVIANNE CHAUMONT : Thank you. []

KATHY CAMPBELL: We will next go to the item on our agenda on public comment. And I just would like to start out and say that we have received from...a response from the Nebraska Consumer Advocates and Providers from a number of agencies and organizations. And Jeff did provide that for us. So if you are here representing that group, we did receive this and we all have copies of this report. If you had planned to talk today about the CHIP program and think, hmmm, I'd really like to hear more, and maybe visit with us again in November, that's fine. Do not feel that you have to make comment today or if you would like to send comments between now and when we meet in November, those comments certainly are welcome also. Otherwise, we will start with any public comment. And I think we'll break it down today whether there is anyone who wants to make public comment on the CHIP program or all of that that we heard today about Kids Connection. Yes, please come forward. And you just want to provide your name and where you're from and who you represent. []

JENNIFER CARTER: My name is Jennifer Carter and I am the director of the Health Care Access Program at Nebraska Appleseed. And actually, I'm here speaking on

behalf of that coalition of groups that sent around the report. And I'm not going to go through the whole report again for you. But we did want to make a few points. And actually, one oversight that is my fault, I wanted to be clear, Nebraska Advocacy Services and the Nebraska Chapter of the American Academy of Pediatrics also signed onto this. And that was my fault, I thought they were on there in the final draft and apparently it was a different draft that they got on. But they have joined with us in that. And I just wanted to, especially after now hearing the other testimony, highlight a few points which is more about the context of these potential reforms. Kids Connection, as you know, serves about...last year served about 44,000 kids. According to the U.S. Census Bureau, there are still 45,000 uninsured children in Nebraska. What I think is most important is that 63 percent of them are in families that make incomes at 200 percent of the federal poverty level or lower. So the majority of these are families who at least by income might be eligible for Kids Connection, whatever the eligibility requirements. But we're talking about low-income families. And actually the other thing that I thought was very striking was in another Robert Wood Johnson report, I think was from March of this year, 78 percent of our uninsured children live in households where there is a full-time worker. And I think that reflects what we've heard generally, there is a significant decline in employer-sponsored coverage, mainly in low-income families. And I think that point is important because we've heard when we're talking about decreasing enrollment under some of these options, we're concerned about where are those children going? Because we think most of them are ending up uninsured. And I would hope we could all agree that that is not a good thing []

JENNIFER CARTER: And that the point of the Kids Connection program was to help those families that are falling into that gap between Medicaid eligibility and being able to afford coverage in the private market. And that that gap is getting wider and wider. So while we fully appreciate and also want the program to be fiscally sustainable, we want to make sure that we're also keeping in mind what the program was meant to do and that the need may even be greater out there. And I think that given those statistics, we believe that a lot of those children are going to end up uninsured. These are not families

that are just leaving the private market because they think they get a better deal on Kids Connection. I mean, they're really going to have a hard time with that. And also I'd just like to remind that while we are also interested in fiscal sustainability, the program has remained stable in the last couple of years. As everybody already said, kids are less expensive to cover. And in terms of the SCHIP legislation at the federal level, if the current bill, if there is a veto override or some form of the current bill is passed, at the very least I expect--having now lived and breathed this for like ten months--that at the very least we're going to have enough of an increase in federal funding to cover the shortfall that Nebraska has been experiencing. So there would be...I don't know what the number is, and I don't know how large it is, you know. But to the extent that we've been paying for a differential between our SCHIP match rate and the Medicaid match rate for our SCHIP kids, that would be taking care of, and there would be those savings in the general funds. This current bill, and I hope something like this will be passed at the federal level, would provide performance bonuses for covering low-income children and increasing the enrollment. It would provide per capita funding for when we do increase their enrollment to eligible...to low-income eligible children. So there would be more federal dollars coming to the state. There is a state match to that, but we would be getting an influx of additional federal dollars. In terms of the actual options, we support Option A. We think it provides at least some cost savings to the state, and that it's really helpful to these families I'm talking about, who are on the margins, who may have private health insurance but are really each month wondering if they can afford it. And this would be a way to keep them in the private market. Although I understand there is some concern about the cost-effectiveness. And I guess we would need to see more about that. We're also--and this is true of Option A and Option B--very happy to see that EPSDT services would be mandated. We think they're critical to kids' care. We think they make sense in terms of long-term fiscal savings. When you get kids screened, chronic illnesses treated right away, so that's one of the things that we were most pleased about with that. Option B we have some really serious concerns about. As I said, we're very concerned about the decrease in enrollment, because we think that equals increase in uninsured children. And where are those children getting those

health care? And what does it mean for the broader health care system? The more uninsured children we have, you have delays, you have no preventative care, delays in seeking care, you end up at the emergency room. I mean, all of the cycle that we hear about in terms of costs to our broader health care system and where somebody is going to bear that burden. And who is going to bear that burden? I mean, obviously the children bear it, in terms of their health. But then who is in term paying the long-term consequences? So there are...our other main concern with Option B and c is cost-sharing. We think it can lead to a decrease in preventative care, it can have a negative effect on access to care. It really puts the providers in the position of policing and enforcing this rule, because they are allowed to refuse services if a patient can't pay the copay. And we're concerned that a lot of physicians are not going to want to be put in that position, where they're kind of having to enforce this to the potential detriment of their patients' health. I mean, if they so choose, if they need the copay. And then is that going to limit how many providers are willing to participate in the program? And then you're talking about real concerns about meaningful access to care for people who are on the program. The other thing we wanted to remind people, and I think sometimes it's really hard to know, unless you've got...somebody is actually sitting there and showing you a family's budget. But these...our eligibility is one of the ten lowest in Nebraska. We are talking about low-income families, most of them working. But there is not disposable income available to them, sometimes even to pay what seems like minimal copays and coinsurance and premiums. And so at the very least we would like the state and this council to be mindful that we really need to be talking about nominal cost-sharing, if we are cost-sharing. Or you're really just going to push people right out of coverage. And I was glad to hear the discussion about the benefits, because we were very confused by the report: what is the basic plain? And I think I'm still a little confused as to if we know for sure. And I think that is still under development. Is the basic plan really just absent dental, vision, and mental health services? And it's all of what you would usually get under Medicaid? Or are we talking something much more basic than that? And what does that mean for kids in terms of the kind of care they're getting and the kind of preventative care that they're getting? So we would like to hear more about that in the

future. Option c we oppose. It was really concerning to us that this was an option that increased state spending and decreased enrollment by the most. So we're talking about spending more money to make more children uninsured, and we have a real problem with that, despite, I understand there is flexibility. But there is no EPSDT services required. I mean, it would depend...this would have to be very carefully set up. And we would like to make sure we're keeping the needs of the kids in the forefront. So we generally oppose that. And we have some concerns about other administrative burdens. I mean, you would need to set up new policies if you set up a separate SCHIP. Those are subject to judicial review or other rule-making. I mean, we know now what you can and can't do under Medicaid. And that's been, I think, a great help in administering the Kids Connection program. I just had, I think, one other point. I just actually...one thing, I was a little confused and I apologize if I'm just like slow on the uptake here. But what we decided, or what you decided in terms of what is due on December 1, and I think we would have a real concern if December...and I'm not saying it has to be done by December 1. But if December 1 is just a finalization of the potential options, that's fine. But then what is the process for having public comment on what the actual final decision is and what HHS will do, because my understand of LB1248 and the role of this advisory council was to allow for some public notice and comment on what HHS would actually be doing. So that in the intervening legislative session, if any action needed to be taken or if any legislators wanted to take action to either prevent or change what HHS anticipated to do, we would have the chance to do that. And if we still don't know what the actual options are, does that mean we wait yet another legislative session, or what happens? When do we get the public notice so people really understand what changes are going to made in the program and allow people the opportunity to speak to that? And I think my final thought is: enrollment caps and waiting lists, I know we're on the benefit list of Option C, those are not benefits for children who need health care services. So...just, that's just, you know, philosophically I wouldn't call it a benefit. So anyway I'm happy to take any questions and I appreciate the time. []

PAT SNYDER: I don't know if I have a question as much as I do a comment. I share

your same concern. The way I read the statement from the Nebraska Revised Statute--and I'm no lawyer, so I really don't know if I'm reading it right or not--but it appears to me that the department is to identify the provisions of health care and related services for Medicaid-eligible children and what those recommendations are going to be. If I'm confused, and I'm on the Council, you're confused as a very, very active advocacy group, I would recommend that we may want to ask the Health and Human Services for a legal opinion on what really this means. Are they supposed to identify what the plan is? And get that out to us so we have a good understand of what the outcome should be by December 1. []

KATHY CAMPBELL: We'll try to get that clarified for you. []

JENNIFER CARTER : That would be great, thank you. []

KATHY CAMPBELL: Any other questions for Jennifer? Thank you very much. Other comments on that SCHIP program, the Nebraska program? Okay, are there any comments on the general Medicaid reform strategy that Vivian might have covered? Yes, sir. That's fine, come forward. []

DAVID FRIED: This is my associate, you can (inaudible). I represent Community Alliance in Omaha, Nebraska. []

KATHY CAMPBELL: And sir, could you provide your name and... []

DAVID FRIED: It's David Fried, I represent Community Alliance, it's a rehabilitation program in Omaha for people with mental disabilities []

KATHY CAMPBELL: Okay. You want to go ahead with your testimony? []

DAVID FRIED : (Exhibit 2) Hi. My name is David Fried. I'm a citizen in the state of

Nebraska and I am a person with a disability. My story is not unique; there are a large number of people with disabilities who inhabit our state with the same problem. We need your help. I'm here today to ask you as legislators to make changes in the Medicaid laws that would allow me to work at a job to earn a decent enough income so that I could apply talents and skills to be a more productive member of society...one where I can lead a more normal lifestyle. I grew up as normal kid, going to elementary school, playing the piano, and participating in swimming competitions. I was a straight A student, also went to a program for gifted kids at UNO, was a Rotary Club honor role winner, and won the citywide debate tournament in eighth grade. I had a promising future. I tried to perform to please my father, but at the age of 14 my father died, which doctors believe triggered my schizophrenia. I was hospitalized for three months, taking various medications which had minimal beneficial effects. I then went to Central High School and was barely functioning, receiving D's and F's for my grades. They told me I wouldn't finish high school. I was then hospitalized a second time for four months, without much overall improvement. I ended up getting a GED. I was able to hold down a part-time job as a busboy. Then I applied to Creighton University, where my father had tenure before he died, at the time achieving only a score of 15 on my ACT to show in my favor. After some hard work and determination, and with better medication, I studied for the ACT and received a score of 24. I applied to Creighton second time and I was actually accepted. I started taking one or two classes a semester, earning average grades at the time. Then a miracle happened. I was started on a new drug which opened up a huge window for me and my future, and I felt like I had been given a second chance at life. This drug truly turned my life around. I had determined to prove and to others as a force to be reckoned with. I started taking ten to twelve hours a semester, taking classes like physics and calculus, earning A's in my courseware. My favorite was physics, but I chose to major in political science, which was a faster route towards completing a degree and would hold better job opportunities for me after I graduated. I even went to Washington D.C. on an internship to lobby for a private group called High Frontier, that promoted the Strategic Defense Initiative that was part of Reagan's "Star Wars" defense shield. After getting a bachelor's in political science from

Creighton, I then went to Metropolitan Community College where I received an associate's degree in computer programming. I started out volunteering for former Senator Kerrey's office, also with the Omaha Community Playhouse, and the Martin Davis campaign. I then joined Community Alliance, a mental health rehabilitation program which would provide me with a promising future. Being 80 to 90 percent functional, I wanted to earn a decent living and get a part-time job with the aid of medication, which costs several thousand dollars a month. At this time I was on SSDI benefits for my disability. This program has work incentives to individuals to go back to work, which is my goal. I started out going through the nine-month trial work period being a database developer for a small insurance company and an express person for Kinko's copying firm. In addition I honed my computer skills by volunteering to build a database for clients of Lutheran Family Services. I just wanted to prove myself and do the best I can. I then received A+ certification from Metro, which qualifies myself as capable of repairing computer hardware. Fortunately I can function well in society. Unfortunately, my progress is being held back by Medicaid laws, which limit the amount of money I can earn a month, thus excluding from finding any meaningful employment. I still struggle at work due to the crippling aspects of my illness, but I want to work toward becoming a full-time employee in the future. My ultimate goal is to become a productive member of society, to make a decent living, and to progress to the point where I can make my own way in life. The stumbling block for me is that after completing what is called the three-year extended period of eligibility, Medicaid stipulates that if I earn any substantial income my Medicaid will be terminated, which in turn will take away my medical coverage which I desperately need in order to function, jeopardizing all that I have worked to for to achieve these past ten years. In addition, I have to pay approximately $104 a month in Spend-Down in the form of health insurance from my SSDI check to qualify for Medicaid. Without these changes in the system, people like me are limited to a life without meaningful existence and cannot excel in society. I know there are others out there just like me. I'm here today to plead to you as legislators to make changes in the Medicaid laws that will let me earn a suitable amount of money and allow me to lead a more normal life. The Medicaid Program that can be changed to

allow me to do so is called the Medicaid Insurance for Workers with Disabilities. This would be a cost-neutral change, as only language would need to be amended. In addition to helping the mental health consumers, by allowing this reform, workers would help by contributing to the free market economy by buying goods and services in the state of Nebraska. Not only would this change help the Nebraska local economy, but consumers would also pay into the system, actually increasing revenues for government, by having them pay federal, state, and local taxes. Finally, any disability work reform would require a premium, which just adds more spending money for the state. Ultimately this change would be a cost-neutral and a win-win situation for all parties involved, including mental health consumers, the government, and a healthy economy. I therefore propose that the Medicaid Insurance for Workers with Disabilities be put up for a vote in the Unicameral this next session. Thank you for listening. []

KATHY CAMPBELL: Thank you, David, for a well-thought out testimony, and we will see that it is sent to the Senators who sit on this panel, because we all are private citizens, but we'll see that they get a copy. Did you want to add comments with David's? []

STEPH MESSER: Thank you very much, I would very much like to do so. I am Steph Messer, I represent Community Alliance. We are a mental health rehabilitation agency in Omaha. We are the largest in the state of Nebraska and we provide an array of services, whether it is residential, community support, vocational, etcetera. And again, the program that David is referring to, Medicaid Insurance for Workers with Disabilities, I don't know how familiar you are all with it, but it was done in the Balanced Budget Act of 1997. And what HHS did at that point--this is kind of an analogy I've heard throughout the morning--they mixed some apples and some oranges, in terms of eligibility criteria, and they actually recognize that now. George Kahlandt, Sally Hinds, some of the Medicaid folks recognize that. What David was referring to, this program is very much geared for individuals on Social Security Disability, qualified workers that we've paid into paid into the Social Security program, and ultimately want to go back to work. And that

is our goal to help them achieve that. However, in writing this Medicaid program, as David referred to, the Social Security program has incentives to help you go back to work. And he referred to some of that lingo. And again it's mixing apples and oranges. The state has their own language, Social Security has their own language. But this is basically for individuals to start off the process, going back to work. It's about a four-year period of time where they can possibly maintain their benefit check. Well, for individuals like David and other folks that we serve in our community, they've been in our vocational program, have been working part-time, getting the education, the services they need to go back to work. By the time they're ready to do so, they have used these incentives. And so with this Medicaid MIWD, as we'll acronym it, by that time they are no longer eligible for this Medicaid program, because they've used these work incentives. And yet these are the very individuals that would be best served by it. I have worked under a Social Security contract and worked with 14 other states and am familiar with, for example, Iowa, Missouri, Kansas, Colorado, a lot of their Medicaid programs. And as David said, this is simply a cost-neutral language that needs to be amended. At this point in time there is usually only about 100 individuals in the state on this program, simply because of the fact, that as David has, have used these Social Security incentives, are not eligible, but desperately want to go work. Under the Medicaid Infrastructure Committee that I was on, public policy group actually devised a calculator that showed exactly what David said: if this person can go back to work that they will contribute to the local economy, the state economy, and it actually shows the decrease in food stamps, every public benefit that that individual is on at that period of time. And our state has the opportunity not only to just amend the language, but we can also do that under what we call the Ticket to Work legislation, which is the Social Security legislation. Other states...have done...is defined work, I don't propose we go so far as Iowa, where they say you work one hour a month. But we can use a definition of 20 hours a month, minimum of earning $200 a month, and attach that type of definition to it, not something that you have to be in these Social Security work incentives. And I will say, in my experience, because it is so little used, any time that I have someone who is eligible and needs to use it, the amount of education that I have to do to that

HHS worker is just very time-extensive. And I don't blame them for that, because they received initial training, and if you don't use it, you lose it. Okay? And I'm in that with another individual right now and it takes coordination with Social Security, etcetera. So again, it would be cost-neutral in just amending the language, getting rid of the orange, maintaining apples, and just coming up with whatever we construe as a definition of work. In addition, as David said, for example, Iowa, Kansas, they actually impose a premium on an individual earlier. We have a two-part income test that is so darn complicated you have to be an accountant to understand it. And we don't impose a premium very early. Well, David, for example, would be thrilled to pay even if it's $50 a month, $75 a month to have access to Medicaid so that he can go to work, because Medicaid is already paying for his services now. So if you're already paying for it and David can go to work, and individuals such as himself impose a premium earlier, that is reasonable, you know, whatever that may be. Then he can go to work and achieve all that he actually presented to you and spoke about: you know, contributing to his economy, being productive part of our community, etcetera. So that is...as Community Alliance, as an organization, we truly would want to see this put up in front of the committee and the Legislature next session. You could increase, in our estimation, a hundred people into the thousands of people, just as in Kansas and Nebraska and other states that have revised their model. []

KATHY CAMPBELL: And we'll certainly provide that testimony to the department. []

STEPH MESSER: Thank you so much. []

KATHY CAMPBELL: I'm sure that they might want to visit with you afterwards, so thank you for coming today. Anyone else in the hearing room who wishes to provide comments to the Reform Council? Yes, ma'am. Good morning. Once again, you and I spoke earlier.

KATHY HOELL: Yes, we did. My name is Kathy Hoell, I'm the executive director of the

Statewide Independent Living Council. And just regarding David's earlier testimony, the Statewide Independent Living Council has developed a draft of legislation to be introduced in this upcoming session. We're in the process of trying to find a senator to introduce Medicaid Insurance Workers with Disabilities program under the Ticket to Work legislation. So hopefully we will be addressing this issue and if there's anything that this council could do to help us in that effort, I'd be ever so grateful, because like they were saying, there are a lot of people out there who are being kicked off their Medicaid, so it's a more of a fear that they will lose everything when everything is maybe just barely living. So we need to help these people and basically that's all I wanted to let you know. []

KATHY CAMPBELL: Thank you, Kathy for that update. []

KATHY HOELL: If you have any questions...

KATHY CAMPBELL: Any questions? Pam.

PAM PERRY : I have a quick question. I was just wondering, Kathy, when SILC has worked on this, have you partnered with any business organizations, or do you have any opinions from business organizations about whether they would be supportive of your proposal? []

KATHY HOELL: a number of people have said they will be supportive, but they cannot take a lead role. And so our organization is saying, okay, this is wrong. This needs to be fixed. We've got people out there who are willing to work, are able to work. I think my favorite story is in Omaha with First Data Resources. They were hiring a gentleman who was a client of the Arc of Omaha. And they had to go in and negotiate his salary down in order for him to remain eligible for Medicaid. So he had an opportunity to make more money, which is what this particular position started at, and, you know, the businesses see this is a problem. (Inaudible), you know, I have a friend who works at Metro

Community College in the computer help lab, and she has turned down raises for like the last ten years to remain...in order for her to continue receiving her health care insurance. And the way the bill we have drafted is, the premium would be based on a sliding scale, so the more an individual makes, the more they would pay in, but if they don't make a lot, they would not pay as much. []

KATHY CAMPBELL: Does that answer your question, Pam? Thank you, Kathy. Did you want to provide comments? Cory, you want to move the chair? Thank you. Good morning. []

J.ROCK JOHNSON: (Exhibit3) Good morning. It's kind of hard when your chin is on the table, but...(laughter)...I'm sure I can adjust. My name is J. Rock Johnson. That's initial J., Rock, R-o-c-k, Johnson, J-o-h-n-s-o-n. And for purposes of identification only, I would note that I'm a member of the Behavioral Health Oversight Commission. And I want to commend David Fried for coming forward. You know, every single person who begins to understand this problem enhances our ability to solve it, because the Social Security Disability is set up to keep people from working, basically, or to penalize people. So I really appreciate that testimony and Kathy's testimony today. And now that you all are more informed and will become champions, I hope, of making these kinds of changes, what I want to bring forward today are four documents. One is from CMS regarding peer support. It's a letter that was sent out to the Medicaid directors. And just a short paragraph about peer support, and some of you may be aware that there is activity that has been going on now for about four years in our state around peer support. The centers for Medicare and Medicaid Services recognizes that the mental health field has seen a big shift in the paradigm of care over the last few years. Now, more than ever, there is great emphasis on recovery from even the most serious mental illnesses. When persons have access in their communities to treatment and supports that are tailored to their needs. Recovery refers to the process in which people are able to live, work, learn and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life, despite a disability. For

others, recovery implies the reduction or complete remission of symptoms. This is acknowledged as an evidence-based practice. And it also recognizes that we operate on a state-by-state basis as far as what the education and the certification and so forth are something that is decided on the state level. But it is something that I think is very important that we begin to look about, then begin to develop a foundation here. So that we can get those regulations. But even more so is the champion role, I think, that the Medicaid director and others can play to promote these concepts of putting people to work within the system who have their lived experience, which cannot be replaced by any hours in school. Another is the self-directed peer assistance services, this again is another letter from CMS to...I'm sorry, I should have told you that the peer support letter came out on August 15 and the self-directed peer assistance services came out on September 13. We do have in Nebraska regulations on personal assistance services. The problem with those regulations is that they are limited to specific medical conditions that does not include a psychiatric diagnosis or a psychiatric condition and needs. And that's something those regulations would have to be changed. They need to be changed from two perspectives. One is so that people with psych disability, for example, a woman whose voices are exacerbated by a vacuum cleaner, so a person comes in, vacuums the house, she goes somewhere else. So someone with a psych disability could receive assistance. And also there are people out there, pat of the support, there are many different levels and kinds of peer supports. So somebody could be employed as a self-directed peer assistant worker. And I've brought...this is called "Free to Choose Transforming Behavioral Health Care to Self-Direction." It's a report of the 2004 Consumer Director Initiative Summit. And I'm sure that some of you are familiar with the Robert Wood Johnson move that began in the late 1990s, the Cash and Counselling is what it was called. So this is basically self-determination Cash and Counselling for people with psychiatric disabilities. There was a program, it's now closed, in Florida, using state dollars, where it was estimated and a figure arrived at of what would be spent on that individual through Medicaid. They had to develop a recovery plan and tie any of the services, which they could choose their own services, to that plan. For example, this woman, who was actually overweight, started going to Weight Watchers.

But not for the purpose of Weight Watchers, it was a socialization activity. She wanted to become a writer, so she was able to use that money for a correspondence course. Now these are concepts that are so far beyond are history, but it doesn't mean that they can't be part of our future. The last area is the fact that people with schizophrenia die two to three times sooner than...I'm not saying that right, let me start that one again. The age at which a person with schizophrenia dies now is 51 years, which is about 25 years less than the general population. This is a...what I have here for you is just a kind of quick medical once-over. But they do note that the newer medications for schizophrenia cause unhealthy side effects like weight gain and an increased risk or type 2 diabetes. But what often happens to people is they get sent back to the hospital, but back on these medications which are basically potentially deadly and lethal. So we're not...we're not operating very well in our medical understanding. When I talk about this, I also want to talk about the critical role that general practitioners play, and that they can increasingly play. I'm seeing more and more articles that that's where people go first for medical help. So that say something about the need, you know, for education, for linking up networks. And one of those being the "telehealth." We haven't really gotten as far as we need to do, I think. It's just one more area there's so many things that need to be done. But I'm looking at it particularly from the people who have the psychiatric needs. I would also encourage in the development of the data system that it be, and I'm sure it will be, but just to say it on the record, more than simply a payment, because that's pretty much what we've had, is a payment system. For example, one thing that the Behavioral Health Department, one figure that they can tell us with reliability is people who are not in the community, because they're in the public hospital system. We need a data system that will answer questions about recovery, give us information about housing, education, you know, and there's...I recognize there are a lot of benders out there, but this is an opportunity to plan for the future with our data. Data has been very difficult, because we didn't ever build our systems with the expectations that we would need data so that we could have data-driven systems and data-driven decisions. But we're there now. And I appreciate the fact that a lot of attention is going into this. And if I may, I'd like these four to become part of the record and I'm sorry, I do have one copy

each, but I'm sure others can be made. Thank you. []

KATHY CAMPBELL: That's fine. Thank you very much for coming. []

J. ROCK JOHNSON: Thank you, I appreciate your time.

KATHY CAMPBELL: Anyone else? Seeing no one, we will, the chair will call for an adjournment of the meeting, and we will be on call for November. Thank you, everyone, for coming today.