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The Children's Behavioral Health Oversight Committee met at 1:30 p.m. on Monday, December 14, 2009, in Room 1113 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public hearing. Senators present: Kathy Campbell, Chairperson; Bill Avery; Colby Coash; Annette Dubas; Tom Hansen; Amanda McGill; and Pete Pirsch. Senators absent: Gwen Howard and Jeremy Nordquist. []

SENATOR CAMPBELL: Good afternoon. Can you hear? I am Senator Kathy Campbell and serve as the Chair of the LB603 Oversight Committee. I want to welcome you. This is the third in our series of education for the committee in preparation for the package of LB603 to go into effect, announced for January 1. I'm going to go through a few announcements before we start. First of all, I would like to have the senators introduce themselves and we'll start on my far right. []

SENATOR McGILL: I'm Senator Amanda McGill from northeast Lincoln. []

SENATOR AVERY: I'm Senator Bill Avery, District 28. You're in it right now. []

SENATOR DUBAS: Senator Annette Dubas, District 34. []

SENATOR HANSEN: I'm Tom Hansen from District 42, North Platte, Lincoln, County. []

SENATOR COASH: Senator Colby Coash from south and west Lincoln. []

SENATOR CAMPBELL: Several of the other senators may be joining us as the afternoon goes along. There are agendas available. I'd like to introduce my legislative aide, Claudia Lindley, who is distributing agendas, so there are some at the table if you do not have an agenda. And we need to note a correction. The first gentleman's plane was cancelled out of Philadelphia, so he will be unable to join us this afternoon. There

will be a sign-in sheet for public testimony when we get to that point. This afternoon I'm going to be very, very strict on the time. When we get to 3:00 then we will end. Director Chaumont and several of the senators have other appointments. We will go to the next item on the agenda and promptly at 3:15 we will take comment. I know that today is...there is just no way that today is meant to have every question that anyone in this room has ever had about Magellan and its services that we can answer, so I do pledge to the senators and certainly to all of you who have come today that we probably will have a follow-up session on additional questions. I also know that in public comment we may not be able to get you all in, but we will make every effort to try to explain how you can access that, and we will have another meeting for public comment as we go along in the process. So with that, introductions at hand, we will begin. And Director Chaumont was pleased to provide some education materials for the committee. Good afternoon. []

VIVIANNE CHAUMONT: (Exhibits 1, 2, 3, and 4) Good afternoon. My name is Vivianne Chaumont, and I'm the director of the Division of Medicaid and Long-Term Care of the Department of Health and Human Services. Thank you for the opportunity to speak to you about the Medicaid behavioral health managed care program and Medicaid's Administrative Services Organization contract with Magellan. Is that really loud? Since the early 1990s, state Medicaid programs have turned increasingly to managed care to improve access to care and contain costs. Many states have enrolled sizable portions of their Medicaid beneficiary populations in some form of managed care, most often in managed care plans that provide comprehensive services to their members on a coordinated, prepaid basis. For state policymakers dealing with Medicaid budgets, Medicaid managed care emerges as a particularly attractive alternative to the other primary options available to control budgets, including reductions in eligibility, benefits, or cuts in provider payment rates. Savings opportunities in Medicaid managed care are largely created by the inherent structural challenges of coordinating care and containing costs in the fee for service setting. Managed care provides the opportunity to contain costs while still ensuring access to necessary medical care. States can establish

managed care in their Medicaid programs in two ways, through the Medicaid state plan or through a managed care waiver. Nebraska's behavioral health managed care program has been done through a 1915(b) waiver since 1995. In order to have a 1915(b) waiver approved by the Centers for Medicare and Medicaid Services, CMS, the state must show cost-effectiveness. Simply stated, the state must show that, by using the managed care program under the waiver, the state saved money. The savings that come from the use of more cost-efficient medical care for clients is then allowed to be used to provide clients with additional services. Nebraska uses the savings from managed care to offer additional mental health services which might not otherwise be eligible for Medicaid reimbursement. These services are: intensive case management, psychiatric nursing services, client assistance program, treatment crisis intervention, intensive outpatient, crisis stabilization, community treatment aide, consultative services, and adult substance abuse treatment. Medicaid managed care can be administered in several ways: at-risk capitation through managed care organizations, prepaid health plans, and primary care case management. In an at-risk managed care program, the managed care organization is paid a per member per month fee for each enrolled client, and the managed care company is at risk for providing all services in the contract. In a primary care case management program, the managed care company is risk free. The company is paid a monthly fee for case management and services are paid directly by Medicaid on a fee for service basis. Nebraska's behavioral health managed care uses a version of primary care case management called specialty physician case management. This model is used to manage special types of care, most commonly mental health and/or substance abuse services. In this model, no primary care case management may be provided, primary care being, you know, physicians for primary care physical health. The case management is limited in our version to a specific specialty service or services. The payment arrangement is risk free. Payment to providers is fee for service and paid directly by the Medicaid program to the provider. We pay a case management fee, a per member per month, to a contractor to case manage the mental health and substance abuse services for Medicaid clients. This contractor is Magellan. Medicaid contracts with Magellan as an administrative service

organization, not an at-risk managed care organization. This means that Magellan provides administrative services for the Medicaid program. It does not pay for services. Magellan is not at risk financially for those services. Magellan's primary responsibilities under the contract with Medicaid are: client enrollment, provider credentialing and network development, utilization review and case management services, quality improvement and quality assurance, advocacy and education services, and system support. In the interest of time, I will focus on the two areas that receive the most public attention, provider credentialing and network development, and utilization review. In the area of provider credentialing and network development, Magellan is required to credential and contract with a sufficient provider network to meet access standards for the Medicaid population. To be considered for inclusion in the network, a provider must meet Magellan's credentialing criteria. Magellan monitors access adequacy for outpatient services provided by individual and group providers, primarily though the use of Geo-Access. Geo-Access is a data tool that provides network accessibility analysis to assist managed care companies in managing their networks and ensuring access for clients. They also review demographic data, utilization data, appointment availability, and satisfaction surveys. The contracts provide standards as to access that are reported quarterly by Magellan to the department for review. In discussing utilization review, we need to start at the core principle of the Medicaid program. Medicaid is a health insurance program for eligible pregnant women, children and their caretaker adults, the aged, and the disabled. In order for a service to be eligible for Medicaid reimbursement, it must be medically necessary. Medical necessity is a requirement of federal Medicaid law. If a service is not medically necessary, the Medicaid program cannot pay for it. If the Nebraska Medicaid program pays for services that are not medically necessary, it risks the loss of federal funds. Medical necessity is not a requirement unique to the Medicaid program. Medical necessity is at the core of every health insurance policy, including Medicare. The definition of medical necessity in Nebraska Medicaid regulations parallels the definition of medical necessity in the Blue Cross and Blue Shield of Nebraska benefit guide for its policies. Services determined by Medicaid to be not medically necessary are not covered under the Medicaid plan, just

like the services determined by Blue Cross not to be medically necessary are not covered under the Blue Cross plan. The benefit guide for Blue Cross also provides that benefits will not be provided for programs ordered by the court which are not medically necessary, as determined by Blue Cross and Blue Shield of Nebraska. in sum, medical necessity is a core principle of all health insurance plans, including Medicaid. Prior authorization is one tool by which Magellan determines, on behalf of the Medicaid program, whether a service is medically necessary. Prior authorization of benefits is prior written approval of certain benefits. It is based on the information submitted to Medicaid, to Magellan, and may be effective for a limited time...period of time. Magellan is required to prior authorize all services. When Magellan receives a prior authorization request, it reviews the appropriateness of the setting and the level of medical care, as well as the timing and duration of the service. Prior authorization is requested by the provider. All initial level of care decisions are made by a Magellan care manager who considers each case on its individual characteristics and recommends treatment decisions based on medical necessity criteria. The goal of the criteria is to provide a framework in which clients receive the right service at the right time in the right amount at the lowest level of care that meets the client's clinical need. If a provider or member wishes for formal review of the decision, they request a peer review. The initial decision is then reviewed by a Magellan psychiatrist. If the Magellan psychiatrist agrees with the recommendations by the provider, the requested service is approved. If the Magellan psychiatrist does not agree with the recommendations made by the provider, the provider or the member has the option of requesting further review by a reconsideration panel, a group of Nebraska psychiatrists. If there is still no agreement, the provider or member can file an appeal with the state and proceed to an administrative hearing. We are providing data regarding the numbers of requests for services received and the number of those requests that are approved and denied. And that is all in handout Attachment 3. One important note needs to be stressed. The fact that a request for a particular service was denied does not mean that no service was provided. In the large majority of cases, if a particular service is denied, it is discussed with the provider and agreement is reached for a different service to be substituted for the requested service.

This goes back to the goal of providing the right service at the right time in the least restrict setting. The right service might be community-based rather than residential. It might be a different level of residential treatment. Pursuant to the contract, Magellan is required to focus on development of appropriate community-based services as an alternative to residential treatment. National data shows that Nebraska is in the top 20th percent nationally in terms of utilization of residential treatment for children and youth, a trend that Nebraska would like to reverse. Nebraska's vision is to design and implement a system of care to serve more children in their own homes and provide the right level of service to all children served. Prior authorization of out-of-home services is a key tool in making this vision a reality. If you look at Attachment 1 and Attachment 2, they're two different ways of showing the ranking among states of out-of-home residential placements, and you'll see that Nebraska ranks, I think it's number nine. Let's see, again, prior authorization of inpatient admissions related to the treatment of mental illness or substance abuse is fairly standard in the commercial industry...insurance industry. Going back to Blue Cross, all such inpatient admissions must be prior approved for benefit payment. Blue Cross determines whether or not the benefits will be approved and the number of days considered medically necessary. As discussed earlier, the contract between Magellan and Medicaid is not at risk. Magellan does not pay for the actual services. Medicaid pays for them on a fee for service basis. Magellan, therefore, has no financial incentive to deny services. The contract between the parties does not provide any bonuses or other remuneration that Magellan can earn by not authorizing services. The determinations regarding appropriate care are based only on the clinical criteria that have been developed and the goal of providing the best and most appropriate care for Medicaid clients. Thanks again for the opportunity to speak with you. I'd be happy to answer questions. I also have several staff from Magellan with me today to help answer you questions. []

SENATOR CAMPBELL: Director Chaumont and I discussed how to proceed and I know there is someone from Magellan who is going to join you at the table. Is that correct? []

VIVIANNE CHAUMONT: Yep, Deb. []

SENATOR CAMPBELL: For the senators' benefit, we had four questions that were submitted by senators and then three additional that were sort of a composite that came from me and a lot of other information which we gave to the director. But how we're going to proceed today is that the director is going to cover the first four questions that were submitted and then we're going to open it up to the senators' questions. So whatever then you want to ask and we'll spend that time from now till 3:00 on questions. So, Director Chaumont, perhaps you read the first question and we'll proceed. []

VIVIANNE CHAUMONT: Okay. Can I let... []

SENATOR CAMPBELL: Absolutely. []

VIVIANNE CHAUMONT: ...Deb introduce herself first? []

SENATOR CAMPBELL: Absolutely. []

DEB HAPP: Hi. I'm Deb Happ and I'm the vice president of public sector operations for Magellan health services. I'm also a licensed clinical psychologist and before coming to Magellan I actually ran a community mental health center that focused on serving children and families. I've been with Magellan for 13 years, though I've been involved with the Nebraska Medicaid account actually since its inception in 2002. []

SENATOR CAMPBELL: Welcome. Thank you for coming. []

VIVIANNE CHAUMONT: Okay. The first question that we had was our office has had more than one call where a client's doctor determines the procedures necessary and Magellan denies coverage. After calling DHHS, it usually works out, but the question is, is it standard practice for Magellan to deny coverage for certain procedures at the

onset? And I'm going to let Deb answer that. []

DEB HAPP: Okay. First of all, I want to say that this is not a standard practice. We have no policies and procedures which would say to deny any service at its outset. However, every request for services is reviewed according to the medical necessity criteria that have been developed jointly with the department, and so we want to make sure again, as Vivianne has noted, that we are authorizing the right service at the right time and that it's the least restrictive care that is likely to meet the client's clinical needs. And so we review every request for medical necessity and a determination is based, based on matching the criteria with the clinical needs that are presented for the person to be receiving services. Think also, as was noted, is that we never would say no to a service without saying yes to something else. So if someone makes a request for, for example, residential services and it is our determination that residential is not the appropriate level of care and that medical necessity criteria is not met, we would make a recommendation for another level of care that we would believe would meet that person's clinical needs. And any decision...I should say, too, any decision not to authorize the service is made by a physician, a psychiatrist. []

VIVIANNE CHAUMONT: Okay. The next question was on medical records and foster children. I'm concerned about multiple doctors prescribing multiple psychotic drugs to juvenile wards of the state. Boys Town was doing some type of work along those lines. And I'm going to go ahead and answer that. First of all, Magellan has absolutely zero responsibility in managing drugs for the Medicaid program. Most states leave drugs out of their managed care for financial reasons. It's because the rebates that Medicaid collects on drugs which help finance the program cannot be paid if the drugs are being managed and paid for by a managed care company. So I'm not saying that this makes absolute sense, because it really doesn't, but that's the way most Medicaid programs throughout the country manage it. So this really is not a Magellan issue at all. And the interesting thing about it, part of why it's so difficult to manage drugs in a managed care company is that the largest percentage of behavioral health drugs are prescribed

outside of the behavioral health system. Most of them are prescribed by primary care docs and, in the case of kids, pediatricians and everything else. We haven't done anything like this, looked at the data here in Nebraska, but I know that we looked at the data one time in Colorado and the largest portion of behavioral health drugs were prescribed by family doctors and then it went down from there. Psychiatrists weren't second or third or fourth; they were way down in the line. There aren't that many psychiatrists and, you know, your average person goes, you know, to their doctor, their family doctor and asks, says, you know, I'm having some problems, and gets their prescriptions from them. The pediatricians, family doctors are not in the behavioral health network, so that whole system of drugs, of drug prescribing is just outside, outside of the behavioral health system, which is a problem, admittedly. Some of the things that we do do in just fee for service Medicaid is when we see that someone is getting a lot of different drugs from different pharmacies and different doctors, there's a program called Lock In where we talk to that person and then lock them in to a particular physician. You know, could be a primary care physician, a family physician, an internist, whatever. We pick one doctor, work with that doctor to manage that client's medication, and then that client has to go to that "Dr. Ken." We won't reimburse for anything if it's not prescribed by that doctor and usually I believe we also say it has to be in a certain pharmacy so that the pharmacy can track as well. Most of the time, that happens with pain medication. People are going to different places to get pain medication. So the issue of kids getting too many antipsychotics or a lot of different ones from different people is kind of a different issue. One of the things that we do also that helps us with the drug in is we have a Drug Utilization Review Board and they have recommended that we do not...that they have recommended to the Medicaid program to not pay for prescriptions for antipsychotics and some other psych drugs for children without a prioritization, so that if it's below a certain age that a child would just not be given a psych drug without it having to be prior authorized, which means that the doctor has to consult with another doctor for prior authorization purposes. Providers have been very opposed to that. That's one of the things that we can do. Another thing that...let's see, the DUR, is if there's more than one, you know, if there's more than one then you

could use the pharmacy system to have to prior authorize that. But other than that, that doesn't have anything to do with Magellan. So I'll go on. In the out-of-home... []

SENATOR HANSEN: Senator? []

SENATOR CAMPBELL: Senator Hansen. []

SENATOR HANSEN: Can we ask questions as we go along? []

SENATOR CAMPBELL: Sure, because this is...that was his question. []

SENATOR HANSEN: Yeah, that was my question. []

VIVIANNE CHAUMONT: Uh-huh. Oh sure, uh-huh. []

SENATOR HANSEN: And I guess that line is a little blurry for me about medical necessity, for approving medical necessity and not proving medical excessiveness. []

VIVIANNE CHAUMONT: Uh-huh. []

SENATOR HANSEN: And I still...I still don't see where that line is. If a ward of the state in a foster home goes from one to two to three to four different homes and those psychotropic drugs continue getting piled on, someone has got to notice that. And if we do it through the pharmacy, I get Claritin-D over the counter but I have to sign away, you know, sign my name, give them my driver's license and all that stuff. But these foster kids, who checks on that? []

VIVIANNE CHAUMONT: You know, we currently do not. The Medicaid program doesn't have a program for checking on those, on those, on drugs, and we don't have the resources to do that beyond what I was talking about, the Drug Utilization Board, you

know, just prior authorizing. So from the start we don't have a program. That's an issue that's coming up. You're reading about it in a lot of different states with children and with foster care children in particular, that you just find a large percentage of kids with mental health drugs and some of them with, you know, three, four, five different mental health drugs and that's something that we just currently don't have a program for. []

SENATOR HANSEN: Does HIPAA disallow that foster parent, the second or the third foster parent, from knowing that? []

VIVIANNE CHAUMONT: No. No. []

SENATOR HANSEN: No, it doesn't prohibit it? []

VIVIANNE CHAUMONT: No, it does not. No, if the foster parent is... []

SENATOR HANSEN: So the foster parent can... []

VIVIANNE CHAUMONT: ...yeah, is, you know, legally responsible for that child because they're in their care, that foster parent would have access to all that child's medical records. []

SENATOR HANSEN: What's the time frame on that? I mean they leave foster home three and go to foster home four. How long will it be before they get those medical records then? []

VIVIANNE CHAUMONT: Well, they have to request them. []

SENATOR HANSEN: They have to request them. From who? []

VIVIANNE CHAUMONT: From whomever was treating the child. []

SENATOR HANSEN: Okay. From a provider then. []

VIVIANNE CHAUMONT: Yeah, uh-huh, from the provider, right. []

SENATOR HANSEN: And the provider won't balk at HIPAA regulations for that? []

VIVIANNE CHAUMONT: I don't know if the provider would balk, but the provider should be providing those services. []

SENATOR HANSEN: Okay. All right. Thank you. []

VIVIANNE CHAUMONT: Those copies. []

SENATOR HANSEN: I think that's a problem we need to continue to look at. []

VIVIANNE CHAUMONT: Uh-huh. Uh-huh. I agree with you. []

SENATOR CAMPBELL: Senator Avery. []

SENATOR HANSEN: Thank you. []

SENATOR AVERY: Thank you, Senator Campbell. I'm curious about this prior authorization process. From what you told us and what I'm reading here, Magellan makes the determination... []

VIVIANNE CHAUMONT: Uh-huh. []

SENATOR AVERY: ...when a provider requests service. If the...so you have, first of all, you administer the program. Then when you get to the point where the provider...say

your Magellan caseworker says no to the service, you are there you're playing at more than just an administrative role there. You're judge as well. Correct? []

VIVIANNE CHAUMONT: Well, that is their administrative role, is to look at the service and determine whether or not it meets the criteria. []

SENATOR AVERY: And if you...and they find that it does not it then goes to a peer review. []

VIVIANNE CHAUMONT: Right. []

SENATOR AVERY: That peer review is conducted by a psychiatrist employed by Magellan. []

VIVIANNE CHAUMONT: Correct. []

DEB HAPP: Correct. []

SENATOR AVERY: That is an adjudicated function, right? []

VIVIANNE CHAUMONT: No, that's a function where the two providers, the doctor that prescribed the service and the Magellan doctor speak and discuss the, you know, the individual facts of the case. []

SENATOR AVERY: No, I don't mean a formal adjudicative function. []

VIVIANNE CHAUMONT: Okay. Right. []

SENATOR AVERY: I mean in a general sense this Magellan psychiatrist is deciding whether or not the claim is valid or the request... []

VIVIANNE CHAUMONT: Whether or not the request is valid, yeah. []

SENATOR AVERY: ...the request for treatment. Right? []

VIVIANNE CHAUMONT: Yes. []

DEB HAPP: Yeah. []

SENATOR AVERY: Okay. So you administer and you judge. []

VIVIANNE CHAUMONT: Uh-huh. []

SENATOR AVERY: All right. Then at some point if a person is denied service then they have an alternative to go to a reconsideration panel. []

VIVIANNE CHAUMONT: Correct. []

SENATOR AVERY: Who selects that panel? []

VIVIANNE CHAUMONT: They are Nebraska psychiatrists that have contracted with Magellan. They are psychiatrists here in Lincoln and here in Nebraska who have private practices and, as an aside, they contract with Magellan to do review, to do basically a peer review of their other providers in the state of Nebraska. []

SENATOR AVERY: So they are compensated for this, I presume. []

VIVIANNE CHAUMONT: Yes. []

SENATOR AVERY: And Magellan pays this compensation? []

VIVIANNE CHAUMONT: Yes. []

SENATOR AVERY: Okay. So Magellan administers the program. If there is a challenge to the decision, Magellan makes a ruling on that. If there is a challenge to that, Magellan's employees here in the state of Nebraska comprise a reconsideration panel. []

VIVIANNE CHAUMONT: No. []

DEB HAPP: No. []

VIVIANNE CHAUMONT: Magellan's... []

SENATOR AVERY: You reimburse them. []

VIVIANNE CHAUMONT: ...Magellan's contractors. []

DEB HAPP: They're not employees. []

VIVIANNE CHAUMONT: They're not employees. []

SENATOR AVERY: Okay. You contract with them. []

VIVIANNE CHAUMONT: Right. []

SENATOR AVERY: You pay them. []

VIVIANNE CHAUMONT: Yes. []

DEB HAPP: Just like we contract with providers to provide the service. []

VIVIANNE CHAUMONT: Yes. []

SENATOR AVERY: Yeah. You don't see anything wrong with that? []

VIVIANNE CHAUMONT: No, that's how insurance companies work. []

SENATOR AVERY: Oh, wait, wait, wait, that's how insurance companies work? []

VIVIANNE CHAUMONT: Yes. []

SENATOR AVERY: And that's a good thing? []

VIVIANNE CHAUMONT: Yes, because otherwise you would have unlimited, unadulterated costs. []

SENATOR AVERY: That's is under debate right now. []

VIVIANNE CHAUMONT: Well, you know, it is under debate but let me tell you that's the way any insurance company. If I go in to the doctor and my doctor says, you know, I need an MRI on my knee, that has to be prior authorized by Blue Cross Blue Shield. And if the Blue Cross Blue Shield employee doctor says no, then my doctor has to go forward and do the same thing. That is exactly how it works, yes. []

SENATOR AVERY: I know how it works because I can read that. I'm raising questions about whether this is the best way to go about resolving challenges to the initial ruling. []

VIVIANNE CHAUMONT: And I think it is the best way because we hire...Magellan hires doctors who are used to the way that Nebraska doctors practice. They are Nebraska

physicians and they review what their peers are...and sometimes they're the ones who are requesting, you know, a prior authorization. So, yes, I think it is the best way. []

SENATOR AVERY: So sometimes you can have on this reconsideration panel physicians who actually would directly benefit from a favorable or unfavorable decision by that panel? []

VIVIANNE CHAUMONT: No, they don't. They don't benefit. They look at each case individually. They're contracted by the hour to review, to do the peer review of that. So do they benefit because they get paid? Yes. Do they benefit because it's, yes, you can give the service or, no, you can't give the service? No, they do not. []

SENATOR AVERY: Oh, I thought you... []

DEB HAPP: And they could not... []

SENATOR AVERY: ...I thought you said that they may sometimes have...be the provider. []

DEB HAPP: No. []

SENATOR AVERY: So you... []

VIVIANNE CHAUMONT: Not in... []

SENATOR AVERY: ...you do not ever have on the reconsideration panel psychiatrists who might actually be providing the service down the road. []

VIVIANNE CHAUMONT: No. []

SENATOR AVERY: Okay. Thank you. []

DEB HAPP: I just want to make one clarification. That is that our care managers, who are licensed clinicians in the state of Nebraska, they are not the people who ever say no. All they can do is make a recommendation that they don't believe it meets medical necessity criteria and then it goes to a physician for that determination, to a psychiatrist. So every decision not to approve a service is made by a Nebraska licensed psychiatrist. []

SENATOR CAMPBELL: Director Chaumont, I think part of the...one of the questions that might be also behind Senator Avery's that we received, I think we might have forwarded it on to you, where a provider had been denied and then the peer review ended up being this same physician that had denied them initially. And I think that's one of the questions, whether...I mean it would seem to me that that practice would be suspect. []

DEB HAPP: Right. That should not occur and we would need to look at any individual case where that might happen. People could contact us. But at each level, the protocol is to have a physician who was not involved in the initial decision so that every time it's looked at it's by someone who was not involved in any of the previous decisions so that they truly are looking at the case with fresh eyes. And again, we want them to have a conversation with the treating provider so that...because sometimes, quite honestly, they get additional information that we may not have had initially. So everyone, you know, if they get additional information, you know, not everything that goes through that process remains denied. Sometimes those decisions are overturned based on the clinical information that's presented. []

SENATOR CAMPBELL: Senator Pirsch. []

SENATOR PIRSCH: Thanks for your testimony here today. Say, I was just wondering

about average, in terms of time frame, assuming you have a case in which, you know, the...I guess the best word is "appealed," so to speak, the Magellan care manager's initial assessment, which then flows through that peer review and then later a reconsideration panel. But what...typically how long do these...say a case is to go to a reconsideration panel. On average, what type of time transpires between the start and reaching that, the determination of that panel? []

DEB HAPP: Yeah, okay. And I just want to say that I'm not sure of the exact time frame and I may need... []

SENATOR PIRSCH: Oh, sure. []

DEB HAPP: ...Kathy to help me out. But the...if it's an initial request for a higher level of care, such as inpatient, those we really try to get done within 24 hours because that's a request where someone is needing to make a decision quickly. On other levels of care it would be about 72 hours for the process to unfold. []

SENATOR PIRSCH: And then if...from that initial determination, and again I don't want to...if, you know, you don't have an exact answer and you would rather defer to somebody who does, but just a general type of ball park time frame with respect to the other avenues then from that initial determination, you said that's from the Magellan care manager, right? []

DEB HAPP: Right. No, it's from the initial physician, right. []

SENATOR PIRSCH: Peer...oh, I see, okay,... []

DEB HAPP: Right. []

SENATOR PIRSCH: ...from the original physician. And then the next step would be

then...what would that be then from the original? []

DEB HAPP: The next step would be the panel and that's within... []

UNKNOWN PERSON: I would have to take that back (inaudible). []

DEB HAPP: Well, the initial steps are very quickly because we realize people need a decision quickly and we don't want to hold up people's care. So I can just say, as a company, because I work with all of our public sector programs across the country, that you know we try to get that all done within a 72-hour time period in order to expedite (inaudible). And the last piece, if they would take it to...and really with an administrative hearing with the state, a state fair hearing, that I believe they have to request within 30 days of the decision and then that's scheduled. So that's the piece that probably takes the longest but the internal pieces go quickly. []

SENATOR COASH: I have some questions but I'm going to...she's going to go to three and four? []

SENATOR CAMPBELL: That's okay. Go ahead. We'll want to finish them out. []

SENATOR COASH: Okay, we're going to let them...my question is maybe answered through those so I'm going to hold off. []

SENATOR CAMPBELL: Okay. Let's go ahead and pick up question... []

SENATOR DUBAS: Senator Campbell, can I ask... []

SENATOR CAMPBELL: Oh, sure. Sorry. []

SENATOR DUBAS: ...a question quickly? Since we're kind of talking along the lines of

requesting these reviews, if a provider calls in challenging or, you know, a provider calls in and requests a service, that service gets denied, how much time does that provider have to ask for the next level, the next review? []

VIVIANNE CHAUMONT: In that conversation. []

DEB HAPP: Right. It's done in that conversation, and they can appeal up to 24 hours afterwards. []

SENATOR DUBAS: Okay. If it goes past that 24 hours, do they lose that option to request a review? []

DEB HAPP: Yes. And for...it's different for, for example, inpatient care, you know, residential levels versus outpatient care, and when the determination is made, the physician, as part of the discussion, let's the person know how much time they have to make that appeal and what that process is. They also receive, both the provider and the member, receive a letter with all that information in it and that letter is sent, you know, within the next business day and it has all of the appeal information in it as well. []

SENATOR DUBAS: Okay. So if they would receive that letter, you know, if that was the only contact that they got was that letter and it was outside that 24 hours, would they still have the ability to... []

DEB HAPP: Remember, they also received it verbally at the time of the discussion with the physician. []

SENATOR DUBAS: Okay. []

DEB HAPP: So it's given both...it's verbal at the time of the discussion and then followed up with a letter. []

SENATOR DUBAS: And so at the time of the discussion they could say, I don't agree with this, I want... []

DEB HAPP: Correct. []

SENATOR DUBAS: ...to appeal. []

DEB HAPP: Correct, uh-huh. []

SENATOR CAMPBELL: Follow up, Senator Dubas? Okay, let's go ahead and pick up. Senator Howard had presented two questions, so let's pick up three. []

VIVIANNE CHAUMONT: Okay. In the out-of-home care contract, page 3, Section O, the contract says that if Medicaid denies payment for a service for mental health or substance abuse treatment the contractor has to pay for the service. How is Magellan interpreting this section? The out-of-home contracts are contracts between the Division of Children and Family Services and providers, and they do not involve either Medicare...Medicare (laugh)...they do not involve either Magellan or Medicaid. []

SENATOR CAMPBELL: Okay. Any follow-up questions to that? If, Dr. Chaumont, if the...in that situation, assuming the youth or child was state ward, then if the service was denied what recourse would they have then at that point? []

VIVIANNE CHAUMONT: They work through Children and Family to find appropriate care for the child. []

SENATOR CAMPBELL: Senator Howard also had question four. []

VIVIANNE CHAUMONT: Okay. We've been contacted by constituent service providers

about the process Magellan follows when they're asked about coverage. If a provider asks Magellan whether something is covered or for advice on coverage issues does Magellan have procedures for questions like this? Are providers given something in writing or can they get something in writing? []

DEB HAPP: Okay. First of all, I want to say that any of our...when someone calls Magellan, the phone is initially answered by a customer service associate and they have full access and are trained in all of the benefits available under this program, so they would be able to answer any coverage issues. And by coverage issues, I assume what you're asking is what services are covered under the Medicaid contract or under the Medicaid program here in Nebraska. Also, the information about all the covered services is available in our provider handbook, which is on the Web site, and providers may either look it up on the Web site or they can request a hard copy if they would prefer that. And when a new provider comes into our network, they go through training on how to interact with Magellan and how to request authorizations, etcetera, and they are given this information at that time as well. And I assume the question really is about coverage because I also want to make sure that people under...there's a difference between covered and authorized. A service can be a Medicaid covered service but it doesn't necessarily mean that it would be authorized for anyone who requests it because, again, that's dependent on medical necessity. []

VIVIANNE CHAUMONT: []

SENATOR CAMPBELL: There are some days that we might appeal that for him. (Laughter) []

VIVIANNE CHAUMONT: There are some days where he might win. (Laugh) []

SENATOR CAMPBELL: Right. I appreciate you covering those questions because those were specific. Want to open it up to general questions from the senators. Senator

Dubas. []

SENATOR DUBAS: Just a follow-up on what you just referred to, and you talked about a customer service associate. Is that correct? []

DEB HAPP: Yes. []

SENATOR DUBAS: So if a provider calls in and they talk to customer service associate A,... []

DEB HAPP: Uh-huh. []

SENATOR DUBAS: ...does that associate stay with that provider, following through till they finally get a resolution to their question or whatever it was that they called in about, or could they be passed off to multiple associates if it's an extended period of time? []

DEB HAPP: Well, yeah, Magellan really has a first-call resolution philosophy and that is that we don't want to pass people around. We may have them talk to someone else within the office but then, if it comes back to customer service, it would go back to the same person. And again, what we would like to do is not have to have people call five people; that if they call a customer service associate, they would answer that question to the best of their knowledge. If there's another staff person in our office who would be more qualified to answer a particular question then we would...they would, you know, have that person transferred to that person. They would stay on the line to make that transfer occurred so that they make sure that people don't have to keep calling in. Now the other part of that, however, is that sometimes people come in and they shop for the answer they want. So they call in one, they're given an answer about something, they hang up. Supposedly their question is resolved. And then they call back in several other times to see if somebody else will give a different answer. So in that case, they don't always talk to the same person because they're the same person calling in, but if they

call in once, until that particular call is resolved they do stay with the same person. []

SENATOR DUBAS: I've had more than one provider explain scenarios to me where they've called in specifically looking for authorization for services and they have been passed off to multiple people. They requested them to fax in records, and they faxed in records. Then they'll call back to follow up and they'll say, oh, well, I don't have those records, could you fax. You know, they're asked for that same information multiple times. And I've heard a high level of frustration that they never talk to the same person every time that they call in when, basically, what they're asking for is an authorization of services. []

DEB HAPP: And I would again ask that if people have that question they should let us know the specifics because we will then resolve that issue. []

SENATOR DUBAS: Who? Who should they let know? []

DEB HAPP: I mean they aren't going to get the same person every time they call in because, you know, in an effort to...because we also have phone standards. We have to answer our phone within 30 seconds and, you know, not abandon more than 5 percent of our calls. So when people call in, you know, rather than have...since we don't know who's calling in, it is to the first person who's available to take that call in order to expedite that process. If they say they've called in before, you know, we would check that out with that person. If someone does have a concern or a question, they can call Kathy Dinges, who's our general manager, and she will resolve the issue. []

SENATOR DUBAS: Okay. So when someone calls in for authorization of services, what do they have to provide for you in that request? []

DEB HAPP: Right. It really depends on the level of care that's being requested. There are some levels of care, for example, inpatient is always done telephonically, so when

they call in, customer service associate would just note that the call came in. They would make sure that this person was covered under the Medicaid program here in Nebraska and then they would transfer the call to a care manager who is one of the licensed clinicians who would do a telephonic review of the case. So they would take the clinical and make the...and, you know, proceed with the authorization. There are some levels of care that people request via paper packets and I think about residential treatment, for example. That is done by the provider develops a set of, you know, there's requirements for what has to be included in that packet and they send that to Magellan and it's reviewed on paper. So the process for the review depends on the level of care and that's all spelled out very clearly in the provider manual. []

SENATOR DUBAS: So this information is provided. If more than one person is involved with answering questions, is that information available for everybody to access... []

DEB HAPP: Absolutely. []

SENATOR DUBAS: ...so they shouldn't have to send in these reports or requests or whatever multiple times. []

DEB HAPP: No, they should do it once, correct. []

SENATOR DUBAS: If something was faxed in or provided, it should be there. []

DEB HAPP: Correct. []

SENATOR DUBAS: And if there is that time when they're asked multiple times to fax things in, who do they need to call with that concern? []

DEB HAPP: Again, if they have a complaint, they should contact Kathy. []

SENATOR DUBAS: Thank you. []

DEB HAPP: And we will give her telephone number at the end of the... []

SENATOR CAMPBELL: And we will be glad to provide it also. []

DEB HAPP: Okay. Thank you. []

SENATOR CAMPBELL: Senator Coash has been patient. []

SENATOR COASH: Oh, thank you, Senator Campbell. Vivianne, first of all, this was...you gave a great overview and I think it was very educational for the committee, myself, and those who are watching to understand the process. As a whole I'm okay with the process, but I do have some customer service issues. But before I get to those, I have do have a question for Director Chaumont. Our contracts...Nebraska's contract with Magellan, we've been in contract with Magellan for the past how many years are we on now? []

VIVIANNE CHAUMONT: 2002. []

(UNKNOWN): 2002. July 2002. []

VIVIANNE CHAUMONT: Everybody but me knows. 2002. []

SENATOR COASH: So pushing seven years? []

VIVIANNE CHAUMONT: Uh-huh. []

SENATOR COASH: Okay. When is this contract up for renegotiation? []

VIVIANNE CHAUMONT: We are...it's up for an option in July. We just... []

SENATOR COASH: This July? []

VIVIANNE CHAUMONT: Yeah, we just rebid the contract and had a couple of bidders. Magellan won the contract. And we did a two-year, a two-year contract with three one-year options. So the first two years are up June 30 and we will be using one of the options to renew the contract for another year. []

SENATOR COASH: So barring any major breach of contract, we're in with Magellan for...till June of 2011... []

VIVIANNE CHAUMONT: Yes. []

SENATOR COASH: Okay. If providers and ultimately the service recipients are the customers, then I think we do have a customer service problem. What I'm concerned about, as I think Senator Dubas is indicating, is some poor communication and relationship with the providers out there. That's who I'm speaking with. And this might be a question for Ms. Dinges, but I'm very...I want to know today what the plan is for Magellan to address some of the provider customer service issues similar to what Senator Dubas...specifically, just overall education for providers on expectations to try to expediate the process. Because the process in itself, I've looked at it very carefully, it's fine. You now, the definitions of medical necessity, those kinds of things, I think we could adjust them but over all I think it makes sense. But to negotiate that process in a way that is expedient for the people who need that service, I think we have some problems, and I'd like to hear on the Nebraska side what we're going to do to address those. Because it's the kids who need the service who...when there's delays in phone calls or delays in authorizations that slip through, I'm very concerned about that. So I'd like to have that addressed today. []

VIVIANNE CHAUMONT: Okay. And, Senator Coash, we actually agree with you. We think that there have been some issues with Magellan that we have discussed with them in the recent months and asked them to give us a plan of improvement for how they want to address provider issues, and I think that addressing some of the education issues will improve the system and quiet the system down. I think sometimes we're just not communicating sufficiently. So we have asked Magellan to provide us with some...with a plan on how they're going to improve their provider relations in this state, and then I'll let Deb go ahead and talk about that. []

DEB HAPP: Right. And I will say we have developed a plan which we have submitted to the state and which we have actually started working on, and just...I'll tell you about a couple things and then actually I may have Matt Miller chime in for the things that I forget about. But for example, one of the things that we've used successfully in other states where I've worked is we have a provider advisory group and it's really a group of about ten providers from throughout the state who come together on a regular basis, and we're...actually we have our first meeting tomorrow and we're going to have it every other month with the providers, and it's an opportunity for providers to, you know, not all providers but at least for providers, and they represent various constituency groups, to really be part of and in on the ground floor of process decision and discussions about what they hear from...what they experience and what providers that they talk with in various parts of the state or various types of providers. They have an opportunity to discuss it at that time so that it's in a small group setting. We also have large provider meetings that occur on a regular basis and we have those, I think, in conjunction with the state. We plan to do more provider forums where we go around the state and really gather information from providers, give them information as it comes up and really engage in a discussion around those processes, in addition to written communications that we've started to send out on a more regular basis, too, to make sure everyone is trained. And, Matt, for things I've left out... []

MATT MILLER: Yeah. Sure. A larger part of the...a larger part of the training plan or the

PR plan is to really try to understand what the training needs are in the provider community. So we recently sent out a survey to all providers in the Nebraska plan asking basically what they're looking for from a training perspective, whether it's administrative, programmatic, best practice. So we are in the process of aggregating those results and we will build that into a larger provider training program for 2010 and into the future. In addition, we're going to start a process where we're going to bring providers into our office and have them work, train our care managers on what their programs are to give us a better understanding of some of the things that they do on a day-to-day basis. []

SENATOR COASH: Thank you. Would it be possible for the committee to get a copy of that performance improvement plan so we could...? I mean if there are certain benchmarks, like we're going to have a provider... []

DEB HAPP: Uh-huh, advisory group tomorrow. []

SENATOR COASH: ...advisory group set up by this date and network training across the state for these states, I think that would be really help for me at least and the committee to see how that...what's in that plan and then we can share with people who can be impacted by that. []

VIVIANNE CHAUMONT: We'd be happy to provide that. []

SENATOR COASH: Thank you. []

SENATOR PIRSCH: And if I may, Madam Chairman, and you're Matt Miller. Is that right then? []

MATT MILLER: That's right. []

SENATOR PIRSCH: Okay. Just for the record, I just wanted to establish that. So you're with the...vice president with the network public sector then with Magellan. []

SENATOR CAMPBELL: Senator Coash. []

SENATOR COASH: Another question has to do with Magellan's relationship with HHS. I know we have the relationship with Medicaid, but specifically with Children and Family Services Division, providers and families are often working with both. And the relationship and who knows what between Children and Family Services and Magellan, there seems to be some gaps in that communication as well, and I know there's a question to that. HHS workers, CPS workers in particular, unfortunately, a high turnover group and need educated on those processes as well. Can you speak a little bit about how we're going to work to close that gap within the Children and Family Services department as well? []

VIVIANNE CHAUMONT: Sure. We...I spoke to Todd Reckling about this question that was on here. He's the division director for Children and Family Services, and what he said was that new caseworkers are trained on the whole system and how to approach that; that there shouldn't be any issues with caseworkers getting information from Magellan and that if there are any issues with that there to, the caseworker is to go to their supervisor. And if there is an issue with that, they can always go straight to Todd or straight to me, the supervisor can if there's an issue, and we'd be happy to take care of it. []

SENATOR COASH: Okay. Thank you. []

SENATOR CAMPBELL: Just as a follow-up to that, this morning we had a meeting with the department with regard to the department's follow-up to the federal fostering connections and the federal law, and just one piece that seemed interesting to all of us was the fact that N-FOCUS, none of the information that goes into N-FOCUS is linked

to Medicaid or vice versa. And so that goes back to Senator Hansen's point that you wouldn't necessarily know those two pieces of information because they're not linked together. When we redo the system, Director Chaumont, on the computer, at some point would that be advantageous for us to be able to do that? That might get at Senator Hansen's concern. []

VIVIANNE CHAUMONT: Uh-huh. Yes. (Laugh) []

SENATOR CAMPBELL: And I realize that's kind of a...but we were somewhat surprised this morning because we were talking about health issues for kids in foster care... []

VIVIANNE CHAUMONT: Uh-huh. []

SENATOR CAMPBELL: ...and being able to follow, you know, how they're with this person and then the next, and we were somewhat surprised that those two systems were not linked in some way. []

VIVIANNE CHAUMONT: We...they're linked in some ways but probably not in the way that you are talking about. I think that what we would be looking for in a new system is, you know, more of an enterprise type of system. I mean that's the goal, is to have an enterprise system, where different state systems can talk to each other and communicate so that you can get the information that you need. So that, I mean I hesitate to say, yes, this will be so once we have a new system, but I do not hesitate to say that that's one of the goals that we have, to have an enterprise type of technology where these systems speak to one another. At the same time, you probably know that there's a lot of effort and money and time being spent on the whole issue of health records and electronic health records, and we...and one of the things that Medicaid agencies are being not only asked to do by the federal government but will be required to do is to become more friendly towards the whole electronic exchange and come up with a plan for Medicaid to be able to exchange its health information. And Medicaid

takes care of not just on the behavioral health side but we take care of, you know, currently 224,000 of Nebraska's, you know, residents, so the ability to participate on the physical health side as well as the behavioral health side is just crucial. So these are all things that, you know, where in the future that is sort of being pushed closer to the present by new federal requirements that we'll probably be having to talk about. []

SENATOR CAMPBELL: Senator Avery. []

SENATOR AVERY: Thank you. I want to go back just briefly to this reconsideration process. Do you have any idea how many of these reconsideration cases actually get overturned? You give us approval rates and denial rates, but you don't...I couldn't find any numbers here on whether any of these get overturned or, if so, how many. []

VIVIANNE CHAUMONT: Yes, they do, and we have that data. I didn't provide that data but we can provide that data as well. []

SENATOR AVERY: I'd really like to see that. []

SENATOR CAMPBELL: Director Chaumont, one of the questions that I hear time and again is people say, well, you know, it's really not the department that's saying no, Magellan is making the decisions. And then at other times it's, well, it's not really Magellan's decision, it's...you know, the department is making those decisions. How much latitude does Magellan have from the department's Medicaid and how it lays out? Because for a lot of people, I think they're...I hear both sides of the coin--you have a lot of discretion; you have no discretion. How would you view that? []

VIVIANNE CHAUMONT: Well, every decision regarding...okay, well, let's sort of start at the beginning. You know, the Medicaid program is the ultimate responsibility of the Division of Medicaid and Long-Term Care in the Department of Health and Human Services. You know, we run the program. We contract with Magellan to do this service

for us because, you know, we do not have the people to do that service in house. So, as our contractor, they are subject to doing what we want them to do, and what we want them to do is follow, you know, federal and state requirements and provide the best...the best case management and medical criteria decision making on individual services that their expertise can bring. Do they have discretion? Yes, I think they have discretion because within those bounds, within the bounds of medical necessity, because the bound of medical necessity is looked at on an individual basis. You know, there is no such thing as, you know, this is all okay in this situation, this is not all okay. When a physician makes a recommendation and then when any prior authorization, whether on the behavioral health side or on the physical health side, looks at that recommendation, they're looking at an individual case. So in that sense, they have the discretion, but they can't just say, you know what, I want this client to get this and it's not medically necessary and we're going to go ahead and approve it. They don't have that kind of discretion. But they have the discretion to evaluate each client's individual situation and make the best judgment possible for that situation, just as a provider has that same discretion. []

SENATOR CAMPBELL: It seems that certainly, as you read through the comments and even through your own comments, it's like we try to find the best service at the least restrictive level. But in some cases, if we talk to parents or to providers out there, it seems as if we're waiting. I mean we're saying, okay, you start at this level and then you have to get worse before you get to that, and I think there's...I thought you all may want to comment on that perception because clearly that perception is out there that you have to fail up... []

VIVIANNE CHAUMONT: Right. []

SENATOR CAMPBELL: ...before you get to the actual service that child needs. So I thought we might just as well discuss that perception. []

VIVIANNE CHAUMONT: We appreciate the opportunity to talk about that. []

DEB HAPP: Yes, we do. And we realize that that perception is out there and we saw that in the questions and, you know, we've heard that before. That's a myth that you have to fail up the system. For example, if someone calls in and they're calling from an emergency room and they say, you know, a person came in, they had a gun to their head, they had five bullets, and they had no support at home, we wouldn't say, jeez, let's try an outpatient session first and then if they still do it tomorrow we'll consider something else and something else. I mean you would immediately look at a case like that and you'd say this person needs to be in inpatient care. So there really is no fail up the system. We really do try to look at the clinical needs of that person today and what we think the least restrictive level of care is that can clearly meet their need. And also I will say, too, that in addition to looking at what service, you know, is medically necessary, we also realize that at times, particularly out in some of the rural areas, not every single service is available, or it's limited and may not be available to that person, in which case we would authorize something that was higher level in order to make sure that that person was safe and was receiving the needed services. I'll just give you an example actually of something I heard about today, a case where someone had requested residential and we did not find it medically necessary. And initially, the guardian was very upset that...it was a relative guardian, very upset that we had not authorized residential and really wanted the child away and in a residential treatment setting. We did arrange for this family to receive multisystemic family therapy, which is family therapy that's done in the family's home, and they tried that. They actually contacted us recently to say they were now graduating, they were finishing their course of treatment in multisystemic therapy, and she said she's very thankful and please tell other parents that it's a great...they're so happy they were able to keep the child in the home. So, I mean, I think people sometimes when they request residential, for example, it's at a moment of frustration because they can't seem to resolve the problem and it's like I just want them away, somebody take them, make them better and send them back, and you know it just doesn't, in the real world, work like that. The research shows

it's not very successful treatment and that you really, if you can keep children in their homes and provide services to the entire family and keep them in the community, you get much better clinical outcomes for everyone. So, no, you don't have to fail up, but if we think something can be more successful at a lower level, yes, we're going to try it. []

SENATOR CAMPBELL: Senator McGill. []

SENATOR McGILL: I just really want to chime in real quick, and I don't disagree with anything you're saying. I think you're right about treating people in the home. But I do think solving kids' problems aren't easy at this level... []

DEB HAPP: No. []

SENATOR McGILL: ...and so I certainly don't place, you know, all this blame on your guys for, you know, no providing enough care or proving enough. But, you know, we wouldn't have had so many kids dropped off in safe haven either if families thought they were getting the level of care they need. So I just wanted to make sure that we all acknowledge that the system isn't perfect. []

DEB HAPP: Right. Absolutely. []

SENATOR McGILL: There's always things that we can do to improve because... []

DEB HAPP: Absolutely. []

SENATOR McGILL: ...there are a lot of families out there who are really frustrated, who are afraid of their own kids... []

DEB HAPP: Uh-huh. []

SENATOR McGILL: ...and, you know, I became close to one of the safe haven moms who felt very threatened and very scared and wasn't getting as many days of service and care for her child as was necessary. And so as long as we all still maintain that things aren't perfect... []

DEB HAPP: Oh, absolutely. They never will be, quite frankly. []

SENATOR McGILL: ...and can still be improved. That's true too. []

DEB HAPP: We'll always keep working at it. []

VIVIANNE CHAUMONT: There is no system of care that's perfect. []

SENATOR McGILL: Yeah. []

VIVIANNE CHAUMONT: The best that we can do is do the best that we can to make it as good as we can for our clients. []

SENATOR McGILL: And keep working together to try to do that. []

VIVIANNE CHAUMONT: Uh-huh, absolutely. []

SENATOR CAMPBELL: Senator Dubas, you wanted to follow up? []

SENATOR DUBAS: Yes, I would. I'm going to make some general comments that if you'll please feel free to comment to, and then I will have a more specific question. This file here and I have another one back in my office is full of correspondence from providers all across the state. So when I first started hearing about issues with Medicaid and Magellan, sometimes you know, okay, this is just an isolated issue, this person maybe has some issues that need to be worked out. But it's become quite evident to me

that it's not an isolated issue. The communication problems that Senator Coash brought up, you know, these files tell me an awful lot. So I'm very happy to hear that you are working on a plan and some of those things and I'll look forward to seeing that plan in completion. I think that will go a long way. But there was a survey done by the private practice therapists that I'd just like to raise some of the issues, and I'm hearing this from my providers, too, who are saying, you know what, I'm not going to service Medicaid patients anymore, I can't, I can't handle the hassle, I can't handle...this survey basically outlined their concerns: the paperwork is very burdensome. The lack of clarity on compliance, the risk of not getting paid, interference with client-therapist relationship, not being able to get clear answers, kind of what I brought up earlier where you talk to multiple people and you get multiple answers. Because of that, many are considering terminating their service to Medicaid patients. Many of them said, I don't have this same issue when I'm dealing with private insurance. I have a lot better working relationship with private insurance. Several providers have told me, and this was also indicated in this survey, that they are recording all conversations with Medicaid and Magellan just because of that, the right hand doesn't know what the left hand is doing. And many feeling fearful about calling in to Magellan because of the way they're treated. It's almost like they're guilty before...it's not innocent and then prove guilty; it's like...it's like they feel like they're intentionally trying to defraud you when that's not what they're trying to do. So those are just, in a nutshell, some of the issues that have been brought to my attention and I think are reinforced by this survey that was done. So, like I said, you feel free to comment to those, to those issues, but then I would also...I'll let you comment first and then I'll follow up with my question. []

DEB HAPP: Well, first of all, I want to say that I really can't comment on some of these, you know, unless I've talked to people directly about what their experience was. I can say that none of those things are things that, quite frankly, I would tolerate in our programs. I have a very high standard for how we treat people. I mean without our...we need our providers. They are the ones that provide the actual services to people. Are there sometimes things where us and a provider don't agree? Absolutely. Are there

great providers out there and providers who are not good providers? Absolutely. But, you know, we try to treat everyone with respect and when there are problems to address those individually with that provider. So, yeah, I can't address them specifically. I can say that these are not behaviors that, quite frankly, we tolerate. []

SENATOR DUBAS: Well, I am glad to hear that and, again, I think your plan will go a long way... []

DEB HAPP: Right. []

SENATOR DUBAS: ...in addressing those. And as I've talked to multiple providers who really have a fear of bringing issues to your attention for fear of retribution, so whether those are valid fears or not, they do exist... []

DEB HAPP: Right. []

SENATOR DUBAS: ...and so hopefully that this plan that you're working on will help to address some of those concerns. []

DEB HAPP: I also want to say, too, that we also record our calls and we record our calls not as a way to get back at a provider. We record them really so that we can hear how our own team members are interacting with our callers. And we review a certain number of calls from each one of our staff members every single month. It's reviewed by their supervisor, it's reviewed with them, we discuss them with them in an effort, again, to make sure that people are consistent, to make sure that people interact with our callers in the way that we want them to interact, and that they have appropriate decisions, are asking appropriate questions on the phone. So just to let you know, we also record but for the purposes of improving the quality of our service. []

SENATOR DUBAS: All right. Thank you. []

DEB HAPP: Yep. []

SENATOR DUBAS: Well, my follow-up question would be I think in the past, before we went to the Magellan contract, we had what was called Valued Options. Is that correct? Okay. And the Value Options were supposed to save money. Apparently we weren't getting where we wanted to so we moved to this contract with Magellan, which again was hopefully to be...have our services in a more efficient manner and also to save money. But yet, as I've been doing my research, I'm hearing the same issues with Magellan that we had with Value Options. And so where are we at? Are we in a better place with Magellan than we were with Value Options or... []

VIVIANNE CHAUMONT: You know, let me try to answer that. The...and the Value Options contract started as an at-risk contract, okay, so when it's an at-risk contract, the provider, the managed care company, gets paid a per member per month, and they're responsible for all of the care. So they get a certain amount a month and then if the person needs inpatient, out patient, whatever, the company is responsible for all...for all of that, all of that care. There...so...and then when we switched, I think initially when the Value Options contract was switched to an administrative services contract like the one we have with Magellan, and then I think the contract was bid and Magellan won that contract and has had it ever since. And let's be frank, a lot of providers don't like managed care. A lot of providers see managed care as interfering with their ability or...to provide the care that they think is necessary. So I think...I think it would be dishonest not to acknowledge that a lot of providers just don't like managed care. They prefer fee for service the way we had it where whatever they do just gets paid for and nobody asks any questions. And, you know, we could debate the pros and cons of that all day long, but just like...I mean, you know, talk about self-interest, you know, there is a certain amount of interest that providers have in providing care and getting paid for it. So the conflict of interest that Senator Avery was talking about at some point that Magellan might have in providing is a conflict of interest that that provider has when

they request every single item of care. Does that mean that providers are out there requesting services that they know aren't necessary? No. You know, 99, 98 percent of the time that's not true, but does it mean that there are providers that do that? Yes. Would it be easier for providers if they could just do...not have to deal with an agency? Yeah, probably, but it's not the best system I don't think. So are we better off? I think that managed care saves money. Managed care saves money and in the behavioral health system, the way we have it set up in Nebraska is what I was talking about, the 1915(b) waiver, and without getting too technical, we actually have a 1915(b)(3) waiver, which means that...and this is a section out of the Social Security Act is what the 1915 is, which means that the savings that come out of...from running a managed care company are put into services that Medicaid otherwise probably wouldn't pay for. So the money that we're saving from managed care is going right back into the behavioral health system to pay for services that otherwise, you know, might not be covered by the federal government, you know, with their matching. So I think that, you know, in closing on your questions, Senator Dubas, I think that we are continually trying to make a better system for our clients. I think in order to have a good system for our clients, we need to have providers that are providing good services and we need to try to keep them happy so that they can continue to provide the services to our clients. I think we need to balance that with the fact that there is some...there is some need for some control and for some...so it's that balance of getting people everything that they want with the fiscal responsibility that we have to ensure that we have a Medicaid program that's viable and that we provide...that we have a program that's here to provide services for clients. So that's about as pinned down as you're going to get me. []

SENATOR DUBAS: Is there a way that you can actually track those savings and see how they go back in? []

VIVIANNE CHAUMONT: There is. I won't be able to explain it to you but (laugh) the 1915(b) waiver has to be renewed. One of the difficult parts of running a waiver like this is it has to be renewed and approved by CMS every two years, and a big portion of it

are all these financial things at the end that talk about, you know, analyze how we save the money and then how, you know, that's the money that can then go back into other services. So I can provide you those portions of the waiver and then... []

SENATOR DUBAS: Well, oftentimes we talk about, well, we save money here so we can put it back in, but we never really seem to see those dollars as a real... []

SENATOR McGILL: Track it, yeah. []

VIVIANNE CHAUMONT: []

SENATOR DUBAS: So if there is some information that I could understand, I'd love to see it. []

VIVIANNE CHAUMONT: Yeah, it's...the services that I mentioned, the waiver actually lists a bunch of services that I mentioned in the first part of my testimony that are services that we pay for through the savings. Without the savings, we wouldn't be paying for those services. []

SENATOR DUBAS: Okay. Thank you. []

SENATOR CAMPBELL: Senator McGill. []

SENATOR McGILL: Can we just discuss number five, have you talk a little bit about number five? Because I know coming up next at 3:00 we have Head Start and so... []

SENATOR CAMPBELL: She's right on. Wow, that's a great segue. []

SENATOR McGILL: Yeah. (Laugh) And so...and you know this is something that's important to me, the kids under five and just how you are part of the system, what your

responsibilities are or are not. []

DEB HAPP: First of all, I want to say that, you know, about 99 percent of the services that are requested for children zero to five are authorized, and I think you'll see that in the data that you were given. So, you know, it's always like, let's say, the squeaky wheel. You know, the minority of people who are not getting authorizations are a loud group. Quite frankly, almost all of the services are authorized in total. And again, it may not be the exact services that people request. But let me just tell you a little bit, I think, about how we think about treatment for children under the age of five. First of all, I mean, I've worked in a lot of different settings over the course of my career. I've worked in...I'm a child psychologist, by the way, so I've worked in children's inpatient units, the state hospital and a private hospital. I ran a community mental health center that focused on services for children. And I got to tell you that sometimes when I go back to the early days many years ago, and I won't tell you how many, when I worked in some of the inpatient and residential units, really I'm appalled at how long children were there and little tiny children. And, you know, that's not always a safe place either, let me just say that, for little kids to be. That really, I think, our bias and the direction that the state has asked us to proceed in is to really always try to provide services to children in their homes and communities, and I think particularly when we look at children under the age of five that the most efficacious treatments as shown by the research that's been done on treatment for small young children really is family based treatment, you know, where you actually work. Most of the behaviors that the children have are behaviors that are evident in the home setting because that's where they spend their time, young children, and so it's really helping the family to understand the behavior and to learn techniques on how to work with their own child. So I would say that, first of all, that's where I would start with probably what we want to try to accomplish for children of that age group, and that's really what the research shows us is most effective. Do I think it's important to provide that service to them? Absolutely, because I think the research also shows us that if we can work with children and their families at that age that oftentimes things go much more smoothly as they progress and become older children. And the last thing

you want to hear is a parent of a 12-year-old saying, you know, Johnny had problems when he was 2 and 4 and 5 but, you know, I could control him when he was that young, and now he's 12 and he's bigger than me and I can't. []

SENATOR McGILL: That's what we see a lot of, yeah. []

DEB HAPP: And so we do want children that age to receive services, but honestly, taking a little child somewhere and trying to change their behavior, what they find is it doesn't generalize back to all settings. It generalize...it's only to that person. So you really want to try to work with the family so they can work with their own child and that's what, you know, has been found to be most effective. []

SENATOR CAMPBELL: Senator Coash, you may get the last question here. []

SENATOR COASH: Goody. While we're on the topic of children under five, earlier you mentioned that there were written materials on authorizing all services available to providers. Are those materials available for materials on how to authorize services for children under five as well? []

DEB HAPP: I don't believe that's broken down by age group other than children and adults. []

SENATOR COASH: Okay, so given that providing services...I mean, five seems to be this magic number according to Magellan where, you know, services can be authorized. So wouldn't it be... []

DEB HAPP: No, I would not say that at all actually. I wouldn't say that. I would say that we would...we want people of all ages to get services and, as I just mentioned, actually I would prefer that if problems are identified...I think the issue is that, you know, most children at age two, for example, don't really have a mental health diagnosis. And a

diagnosis is required to receive services under Medicaid and often it's...the diagnosis that's given to very young children often is one of the developmental disorders or autism, and those are not covered diagnoses under the Nebraska Medicaid program. So I mean there's the other issues where you get into. We also have to follow our contract and the waiver. []

SENATOR COASH: Uh-huh. All right, so the short answer is there aren't any specific instructions on authorizing kids under five. []

DEB HAPP: No. But there's no services not to...I mean no instructions not to either. []

SENATOR COASH: Okay. In closing, I...since we have the next testifier, I want to comment on something you said in response to Senator Dubas' presentation of those concerns from families and providers. What I heard from you is that...from your response is that you have a commitment to make those relationships, communication and education, better. []

DEB HAPP: Absolutely. []

SENATOR COASH: Okay. So that's correct? []

DEB HAPP: Absolutely. []

SENATOR COASH: Okay. I want to make sure we have that because that is going to be the key and I'm going to hold you to that commitment because I think it's important. []

DEB HAPP: Absolutely. []

SENATOR COASH: Thank you. []

DEB HAPP: You should hold us to that. []

SENATOR COASH: We will. Thank you. []

SENATOR CAMPBELL: And I think, clearly, from all of the information that's been submitted to the committee, I think everyone would say that you don't want to process to obscure care and treatment for children, and I think that part of today's effort has been to just open the door and start a dialogue between what the process you use and how kids are actually served and how important that is. And so I would say I appreciate very much the director's willingness to say, yes, let's sit down, and I'm sure on an ongoing basis, because we are still getting a lot of e-mails about, boy, these are the questions I'd ask if I could. I would guess that just in these pages we've probably got well over 100 questions. So what I would propose, that perhaps we identify someone from Director Chaumont's office and maybe with Kathy and we continue to provide for you the information and questions and concerns we're getting because, without a doubt, the process is obscuring how we serve kids, in my estimation. It's the concerns that are there. We have to get past that. So hopefully we can set up some ongoing basis and then perhaps after you've done your education we could come back in another session and spend some time talking about additional questions. I hope that would be okay. []

VIVIANNE CHAUMONT: I was going to offer that. []

SENATOR CAMPBELL: Good. []

VIVIANNE CHAUMONT: You know, we are interested in making this the best program that we can and I think communication is a key to that. I think there's a lot of misconceptions out there about how managed care works and how the Magellan contract works and how Medicaid itself works. So anything that we can do to help educate and communicate and get people, you know, at least on the same page talking about the same issues I think would be great, and we would be committed to doing that.

[]

SENATOR CAMPBELL: There are lot of misconceptions about how this operates and, as I've said, the answer to some of the gaps that this committee is going to identify in the coming year, all of those answers may not come from the state funding. It may have to be other ways in which we partner and bring people together. But the wisest use of state dollars is to try to make sure that we are filling as many of the services as we can for kids. []

VIVIANNE CHAUMONT: We agree. []

SENATOR CAMPBELL: I appreciate the dialogue and certainly the open communication from the senators. And I know that you all have meetings to go to, so thank you very much. []

VIVIANNE CHAUMONT: Thank you. []

DEB HAPP: Thank you. []

VIVIANNE CHAUMONT: Appreciate the opportunity. []

SENATOR CAMPBELL: We're going to go to the next item on the agenda and, really, Senator McGill and Senator Coash were just segues. I was going there myself and they just opened the door where you can't pay people to do that, you know? One of the things that we heard when Senator McGill and Senator Coash and I met with people from the department in terms of children under five, and we'll probably come back to that topic at some point because it may take a little bit longer time, one of the things that was talked about was this is what we can do but there's also things that are being done on the education side. So we decided to contact someone from the Department of Education and Eleanor was that person that we found to try to give a little window for

the senators as to what's happening on the education side. And based upon what we're hearing, Ms. Kirkland, my guess is that we'll have you and other people back from the department because you are also impacting what happens with children and behavioral health. So we're really pleased to have you. Welcome. []

ELEANOR KIRKLAND: (Exhibits 1, 2, and 3) Thank you. Thank you for the invitation, Senator Campbell and committee members. My name is Eleanor Kirkland. I work at the Nebraska Department of Education in the Division of Early Care and Education. My primary role is to help impact the systems of early care and education. And I'm a macropractice social worker, I'm also a licensed chemical dependency counselor in Nebraska, and so I have background and experience in working around some of these issues, both from a clinical perspective as well as an educational perspective. So it's a great opportunity to have this conversation. I want to share with you and have provided you with just very limited materials because a lot of the work that we're doing in early care and education is across-agency effort and we do have some partnerships with Department of Health and Human Services in life span health; maternal, child health services; children behavioral services. A lot of different stakeholders and persons are involved in the work that we do across agencies. But for today, since the time is very limited, I just wanted to give you sort of a broad overview, and one of the things that actually I've been working on with a Magellan partner is to help us do sort of an environmental scan about what really is involved and what do we have available for early care and education, mental health services, and supports. So I'd like to draw your attention to this very drafty sort of first attempt at that environmental scan, and we tried to frame it based on a continuum of supports: prevention, early intervention, interventions. And then the intent...(Recorder malfunction--some testimony lost)... with Disabilities Education Act. Two of those funding streams, one is the Part C that serves children birth to age three, and then the Part B-619 section which serves early childhood special education services for children three to five. And so that's primarily where we might see young children in the school system accessing some kind of behavioral health type of support or service if they were a verified child for that kind of a

developmental delay or a disability. And as I said, this is very drafty so you kind of can walk through this continuum and see that there might be more intensive supports available or how people...how children might enter into those early care and education services, trying to take a broader view, looking at that from both the education and the health side, as I said. But one of the efforts that I kind of wanted to highlight today is a statewide initiative called Early Childhood FRIENDS and in your packet, too, I have a brochure for your reference. It's a little colored brochure that has the icon of a pyramid on it. And this initiative is something that has taken hold in many areas of the country. It's an evidence-based approach, a model for addressing some of these challenging behaviors. And we believe, in early childhood, that, yes, the earlier that you can reach children with some of these issues, the challenging behaviors that might be evident in their preschool setting, their childcare setting, even in the home, if we can provide those kinds of in-home supports then the earlier that we can address that the better. So at the bottom of this pyramid you see that the effective work force is the most important thing to stabilize that continuum of support and, then moving up that pyramid, looking at the positive relationships that early childhood professionals may have, not only with the staff within their system and not only with the children but also working with their families and other community resources. Going further up the pyramid, the classroom prevention...preventive practices, so actually helping preschool teachers understand ways that they can intervene and be more effective in that kind of a classroom setting so that they have an environment set up where children feel protected, feel comforted, and that their day-to-day and hour-to-hour, minute-to-minute kinds of transitions, that there are supports for that. And then number four on the pyramid as we move up, sometimes we see the need in our early childhood settings to really be more intentional about teaching social, emotional strategies, having teachers actually help children understand simple things like how to say please and thank you, how to be respectful, how to be a part of a community in their small world that they live in from day to day. And then if those efforts, moving up that pyramid, if those...if that effective work force, if those teachers, those relationships with children and their families, if those strategies in the classroom need a little more support for an individual child then that would be at the

very top of the pyramid. And we are hoping that those early childhood professionals would be able to make an appropriate referral and/or to work with a possible contracted mental health therapist to help coach them about what would be a better strategy. So this is an approach that we're trying to implement statewide. Right now we only have four pilot programs in Nebraska, one in Lincoln, two in the Omaha area, and there is one in the central Nebraska area as well, and they are in sort of little different settings. Some are directly in schools, some are in childcare types of services, and some are in Head Start programs. And I know more about Head Start because that's my primary constituent group across the state and Head Start has been familiar with this approach for many, many years but have lacked funding and technical assistance resources to actually implement it more fully. So we do have some Head Start programs that have that, but the four pilots that we're working with in our statewide initiative are those that I'm more familiar with. We're collecting data on those pilots and that might be information that would be of interest to the committee. We are just really into the first year in terms of formal evaluation and collecting those data, but thus far, with some of the preliminary reports that we've seen, this approach has been very effective. And if we can work more with the parents as they bring their children to the preschool or the early childhood setting, if we can get information to them and really be more effective in those relationship-building strategies, I think that it's a win-win for everybody. It can be a cost containment factor for schools. It can be a cost containment factor I think in the long term for families. It can definitely help with defraying possible costs around actual mental health or clinical services if we can go to a more comprehensive, systemic approach and looking at prevention, really looking at it primarily, and then targeting where those interventions and strategies need to be as we move along. We have a lot more of this kind of information available on a Web site and I think I sent that to Claudia and so, you know, I would really welcome the opportunity to have more conversation with you about this, since this is just our sort of, like I said, broad-brush introduction to this topic for the committee. The other thing that I will say that we are trying to look at are some of those cost factors because I know that that's always a concern. So when we started this statewide initiative, and my office is coordinating this from the statewide

perspective, we tried to get some of our pilot programs and some of the Head Start grantees that had gone to either partial implementation, maybe within one county that they serve, or we do have one Head Start grantee that I'm aware of. They have gone absolutely what they call programwide with this kind of pyramid model and trying to get a cost projection, what does it take to implement this type of an approach. And it just varies very widely because of access to other resources that might be or might not be in their area, also with the level of knowledge that the staff may have and the time that it takes to move to fully implementation. So it could run anywhere from, you know, a basic staff person around, you know, in the early childhood field. I'm going to just put a plug in here for my colleagues. The early care and education work force is woefully underpaid for all that they do. So it could take as little as possibly $50,000 to $60,000 to fund a staff person to fully...to work towards implementation all the way to millions of dollars if you have a program that serves a lot of high-need children, has a lot of need to work with those parents and community resources to develop that systemic kind of an approach. So that's something that we're continuing to work on. All we have right now in looking at what funding sources in early care and education, this is a draft of a funding matrix of Together for Kids and Families, which is a partnering project out of Department of Health and Human Services. I work very closely with that initiative and it is federally funded by the Maternal, Child Health Bureau and it's called an Early Childhood Comprehensive Systems project. In Nebraska we have called it, named it Together for Kids and Families. And one of the activities as a part of that comprehensive systems development is to look at the funding that's available and this is due for an update and we are hoping that we can get this done within the first quarter of 2010, to have an updated matrix, so that you can kind of get a picture, a flavor of the funding that comes into Nebraska that supports early childhood services and then this is just a cover memo. This information in sort of the condensed version was available...made available to the Governor as a part of the Early Childhood Interagency Coordinating Council, the statewide advisory council for early childhood. And so every biennium that council provides a full early childhood status report, so that would also be another document that may be of interest to the committee. []

SENATOR CAMPBELL: That would be great. Thank you, Ms. Kirkland. []

ELEANOR KIRKLAND: Do you have any questions for me? []

SENATOR McGILL: Just going to say I'm going to want to set up a personal appointment to sit and ask you a ton of questions. (Laugh) In Lincoln, how is it being implemented, through the ExCITE Program or is it... []

ELEANOR KIRKLAND: I would say that there are elements of that, but in the Lincoln area the specific pilot entity... []

SENATOR McGILL: Uh-huh. []

ELEANOR KIRKLAND: ...is CEDARS Youth Services... []

SENATOR McGILL: Okay. []

ELEANOR KIRKLAND: ...and then their partners would obviously include the Lincoln Public Schools but... []

SENATOR McGILL: I know one of my best friends is an ExCITE teacher... []

ELEANOR KIRKLAND: Yeah. []

SENATOR McGILL: ...and she is a social worker. All this...all the stuff that those teachers do for families is... []

ELEANOR KIRKLAND: We sort of perceive this that the research does say that if we can provide for every $1 that we put into early childhood services today we will save

anywhere from $7 to $14 down the road, so...and it's a huge investment over time on their behalf. Thank you. And I would love to have more conversation with you, Senator McGill. []

SENATOR CAMPBELL: Senator Hansen. []

SENATOR HANSEN: Thank you. Thank you, Eleanor, for being here today. My wife is a special ed teacher with...works with three children in the North Platte school system, so I hear about this a lot, and the $7 to $14 savings is quite appealing. Now you mentioned in your...on your draft thing here Head Start and Early Head Start. []

ELEANOR KIRKLAND: Uh-huh. []

SENATOR HANSEN: Is the Early Head Start, is that the preschool for high-need, low-income students? []

ELEANOR KIRKLAND: Yes. Head Start and Early Head Start are...you have the categorically eligible children so children must meet...families must meet... []

SENATOR HANSEN: I know that the Head Start is but the Early Head Start, is that? []

ELEANOR KIRKLAND: The Early Head Start specifically serves children birth to three. []

SENATOR HANSEN: Oh, that is the birth to three, okay. []

ELEANOR KIRKLAND: And we do not have nearly as much funding... []

SENATOR HANSEN: I must not have listened at home. (Laugh) []

ELEANOR KIRKLAND: Yes. That's all right. Yeah, and it's relatively new, Early Head Start. []

SENATOR HANSEN: No, I think it is. []

ELEANOR KIRKLAND: Head Start has been around since 1965 as a part of the war on poverty legislation. Early Head Start was funded in 1995 at the federal level, and with the stimulus funding we will see some additional funding in Nebraska for those birth to three services. But it, again, is a comprehensive early childhood program of which they are required by federal law to address mental health services. And so if they can't provide it right on site, they have to contract or access those services to make sure those children's needs are being met and they also are required to work with the families. []

SENATOR HANSEN: It's a good program. And like Magellan was talking about earlier about working with those families, and that's what my wife does, I mean you can't teach a newborn but you can teach the family. So those programs are really valuable. And I see the cost savings in the long run very valuable to the school districts and clear across the state. []

ELEANOR KIRKLAND: Thank you for that comment and we hope that, because Head Start does not have enough funding to serve all eligible... []

SENATOR HANSEN: Yeah. []

ELEANOR KIRKLAND: ...children, that we are working with Head Start programs in partnerships with schools so that we can expand the access to a quality, early learning experience. []

SENATOR CAMPBELL: My guess is at some point we will have to divide up our work or

at least more education by age groupings, which is part of what Senator McGill has talked about to us and when we met with trying to get some more education about mental health services for children... []

ELEANOR KIRKLAND: This... []

SENATOR CAMPBELL: ...five and under because this is an area that we have received a lot of...I don't know about the other senators but I know the three of us who met had received quite a bit of information... []

ELEANOR KIRKLAND: And we do, too, you know, from... []

SENATOR CAMPBELL: ...anecdotally. []

ELEANOR KIRKLAND: ...from the professionals out in the field: We want more training on challenging behaviors. And so I've been working in this realm for over ten years and so every time we have resources that we have, we try to provide some sort of training. I would like to just say, too, that the school-age...kind of this prosocial emotional behavioral health initiative is also offered through professional development and technical assistance to schools that are a part...that want to be a part of that. I do not manage that school-age positive behavior support. []

SENATOR CAMPBELL: We will certainly have you come back and talk to the committee with more questions because we want to hear the question and answer from Senator McGill. That's for sure. (Laughter) []

ELEANOR KIRKLAND: Okay. []

SENATOR McGILL: I know too many questions. I wanted the public to have a chance to talk. []

SENATOR CAMPBELL: Yeah. But thank you very much. []

ELEANOR KIRKLAND: And maybe by then we would have some data that we could also share with you at that time. []

SENATOR CAMPBELL: That would be excellent. And it's great to see the chart for us all in one place. That's... []

ELEANOR KIRKLAND: Work in progress, just that caveat. []

SENATOR CAMPBELL: But it gives us an idea. []

ELEANOR KIRKLAND: Okay. []

SENATOR CAMPBELL: Thank you very much for coming today. []

ELEANOR KIRKLAND: Thank you very much. []

SENATOR CAMPBELL: We will go to that part of our segment in terms of public comment and I guess I got just a couple of words. I'd really encourage you that if you have written comments that you kind of...we'll be glad to receive them and if you could kind of summarize them. We're going to try to keep comments maybe three to five. We won't run a light system here but we do encourage you to keep your comments succinct because there's a number of people who do want to speak today. If my colleagues would allow, we will probably go a little past 4:00 and then we will have more sessions like this. So if you say, golly, it's getting close and I...trust me, we will have many more sessions for open comment from the public. So we don't want to discourage you if you don't necessarily get up today but we'll try to get in as many. Carol Stitt has asked to go first because she has another meeting, and so welcome. []

CAROL STITT: (Exhibits 1 and 2) Yes. Thank you. I'm Carol Stitt, the director of the review board, and all I would like to say is I'm submitting written testimony. But I would like to share with the senators, when we reviewed 554 children who enter care due to their own behaviors, at the time of review 45 percent of those children had no services in place. I think one of the primary issues that we have in our system is just lack of services, whether they're denied or whether they aren't, and I would really like to thank the committee sincerely for looking into this issue and exploring building mental health services for our children. And that's all I have besides our written testimony. []

SENATOR CAMPBELL: Thank you. []

CAROL STITT: Okay. []

SENATOR CAMPBELL: Any quick questions from the senators, note the word "quick"? []

CAROL STITT: I know you have a lot of time. []

SENATOR CAMPBELL: Thank you very much. []

CAROL STITT: And thank you. Thank you. []

SENATOR CAMPBELL: And we will probably be back in touch with you too. []

CAROL STITT: Okay. []

SENATOR CAMPBELL: Second on the list? []

CLAUDIA LINDLEY: The other people are signed in, if they just want to start coming up.

[]

SENATOR CAMPBELL: If you just want to start coming up if you signed in. Good afternoon. []

VICKY WEISZ: (Exhibits 1 and 2) Hi. Thank you, Senator Campbell, for inviting me to testify at this hearing. Good afternoon, members of the Oversight Committee. My name is Vicky Weisz and I am employed as a research professor of psychology at the UNL Center on Children, Families, and the Law. I am also the Nebraska court improvement director coordinating improvement efforts for the Nebraska courts in their work with abused and neglected children and children in foster care. I was a practicing child clinical psychologist for a number of years before I began working for the university and the courts, and I am still licensed. Today I am here as a private citizen and, although my experiences and observations stem from my job, my views do not represent the views of the university nor of the Nebraska Supreme Court. I'll just quickly describe my involvement in this area and some of the barriers that mental health providers are facing dealing with the Medicaid Magellan program, especially for young children. Over the past 18 months, Judge Doug Johnson from Omaha led a statewide training effort that my office helped support and coordinating entitled Helping Babies from the Bench. This series of ten all-day, multidisciplinary trainings focused in infants and toddlers in the abuse/neglect court system and how courts and other stakeholders can ensure the best possible outcomes for them. A good deal of the presentations covered the impact of stress, neglect, and trauma on these young children and the critical importance of assessments and remediating interventions. As we traveled around the state with this training, we kept hearing that there were very sparse, if any, mental health services available for infants, toddlers, and preschoolers in many areas of the state. There are a variety of evidence-based approaches that work for these very young children and all involve, not surprisingly, both the child and his or her parent or other caregiver together. The types of symptoms that these young children show might include emotional disregulation, damaged attachment capacities, eating difficulties, and delays to

emotional, cognitive, and social development. Many of these young children in the foster care system sadly do have conditions that are diagnosable and they do have diagnoses in the DSM for. Intervening with these children will prevent future problems but it will also address their current distress, so these services cannot be considered purely preventative. Federal Medicaid rules require that states screen, diagnose, and treat all Medicaid-eligible children for physical and mental illnesses under the Early and Periodic Screening and Diagnostic Treatment Benefit. Young children under five are not excepted from the state's requirement to screen, diagnose, and treat mental illnesses. I have included for your review a briefing paper by the National Governors Association and a printout from CMS, which is United States Health and Human Services Centers for Medicare and Medicaid Services, that describes this EPSDT benefit. Nebraska mental health providers who are trying to provide services to this group of children report significant Medicaid reimbursement barriers and paperwork burdens when they provide services for children under age five. For example, I recently saw a claim denied by Magellan for a family therapy session with a young child with the reason for denial stated as, "You are too young to participate meaningfully in therapy." Further, providers have difficulties obtaining information about the criteria that are used to evaluate claims. I am concerned that it will be difficult to expand these important services statewide and that young children who need mental health services, especially those in the child welfare system, will not be able to receive them. I appreciate your interest in learning more about Magellan/Medicaid's management of mental health services for children, especially the youngest children. Thank you. []

SENATOR CAMPBELL: Questions or comments from the senators that you have? I'm sorry. Senator Pirsch. []

SENATOR PIRSCH: Great, and I'll be brief. But you mentioned one particular case that you cited that they were denied by Magellan, a zero to five, based on their age with respect to mental health. Is this...is there any way to quantify the number? Is this a common problem or what...have you taken any measures to kind of quantify this

problem? []

VICKY WEISZ: I have not done anything systematic. []

SENATOR PIRSCH: Yeah. []

VICKY WEISZ: We've been, after we went around the state with Judge Johnson, we've actually been trying to help expand some of those services, and we've brought a national and international consultant who trained people and is providing ongoing phone consultation. So I have informal connections with some of the people in that, and so it was an informal kind of thing. I don't know, I think that there may be efforts to collect these in a systematic way, but I'm not doing that. []

SENATOR PIRSCH: I see. Thank you. []

SENATOR CAMPBELL: Thank you very much. Oh, I'm sorry, Senator Coash, did you have a question? []

SENATOR COASH: Well, thank you, Madam Chair, and I don't know if I have a question. It's more of a comment. I mean this just seems to be like a...I don't know if it's a philosophical debate about services for children under five or if it's an academic debate or a clinical debate, but clearly there's a need for those services. And, you know, Madam Chair, as a committee, can we get Magellan and Medicaid to answer these issues? []

SENATOR CAMPBELL: I think what we will...I think what we will do is provide a copy and write in a letter directed to Director Chaumont and certainly to Magellan and say...along with the materials that Ms. Weisz has presented and say, would you please clarify because we hear one thing and then the other. So I think we'll ask for something in writing. Would that be sufficient on behalf of the committee? []

SENATOR COASH: I would appreciate that. Thank you. []

SENATOR CAMPBELL: Okay. We can do that. Because I think we need it in writing as a response. []

VICKY WEISZ: Good. []

SENATOR CAMPBELL: Thank you very much. []

VICKY WEISZ: Okay. Thank you. []

SENATOR CAMPBELL: Good afternoon. []

ANGIE THIEL: Good afternoon. Thank you, Senator Campbell, for having me. My name is Angie Thiel and I'm here as a mom, a mom of a son who is 13 almost 14, and I think what's important is to give you a picture of him. I'm also really excited to have Magellan here and I thank you for being here because we're teammates, we're teammates helping my son in getting his services that he needs. Currently, he's in a residential treatment center. He's doing fairly well. And the point that I think is important with Magellan is that as time has gone on, as the reviews have gone on, the services that he needs that are recommended by his physicians, recommended by the treatment staff often have to be fought in order to maintain the services that he's getting. And as a parent who retains custody, I've not had to do safe haven. My child still...you know, I retain all parental rights. It is very, very difficult to continue to battle every time. And the battles aren't so much that I want him to remain in a residential center. It's, in fact, quite the opposite. But I also understand as a parent, I want him home and keep him home. And so I just ask that (crying)...gosh, sorry. []

SENATOR CAMPBELL: You're fine. []

ANGIE THIEL: I ask as a parent who does, again, retain custody that I don't have to be forced down a road to give up rights to my child to be a state ward to get him the services that he needs. That's the most unfair decision as a parent that I've ever had to imagine. And we fought and done really well not to have to go down that road, but it's something that a lot of parents like us do face. It's very real. And Alex also has asthma and I can't imagine when he was younger going to the emergency room when he needed to and getting nebulizer treatments and doing everything we needed to but coming to a point that our physician said, gosh, you know, you're still catching these colds, Alex, and you're still getting...you're still needing these nebulizers, let the state take custody of you, we'll make sure that there's never a chance that you don't have a nebulizing treatment. It doesn't happen that way. I work full-time. I have great insurance. I work for the state of Nebraska. And if there was a way that I can continue to always have coverage for him, whether it be through Magellan or my private health insurance, I would do anything and I have done anything that I needed to do. And so I appreciate this opportunity to talk. I appreciate the opportunity to get situations across that reflect our children. And again, that's why this picture is so important, because sitting here in a group with individuals who we are all very knowledgeable about these services, we understand, we can read the materials that we get, but this is why I'm here and this is the reason that parents fight so hard. I was...when safe haven happened, when the first safe haven case came to Nebraska and made light for our state, I was encouraged from his treating therapist at the time to utilize safe haven. And I don't say that as the physician or treatment team said, you know, Angie, you've done what you can and there's nothing more. They looked at me and said, we know there's more we need to do but unless there's the coverage, and at the time Magellan was refusing, refusing the coverage, the only way that could have happened was making him a state ward by walking into a hospital and walking back. And I didn't do it. What I did do, quite honestly, was I went to the front of theLincoln Journal Star and I was able to get our story out, and from there a lot of good things fell into place, and those good things were that Magellan covered our case. So for parents who do get to speak out like me, I think our kids and

the kids in the generations are really going to have a good effort and opportunity to get the care that they need. []

SENATOR CAMPBELL: Thank you very much. []

ANGIE THIEL: And I offer any questions if anybody has them. []

SENATOR CAMPBELL: Senator McGill. []

SENATOR McGILL: I just want to thank you for being such a great advocate over the last year and some, because there are so many families just like you and everything fell into place so far for you... []

ANGIE THIEL: It did. It did. []

SENATOR McGILL: ...because you've been an advocate. []

ANGIE THIEL: Oh, thank you, and I appreciate it. []

SENATOR McGILL: So thank you for being here. []

ANGIE THIEL: And thank you for letting me be emotional. I didn't think I'd quite get that way. (Laugh) []

SENATOR CAMPBELL: That's fine. []

ANGIE THIEL: Thank you. []

SENATOR CAMPBELL: We know you care a lot. Senator Avery. []

ANGIE THIEL: Yes. []

SENATOR AVERY: Did I hear you right, that you were turned down by Magellan until you went to the newspaper? []

SENATOR McGILL: Yep. Yes. []

ANGIE THIEL: Yeah, and that statement that I say, I stand behind it. At the time, my son was in the hospital. His treating psychiatrist wrote a letter stating the services that my son would need in order to be successful and independent. He wrote the services that had been utilized in the past. And Alex had been a product of the revolving door. He may get a service and then the services were cut. And there was an opportunity for him to get residential help based off of what our treating physician was recommending. The coverage through Magellan, it was denied. And we have done the appeal process. We have gone to the review board. I've had physicians write letters and talk to the individuals through the Magellan Services, so we're very, very familiar with that process. We've done that twice. Once was successful and once was not successful. The time that he went directly from the hospital into a residential center, it was directly related to Magellan first denying and then I believe that they re-reviewed it and he did get...he did get that coverage. []

SENATOR AVERY: Do you mind if I ask you how long it took from the denial to the...through the review process and the reconsideration panel and the ultimate success? []

ANGIE THIEL: Sure. That time it was about three weeks, and the reason that I know that is because he was denied while an inpatient. While he was inpatient, the hospital staff did the, you know, the reconsideration and the appeal. From that there, when he finally was given the coverage through Magellan, he had to go directly from that level of care to a residential center. He couldn't necessarily come home. So from the time that

he was given the denial until the time that he was approved for the residential, it was about a three-week process. []

SENATOR AVERY: That sounds like not a long time, because I have a file older here... []

ANGIE THIEL: Uh-huh. []

SENATOR AVERY: ...of complaints from constituents who say that it took three, four, five months. []

ANGIE THIEL: Uh-huh. Uh-huh. Yeah, and I've heard of that and, you know, from my standpoint again of being a parent and being a community member, that's three, four, five months way too long when you're dealing with the life of children. []

SENATOR AVERY: Yeah. Yeah. Thank you. []

ANGIE THIEL: Uh-huh. Thank you. []

SENATOR CAMPBELL: Thank you very much. []

ANGIE THIEL: Thank you, Senator Campbell. Thank you. []

SENATOR CAMPBELL: Good afternoon. []

KRIS JENKINS: Good afternoon. My name is Kris Jenkins and I am speaking on behalf of my husband and myself and I am a director of a very large preschool here in Lincoln so I'm very familiar with early childhood education. But I'm speaking on behalf of our ten-year-old son. J.R. came to live with us when he was two. He was in the foster care system. We did end up adopting him three years later. I have spoke to Senator Avery

about the problems that we had been going through with Magellan. Our story is somewhat similar to Angie's in the situation that we have been denied over and over and over care. One thing that struck me, I was just surprised when the Magellan ladies, Kathy was up here and she said the thing about a fail up myth. It is not a myth. I was told two months ago by someone at Magellan that someone needs to fail more in order to get RTC placement. I don't want my son taken out of the home because we don't love him, because we can't handle him. It is a safety issue. Our knives are locked up. He's been in hospital care about six or seven times. He's been under a psychiatrist's care for about three or four years. We did MST placement. It was a joke. Our MST therapist ended up wanting to play the Wii and wanted to know what was for supper and for dessert and did I have coffee. It just...it was six months totally wasted of our time. J.R. was in a preschool where we did, you know, talk about social, emotional skills. We saw no problems with J.R. during the early years of his life but, remember, he wasn't placed with us till he was two, and he was in an abused home. So we are somewhat cleaning up someone else's messes. I am just flabbergasted at what a family has to go through in order to get care. I have pictures at home of abuse that J.R. has done to us. I love him very much but I don't think parents should have to put up with that. And we have gone through all the circles and, you know, jumped through all the hoops that I feel that we've had to go through. Angie said she went to the Journal Star. I went above and beyond that. I went to the national level and I asked Dr. Phil for help. I was on the Dr. Phil show the 1st of September to talk about behaviors and to talk about kind of the lack of help that kids don't receive with behaviors, and unfortunately it hasn't turned out to be such a good situation for us with the Dr. Phil show. They've kind of said you need to keep doing what is available in your community. What is that? What is that? That's what I want to know. We've had therapists, we've had psychiatrists. I guess the most devastating moment came September 27 or 28 when--J.R. is in 5th grade--when his elementary principal called, screaming in the phone, and this is where I'm going to lose it, I don't run an insane asylum in this elementary school, come get your son. Filed a grievance with the district office. She's under review right now for that. We saw the same principal about two weeks ago and her first comment to my son is, where's your

parents and what are you doing here? We were at a music concert for our nine-year-old daughter. Not, we miss you, how you doing. No. Where's your parents. Nobody wants...I mean I just...we don't know how to move forward. We don't know how to move forward. So unfortunately, our workings with Magellan has been totally a negative downfall, totally. We've had reconsideration appeals with our psychiatrist. We've done everything. His therapist has written papers and papers for this little boy, and all we want is a year or two of intense treatment so the rest of his life can be normal. We don't...we haven't known normal since he was five and he's now ten and a half, so. []

SENATOR CAMPBELL: Are you currently in any appeal with... []

KRIS JENKINS: Let me tell you where we're at right now. []

SENATOR CAMPBELL: Oh, okay. Thank you. []

KRIS JENKINS: This is really interesting. I hope the people from Magellan hear me. I'm sure they can. We got denied for RTC placement, which is up here. We got approved for day treatment, which is right here, the Child Guidance Center. Child Guidance Center said, no way, he's too violent. So where is J.R. and his family? We're right in the middle with absolutely no services. We have a conference call tomorrow with Magellan, with J.R.'s therapist, and with people that are going to try and get us help, but it's only because we keep asking, what do we get, what do we need to do, what do we need to do. I'm not willing to make J.R. a ward of the state. I'm not willing to do that. That's not what needs to be done. []

SENATOR CAMPBELL: Senator McGill. []

SENATOR McGILL: If J.R. doesn't get services, what kind of future do you think he will have as he grows up into an adult? []

KRIS JENKINS: One where his parents are very, very stressed out. We have a very, very strong marriage, thank God for that, very, very good jobs. Right now the school, he's on a 45-day suspension from the school. Prior September 27 he had been suspended for nine days already. You're talking five weeks of school, suspended for nine days. []

SENATOR McGILL: So in ten years from now, where is he going to be? []

KRIS JENKINS: How many years? []

SENATOR McGILL: In ten years from now. []

KRIS JENKINS: Probably living in our house. Twenty years from now, maybe living in our house. My parents won't watch him. We have very few people that are willing to watch him because of his level of aggression. So just asking for some help. []

SENATOR CAMPBELL: Oh sorry. Senator Avery. []

SENATOR AVERY: You and I have had some conversations about this. []

KRIS JENKINS: Yes, sir. []

SENATOR AVERY: And I have a rather lengthy file on J.R. here detailing conversations we have had. At one point you said to me and to my staff that J.R. had not...didn't have enough failure. Did Magellan tell you what that meant and what kind of failures you had to achieve? []

KRIS JENKINS: They absolutely did--more in-hospital patient...more inpatient care. They said until he becomes more of a financial liability for them, they're not willing to authorize RTC treatment. They said he needed to have more in-hospital placement.

And I strictly said to the employee, are you telling me I need to set my son up for failure? And she said, yes. I said I just...I can't, I can't take that as an answer, I just can't. []

SENATOR AVERY: So what do you see your options now? What are your options? []

KRIS JENKINS: I'm here. I try to keep up on the Legislature. I try making phone calls every day, e-mailing people that I think are going to be able to help us. We're kind of at a standstill with this therapist, but I'm hoping that the conference call tomorrow will give us a little bit of light, but I'm not...am I optimistic? No. No. []

SENATOR AVERY: You don't have to answer this if you don't want to. We heard from Magellan, we...and we hear one thing, and we hear from parents and it's a little bit different. In fact, it's quite a bit different. Can you help me understand the difference between the real world of the parent and the world we hear about from Magellan spokespeople? []

KRIS JENKINS: It's money. []

SENATOR AVERY: It's money. []

KRIS JENKINS: It's money. []

SENATOR AVERY: What do you mean by that? []

KRIS JENKINS: The employee told me that until...RTC placement is very expensive and we are willing...I mean we'll do anything, and she said until he becomes more expensive that they have to look at cheaper avenues, which would be MST placement, which would be day treatment, which would be things that we've already gone through. But they said he's not to the level yet to do the RTC. He hasn't had enough

in-hospitalization. []

SENATOR AVERY: Thank you. []

KRIS JENKINS: Uh-huh. []

SENATOR CAMPBELL: I would hope that you would get back to us, via e-mail or... []

KRIS JENKINS: Would love to. []

SENATOR CAMPBELL: ...and let us know how tomorrow goes. []

KRIS JENKINS: Would love to, absolutely. []

SENATOR CAMPBELL: And the Magellan people behind you have taken quite a few notes so... []

KRIS JENKINS: I'm sure they're behind me. I can feel it. (Laugh) []

SENATOR CAMPBELL: That's okay. I think they're taking notes. That's... []

KRIS JENKINS: And I appreciate that. I really do. []

SENATOR CAMPBELL: That's part of what today is, is to hear your comment. []

KRIS JENKINS: I really do appreciate that. []

SENATOR CAMPBELL: Thank you for coming. []

KRIS JENKINS: Yes. Thank you. Thank you. []

DEB HAPP: And the reason we're taking notes is because, I mean, I (inaudible) and find out (inaudible). []

SENATOR CAMPBELL: Good. Absolutely. Good afternoon. []

MELANIE WILLIAMS-SMOTHERMAN: (Exhibit 1) I didn't make a copy for everyone but I'll give it to... []

SENATOR CAMPBELL: That's fine. You can give us that and we'll make sure that copies are given to the committee. []

MELANIE WILLIAMS-SMOTHERMAN: My name is Melanie Williams-Smotherman. I'm the executive director of the Family Advocacy Movement, otherwise known as FAM for short. I'm not going to be as composed as I thought I was going to be, because after Angie, who is associated with our group, spoke about her personal experiences, it touches my heart. I'm not just an executive director. That came from being a family member who was adversely affected by the system, so that's my approach to my comments. My general comments were to be more overarching and general rather than sharing anecdotal stories between real families and Magellan, although I could do that. We have a lot of families in our group who have many stories to tell and they're all important and they follow the same line as those that you've already heard. But I think that the most important message that is coming from families is that most children could be kept in their homes with proper services but they don't necessarily exist. But every child is unique and every family is unique, and the most important thing that we need to consider when looking at the care of families and children is that the provider, in coordination with the families, know these children better than anyone else could. Having somebody on the other end of the phone make a decision which quickly trumps the years of experience of a parent and of the providers who have cared for these children for years is just not appropriate and it needs to be considered that it's very

unlikely that a provider and a family member who ask for a level of care and are denied would be wrong. I first would like to thank the Oversight Committee and each senator here for providing me with the opportunity to offer comment on what I believe is not only the most important element to these discussions but paradoxically seems to be the most often-missed element within undertaking any sort of family and child service and reform efforts. The FAM is a collaborative effort borne from the immediate aftermath of LB157, otherwise known as safe haven, when the public and elected officials became aware of what so many families have personally suffered in relative obscurity and isolation prior to the passing of a law that allowed families to seek desperate help with the very important and necessary promise of immunity from criminalization on charges of abandonment. Our membership is uniquely aware of the intrinsic value and interest of families and children, as these relate to the successful or unsuccessful functioning of services, advocacy organizations, and system treatment, whether that be accessibility to behavioral health services, the effectiveness of programs and initiatives, the state's approach to families through law enforcement, the Department of Health and Human Services, the courts, and the resultant outcomes of each. For any effective discussion and movement forward, we must first review the lessons. First, we learned that had it not been for the openings provided to allow for the voices of families following the passing of LB157, we would not have known that families experiencing crisis have been criminalized simply for experiencing situations beyond their control and ability, through no fault of their own, to access appropriate levels of help for their children that were so desperately needed. Next we learned that had we only relied on the reports and summaries of agencies and officials, we would have simply continued blaming the situation on bad parents who simply seem too lazy to care for their children, families who were labeled as not much more than parasites taking advantage of good intentions of lawmakers while coldly harming their own children, a mistaken understanding during which our Governor prioritized closing the loophole that families had used to seek help, and the department prioritized targeting safe haven families, such as Sue and Avery Quakenbush. Without the media, the caring efforts of a few Nebraska state senators, some of whom rightly sit on this committee, and the rallying of courageous parents few

would have known what had really been happening to families who were and are struggling to raise children with serious behavioral health needs prior to and since the passing of LB157. A significant and related aside here would be to consider this: If it is true that we have proper, independent, and motivated oversight systems in place within our state to recognize and address serious issues and injustices that can and do have tragic consequences, even when families are crying out for help, none of us would be here today. And this fact is the primary inspiration for what I am attempting to share with you. While there are so many facets of family need that are beginning to be addressed by the passing of LB603 in response to what we have begun to learn, there is one need that is critical for success with any initiative or program or service our state may support, that is the necessity of providing room and encouragement for families to continue sharing real-life experiences. Only with the voices of families will this committee truly gain an accurate picture of the success or failure of reform efforts and new or enhanced programs. As we families like to point out, anything can look good on paper. Intentions are usually good and a lot of hard work and passion goes into moving government forward with social programs and innovative efforts. Reports of contractors will most likely pain the rosiest pictures possible, as that is the nature of business. But if this committee wants to gain the best sense of how our collective efforts are really progressing, show the contractors for LB603 initiatives are really serving the public, I strongly urge this committee to set up and publicize an independent public reporting system or build into your own oversight program the ability to track real families from the beginning, soliciting honest family reports. Invite parents, not only agency directors, to share their own observations, which may not always be positive but will help lead our state from callowness to insightful, caring solutions for families and children. Thank you again for your time and consideration for Nebraska families. []

SENATOR CAMPBELL: And thank you for your overview. It was very good. []

MELANIE WILLIAMS-SMOTHERMAN: Thank you. []

SENATOR CAMPBELL: And we hope that you'll stay connected with us. []

MELANIE WILLIAMS-SMOTHERMAN: Thank you. []

SENATOR CAMPBELL: Others who may wish to testify today? I do want to encourage you to pick up an agenda because it has a place, at any time you can share comments and we will see that the entire committee gets them. We will be holding additional public comment and meetings as we go along. I want to say to the committee, we'll probably convene some time during the early weeks of the session just to see where you want the next steps to go. But we will not convene you again before we start the legislative session. I promised. With that, I want to thank everyone today for coming and your heartfelt comments, and hopefully and certainly for (inaudible) for listening to everyone. And Doctor...is it Happ? Am I saying that right, Dr. Happ? I appreciate you coming in, taking your notes, and we will have you back again to see how you think things are going, and hopefully many of these people will also be here to comment. So with that, have a great and safe holiday system and find the children in that holiday. Thanks, everybody. []