STINNER: We will now open our hearing with Agency 25 Department of Health and Human Services Medicaid, Public Health, and Long-Term Care. Good afternoon.

DANNETTE R. SMITH: Good afternoon. Good afternoon, Chairman Stinner and members of the Appropriations Committee. My name is Dannette R. Smith, D-a-n-n-e-t-t-e, middle initial R, last name Smith, S-m-i-t-h, and I am the chief executive officer of the Nebraska Department of Health and Human Services. Today and tomorrow I will be joined by the department's directors Sheri Dawson, director of Behavioral Health; Matthew Wallen, director of Children and Family Services; Courtney Miller, director of Developmental Disabilities; Dr. Matthew Van Patton, director of Medicaid and Long-Term Care; and Bo Botelho, interim director of Public Health. I began my tenure at the Department on February 25, 2019. Over the past month I have begun to learn about all of the department's efforts and have been focused on learning the culture of DHHS. I have found a team filled with individuals who are dedicated to helping people live better lives through effective, efficient, and customer-focused services. My focus as CEO of the department is a full-- four-prong approach: right fit, right size, the internal infrastructure; integrating our current service delivery system; establishing and enhancing collaborative relationships with legislators, stakeholders, and the community; and finally, aligning teammates under our mission of helping people live better lives. I would also like to take a moment to thank the Appropriations Committee for their support last session when the Legislature invested in our child welfare system. It was-- it allowed us to come-- to continue to administer a vital program that ensures child safety, improving family engagement, and offering appropriate support to reduce trauma by strengthening families. In my short time at the department, I have reviewed our budget requests and agree in concert with my team that the Governor's proposed budget empowers us to live our mission. The Governor's biennial budget recommends strategic reductions and necessary increases. For the first year of the biennial, the total appropriation is $3.8 billion. This includes a net increase of nearly $232 million or 6.4 percent in total funds. The state General Fund increase will be $17.3 million or 1.1 percent. For the second year of the biennial the total appropriation is $4.2 billion. This includes a net increase of $570 million or 15.7 in total funding. The state General Fund net increase is $83.6 million or 51-- or 5.1 The main financial driver of this increase is the need to implement Medicaid

expansion. Each of our division directors will discuss critical issues requested in their budget. However, I want to address a few items. Over the biennium, the department will be focused on delivering Medicaid expansion. It is my understanding that Dr. Matthew Van Patton discussed the scope of work necessary to fulfill Medicaid expansion with you in February. We are committed to have a fully functioning product for eligible Nebraskans. It is also my understanding the Appropriations Committee has agreed in most part with the provider reimbursement funding in the Governor's recommendation. Although provider reimbursement is challenging to address through appropriations and alignment of services, there is a great opportunity to more effectively and efficiently move forward. Safety-- safety is paramount and the Family First Prevention Service Act provides an opportunity to redirect our services. Child welfare focus has evolved to provide increased prevention and services and evidence-based practices that ensure we keep families together and minimize child and family risk. For the upcoming year, we'll be working on the infrastructure that is necessary to fulfill our mission. Two of those areas are human resources and information technology. In addition, I have tasked my team to dive deeply into our human resources practices in regards to recruiting and retaining teammates. We will also continue to evaluate processes of our current information technology platform for future needs. In closing, my team and I appreciate the difficult task you have as appropriators. We believe the Governor's budget recommendations give the department the best opportunity to enhance internal infrastructure, integrate service delivery, establish and enhance collaborative relationships, and align teammates under our mission of helping people live better lives. I encourage you to adopt the Governor's recommendation. Thank you for your time. Today I will be followed byDr. Matthew Van Patton, director of Medicaid and Long-Term Care, and Bo Botelho, interim director of Public Health. On tomorrow you will hear from directors Walden, Miller, and Dawson in their testimony. I would ask the detailed question on budget numbers be deferred to the directors. This concludes my remarks.

STINNER: Thank you and welcome aboard.

DANNETTE R. SMITH: Thank you.

STINNER: Questions? I'd just ask you one thing. Have you looked at the State Auditor report?

DANNETTE R. SMITH: Not as of yet.

STINNER: OK. I won't ask you. Well, seeing no other questions, thank you very much.

DANNETTE R. SMITH: Thank you.

STINNER: Afternoon.

MATTHEW VAN PATTON: Good afternoon, Chairman Stinner, although I think we're past the cocktail hour so I think we're probably working in the evening--

STINNER: We're at evening.

MATTHEW VAN PATTON: --at this point aren't we? Well, Chairman Stinner and members of the Appropriations Committee, my name is Dr. Matthew Van Patton. That's M-a-t-t-h-e-w V-a-n P-a-t-t-o-n, and I am the director of the Division of Medicaid and Long-Term Care in the Department of Health and Human Services. I want to begin by thanking Chairman Stinner, the members of the committee, and your staff for working together with us. Medicaid is a significant portion of the state's budget and has significant impact on more than 240,000 eligible beneficiaries in a given month. I am committed to serve Nebraska's most vulnerable residents and have worked with the Governor on a responsible budget to continue our work. The Governor has proposed a fiscally responsible budget for the Division of Medicaid and Long-Term Care. I recommend it to you. The current state fiscal year appropriation is $2.2 billion of which $865 million is state General Funds. The Governor's budget recommendation totals nearly $2.4 billion for state fiscal year 2019-20, of which $883 million is state General Funds. For state fiscal year 2020-21, the Governor's budget recommendation is $2.7 billion of which nine $947 million is state General Funds. I would like to highlight some of the items in the budget. First, there is a significant change in the federal matching assistance percentage or FMAP for the state. The FMAP formula is set by the federal government and is based on a three-year rolling average of a state's relative per capita personal income. The FMAP for fiscal-- federal fiscal year 2020 which begins in October of 2019, of five-- 54.72 percent is an increase in federal financial participation of 2.14 percent. This increase is also in the initial estimate for federal fiscal year 2021 FMAP. This results in less reliance on state

General Fund of around $31 million in state fiscal year 2020 and $42 million in state fiscal year 2021. Second, we request the Governor's recommendation and committee has included in its preliminary budget increased funding for the Children's Health Insurance Program or CHIP for the next biennium. CHIP traditionally has a higher federal matching rate. Due to recent federal law changes, the CHIP FMAP has been reduced. Up until federal fiscal year 2020, states were eligible for an additional 23 percent federal financial participation on top of the enhanced CHIP FMAP. Beginning in federal fiscal year 2020, the 23 percent increase is being reduced to 11.5 percent; and effective federal fiscal year 2021, the remaining 11.5 percent increase is eliminated completely. This results in an increased need for state General Funds of around $8 million in state fiscal year 2020 and $19 million in state fiscal-- state fiscal year 2021. Third, the Governor has included in his recommendations funding for Medicaid expansion. The amounts included in the budget correspond to what we anticipate will fund the first year and a half of this program. MLTC supports the recommendation to fund a net increase in aid of approximately $19.3 million in General Fund and $168.7 million in total funds in state fiscal year '20 and $49.1 million in General Funds and $419 million in total funds in state year '21. The committee also included this level of funding in its preliminary budget. Fourth, we request for state fiscal year 2021 $15.5 million in General Funds for the health insurance premium fee or HIPF. This is a federal tax the managed care organizations or MCOs must pay. While this tax is currently under a one-year moratorium, current federal law requires this tax to be paid by our MC0s in September 2020. Both the Governor and the committee included this item in their respective budget recommendations. Fifth, due to an increase in the number of Nebraskans we serve, there has been a corresponding increase in the number of services utilized in capitation payments to MCOs. In the past two state fiscal years, we have seen an increase in Medicaid and CHIP eligible persons by 1.94 percent and 1.96 percent, respectively. This results in an increase in state General Funds of around $16 million in state fiscal year 2020 and $31 million in state fiscal year 2021 needed to finance the medical assistance program. The Governor and committee have included the funding needed for this increased utilization of services. Finally MLTC supports the Governor's recommendation to include funding for rates averaging 2 percent for long-term care providers and services primarily for nursing facilities. This represents an approximate increase of $4.7 million in General Funds and $10.6 million in total

funds for state fiscal year '20 and $9.7 million in General Funds and $21.4 million in total funds for state fiscal year '21. MLTC would encourage the Appropriations Committee to support the Governor's budget recommendation which focuses the increases towards long-term care, given the state's need to also cover the expansion population. I support the Governor's budget recommendation as the prudent course forward. The recommendations build upon MLTC's continued focus on the quadruple aim which is improving the patient experience of care, improving the provider experience of care, improving the health of populations, and reducing the per capita cost of healthcare. Thank you for your consideration of these items, Mr. Chairman. This now concludes my remarks.

STINNER: Questions? Senator Bolz.

BOLZ: Got a few. Good evening. Good-- good cocktail hour, whatever it is. Thank you for coming, Director Van Patton. I have a few questions. The first is per your testimony, the amounts included in the budget for Medicaid expansion include what you requested for what you anticipate will be the first year and a half of the program and our budget notes say that the assumption is that Medicaid expansion will be implemented on January 1, 2020, and then the corresponding request of $19.3 million and $49.1 million. So is my takeaway to be that your intention is to implement on January 1?

MATTHEW VAN PATTON: Senator Bolz, what I can tell you is at this point we do have a date that we anticipate a go live and we will be announcing that date on April 1 when we submit our state plan amendments to CMS. I believe you all received an invitation today to a briefing on April the 1st when we will roll out for you the constructs of the plan as well as tell you the date that we intend to go live. Now I'm not at this point going to reveal what that date is in particular because at this juncture what my staff are doing per my direction for the next week is they are taking what I reviewed with you back in February which was a Gantt chart that contained all of the swim lanes and the work elements that we will be building to-- to accommodate expansion. What we're now doing is we're going back around through the narrative that we've created that will constitute the submission of those state plan amendments and we're testing our narrative against our work assumptions so that we can ensure that once

we put that go live date out there that we can hit that go live date, Senator. So that's where we are at this particular juncture.

BOLZ: Can I-- can I count on you to share with us any corresponding updated fiscal requests related to that go live date?

MATTHEW VAN PATTON: Senator, it's our intention to work with this committee as we move forward. We realize that this is a monumental undertaking for the state of Nebraska, probably nothing like it since the beginning of Medicaid for the state in all candor. So we will, of course, be working with you as we move forward.

BOLZ: Very good. I appreciate that very much. I have a couple more questions, one, one related to managed care. And I'll start with the bigger question and go to the smaller question. I guess, forgive me for asking such a big question. But I think it's worth dialogue about which is, is managed care saving us money? I think when we started managed care and when we expanded managed care part of the promise was that it would create efficiencies and cost savings. Do we-- do we have that evidence? Can-- can we show that that's what the data says and can you help us understand?

MATTHEW VAN PATTON: Sure. So, Senator, as I referenced you've heard me talk many times so forgive me if this feels to be a bit ad nauseum; but when I referenced the objectives of the quadruple aim, that's not just an embedded management element of Medicaid Nebraska. That's a broad marketplace objective that's been widely circulated among the provider communities and payor communities for a good 15 years. And again that goes back to what's the beneficiary experience of care in both quality and satisfaction? What's the provider experience of care in both quality and satisfaction? What is the outcome? Are we improving the health of populations and therefore are we reducing the per capita spend? Now that being said, we've only been in Medicaid managed care in the state of Nebraska for two years. So you're just now beginning to set what I consider to be baseline data. You've also heard me talk about where we're going in terms of infrastructure building in terms of the talent repositories that I'm working to, to add to the cadre of staff that I have, onboarding someone like Dr. Laura Peterson who comes to us from Nebraska, excuse me, from Methodist in Omaha. She was the director of quality and population health there within that health system. She now brings her talents into the construct of our-- our business paradigm of Medicaid. The

intent of that is so that we can begin to start taking the data that we have, look at our utilization trends, and begin to run those true healthcare economic studies-- studies of utility, of maintenance, of cost benefit and efficacy. Those true healthcare economic studies measured against our spend as well as the outcomes or consequences achieved within the construct of our beneficiary population. As we move forward, again as I said, you've got two years of baseline data. From here we now begin to run those true assessments and we'll be able to tell a better story as time progresses to really quantifying, give you the answers that you're looking for. I appreciate that question because I do share the same objective. My objective is to tell the value in quantifiable terms that the state of Nebraska, its taxpayers, are making within the constructs of its buy within the Medicaid program.

BOLZ: I appreciate the nuanced answer. I-- I wonder-- I wonder if we could either through intent language or just through practice start articulating what those benchmarks that this committee should be looking for over time. I think being in a term-limited environment the institutional memory isn't what it used to be. And so soon there will not be anyone on this committee who is here before managed care and who-- who-- who can-- can from memory compare the information. So maybe there's a standardized way that we can start reporting that between our two branches. One specific question that I want to ask you that is directly related to communication that I've gotten from my constituents is I've heard from several stakeholders concerns about changes under managed care to over-the-counter medications and copayments. So specifically over-the-counter medications covered under managed care last year that are no longer covered and then copays for patients over 65 that are now in place that were not previously in place. Can you help this committee understand changes that have happened there and the justification for those?

MATTHEW VAN PATTON: Yes, ma'am, I sure can. As a matter of fact, Senator Wishart, I believe you and Senator Howard made inquiry of our office and we sent back a letter with a response to this effect. And if you'll bear with me one moment I'll put my hand exactly on that letter so I can let you know. So I think the first thing to start with here on the copay, Senator, they have been covered as a value add within the construct of our managed care benefit package by the MCOs. That being said, the value adds are something that the MCOs put forth as a way to distinguish their-- their package within the marketplace

since we allow beneficiaries to choose. So some of the value adds of one particular organization may not be the same as another and that's intended to be that way. It lets them tune their value adds to the constructs of the population that they manage as well as distinguish themselves in the marketplace. So they had been covering these copays and they have since stopped. Now as it comes to Medicaid's obligation to pay these copays, we do not have one. As a matter of fact, quite the contrary. The state, through our regulations, prohibit us from covering these copays as does federal regulation. And you can cite the federal regulation in 42 of the CFR 423.906(b)(2). So we are not only allowed to not cover them. Again it was covered as a part of the value add and those value-add packages are modified annually to better tune the service array within those value adds for the populations the MCOs serve.

BOLZ: I think that's-- that's a-- it's an explanation. I think the thing I struggle with as someone who's supposed to represent constituencies and respond to the people is that even though that is allowable under the contract the folks have communicated with me were surprised by the changes, didn't know how to manage the changes, and didn't know how to appeal or respond to what was now a burden that they didn't expect. Can you give us suggestions as to how we should respond to our constituents when those things happen under MCOs?

MATTHEW VAN PATTON: Senator, I think there's been a number of inquiries that have come in to our office as well as through the MCOs and again we've tried to stay on top of these inquiries as quickly as we possibly can. I think the nuances of changes that are made and putting those communications out we do have protocols in place within the constructs of Medicaid such that when-- when the MCOs are making changes and they make communications-- are asking to make communications to their beneficiary groups that we approve those protocols. And so those things did work their way through. I think we can always look for strategies to be more effective at communicating, whether it's using Web sites or it's using provider bulletins or whether it's looking, you know, drilling down into data to try to determine exactly how many individuals are going to be affected by change and being proactive in using the constructs of active care management to reach out to those individuals and say there's a change coming. We want to talk to you about how how this is going to impact you. So I'm always open to additional resources for communication and that my-- my perspective, Senator, is you can never communicate

enough. You continuously have to keep those strategies deployed, continue ongoing engagement.

BOLZ: But I'll give up the microphone. I think the struggle is how do we-- how do we create efficiencies and create cost savings where appropriate under managed care without losing track of how those efficiencies and cost savings impact the people that we on this side of the table are here to serve? Thank you.

STINNER: I have a couple of questions.

WISHART: I have one to follow up on that.

STINNER: OK. Senator Wishart.

WISHART: Yeah. I just wanted to be a little bit more specific about the-- what we have heard. So specifically we've heard from some assisted living facilities that tend to-- their clients tend to be-- have mental health issues. And so what's happening is they are going to the pharmacy and being required a copay. They can't afford that copay. And so the pharmacy is now-- has thousands of dollars that are-- that somebody needs to pay. And those facilities, assisted living facilities, are concerned that they will be the ones that end up needing to pay it. And as you know, they're already struggling as providers. So what-- what is it that they should be doing to-- who should they be talking to within your department and what is it that they should be doing to manage this situation? These are-- the clients that they serve, I mean, these are people that have absolutely no savings. They're getting $60 a month. There's no way they're going to be able to afford the copay for very expensive medications.

MATTHEW VAN PATTON: Senator, it's not that I'm unsympathetic to the plight but from the constructs of Medicaid and so communicating with our department again this was covered as a value add. So it was done by the constructs of our managed care organizations within that infrastructure. If it's coming back to Medicaid, again, federal law as well as state regulations prohibit us from covering those copays. Again, it's not that I'm unsympathetic to that-- the plight of those individuals. I understand. But at the end of the day, I'm bound by the rule of law as it is applied in this space.

WISHART: So is there something we could do on a statutory level at the state to help resolve this situation?

MATTHEW VAN PATTON: Well, again, you've got two levels of government here that are at play. You've got the state level of government but then you also have that 42 CFR section that I referenced in this space that's also going to be a rate-limiting factor in what-- what can be done with this population.

WISHART: OK.

STINNER: Senator Erdman.

ERDMAN: Thank you, Senator Stinner. Thank you, Dr. Van Patton, for coming. So in your comments you had commented that we have 240,000 people today on Medicaid. And if we expand that by 100,000 we're approaching nearly one out of five Nebraskans on Medicaid. As you have reviewed other states that have expanded Medicaid, is their population about the same, 20 percent of their population on Medicaid?

MATTHEW VAN PATTON: Senator Erdman, I'm going to be reticent to give you an exact percentage but what I'll walk you through is exactly what we've done as we've-- as we've spent the last five months researching and engaging as we've worked to create the product that we'll be rolling out next week. We've spent a significant amount of time again benchmarking with certain states who've already gone through expansion. What have they learned about their population, not just in terms of volume but those populations in terms of acuity of care as they come within the constructs of managed care? So we've done that benchmark with other states. We've also asked our three MCOs what data do you have that you can share based on your experiences within those other states? More specifically, we've worked with our actuary Optumas as they are also in other states who have managed care and looked at what's happening. So in the numbers that you see included in the budget that you all have agreed with, we've taken all of those factors into account to put what we consider to be that baseline number. It's about 94000 we believe. Now that being said, there are things that, you know, something could happen that that number fluctuates, that it goes up, maybe it goes down. But we believe that this is the best baseline that we have at this particular juncture and we feel pretty confident because we've worked with-- within the constructs of those

three entities to glean as much data and market knowledge as we possibly can.

ERDMAN: Thank you.

STINNER: Senator Clements.

CLEMENTS: Thank you, Chairman Stinner. Thank you, Dr. Van Patton. I see your testimony about the CHIP FMAP decreases due to recent federal law changes. So that wasn't built into the original Affordable Care Act, that decrease.

MATTHEW VAN PATTON: Senator, I can't recall off the top of my head if that decreased methodology was incorporated in there or not. What I can tell you is that the reason it's being put forth in this is that as we did accept those funds, as we did accept those, it's my understanding that there's what's known as a maintenance of effort, meaning that since we took it we have to maintain effort to keep those funding levels and those volumes at the rate that they currently are. So that's why you see the numbers put forth in this particular budget.

CLEMENTS: And regarding Medicaid expansion, you're assuming that the FMAP is going to be 90 percent.

MATTHEW VAN PATTON: That was the assumption I believe, Senator.

CLEMENTS: Could the federal law change that?

MATTHEW VAN PATTON: Senator, after a tour of duty on Capitol Hill, I make no predictions about what the federal law is going to do today or tomorrow. It's about as predictable as, well, Clemson football is pretty good; but [LAUGHTER] I just-- I'm not making predictions on what Congress will or will not do. But in the realm of possibility can it change? Yes.

CLEMENTS: And according to our Medicaid expansion statute now, is Nebraska required to make up the difference if the FMAP reduces expansion?

MATTHEW VAN PATTON: No, Senator. That would be a line of law that I can't speak to off the top of my head, but I can make an inquiry and get back with you on a direct answer if that's satisfactory.

CLEMENTS: Thank you. That's a concern of mine.

MATTHEW VAN PATTON: Sure. Thank you.

STINNER: Our provider rates are different than the Governor's. And ours, we do feel as a committee that we need to reimburse providers. We need to give some reasonable increase. Now it's 2 percent, 2 percent so we weren't that gratuitous. Is it your intent on the Medicaid side to get that-- to get that increase out that we recommend from the Legislature?

MATTHEW VAN PATTON: Senator, I will go back to where we are with the constructs of the budget that's been presented to you, and I believe the Governor's put forth an increase that's different as you've already articulated. And I believe his intent because we have consistently heard, as I heard in the testimony and in the hearings that preceded this one, the concern from the long term-care community. I share those concerns as was articulated by my staff today. It's our intent to focus those provider rate increases, if you will, on that long-term care community as part of their base. Now that being said, what I would tell you about provider rates and where I would encourage you to be judicious in your-- in your deliberations moving forward is that you do have an expansion population. And again, there's-- there is a concern that I have that lingers in the back of my head about this population is that they're going to come on board and they're going to come in with some unmet health needs. You're going to have a higher acuity of care coming into this population. And I'll give you an example. You may have a hemophiliac whose annualized care cost are a million dollars each. So you bring on two or three hemophiliacs into the population, you've got a significant run on your budget already. So what I would-- what I would tell you is let's be judicious and target where we have already heard considerable what I would consider marketplace issue relevance around rates and let's-- let's target it where we know it is at this particular point in time. And let us begin to move forward as we look at other provider rates and time moves forward in a more judicious manner on our internal side as we analyze where we are after we go through expansion and as we see through, again, those elements of healthcare economics, those studies that I said earlier, let us assess those provider rates with-- with good benchmarks around us and then come back with recommendations.

STINNER: I will take that as a no, that you are not intending on sending the provider rates out the way that we prescribe. But you're going to make up your own way of doing it. And if you have a bust in your numbers like the hom-- the-- whatever it was, the blood disease thing, that that causes some budgetary stress that you're going to take it out of the providers. Is that what I heard?

MATTHEW VAN PATTON: Senator, those were not my words.

STINNER: I sure as heck heard it that way.

MATTHEW VAN PATTON: No, I didn't say that at all.

STINNER: We've increased providers by 2 and 2 percent. That is our intention and we expect the 2 percent to go out not only to that but we also increased I think behavioral health, we increased DD, we increased provider rates to hospitals across the board, all the providers. We think that's fair. We think that kind of keeps them up with inflation given the fact that it was flat and their operating costs continued to increase. But I-- you know, the way that we account for your department as, at least before today, we just looked at all of those things and then we dumped in the dollars into the Medicaid side. And then obviously some things happen. They move around. On long-term care, that-- those funds never went out. You know that and I know that. Now I mean, but you're telling me that you want to have the discretion within your budget to say I'll treat the providers the way we see fit. That's the way it came across to me. If I'm wrong, you need to enter that in the testimony and say I'm wrong.

MATTHEW VAN PATTON: Senator, we-- there-- there are multiple ways that providers are paid in-- within the constructs of Medicaid. Some of those payment methodologies as you've heard today are institutionalized within your regulatory framework. We've already heard about that. And then other provider rates are folded into managed care and that's where those rates are set. Now we calculate what we pay in managed care based on a per member per month as you-- as you know. So, you know, Senator, my-- my response to you is, again, I'm going to-- I'm going to go back to what's included in the Governor's budget because I believe that's the responsible number at this juncture, again, given where we are with an upcoming expanding population. And I would like to target that at long-term care. So if it is there, we will fold that into the base right now. I heard the

conversation earlier and I want to continue to reiterate when you put money into that methodology, the methodology can influence the base rate. But at the end of the day if a facility is billing, they're billing based on utilization. There has to be a head in a bed. Otherwise we can't pay. I can't pay for a service not rendered. So if you say the money is there and it's going to go towards long-term care, we will fold that into the base rate. But again, that base rate, because of that methodology that we talked about earlier with you, that methodology is going to be taking other things into account such as your cost report and census that's going to dictate that. That's why we've been advocating and why staff have deployed those processes to begin promulgating the removal of that particular section of our regs so that we can innovate, so that we can put forth a new payment methodology to allow us to take and put money more specifically to a provider base such as what you're referring to here today. That's the challenge that we have within the construct of just the long-term care space as it stands.

STINNER: OK. Before the meeting today, I sat down with Fiscal and we looked at and I always look at cash carryover. We had $53 million in cash carryover. Right now in looking at the status, it looks like the cash burn will-- will actually-- you'll end this part of the fiscal year with about $13 million which means that there's about $40 million of carryover cash burn. Now that also means that we're actually spending more than the budget that was given at that time and it's probably OK to do that. The only thing I have to ask is, you know, first of all, is there going to be a deficit request? Secondarily, does the budget need to be adjusted?

MATTHEW VAN PATTON: Well, I think there are three drivers of our expenses right now. The HIPF, the liability for the healthcare insurance provider fee or tax, that's certainly an element. The clawback premiums, that's certainly an element. And then we did have one of the MCOs in the original construct of the contract language there was a lost corridor and we had to make that up for I believe that was a previous fiscal year and so that did drive into those numbers and drive that-- that 13th month of reserves down. So, yes, Senator, I believe that there will possibly be a deficit request coming.

STINNER: OK. Thank you. Any additional questions? Seeing none, thank you.

MATTHEW VAN PATTON: Thank you.

STINNER: Good evening.

BO BOTELHO: Good evening, Chairman Stinner, members of the Appropriations Committee. For the record, I am Bo Botelho, B-o B-o-t-e-l-h-o, interim director of the Division of Public Health Nebraska Department of Health and Human Services. Division of Public Health serves the entire population of the state of Nebraska and is organized into three operational sections. First is community health, the scope of which includes rural and minority health, health promotion, life span health services, and public health preparedness and emergency response. Second is health data including the vital records office and the epidemiology and informatics unit. Third is health licensure which includes facility, professional, and occupational licensure as well as licensure investigations and environmental health services. Whether it's ensuring that all 26,000 infants born each year in Nebraska are screened for a range of life threatening or debilitating conditions or alerting the public to the presence of a virulent strain of influenza or protecting Nebraska's access to safe healthcare by holding individuals and facilities to a common standard, the Division of Public Health promotes the DHHS mission of helping people live better lives every day. In the past biennium, the Division of Public Health has made several notable achievements. Last year, Nebraska Women, Infants and Children, WIC, completed the rollout of the eWIC statewide, replacing a complicated system of paper check-based benefits with a simple and easy to use electronic benefit transaction card similar to a debit card. Nebraska is a national leader in child immunization coverage ranking fifth in the nation in the latest CDC review. The division has restructured its vital records customer service area to reduce wait times for certificates from 30 minutes to under 5. Looking forward to next biennium, we are in the process of releasing an RFP to replace our aging licensure informatics system and implement an on-line license renewal for healthcare facilities. The budget proposed by Governor Ricketts will enable us to continue to prioritize efficient, effective, and customer-focused state government. I would like to thank the members of the Appropriations Committee for including the Governor's recommendation to increase cash and federal spending

authority for Program 175, the Rural Health Provider Incentive Program. The funding request relates to Health Resources and Service Administration, HRSA, State Loan Repayment Program. The federal program provides the state with one-to-one matching funds to provide loan repayment assistance for qualifying educational debt. Under this program, matching funds are provided by local entities with no direct cost to the state. In exchange for a minimum commitment of two years of practice in a federally designated health shortage areas across the state, physicians, nurse practitioners, physician assistants, dental professionals, mental health professionals, and pharmacists can receive $50,000 to $100,000 over a two-year period with an option to extend an additional two years for up to $200,000 in student loan assistance. There are currently 30 professionals enrolled in the program across greater Nebraska practicing in 19 counties from Scotts Bluff, Morrill, and Sheridan in the northwest to Gage, Johnson, and Richardson in the southeast of the state. Not only does this program support health infrastructure statewide, it also sparks economic growth in our rural communities. According to an analysis conducted by the National Center for Rural Health Works, one rural primary care physician generates a direct and indirect employment impact of 26.3 jobs with $1.4 million in wages and benefits. Division of Public Health applied for and has successfully awarded a $150,000 increase in federal grants for the HRSA State Loan Program along with cash spending authority requested. This will allow us to invest an additional $300,000 per year to support medical access in Nebraska's shortage areas. The agency's request and the Governor's recommendation also includes an offset of General Funds in the Ryan White HIV/AIDS program that is made possible by an increase in drug rebate revenues to the Division. Thank you for including this in your recommendation which will allow us to continue to serve Nebraskans while remaining good stewards of taxpayer dollars. I'd like to thank the committee for including these recommendations. Finally, you will likely recall my opposition testimony during the LB481 hearing. And I urge you to include the Title X language recommended by the Governor in the budget consideration. Thank you. I'm happy to answer any questions.

STINNER: Questions? Senator Bolz.

BOLZ: Just-- just one briefly. I want to give you the opportunity to talk about your tuberculosis request and just give us any more information. I don't think that the committee took action on it and you didn't reference it so I just wondered if that was a priority or

if you are OK with the committee's decision to not grant the cash fund switch for the tuberculosis.

BO BOTELHO: I don't have any specifics on that program.

BOLZ: OK. We-- we can follow up.

BO BOTELHO: And we will too.

STINNER: Additional questions? Seeing none, thank you.

BO BOTELHO: Thank you.

STINNER: Good evening.

TODD LEWIS: Good evening. Thank you, Chairman Stinner. Thank you, members of the committee. My name is Todd Lewis, T-o-d-d L-e-w-i-s. I'm here tonight representing the Nebraska Home Care Association, Craig HomeCare where I'm the director of branch operations and also Maxim Healthcare Services. I do want to thank those of you who have accepted our invitations, both ours and Maxim's, to visit some of the medically fragile kids that we serve throughout the state. I've seen photos on Facebook of those visits. I talked to the parents and there was overwhelming gratitude for that so thank you. We appreciate the consideration for the Medicaid reimbursement increase. However, specifically for Craig HomeCare and Maxim we ask for consideration for a targeted appropriation specifically for two codes: S9124 and S9124 TG, which represent both low- and high-tech LPN private duty nursing services. For some background, our agencies provide in-home LPN and RN nursing care for medically complex pediatric patients and their families. These are very sick children whose condition would otherwise require continuous or extended stay inpatient patient hospitalization. Many are dependent on mechanical ventilation, tracheostomies, feeding tubes, and other technology to sustain life. Our services allow these children to be discharged to their home and community setting instead of living their lives in hospitals. Additionally, our services allow parents the peace of mind necessary to maintain employment and receive the rest they need to be healthy, productive, contributing Nebraska citizens. We improve the quality of life for families. Currently the provider reimbursement rates for codes S9124 and S9124 TG are $25.03 and $31.65 respectively, which is grossly inadequate to allow for hiring, recruitment, and retention of nursing staff. These consequences-- the consequences include compromised outcomes such as

delayed discharges from acute care hospitals, unnecessary/avoidable rehospitalizations, higher emergency department utilization for these patients, all factors that significantly-- significantly increase costs to the state's Medicaid system. In support of our request, I would offer the following and then I'll paraphrase in the interest of time. An American Academy of Pediatrics study published in 2019 in January of this year placed the daily hospital costs at $3,900 per day for this population while comparing that to an average of $311 a day for what we provide. And if you-- if you look at successive bullets, you'll see data from the Nebraska Center for Nursing that studied in 2016 and 2017 data related to LPN and RNs across the state, what they're making. As you can see, when LPNs are on average making somewhere, excuse me, somewhere between $20.44 an hour and $21.63, our ability to pay usually no more than $18 an hour leaves us critically understaffed for-- for this care. I've included in the second to last bullet some comparisons. In the interest of time as well, I'll just paraphrase by saying the average for states contiguous to Nebraska and those having similar programs is roughly $36.05 an hour for reimbursement of LPN services. Based on the current market conditions, we're asking that a consideration the range of $35 to $38 an hour would help us cover the costs of these services for Nebraskans, offer competitive wages to attract LPNs and my time is up so I'll entertain any questions. Thank you for the opportunity.

STINNER: Thanks for the summary. Questions? Senator Dorn.

DORN: Thank you, Chairman. Thank you for coming today. Those rates there that you quoted for those who sets those or who determines those rates?

TODD LEWIS: Which rates are you referring to?

DORN: The $25, the reimbursement rates of $25 and $31.65.

TODD LEWIS: Those are the state published Medicaid rates.

DORN: But-- but our department, I mean not ours, the Health and Human Services Department sets those rates.

TODD LEWIS: Um-hum, yes.

DORN: Based on, what do they tell you, based on how did they come up with those rates?

TODD LEWIS: I'm not aware.

STINNER: Additional questions? Seeing none, thank you.

TODD LEWIS: Thank you.

LEISHA EITEN: Good evening.

STINNER: Good evening.

LEISHA EITEN: It's been a long afternoon. My name is Leisha Eiten. It is spelled L-e-i-s-h-a, last name is E-i-t-e-n. Senator Steiner and-- Stinner and the Appropriations Committee, whoever's left, with your indulgence I think I will provide a fuller testimony, but tonight I think I'll just cut to the chase of what I wanted to talk about.

STINNER: That's good.

LEISHA EITEN: OK. So first of all, I wanted to thank you for mentioning the issues about providing rate increases for the general clinical providers that are out there. So I'm really here as a representative for the Nebraska Speech-Language-Hearing Association to support that. So we are in support of increasing the value of the Medicaid provider reimbursement rates just generally for clinical people who are out there doing their job every day as well. One of the issues that many of our patients and families across the state encounter is trying to find a qualified service provider in their area. If you're lucky enough to be in the Omaha area, providers are pretty easy to find. But even in Lincoln and further outstate that really is a problem to find a qualified provider for speech language services or audiology services who will accept Medicaid payment. So there are many more providers who have said because of the poor reimbursement rates I can't even cover my time. I can't even cover the amount of service that is needed for this client. And rather than providing reduced services, they're basically limiting the amount of service or the number of patients they may see. So they're kind of self-limiting which means patients do have a hard time finding an appropriate provider. So we feel like with the proposed increase in Medicaid rates that may allow reimbursement that's closer to the actual cost of providing the services that people need. Hopefully that

will result in more providers actually taking more Medicaid clients. It's kind of a-- it's the same sort of domino effect that happens in long-term care but it happens in the clinical side as well. So I just would like to thank you for mentioning that because we are out there and we would support an increase in our reimbursement rates.

STINNER: Thank you.

LEISHA EITEN: Thanks

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

LEISHA EITEN: Yeah.

JIM ULRICH: Well, my notes originally said good afternoon but we'll change it to good evening.

STINNER: Good evening.

JIM ULRICH: And Chairman Stinner and members of the Appropriations Committee, my name is Jim all Rick. That's spelled J-i-m U-l-r-i-c-h, and I'm the CEO at York General Health Care Services in York, Nebraska. I'm here to testify on the Agency 25 budget on behalf of my facility and the Nebraska Hospital Association. We are pleased to see this committee recommend an increase for all Medicaid providers at 2 percent this year and next year. We appreciate this recommendation and ask that you hold to these increases as you set your final budget recommendations. Sat through and listened to a lot of the testimony on the nursing homes. Definitely agree that there is an increase needed there. Want to talk about the hospital specifically a little bit. Hospitals that care for Medicaid patients end up providing significant amounts of uncompensated care. That's because Medicaid reimbursement rates generally only cover about 70 percent of the actual cost of care of a Medicaid patient. Despite this, hospitals welcome all Medicaid patients and provide the same quality care for all regardless of ability to pay. Very soon we will be welcoming 94,000 Nebraskans on the rolls when we expand Medicaid. Projections show that 40 percent of this population presently has private insurance which provides a higher reimbursement rate. This shift from private insurance to Medicaid will have a significant financial impact on hospitals. Fifty-three percent of critical access hospitals are facing financial stress. Financial stress is defined as having an operating margin of less than 2 percent. One in three hospitals are operating in the red.

Without an increase in provider rates, hospitals' bottom lines will continue to decrease which could affect access to care. Our hospitals are dedicated to serving the Medicaid population but doing so at a fraction of the actual cost of providing this care is not a sustainable business model. Over time, the gap between what is-- what it costs to provide this care versus what we are paid to provide this care is growing. So because of that, we ask that you increase the reimbursement rates by 2 percent in the next two years for all Medicaid providers. I thank you for your time and am willing to answer any questions.

STINNER: Questions? Senator Erdman.

ERDMAN: Thank you, Senator Stinner. In your comments you made a statement that 44 percent of those people that will be on Medicaid now have private insurance. Did you say that?

JIM ULRICH: 40 percent, yes.

ERDMAN: 40 percent. And they reimburse-- they pay better than the Medicaid so you're going to have another reduction there?

JIM ULRICH: Yeah. It's going to be at rates that are like a private insurance company. And you know, that-- that can be the difference of-- it could be about a 40 percent difference in a percentage off our charges. In our facility, that's probably what it would be. And so when you look at the impact of Medicaid expansion, you know, you can recover from your-- your-- those that maybe would have had charity care before. A percentage of those I'm sure will qualify for Medicaid expansion. You'll get some plus on the reimbursement side there. But then depending on the percentage that flips from the exchange or private insurance back to Medicaid expansion, we're going to see a decrease. And depending on where those percentages line up, Medicaid expansion could very well be a negative overall for reimbursement or it could be break even. It just-- it certainly is not going to be a windfall.

ERDMAN: I think the way that Medicaid expansion initially was presented was those 90,000 didn't have any insurance, none of them. That wasn't the case.

JIM ULRICH: No. There's-- when you get into the 138 percent of poverty, you're going to have some that are on the exchange.

ERDMAN: Thank you.

STINNER: Questions? Seeing none, thank you. If you're going to testify, if you could come up to these first seats, that way it facilitates coming up here. So thank you.

MOLLY McCLEERY: Chairman Stinner, members of the committee, my name is Molly McCleery, M-o-l-l-y M-c-C-l-e-e-r-y, and I'm the director of the Health Care Access Program at Nebraska Appleseed. We are a nonprofit legal advocacy organization that fights for justice and opportunity for all Nebraskans. I testify today in support of the Appropriations preliminary Agency 25 Medicaid budget. I will also keep this short. We support the committee's full funding of Medicaid expansion over the biennium as projected by the Department of Health and Human Services and the Governor's budget recommendation. And we understand and appreciate the committee's use of more conservative offset numbers. But based on other states' experiences, we expect future savings in corrections and in the Medicaid coverage for pregnant women category for which there are no savings currently anticipated. Lastly, we would just echo Senator Bolz's question regarding the alignment of the start date of January 1, 2020, in the budget with the go live date to be announced on April 1. And we'll hear more about that next week. But we would just echo that question as well. And I'm happy to take any questions.

STINNER: Questions? Seeing none, thank you.

MOLLY McCLEERY: Thanks.

NICK FAUSTMAN: Good evening.

STINNER: Good evening.

NICK FAUSTMAN: Nick Faustman, N-i-c-k F-a-u-s-t-m-a-n. I'm the Nebraska government relations director for the American Cancer Society Cancer Action Network which is the nonprofit nonpartisan advocacy affiliate of the American Cancer Society. We support evidence-based policy and legislative solutions designed to eliminate cancer as a major health problem. Last year the Appropriations Committee made a modest one-time increase of $500,000 to the budget to the state's

tobacco prevention program known as Tobacco Free Nebraska or TFN for short. ACS CAN and our partners ask the committee continue this level of funding for the program as the new baseline in the budget. As you may already know, the toll of tobacco is enormous in the state of Nebraska. The total annual healthcare expenditures in our state that are directly caused by tobacco use are $795 million, including an estimated $162.3 million in Medicaid costs. Complicating matters is that the current funding for the program is less than 15 percent of what the Centers for Disease Control and Prevention recommends for our state. We could significantly decrease these costs with the continued investment into TFN. ACS CAN is grateful that the initial budget proposal provides funding for the voter approved Medicaid expansion. The increased access to health insurance enhances the likelihood of detecting cancer earlier, more curable, and less expensive stage. The initial budget recommendation provides funding for Medicaid expansion for the '19-21 biennium through eight offsets to three programs, one of which is listed as executive-- in the executive booklet as Women with Cancer. The executive budget booklet shows an adjustment to this program of $535,302 for the first year of the biennium and $1,070,604 for the following year. We believe that this means that once Medicaid expansion is implemented the women who seek treatment through Women with Cancer would be eligible for treatment under their new coverage. However, we would-- we do not know the implementation date and therefore urge caution in shifting money away from any such beneficial program if Medicaid expansion does not yet exist. While the budget proposal includes initial funding for Medicaid expansion through the '19-21 biennium, it will be necessary to consider alternative funding sources for the out years. So ACS CAN strongly recommends that the Legislature enact an increase of the tobacco tax of at least a dollar to help fund the program in the years to come.

STINNER: Thank you. Any questions? Seeing none, thank you.

NICK FAUSTMAN: Thank you.

TIFFANY FRIESEN MILONE: Good evening, Chairman Stinner and members of the Appropriations Committee. My name is Tiffany Friesen Malone. T-i-f-f-a-n-y F-r-i-e-s-e-n M-i-l-o-n-e, and I'm policy director at OpenSky Policy Institute. We're here in support of fully funding the state's Medicaid expansion which we hope will be implemented no later than January 1, 2020, so that Nebraska can begin to see the economic benefits other expansion states have seen. My handouts, one is just a

general fact sheet and the other one is a sampling of other states and the economic-- economic benefits that they've seen. I'll talk about that one a little bit later. Medicaid has a unique role in state budgets as both an expenditure and a source of federal revenue. In fact, Medicaid is the single largest-- it's the largest single source of federal funds for states accounting for more than half of all federal funds for states in fiscal year 2017. This infusion of federal dollars flows through the state economy and can generate impacts greater than the original spending alone. A University of Nebraska at Kearney report estimated that the influx of more federal dollars due to Medicaid expansion could generate an additional $1.3 billion in new economic activity. This estimate is in line with what other states have experienced since implementing their own Medicaid expansion programs. As you can see from the state handout, a number of economic studies looking at the budgetary impact of expansion-- of expansion found that expanding Medicaid has been-- had either a positive or neutral impact on most states. Specifically a report from Georgetown University that looked at Michigan, Montana, Louisiana, and Colorado found that expanding Medicaid has either been a positive for each state's general fund revenues or hasn't resulted in any additional costs to the state. Another report from Wake Forest University looked at Arkansas, Indiana, Kentucky, New Mexico, Ohio, and West Virginia which also saw reduced, not increased state spending as a result of expansion Virginia's expansion didn't start enrolling until January 1, 2019. But the projected budget savings were firm enough to be included in the governor's budget and reallocated to other priorities. These results are due to a combination of substantial state savings from Medicaid expansion now largely paying for formerly state-covered services and an increase in revenues realized from increased economic activity associated with expansion. Looking at Michigan specifically, a study published in The New England Journal of Medicine found that continuing Michigan's expansion in 2017 and beyond will have clear economic benefits for the state. Specifically, state budget gains outweigh the added costs of the state-- for the state for at least the next five years and probably longer when additional Michigan-specific taxes and contributions for Medicaid expansion from health plans and hospitals are excluded-- included. I have more examples. I'll skip those for the time being. The increased spending attributable to-- attributable to expansion is also likely to brighten the fiscal outlook for hospitals and providers in rural areas where 38 percent of Nebraska's uninsured population lives. Expansion states have seen

fewer hospital closures and greater provider availability which increases access for nearly all residents. We have also no concerns about the accuracy of cost estimates in the state as a peer-reviewed study has found the state's budget projections are reasonably accurate in the aggregate with no significant differences between the projected levels of federal, state, and Medicaid spending actual expenses as measured at the end of the fiscal year. This remained true even in states where initial enrollment numbers exceeded projections.

STINNER: Thank you.

TIFFANY FRIESEN MILONE: With that, I'll try to answer any questions.

STINNER: Additional questions? Seeing none, thank you.

BRIAN KRANNAWITTER: Mr. Chairman, members of the committee, good evening. My name is Brian Kranawitter. That is spelled B-r-i-a-n, last name is spelled K-r-a-n-n-a-w-i-t-t-e-r, and I am the government relations director for the American Heart Association. I know it's been a long day. I'll just make a couple of brief comments. We are pleased that funding for Medicaid expansion is proposed in the initial budget. Many Americans, including Nebraskans, have at least one cardiovascular disease related condition. For these patients, access to affordable and adequate health insurance can be a matter of life and death. Further, the connection between having health insurance and health outcomes for this population is clear and well-documented. Americans with CVD risk-- excuse me, Americans with CVD risk factors who are uninsured or do not have access to health insurance have higher mortality rates. It is clear that not having access to quality comprehensive healthcare is bad for patients. The other thing I would just add is my colleague, Nick from the American Cancer Society, we also echo the same comments regarding funding for tobacco prevention and cessation. So with that, I would entertain any questions.

STINNER: Thank you. Questions? Seeing none, thank you very much. Additional proponents? Seeing none, any opponents? Seeing none, anybody in the neutral capacity? Seeing none, there is five letters of written testimony in favor of the budget recommendations: Patricia Kearns, Carole Boye, Amy Behnke, Grace Knott, and Gina Ragland. That concludes our testimony and hearing for Agency 25 and concludes our hearings for tonight. Thank you very much.