MEDICAID REFORM COUNCIL
March 14, 2007

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The Medicaid Reform Council met at 1:30 p.m. on Wednesday, March 14, 2007, in Room 1510 of the State Capitol, Lincoln, Nebraska for the purpose of conducting a public meeting. Members present: Gayle-ann Douglas, Senator Phil Erdman, Marylee Fitzsimmons, Senator Don Pederson, Pam Perry, and Pat Snyder. Members absent: Kathy Campbell, Steve Martin, and Cory Shaw. []

SENATOR PEDERSON: I will call to order the meeting of the Medicaid Reform Council, and I will announce again that the purpose of this particular meeting is an informative meeting, a work session for the council itself, and we will be presented with a number of items by the staff that's been working on these items. I would suggest that if there any of you that are part of the audience, if you have questions or concerns, that you either mail that to...I would suggest maybe to Mary Steiner or E-mail her, and you can get that information from us. But this is a work session; we're primarily trying to keep track of how we're moving along. We do have a new face in that office handling this matter. Dick Nelson formerly handled it, and now we're blessed with having Mary handle this matter. So the first item on the agenda for today...and we have three absences, and maybe we can introduce ourselves as you go around. Linda, do you want to introduce yourself?

LINDA OLLIS: Certainly. I'd be happy to. I'm Linda Ollis. I'm the CEO of Creighton University Medical Center.

MARYLEE FITZSIMMONS: Marylee Fitzsimmons, representing the community health centers.

GAYLE-ANN DOUGLAS: Gayle-ann Douglas. I'm representing business.

SENATOR PEDERSON: Pat.

PAT SNYDER: Pat Snyder, representing long-term care.

SENATOR ERDMAN: Phil Erdman, representing elected officials.

PAM PERRY: Pam Perry, family member of Medicaid recipient, and I also happen to be director of Nebraska Domestic Violence/Sexual Assault Coalition.

SENATOR PEDERSON: (Exhibit 1) And I'm Don Pederson, Chair of this, and used to be a senator. Okay. Now let's turn to the minutes of the last meeting, and they're not very extensive, because it is a work session. Do I hear a motion to approve the minutes?

MARYLEE FITZSIMMONS: So moved.

SENATOR PEDERSON: It there a second?

PAM PERRY: Second.

SENATOR PEDERSON: All in favor say aye. Opposed? Okay, the minutes are approved. All right, the next item that we have is to have a legislative update from Jeff Santema.

JEFF SANTEMA: (Exhibit 2) Thank you, Mr. Chairman. You have, I think, in the materials that you were given a copy of the legislative update. I won't take a great deal of time in going through it and give you the opportunity to ask any questions that you might have. I listed 15 bills, 14 bills and a resolution there for you that I felt were related, sufficiently related, to the Medicaid program to bring them to your attention. And I wanted to highlight a couple of them for you especially, and give you an idea of where the bills are in the legislative process. I wanted to highlight particularly four bills in that list that have to do with a very important policy area, and that is the area of long-term care. This council has talked a great deal about and heard a great deal about alternatives to institutional long-term care, in-home care particularly. There are four bills--and I wanted to highlight them for you--LB236, LB397, LB523, and LB555, all heard by the Health and Human Services Committee, which have to do with this topic. LB236 has been advanced to the full Legislature by the Health Committee; LB397 and LB523 have been indefinitely postponed; and LB555 is still before the committee. The Health Committee will continue, I believe, discussions regarding this important area of policy, and I would expect legislation to return on these topics. The other couple of bills that I wanted to draw your attention to were LB292 from Senator Hansen, and that bill was discussed on the floor of the Legislature this morning. It was advanced from General File and it creates a...allows counties to transfer an intergovernmental transfer of funds for the purpose leveraging more dollars for disproportionate share providers, and I know council member Ollis has provided a letter of support for that particular legislation, and that was advanced by the Legislature down to Select File this morning, or to E & R Initial. The other bill is LB296, which is a bill that you may be familiar with, introduced at the request of the Governor, to reorganize the Health and Human Services System. That bill has not been enacted, and awaiting the Governor's signature. Another bill, LB395, introduced by Senator Johnson to create a statewide smoking ban, is now being discussed by the Legislature. It is now on Select File. And those are the bills I particularly wanted to highlight for your attention. But I'd be happy, Mr. Chairman, to try to answer any questions that the council might have.

SENATOR PEDERSON: Jeff, was LB292 the one that was advanced this morning?

JEFF SANTEMA: Yes, sir.

SENATOR PEDERSON: And that's the one that leverages this and gets almost twice as much more total dollars for the state, simply I think, as I heard Senator Johnson say on the microphone today, just simply by making the check out differently, we're getting about twice as much money.

JEFF SANTEMA: And Mary Steiner could probably talk with the council more in detail about how the intergovernmental transfer would work, if the council has more questions about it. Yes, and the Legislature also advanced an amendment to that bill dealing with the...another transfer of funds which takes place through a provider tax of intermediate care facilities for the mentally retarded, or ICF-MRs, and that issue has advanced also, along with that bill this morning.

SENATOR PEDERSON: I heard a bill this morning that they talked about--I don't remember if that's on here, but that was one that dealt with insurance for long-term care...

JEFF SANTEMA: Right. Yes.

SENATOR PEDERSON: ...and reducing the age down to 55, I believe, or 50; 50 maybe.

JEFF SANTEMA: Thanks, Mr. Chairman.

SENATOR PEDERSON: And that was the one that we passed before in the Legislature but had a higher entry level, and correspondingly, we weren't reaching the people at a time when they could afford to, perhaps, buy the policy and make it more effective. Is that about it?

JEFF SANTEMA: Exactly. I think LB304 is probably the number.

SENATOR PEDERSON: Yeah, LB304. Is that it? Okay.

JEFF SANTEMA: And the long-term care insurance.

SENATOR PEDERSON: And then, maybe Mary can answer this question, but LB699, by Senator Lathrop, didn't quite make the cut, I understand. But that was one that dealt with prescription drugs and what he perceived to be a savings if we did it that way. But maybe if you would respond at your time, Mary.

MARY STEINER: Okay.

SENATOR PEDERSON: I'm sorry. I kind of monopolized that. Does anyone else have questions of Jeff regarding legislative enactments currently taking place? Yes, Phil.

SENATOR ERDMAN: Just another bill that was before the Legislature regarding estate recovery efforts under Medicaid. LB102 was introduced before the Judiciary Committee. They indefinitely postponed the bill. After they killed the bill, my office worked with the department and the state bar to try to restore that effort in a different amendment. That amendment was not accepted by the body and so we'll have to figure out a different year to do that. But that was a bill designed to assist the state in recovering Medicaid, due to our lower-than-average recovery rate of existing...

SENATOR PEDERSON: What was the number of that?

SENATOR ERDMAN: LB102--l02.

SENATOR PEDERSON Thank you. Other matters of concern?

MARYLEE FITZSIMMONS: Is there an update on the work comp bill? Are you familiar with that one, the payment reform?

JEFF SANTEMA: No, I don't think I could comment very well, but I could get you some information.

MARYLEE FITZSIMMONS: Okay. I can follow up after the meeting. That's fine. Thank you.

SENATOR PEDERSON And if there's anything that you want Jeff to be keeping track of or following for us, please let him know, and I'm sure he will do it. Jeff is always very cooperative.

JEFF SANTEMA: I'd be happy to. Thank you. Mr. Chairman, and if I could, I'd like to acknowledge, along with the other guests in the audience today, members of the Health and Human Services Committee. Maybe some of the council are familiar with the senators, and a newly elected senator, Senator Pankonin, as well, is here, and so I'd like to acknowledge their presence, as well.

SENATOR PEDERSON: You want to introduce yourselves? Senator Pankonin.

SENATOR PANKONIN: I think we have some other members here. I'm Dave Pankonin. I'm from Louisville, Nebraska, new this year in the Legislature and the Health and Human Services Committee; enjoying it very much, so.

SENATOR JOHNSON: Joel Johnson. I'm the Chairman, from Kearney.

SENATOR STUTHMAN: Arnie Stuthman. This is my fifth year on the HHS Committee.

SENATOR ERDMAN: And I believe Senator Gay was here, but I don't see him anymore.

SENATOR PEDERSON: I don't see him, either.

SENATOR ERDMAN: And that was his bill this morning, on LB304. That's Senator Gay's bill on the long-term care insurance.

SENATOR PEDERSON: Yeah, and that was advanced. Okay. A number of insurance agents were talking about the reason that that ought to happen. It's very saleable at age 50. Okay. Jeff, you have anything else that you would like to present to us?

JEFF SANTEMA: No, sir, thank you, Senator Pederson.

SENATOR PEDERSON: Okay, thank you, Jeff. Now we talk to Liz Hruska, from the Legislative Fiscal Office.

LIZ HRUSKA: (Exhibit 3) Good afternoon, Chairman Pederson. You continue to--I can continue to address you as Chair, as you served as chair of the Appropriations Committee that I staff--and members of the commission. I am happy here to present to you today. I appreciate the leadership you have shown and the guidance you have provided to the Medicaid reform process, and this give me an opportunity to publicly thank you for your work. Although my report is heavily laden with numbers, I hope to explain them in a clear and hopefully nonconfusing manner, and I hope to also keep you awake. In my favor, my presentation is short, as far as being able to keep you awake during my presentation, so I will...I would like to take questions at the end of my presentation. The Appropriations Committee came out with their preliminary recommendation a few weeks ago. My presentation will discuss the General Fund impact on the Medicaid program. For all fund sources; that is, general, cash, and federal, please refer to the sheet labeled "Appropriations Committee Preliminary Recommendations for the Medicaid Program." And I found an error late this morning, so that was passed out to you separately. The attached sheet has a wrong number in a federal fund. The General Fund increases including projected savings from Medicaid reform measures are 3 percent in fiscal year '08, and an additional 2.2 percent in fiscal year '09. This compares with average annual increases of 9 percent in the past. Without Medicaid reform, the General Fund increase would be 4.4 percent, and an additional 4.3 percent in FY '08 and '09 respectively. Medicaid reform measures are projected to save $7.6 million in FY '08, and $19.8 million in FY '09 in the aid portion of the Medicaid program. When administrative increases needed to implement the program are factored in, the net savings are $6.6 million the first year, and $18.2 million in the second year. Before going into the biennial budget projections, I would like to review the current year trends that I think will be beneficial in understanding the budget projections, going

forward. In the deficit bill, which makes adjustments to the current year appropriation, the Medicaid budget is being reduced by $13.5 million. Although there are many factors that are influencing this lower-than-projected growth, one clear and quantifiable is the number of individuals eligible for the program. When the budget was put together, utilization was projected to grow at just under 3 percent. In the first half of '07, compared to the first half of FY '06, projected growth in all categories of eligibility were down, and you can see that on the sheet before you. The most dramatic divergent is in the area of children eligible for the program, which were projected to increase by 5 percent, but actually came in at a 4 percent decrease over the prior year. There are three main drivers of the Medicaid General Fund cost. One is rates and/or price, the second is utilization and the number of people eligible, and the third factor that influences General Fund cost is the federal match rate. In the area of rate increases, on average service categories will receive anywhere between a 1.4 percent increase to 2 percent. The exception is ICF-MR rates, which are increasing by 2.5 percent each year. Prescription drug costs are anticipated to go up 10 percent each year, and you have the table before you with the major service categories, and you can review those. Another part of the cost increases to the General Fund are due to what is called the Medicaid Part D clawback. This clawback is a mandatory state payment to the federal government to offset the cost benefit to the Medicaid program resulting from the implementation of Medicaid Part D prescription drug coverage. The clawback amount is set by federal formula and is increasing 6.8 percent in 2007, and 7.1 percent in 2009--I think that first figure should be 2008--and the corresponding dollar amounts are $3.7 million in fiscal year '08, and $7.5 million in fiscal year '09. Regarding utilization and eligibles, overall utilization is expected to grow by approximately 1.8 percent, and you have on the chart before you the increases by eligibility category. The aged population is projected to grow at 1.5 percent, the disabled population 3.5 percent, children 1 percent, and adults are expected to remain level. And the final major cost factor is the Medicaid match rate, and we are experiencing a decrease from 58.37 percent to 58 percent, and that has a fiscal impact of $4.4 million. Before wrapping up I would just like to make a few comments regarding the Medicaid reform savings. As mentioned previously, the net savings of Medicaid reform measures are $6.6 million General in FY '07, and $18.2 million in FY '08, and $18.2 million in FY '09. These savings figures are lower than what was previously thought and probably what you are used to seeing. There is a spreadsheet attached called the "Evolution of Medicaid Reform," and it shows the projected savings, starting with this commission's recommendation in December, '05, through what the Appropriations Committee preliminary recommendations are, that I just presented to you earlier. Although there is a significant decline from the $30 million that was anticipated to be saved in fiscal year '08, down to the $6.6 current projection, this is not atypical of major public policy initiatives and the fine-tuning that goes into a long-term process, and also one that is very complex. Major public policy initiatives often begin with a concept and only rough estimates of the financial impact. As issues are further developed and more information is gathered, new issues often come to light. There may be previously unknown constraints that surface as we move towards

implementation. In addition, time frames may not have been practical or may need to be extended because of resource or workload issues. Sometimes concepts may not have the direct impact that they were originally projected to have, and other times, further study of an issue shows that the cost benefit may not justify implementation. These are just a few of the reasons policy initiatives may not produce the results originally assume to occur. And the last attachment that you have, called "Appropriations Committee Preliminary Recommendations on Medicaid Form," it shows the individual activities of Medicaid reform and the current costs and savings that are projected and included in the Appropriations Committee recommendation. Mary Steiner will provide an update on the individual Medicaid reform measures, and she will be following me. So if you have any questions?

SENATOR PEDERSON: At first, this isn't an question. This is just a comment, that Liz has been very, very cooperative and informed about a very, very complicated subject matter. One of the problems is, the ground rules keep changing, and the reporting keeps changing, so you have different time lines, different things that become a measure of how you figure these things, because you're not always working with apples and apples. They keep changing that. One thing I'd like to ask you: You have a lot of worry, personally, I know, about the clawback. How do you think that's working?

LIZ HRUSKA: It's hard to say. The state actually did have Medicaid savings, because we no longer pay the drug costs for the aged and disabled. But it's based on a formula, and Mary may be a little bit closer to that, that was started. The base year is based on a period of time when many states were implementing controls on drug costs, so those weren't necessarily factored in, and the start point may have been lower going forward. So I'm not sure if Mary has a better idea of whether or not it's been a benefit to us, or is actually costing us money. But we definitely did see a decrease in what we pay out for prescription drugs, but whether or not the clawback is a benefit or a...

SENATOR PEDERSON: You expect that to catch up with us?

LIZ HRUSKA: Yeah, and again, I think Mary probably might be a little bit better. I understand the mechanics of it, but the kind of day-to-day monitoring of where we're at,...

SENATOR PEDERSON: Well, you can see by Liz's answer how difficult it is to keep track of these as a system, because really, literally, the ground rules keep changing. Congress implements a different methodology, and you have to start reforming all of your measures to determine these, but we're very fortunate, because Mary is going to be able to explain all of that to us. (Laughter) Are there other questions for Liz?

GAYLE-ANN DOUGLAS: Liz, I have a question, and I'll be the first one to say I'm not a statistician, so I may be making a fool of myself here. As you projected the 3 percent

increase for FY '08, and the 2.2 percent increase for FY '09, did that take into account the decreased utilization that we're seeing in '07, and do we know why we're seeing that decreased utilization, because if we took that into account moving forward, and utilization goes up, will our projections be the same?

LIZ HRUSKA: These are just projections, and Medicaid is an entitlement program, so if utilization is different, if it's down, the money eventually returns to the General Fund. If it increases at a greater rate than what we projected for, this may end up...the department would have to come in for a deficit, and the Legislature would need to fund it, because it is an entitlement. Was it factored in? I'm trying to think where my base was. I...we were seeing lower-than-projected utilization, so I do think that was factored in. I have hundreds and hundreds of numbers that I work as I build this budget. So off the top of my head, I...actually, I do think there...that should have been accounted for, I guess. I started working on this, probably late September and early October, and have had to fine-tune it. The federal match rate changed, which means all my spreadsheets...

GAYLE-ANN DOUGLAS: Had to change.

LIZ HRUSKA: ...changed.

GAYLE-ANN DOUGLAS: Yeah.

LIZ HRUSKA: But as far as utilization, if we are off on that and the department does not have sufficient resources, they will need to come into...for a deficit, as they have in the past. We'd like to avoid that.

GAYLE-ANN DOUGLAS: Sure.

LIZ HRUSKA: We want these to be realistic. What we're seeing this year is we have overprojected, and so we are able to lapse that money to the General Fund. The reasons why? Oftentimes I'll go to the department and ask, and sometimes they're a little bit closer and they can tell me. I don't really know. There are generally so many factors out there, that it's hard, and basically, Medicaid is a program where if you come and apply and you are eligible, you are eligible, and we don't necessarily know why if, you know, there's a decrease, because more companies are providing health insurance and so there's less need for reliance. Employment is better, so maybe more people are employed and have health insurance coverage versus what we were projecting when the budget was put together.

GAYLE-ANN DOUGLAS: Okay, my next question has to do with the S-CHIP program and the fact that we really don't know what the feds are going to do with S-CHIP and so since S-CHIP for us was a Medicaid expansion and really does, I think, do a wonderful job in terms of ensuring that our children are, indeed, covered with health insurance,

what's the potential impact of that, moving forward, of the potential federal changes?

LIZ HRUSKA: We have funded...the department projected into their budget request and it has been funded by the Appropriations Committee, the loss of federal funds. I think it's $1.1...we put in $1.7 million in fiscal year '08, and $2.2 million in fiscal year '09. And again, the CHIP program is an entitlement program, so unless we do something statutorily to change eligibility or services, everyone that is currently covered will continue to be covered, and anyone that is currently eligible under our criteria will continue to be eligible, and we have planned for a reduction in federal funds. So I guess S-CHIP is fully funded, and no one will denied services because there isn't a shortage of money, and again, if those projections are off and we would see more children coming into the program, the department would probably have to come in for a deficit, really. And Senator Pederson was on the Appropriations Committee for a number of years. On entitlement programs--they are often my largest numbers and they take sometimes the least amount of time to decide. Like if there's a Medicaid deficit, the senators know they have to fund that, unless you know, they can make statutory changes, which generally, for a deficit, you couldn't even do it to react quickly enough. So basically, what we say in statute as provided is the control, and as we build the budget, we take that into account and make assumptions as to what we think the trends are, and maybe make adjustments, either having to fund more or this year, we are making a lapse to the General Fund, basically. Am I answering your questions?

GAYLE-ANN DOUGLAS: Yes, thank you very much. That's very helpful.

SENATOR PEDERSON: Are there other questions? Phil.

SENATOR ERDMAN: Just an observation. First of all, Liz, thank you for your hard work. There is a bill, LB518, that is on your list, that deals with the eligibility of children under Medicaid. And as we talk about the impact of federal funding--and this probably isn't a questions, just an observation, Liz--but as we talk about the impact of federal funding for the S-CHIP program, one of the things that increases the cost to the state potentially, is that if you expand the eligibility, and under LB518 you expand that eligibility to a one-year time frame as opposed to our existing process, and so essentially you will have, if LB518 does become law--it's still in committee--but it would expand the eligibility of children beyond what is currently there, in allowing for a whole year for that individual to be eligible without a review, as opposed to our current law, and I think it's six months. And so as you expand that time frame before a review can be done, you potentially may have children who met the eligibility at an earlier date, family income or something increases, they're no longer eligible, but if you don't have the ability to review that in a timely manner, they're technically still eligible, and that further compounds any of the issues that come with the reauthorization of S-CHIP or funding that needs to facilitate that. So there are proposals that do address those issues that Liz talked about, and that is the eligibility provisions in a number of areas, but specifically with Medicaid and

S-CHIP, LB518 is an example of how that policy decision would play out.

MARYLEE FITZSIMMONS: But what LB518 is, is a reversion to the way S-CHIP was handled when it was initially rolled out, where we did have 12 months eligibility for children.

SENATOR ERDMAN: Right.

MARYLEE FITZSIMMONS: And what I've never seen is what the cost of the department was for reauthorizing kids at a 6-month period, as opposed to a 12-month period, because your authorization on your workers...the work is decreased, and I don't know how that plays out, one way or the other. So LB518 really is a reversion to the way S-CHIP initially was.

SENATOR ERDMAN: Agreed, and I think the department can be here, as they were on the testimony on LB518, to share some of those observations, and maybe not specifics, but I know in general, they've been before the committee to explain the implications.

SENATOR PEDERSON: Okay. Other questions for Liz? If not, thank you very much, Liz, for your report. Appreciate it.

LIZ HRUSKA: Thank you.

SENATOR PEDERSON: Okay. We are now ready for Mary Steiner.

MARY STEINER: (Inaudible) Let's see, I have to...

JEFF SANTEMA: As long as we can hear you for the transcription.

MARY STEINER: Okay, this is a little awkward. (Laugh)

SENATOR PEDERSON: Are you turning your back to us? (Laugh)

MARY STEINER: (Exhibit 4) Not on purpose. Well, let me just make a couple comments to start, while he's bringing that presentation. Senator Erdman and Jeff Santema and I had met to kind of talk about what was still left over from before, and what we needed to talk about today. And so we came up with an update on the behavioral health drugs and just issues around the drugs, because there was a bill about behavioral health drugs in the Legislature; and then also to look at the nursing facility trends, because we had talked last time about, as people get served in the community, what about those...there will still be a need for nursing facility care, and as the lower levels are served in the community, the actual people that are left in the nursing facilities are those that will be seeking nursing facility care, will have higher needs; and then also an update on the

Medicaid reform strategies. Starting off with the behavioral health drugs, Missouri has a project that is similar but larger than what we have. It was instituted as a demonstration project in 2003, called the Mental Health Medicaid Pharmacy Partnership Project, and the departments were assisted by the Comprehensive NeuroSciences company, who provided consulting services, and Eli Lilly, who provided financial and some logistical support. The goal of that project was to increase the quality and decrease costs related to mental health prescription drugs. In the Missouri approach, they used a number of different sources to come up with best practices and guidelines, and then identification of prescribers who deviated from the standards. They have educational resources and in-person physician consultations that are made available to prescribers that are identified in the project. Theirs is very wide, far-reaching, but is similar, in terms of what the goals are, compared to our project. And then the Texas Department of Health Services looked into drugs for foster children, saying that they are often limited...have limited access to mental health professionals and present a variety of symptoms that make diagnosis difficult. They wanted to devise a tool specifically for professionals who deliver services to foster care children through Medicaid that would aid all the parties in determining the appropriate treatment, including the use of psychotropic medications. The result of the collaboration was a list of documented psychotropic medication parameters for foster children, and we've used that list as one of the tools in identifying some of the drugs for us to look at, picking off a couple of those standards to use for children. And then our behavioral drug project that we have implemented is a combination of outreach and education aspects of the Missouri project, and then use of some practice standards such as those in the Texas project. Our project is similar to Missouri's in concept, that we send out letters to providers, but we're doing it on a smaller scale. We're right now doing one letter at a time, and we're doing follow up on the prior letters that we've done. We have no specific staff that are 100 percent assigned full time to our project. Later on I will talk about our Transformation grant application. In it we were hoping to get some staff for this project, but we didn't. And we don't use any outside consultants or funding at this time. We do have some staff psychiatrists that we use, that are contractors with Medicaid, that we use their expertise, and we also use the NMA, as well. Looking at the nursing facility trends, I just have a couple graphs here. As a background, we have a case mix system. We have multiple care levels that are from the MDS assessment forms of people in nursing facilities, and then that is weighted to determine how much we pay the nursing facility for their care. Looking at those care levels, we grouped them on this to the lowest 7 levels of care, the middle 12 levels of care, and the 8 highest levels of care. And then this graph shows, over time, the number of days of care that we paid each month for that range of care levels. So the bottom line is, those that are at the highest level--again, it's a small part of our population--staying pretty stable. And then the top line is those that are in the middle portion, that also being fairly stable. And then the middle line are those lowest seven levels of care. As you can see, there's quite a dramatic decline over this maybe seven-year period. When we did the long-term care reform, that was about the time this graph started, and that was when we began to do the IGT money for assisting with

building assisted living beds. You know, we developed the assisted living regulations, expanded waivers, and that sort of thing. So you can see that the lowest levels of care are making up a smaller portion of the people in the nursing facilities.

SENATOR PANKONIN: Mary, I've got a question on this.

MARY STEINER: Uh-huh.

SENATOR PANKONIN: Days of care--how does that relate to how many people roughly?

MARY STEINER: You could pretty much divide those by 30 for the months that are 30 month, and 31...and the little blips that come down are February of each year. So if you would take the patients days divided by the number of days in that month, that would be the number of patients.

SENATOR PANKONIN: So roughly 150,000 (inaudible) divided by 30, then?

MARY STEINER: Um-hum, 5,000.

SENATOR PANKONIN. Five thousand?

MARY STEINER: Um-hum, yeah. And...

PAT SNYDER: Mary, can I ask a question?

MARY STEINER: Uh-huh.

PAT SNYDER: Do you track anything where Medicare, to see what the impact of Medicare is, because of the short-term stay? Many of our high-end Medicaid end up going to the hospital, becoming eligible for Medicare, coming back in. And what kind of an impact is that having, because Medicare utilization is actually up in our state.

MARY STEINER: We haven't compared that, and we could try to get some of that data. Over the same time period, since '99?

PAT SNYDER: It...probably in the last four to five years there's been a major emphasis and push on facilities in our state to provide Medicare services, and we've increased considerably the number of facilities that are Medicare certified.

MARY STEINER: Yeah, and for the dual-eligibles, that's a direct savings to Medicaid, when they can...and the facilities get a little bit better deal (laugh), from Medicare...

PAT SNYDER: Um-hum. Um-hum, much better pay rate.

MARY STEINER: ...than they do from Medicaid. But I'll look at that, and see if we can compare that. The next graph...this one is a little bit confusing. It's kind of the opposite from the days. This is the weighted care level. Each one of those care levels that we have that's on the regular part of our payment plan has a weight that's applied to it, and it's got to do with the relative utilization of resources in the nursing facility. And so when we take all those weights for the days that we paid for and we average them, you can see that we were between 2.3 and 2.35 as the average weight of the days that we were paying back at the beginning of this graph, but the care levels have increased on the average up to over 2.45, as a weight. Again, it's all relative, but it is a day to see that the care needs of the average patient are higher in nursing facilities now then they used to be; primarily, as those at the lower end are no longer in the facilities.

PAT SNYDER: You know, an interesting analogy of that for those who maybe don't understand the financial implications of this, when you have a declining utilization rate and you're not providing care for those very easy-to-care-for residents, and you see this increased level of care weighting factor, along with less patients in a facility, it has a tremendous impact in the costs associated with the care of those residents. And in fact, what you've done is you've basically spread the actual cost of providing care over less people, and so you really have a higher cost, and therein lies one of the reasons that you might be hearing frequently that we have some very, very bad financial problems in the facilities with losses per patient day, and in fact, it will affect the quality of patient care. You just can't do it for the same amount of money.

MARY STEINER: Yeah, so the cost per person would go up as the census goes down, even if the care level was the same, and at the same time, those that are remaining have the higher needs, and so the cost per person is high.

PAT SNYDER: It's still going to go up, even if you build in efficiencies. There's a lot of efficiencies that have been built in, and facilities have implemented changes in all sorts of things. Of course, you have less staffing. You know, you put in a lot of programs to make up for the less numbers, so you aren't going to have those costs that are variable. You still have the spread on fixed, but it's going to cost you more per patient, because they're heavier care and they're higher-cost residents.

MARY STEINER: Right. And this weighting really has to do with, really, nursing hours increasing.

PAT SNYDER: Yeah.

MARY STEINER: So the next area is updates on the Medicaid reform strategies. I'm going to highlight some that have had some major activity recently. In the area of drugs,

we did issue an RFP for a study of preferred drug lists and pooling, and so we let that RFP and we got the bids back, and we are currently in the contracting process with Mercer, and they will be performing our study with the first portion of the study to come out in June, and the final report to come back by November of this year.

MARYLEE FITZSIMMONS: Mary, this includes behavioral health drugs also? []

MARY STEINER: Yeah, this would be...it's really supposed to look at all of our pricing and purchasing of drugs, so as part of what would be on a preferred drug list, you know, they'll, I'm hoping, will address behavioral health drugs as well as all the other drugs. With Part D, the landscape has changed a little bit, in terms of what drugs are the expensive part of our program, and we really probably can't do a lot without addressing behavioral health drugs. Let's see, the next strategy was in the area of long-term care services. We developed a long-term care advisory committee, to look at gaps and barriers to services in the community, particularly rural areas, and we met for the third time this past month and devised strategies to address those barriers. It was a great group of people to work with. Everybody came from a diverse background, and everybody was really positive about coming up with ideas of things that HHS could really take back and do more work on or research into, as opposed to more lists of just problems. Now that committee is concluded unless we bring them back together to advise us, if we come up with specific areas to implement, and we need their advice or we need to maybe increase availability of services in an area. Okay, and this area was looking at alternatives to the way we currently provide Medicaid benefits. The first comment is, we have to do a study of defined contribution that will be, at some point in the future, once some of the other states have some experience with their programs, but we have Mercer consulting with us now to do a preliminary work to say what's out there, what are states doing, and what needs to be studied, and that sort of thing. And that's just getting started. And then the feasibility of a separate S-CHIP program, we're working on an RFP right now that would be released next month, if everything goes well with the RFP process.

LINDA OLLIS: Can I ask a couple questions (inaudible).

MARY STEINER: Uh-huh.

LINDA OLLIS: I'm relatively new to the state, and certainly new to this committee, so if everybody else is familiar with these groups, but I've noticed the Mercer come up twice.

MARY STEINER: Uh-huh.

LINDA OLLIS: Is there a special relationship between Mercer? Do you bid these projects out?

MARY STEINER: No, actually the...it's somewhat a coincidence that they would have bid on the PDL and pooling and win it. We have Mercer as a contractor in our managed care area...

LINDA OLLIS: Okay.

MARY STEINER: ...already, and when we contracted with them last time to work on our rate setting and pricing their actuaries, we asked them to also consult with us about some of these Medicaid reform issues, because they have experience helping other states do their implementation. They actually worked with Florida in some of their projects.

LINDA OLLIS: Okay, so real specific area of expertise.

MARY STEINER: Yeah.

LINDA OLLIS: Okay.

MARY STEINER: So I think that's the only thing we contract with them for, is these two things right now, so.

LINDA OLLIS: And then on the defined contribution strategies, are you really talking about basically creating an insurance product with like a sliding scale for the population? The enrollees would actually pay back into the fund (inaudible)?

MARY STEINER: Right. We would have a pool...they way they generally work is that we say we spend X dollars on children, okay? And so people can take those dollars and purchase this plan, this plan, this plan, or this plan, and the packages are different. I think the idea is that initially the packages are...pretty much cover what you have in your program today, the full range. But you get into a position that maybe in the future, your $250 per kid won't buy all of that. So now you shave back some of the dental, and you shave back something else, and so that into the future, you have more control over the growth,...

LINDA OLLIS: Okay, thank you.

MARY STEINER: ...by being able to work on the benefit.

LINDA OLLIS: Appreciate that, thank you.

MARYLEE FITZSIMMONS: Mary, but defined benefit, you're not looking just at children, though?

MARY STEINER: No.

MARYLEE FITZSIMMONS: All right.

MARY STEINER: No, that was just an example. The states that are doing it have implemented it differently for different groups, though, and a lot of times it's the children and families that they really do work the best for. It's more difficult for the disabled population that have varied needs, and it doesn't fit as well into an insurance model.

MARYLEE FITZSIMMONS: But that's our lowest cost.

MARY STEINER: Right, but we have a lot of them. So you know...let's see. The next one in the area of encouraging alternatives to Medicaid, we did receive this "Own Your Future" grant. It's the grant that probably should be in quotes (laugh), because we didn't really receive any actual funds for it, but we provided the identification information and...actually, they identified a lot of it, and the feds sent out the mailers to plan for long-term care, and then people can send in postcards or go on a web site and get more information about planning for long-term care. It's more than just, go out and purchase long-term care insurance. It's really about recognizing those costs into the future and planning for those. And then in addition, we have other media things going on. You probably saw the Governor on TV and that sort of thing, so that's what our communications people have worked on. And there have been presentations that have been done to community groups, and then we have a web site that's got to do with long-term care planning that's being kept up by Answers4Families in that area.

SENATOR PEDERSON: Mary, what's been the response to that program?

MARY STEINER: You know, I don't have that, the counts, but there's a little competition between all the states that are in it, to see how many requests for those there are. But I can't remember what it was at last count. I can send you guys an E-mail about that, because it is a lot of response.

GAYLE-ANN DOUGLAS: Can I ask, LB504, what the provisions of that...isn't that the long-term care buy-in? I thought it was that.

SENATOR PANKONIN: LB304.

GAYLE-ANN DOUGLAS: LB304, okay. What is that legislation?

SENATOR ERDMAN: As I understand it, it lowers the age that you're eligible to claim an income tax credit for the purchasing of long-term care from 62 to 55, or 50, whatever the...

SENATOR PANKONIN: It's to 50.

SENATOR ERDMAN: To 50. So it's simply targeting the affordability of the available plans.

MARY STEINER: Yeah, and more people would take, you know, take out a plan early on.

GAYLE-ANN DOUGLAS: Well, 62 is kind of late.

MARY STEINER: Like you're already retired (laugh), and the last thing you have is some money for that.

SENATOR PANKONIN: Here's the other reason for a policy reason to do it earlier, too, it's just so much more affordable. I think when people get to 62 and see what the price tag is...I know I bought mine before 50--my wife and I--because there was a huge break, even before 50. So it's just encouraging people...I think it's going to be not so much sticker shock when people look at this earlier and (inaudible) give them a little help (inaudible). Senator Erdman over there would buy it so cheap right now. (Laughter)

SENATOR ERDMAN: I think they'll actually pay me to get it. (Laughter)

PAT SNYDER: That's true.

SENATOR ERDMAN: Well then, where do I sign? (Laughter) Although I will be retired here in a year and a half, so, I don't know. It might not be as cheap as you think.

MARY STEINER: You'd better buy it now, while you can. Okay, so then the other areas I was just going to update, on things related to Medicaid that you might have heard about, we did receive Money Follows the Person grant. Also, that's a grant in quotes, because it does require us to put up a state match to be part of this program. It...for people that we identify in facilities that come out of the facility and into the community--actual community, not assisted living--we can get enhanced match for their community services, and it's what they call a rebalancing. So we take the enhanced money that we get, and so the freed-up state money that we have available is supposed to be used for more administration and service development, so that we can continue those services into the community. We put in our grant application. Nine hundred individuals...we're to be serving up to 900 individuals, if we can find them. There would be 400 elderly, 200 physically disabled, 100 traumatic brain injury, and 200 developmentally disabled. And those are really kind of targets. Maybe we can get there, but we really don't know that there's that many individuals in the facilities to come out. Anyway, we have to have a whole operations protocol developed by October 31 on how to do this, and stakeholders are involved in that development. And there's...it really

covers five years, the plan.

MARYLEE FITZSIMMONS: And that's been received, Mary.

MARY STEINER: We did, yep. We did get this award, and we're beginning the planning part of it now. Let's see. Any questions on that? The next one is the Transformation grant. We applied for a Transformation grant in six different areas, primarily to help us, really, with some of the Medicaid reform implementation. We kind of did the scattershot, tried to hit up a bunch of different areas. We did not receive the Transformation grant for that, and that would have been a true grant. We had some money in there to help us with that drug project, to maybe be able to go further than we do with the existing staff. And...but anyway, we did not receive that grant. And then the last one, you may have heard about that. That was a...NPRM stands for Notice of Proposed Rule Making, was put out by CMS to try to close loopholes for funding strategies that states have done, and basically, what they're saying is that to certify a match of state, it has to actually be a government entity. You can't pay government entities more than cost. When you do pay providers, the money needs to stay with the providers, basically to close these financing strategies that states have done. In our region, CMS has been pretty narrow on what they've allowed us to do and how strict they are. They've closed down our intergovernmental transfer that we had going for awhile, and we've adhered pretty strictly to rules of not paying government providers more than cost, and doing transfers, taxes, and certified public expenditures, or CPEs, appropriately. So we hope, in Nebraska, that we don't have a big impact from this, but sometimes you'll read about some states that stand to lose like $300 million they had wrapped up in some disproportionate share arrangement with their public hospitals or some things like that. They might get in and do a real strict rule check on us, and we might have a little bit of adjusting in our federal claim, but it would be like a million or less. I mean, nothing to the tune that they're talking.

PAT SNYDER: Mary, and it's not going to affect our ICF-MR? Because I have a financial analysis on that, and it's saying that Nebraska is one of the states that does lose considerable funding.

MARY STEINER: Yeah, we don't see it. the NPRM specifically doesn't mention the tax, the provider tax.

PAT SNYDER: Um-hum.

MARY STEINER: And so I think the provider tax is somewhat held harmless, plus the provider tax was identified at specific level in the bill...a bill that passed at the end of 2006. Probably what we are going to need to do is go in and make sure that we're not paying any provider more than cost, which right now, we use cost reports to set a prospective rate, but we don't go back and retroactively settle. Now for Beatrice, we do

go back and retroactively settle to cost.

PAT SNYDER: This only relates to ICF-MRs. It doesn't relate to the aged program--nursing homes.

MARY STEINER: Except that we might have more work to do,...

PAT SNYDER: Yeah.

MARY STEINER: ...because we might have to go back and settle those cost reports that we don't now. So...

PAT SNYDER: If you've got a declining base?

MARY STEINER: Yeah, and you know, it would be a lot of work for maybe not very many, but we might have to show the feds that we've done that. Again, it depends on how strictly they do that, but...anyway, hopefully, we're not paying more than cost on those, and even DD, the money that comes back in from the tax that goes to the DD providers should not exceed cost, so we should be able to meet that test.

PAT SNYDER: I don't think you're at risk in more than two or three at the most.

MARY STEINER: Yeah.

PAT SNYDER: You could have a couple, but they aren't your big ones.

MARY STEINER: Right.

PAT SNYDER: Yeah.

MARY STEINER: Okay, then...let's see. I'll give you this web site again. Okay, we had some questions that came up before. LB699, the discount drug bill probably had a bigger impact on just the general public, and would help them have some drugs that were more affordable. I'm not sure that there was a direct impact on the Medicaid program, which also leads into a lot of the drug discount programs that were the precursor to the Part D for Medicare impacted the Medicare population, which now we don't pay those costs, other than the clawback. And in terms of the clawback, we are feeling like we're coming out fairly even. The savings should cover the cost that we're paying, if you look at just the state share. The part that's really not fair is, as we came into this year they added an inflationary factor to our clawback amount for this calendar year. Well, the Medicare Part D drug program actually had a decrease in their cost, and so it's not fair that we're paying more of that share, as the program in total isn't going up that much. The...as Liz mentioned, it was based on our average expenditure.

Historically, we do pay a smaller percentage of that each year. That percentage goes down only slightly, and then that helps offset some of our increase that we have on the inflationary side. So as of today, we're pretty even. When we did our budget we went through the big estimate of what the...you know, as the federal share goes down and the state share goes up, that's just a direct increase in our clawback amount (laugh), and so we figure match rate change, population change, increase in the clawback amount going out into the next biennium. Let's see. And the other one...you had mentioned the 12-month guarantee. When we went to the six-month, we did receive staff to do those extra tests, income tests, and now what we do is, after the initial six-month period, we do an assessment of eligibility, and then any change thereafter that's reported could change their eligibility. So even if three months later they got another...or they got a raise or something, they would report that to us, could change their eligibility, as opposed to just, you get six months, six months, six months. And now with this bill, it goes to a 12-month, and in the fiscal note, which you can look up on the legislative web site, there is an estimate of the savings on the staff side, because we will have less eligibility reviews that we would do. Even if...

SENATOR ERDMAN: Mary, do you remember what the total of overall...it would be an overall cost increase to the program, but it would be a savings in the staff; is that accurate?

MARY STEINER: That's correct, and...yeah. And the cost of the program does exceed the staff cost, and I don't remember what those numbers are exactly. So, I guess questions, comments.

SENATOR PEDERSON: The Governor has been mentioning that there has been an overall decrease in the expansion of Medicaid, as far as our state is concerned. To what do you attribute that? Less growth.

MARY STEINER: Oh, in just the number eligible? I really...I don't know. And the numbers are all just smaller. If you look at Liz's numbers, you know, the disabled are still up, which has kind of been the way it's been, is the number in the disability category has been growing faster than the other areas. But now even that is like half of the area...half of what it has been before. And I don't know. A lot of times Medicaid takes awhile to catch up with the economy, or if there's something else related to something going on out there, I don't know.

PAT SNYDER: Have regulations changed or the assessment processes that will...that sets a criteria for eligibility, for medical, for aged or disabled? There was a proposal on that, and I know that the departments are using new forms, and one of the things I'm hearing, just out on the street, is that it's harder to become eligible for your aged services,...

MARY STEINER: Wow, I don't know what that is.

PAT SNYDER: ...so I'm wondering if that doesn't...

MARY STEINER: Does that ring a bell with you?

PAT SNYDER: It's two different departments, is why you may not know.

MARY STEINER: You're 65, you're 65 (laugh). I could find out what that might be. And you think that's true for the elderly and disability categories?

PAT SNYDER: I think the disability categories are not affected, but I think it does affect the aged categories.

MARY STEINER: Okay.

PAT STEINER: And what may have happened is, the process of assessment may have improved,...

MARY STEINER: Yeah. But I can't think of anything in that area, either.

PAT SNYDER: ...because I think we've gone to a more consistent, from an every area agency doing...utilizing their own form to an assessment document.

MARY STEINER: Oh, for waivers?

PAT SNYDER: Um-hum.

MARY STEINER: That's possible, that...I was thinking of just regular Medicaid eligibility, but there probably was something changed with the waivers. I can look into that further.

PAT STEINER: It would be interesting to track some of that, to see the effectiveness.

MARY STEINER: And with Part D, one of the impacts that you'd hope would happen is that people can get coverage for their drugs, and so they don't need to seek Medicaid for that. A lot of times people that are generally doing fairly well, they're on Medicare, they were seeking Medicaid in order to have their drugs covered, because drugs weren't covered in Medicare, but you know, their drugs could be upwards of $200, $300 a month, so it's possible that people don't need to come to Medicaid anymore, and they can be on the low-income subsidy on the Medicare side and get pretty reasonable coverage, so.

SENATOR PEDERSON: Mary, last year we had some discussion about the word

"assessment" and how we are doing as far as assessing people for the a) level of care, b) whether they should go into a nursing facility or be on their own. Where are we with that now? Are we improving our assessment situation?

MARY STEINER: We're still looking at working on that. That's actually going to end up being part of the Money Follows the Person process, that we're going to assess how we assess (laugh). We're going to figure that out, and we have been talking to some consultants about how we would study that. We have implemented an in-home MDS, which is a way to assess what people need in their homes, but did need to have it across the continuum. So we're working on that, but it's going to be awhile.

SENATOR PEDERSON: Do you have a protocol for that sort of thing, to...

MARY STEINER: We don't have time line set out for how that's going to go yet, but we'll definitely have to have that over the next four months.

SENATOR PEDERSON: Pat had mentioned before that the problem a bit had to do with, once you get somebody into a nursing home, it's hard to get them back out, because they're comfortable with that situation, and they have never really been assessed as to whether that should be their level of care of not.

MARY STEINER: Right, and it might be that it was supposed to be their level of care when they first went in, but then with the constant care and food and everything else, they wouldn't need to be there. Hopefully, the Money Follows the Person is targeted exactly at that. People that have been there for six months at least, then how can we arrange services, housing, to get some transition coordinators to really help people through that process, because yeah, it's difficult.

PAT SNYDER: Have you hired a contractor to look at the concept of the universal assessment for all levels of care? And that was the concept...

MARY STEINER: Right.

PAT SNYDER: ...in Medicaid reform, was that as opposed to having each entity have their own little assessment, that--and quite truthfully, you can bias an assessment very easily to whatever, so you can expand...

MARY STEINER: Yeah, and we haven't got that consultant yet, but one of the things is that even if you had some different assessments, who does perform the assessment, and how do you get the accurate information? And is it going to tell you what you need to know, as opposed to just some score or a yes or no? Is it really going to direct you to what the care needs are, some things like that? And we're working on that.

PAT SNYDER: I think there's another interesting...I can give you a couple of just pieces of information that we're seeing, and that is the turnover in our facilities in growing. In other words, we're not seeing the same residents continue longevity in the facilities. We have a compact number that stay and are going to be there. But we're seeing, you know, 40, 50 percent, as high as 60 and 70 percent in some facilities, facilities that are designated as kind of like your rehab centers. You know, they're turning over 100 percent residents a year, which is a tremendous amount of people, because they're short-stay coming in, being rehabbed and going back into the community. On the other hand, what we're seeing is our facilities' residents that are stable and tend to be longer term are the dementia.

MARY STEINER: Yeah.

PAT SNYDER: It's the individuals that, because of dementias, because of Alzheimer's, are...

MARY STEINER: Yeah, it doesn't improve like a physical thing that got them in.

PAT SNYDER: I just looked at a little bit of statistics on some facilities. We're seeing 70 to 80 percent of the residents having oh, probably...not the fourth stage of dementia, but in the third. They're pretty advanced. So those are some interesting characteristics I think that may affect how we look at the capabilities, and then how that relates to cost out in the community,...

MARY STEINER: Yep, and the services that you need.

PAT SNYDER: ...because when you get down to that, you've got to have 24-hour-a-day hands on. That's when you're in a...

MARY STEINER: Um-hum. Well, and the Money Follows the Person, you can't do anything in group settings for more than four. So that does limit your ability to say, we're going to do assisted living or some place that does have some supervision that ends of being efficient, because you have (inaudible).

PAT SNYDER: You know, that was not a national requirement. I've already checked that out. Is there a reason why our state restricted out application and did such a rigid job on that? Because it could have been inclusive of assisted living.

MARY STEINER: I didn't think we did that.

PAT SNYDER: Anyway, that's exactly what the...

MARY STEINER: Well, I should look into that because...

PAT SNYDER: The federal government told me.

MARY STEINER: ...we thought that was a federal requirement.

PAT SNYDER I think it was (inaudible) is one who just informed us of that.

MARY STEINER: Who is the person?

PAT SNYDER Your secretary. (Laugh)

SENATOR PEDERSON: You can talk to her later. (Laugh)

MARY STEINER Okay.

PAT SNYDER: But that just hasn't had an interest, in my mind, because it became extremely restrictive and may not have benefited the state in the long run.

MARY STEINER: Yeah.

PAT SNYDER: And in fact, I might even have something on that, that I can share with you.

MARY STEINER: Okay. Yeah, that would be great, yeah. Also, with our DD population, it's going to be difficult.

PAT SNYDER: Um-hum.

SENATOR PEDERSON: Mary, would you briefly describe how Money Follows the Person works?

MARY STEINER: It's supposed to be more individuals who are in the nursing facility, and we have a transition coordinator help them find a way to serve them in the community. And then we set up services, you know, get them out of the nursing facility and set up in the community. The way we have it designed right now, they will be on one of our existing waivers. We will modify our traumatic brain injury waiver, because our traumatic brain injury waiver right now is just assisted living. And for the services once they get out of the institution, in the community for a year, we can get an 80 percent federal match on it.

SENATOR PEDERSON: Who handles the mechanics of all of that, the assessment and the transitions and all that? Is that you?

MARY STEINER: We will, yeah. We...

DR. JOANN SCHAEFER: (Inaudible) program grant director, and assistant, and three contract positions with the grant.

MARY STEINER: And we'll have a...

SENATOR PEDERSON: You wouldn't have the staff to do that, through your office.

MARY STEINER: Right, and we'll have a consultant that will help us through the process of planning and how it's going to work. And then, you know, for the actual transition coordinators and other case management and that sort of thing, we can purchase that as a Medicaid waiver service. But the oversight of how it's going to work, how you identify the individuals and all of that, we're going...you know, we've targeted five staff, so.

SENATOR PEDERSON: What time line do you have for that?

MARY STEINER: I don't know about getting the staff, but this protocol and how it all is supposed to work is supposed to be done by October, so that's when we actually start implementing our program. So we don't have a lot of time.

PAT SNYDER: Are you doing...are you getting any input from any of the provider communities that are involved?

MARY STEINER: We've going to have to do all the...every stakeholder, and the providers are going to be pretty important.

PAT SNYDER: Are you doing a group, a committee, a council, or what?

MARY STEINER: You know, we've got some possible ideas, but until we get the consultant in here to really help us logistically figure out how we're going to gather up all the information and get it directed so we can get some good information that we can act on, we don't know right now. It's got to be some kind of hierarchy, you know, so yeah.

SENATOR PEDERSON: Are you going to coordinate some of that with the existing regional triple As? Is that a...I just don't understand. Is it a coordinated type program, or is it self-standing or what?

MARY STEINER: Well, in terms of implementing, it will have to be. I mean, once we get to the point where we are...since the triple AAAs and the independent living centers do all of our case management for the aged and disabled waiver, we definitely are going to have to have them partnered up to do that. Now whether they actually become these

transition coordinators or not, we'll have to see...

SENATOR PEDERSON: I see. You're not to that point yet.

MARY STEINER: ...if that's a different function, but they're definitely a major player, in terms of those stakeholder groups, so.

SENATOR PEDERSON: Well, as much as we can, you know, we need to coordinate with people that do somewhat the same things.

MARY STEINER: Yeah, and they've been out there. They know the people in the nursing facility, know why the people are there, and they're staying there, and the people in the community are, you know...know how they can get some services to serve them, so yeah.

SENATOR PEDERSON: Phil.

SENATOR ERDMAN: A couple observations, and maybe you can share some additional information. First of all, LB699, I believe, required the department--that's the preferred drug list/Nebraska RX card bill--as I understand that bill, it did two things. One, it required the department to do a preferred drug list, which according to the time line that you've outlined, the existing effort would be completed before that bill would actually be--well, close to--before that bill would be in law. I think the second part of that required us to apply for a Medicaid waiver similar to what the main RX plan was. I think that's where the potential implication of LB699 to Medicaid was, and those that know, main RX was never fully implemented because it was successfully litigated and the amendment now scales it completely back. But on the sheet that we have, on the Medicaid Reform Strategy Implementation Summary, it looks like we're hitting most of those targets. The only one that I see on here that is past us is on the second page. It's item 6.1a1, from the Medicaid reform strategy. And I read the additional information here, that Work Group N was working on a recommendation on the advisory committee on affordable insurance. In the sheet it states that they are going to come up with a final report and the completion date is February, '07. Is that imminent? Do we not have that, or is that just something there wasn't a lot...as I understand the bullet point that was handed out, as well, there was no potential savings.

MARY STEINER: Yeah. You know, that's a good question, because on the affordable insurance, the committee did have their final meeting, and I don't know what the status of the report is,...

SENATOR ERDMAN: Okay.

MARY STEINER: ...because the recommendations were all complete. So I need to

check up on that, and hopefully, it's not in my E-mail and I just didn't get it read.

SENATOR ERDMAN: That's on the sheet that says, "Medicaid Reform Updates - Personal Responsibility. It's on page two of that handout that we just got (inaudible).

MARY STEINER: Yeah, and I really kind of failed to mention these. You know, this first is just the...kind of the quick look at what it is, and then each of these others...really kind of goes through and says kind of what we're doing. There's not a lot there, but it's short enough that you can read it, and it does talk about the planned completion, you know, what we expect for savings, and that sort of thing, so.

GAYLE-ANN DOUGLAS: I didn't get anything on the affordable insurance. Is that the (inaudible)?

MARY STEINER: Oh, good! (Laugh) You're probably more current on your E-mail than I am.

GAYLE-ANN DOUGLAS: It wasn't on my E-mail when I left, so.

MARY STEINER: But we did have the recommendations, right? You can back me up?

GAYLE-ANN DOUGLAS: Yes, yeah.

MARY STEINER: But a report didn't come out, so.

GAYLE-ANN DOUGLAS: No.

SENATOR PANKONIN: Mary, I think that one would be great (inaudible), because an area of interest for me is the small employer.

MARY STEINER: Yeah, and that really was the target of our group, was to really, now to assist that. And I think we had four or five things we came down to that we pretty much strongly recommended. A couple of them pretty doable as we go forward, that aren't really targeted at Medicaid necessarily...

GAYLE-ANN DOUGLAS: But they would cover more people.

MARY STEINER: Yeah. But all of insurance and groups. So I definitely will follow up on that and make sure everybody gets a copy, including the HHS Committee. Do you know where that report is? Okay. I just got to thinking maybe it got up to some stage and was sitting somewhere. Okay, any other questions on any of these?

PAT SNYDER: Can I ask you where you might be with looking at...one of the initiatives

was also to be the Medicaid rate plan.

MARY STEINER: The Medicaid rates?

PAT SNYDER: Yeah.

MARY STEINER: Oh, yeah.

PAT SNYDER: In the system. Have you done anything there? Is the department looking at a contractor?

MARY STEINER: We're going to need to release an RFP for that. That's going to also be part of the Money Follows the Person continuum thing. Hopefully, that's going to free up the money for it. But we haven't done that yet.

PAT SNYDER: It's a great strategy.

MARY STEINER: Got to find the money somehow. And CMS says that we have to reinvest all of the savings that we get, so we'll have to do that.

MARYLEE FITZSIMMONS: Is a list of our waivers on the Medicaid reform web site?

MARY STEINER: Probably not, but you could probably go to the regular Medicaid web site and find those. I'll check on that. If it's not, I can E-mail you guys the waivers. []

MARYLEE FITZSIMMONS: And the Medicaid plan that the state sends in to CMS, that is on the Medicaid web site? []

MARY STEINER : No. That is, you know... []

MARYLEE FITZSIMMONS: I know it's huge. I know it's... []

MARY STEINER: So I think we've have to probably fax you the pages that you'd be interested in. However, our rules and regs are on the HHS web site, if you go in through Regulation and Licensure, and for the most part, our rules do follow our state plans. So most all of the description of things...you could find every waiver in there, that sort of thing. []

PAT SNYDER: Will there be a plan from the Rural Committee on home-based services? Will there be a resulting plan and report? []

MARY STEINER: I don't think there's really a plan, but we will have a short report of the recommendations. That's being worked on right now, that just basically types up those.

[]

PAT SNYDER: Okay. []

MARY STEINER: In fact, that might be something good to report on, on the next...to bring that. []

DON PEDERSON: Are there some questions for Mary? So under the new restructuring of the agency, where will this fit? Where will you fit in that? []

MARY STEINER: Well, there is a department of Medicaid now going to be in the division, that should have, you know, all of the Medicaid division in it, and then the aged and disability staff are also in that area. Maybe aging is also in that area. So it will be pretty good, in terms of supporting this work, to have that there. And then that division reports directly to the CEO. []

DON PEDERSON: Will it essentially stay about the same as it is, as far as your working area? []

MARY STEINER: I believe so. I really think that once you get down to the, you know, organizational end unit and supervisory structure, that that is pretty much contained. Do you agree? It's really the upper reporting that's different. []

DON PEDERSON: Okay. So what other questions can we throw at Mary? (Inaudible) []

MARY STEINER: Yeah, do you feel like you have to go all the way to a certain time or something? (Laughter) Put Jeff back up here (laugh). []

DON PEDERSON: Mary, do you have any questions of us? []

MARY STEINER: I don't think so. []

DON PEDERSON: Well, you know where we are. []

MARY STEINER: Okay. []

GAYLE-ANN DOUGLAS : I have a comment to make. []

DON PEDERSON: Yes. []

GAYLE-ANN DOUGLAS: The recommendation we're talking about, about the small businesses offering insurance, et cetera. Now I've been on this committee for about eight months or so, and then I got asked if I would serve on that committee and I said

yes, and I got the first blizzard of paper that came in, and one of the ways of...one of their recommendations at the time was to expand the Medicaid eligibility so that more people would have insurance, and I'm like, now wait a minute! Does the left hand know what the right hand is doing? But it was just kind of funny. That wasn't one of the recommendations (inaudible). []

DON PEDERSON: Well, I'm glad you were there to straighten them out. (Laughter) []

GAYLE-ANN DOUGLAS: Well, I think they...people just didn't... []

DON PEDERSON: Yeah, they don't get it. []

GAYLE-ANN DOUGLAS: They didn't think about, it's going to cost money, you know, anyway. []

DON PEDERSON: Well, that's true with a lot of the legislative bills that are proposed. You know, they're for good purpose, but then you have to hold it up to the light of day and say, now how are we going to pay for that? And so that's always the struggle. And in the Legislature, there's a bill proposed, and if it gets very far, then there's a fiscal note that goes with it, and oftentimes, that's a determining factor to say, we're not going to do that, because we can't take on any more obligations. Isn't that about right, Phil? []

SENATOR ERDMAN: Sometimes it stops it before you get too far. []

MARY STEINER: Yeah. []

SENATOR ERDMAN: It just depends on when you get it. But just unrelated but similar, I mean, we do hear a lot of these issues in the Health Committee, and we give you a bad time, Mary, for opposing every bill that gets introduced, it seems. (Laughter) But I think the information is valuable and ultimately, we have to make a policy decision, and that's our job. But you know, as we continue down a lot of these efforts, and I think part of the reason why this council was important to the vision of Medicaid reform was to further expand these discussions, but you know, obviously there's a huge involvement by the Health Committee and the Legislature in any of these discussions, and we're to be a complement to that. And you know, I think you've done the best that you probably can in providing us the timely information that we need, given all the other requirements that you have, and appreciate the time we had to prepare for this. And I know there are some of the issues that you've covered today that are at the forefront of the Health Committee, at least from some of the bills. And I think a lot of times, in the same analogy, I guess, to...some people would say, well, some people in certain departments don't know what other departments are doing. It's become very evident to me that there are members of the Legislature that have no clue what's going on in Medicaid reform, and it's not to their fault. It's just the fact that there is so much going on, and it takes

some time to get to the understanding, and hopefully we have an opportunity to see those people who are involved now stay involved, and to actually understand what the process is and to be a part of that process into the future, because this problem has great opportunities to have a great solution, and it's all based on people's involvement in trying to chart that path, and your discussion and our discussion, you know, have to come up with common goals to make that. []

MARY STEINER: Yep. Well, on that last page of Liz's handout, I know it's kind of complicated to look at them, but that's where you can see that our appropriation is being reduced by those dollar amounts, so we have to have real savings. []

SENATOR ERDMAN: Well...sorry, one last thing. Do you have a...in the past we've seen some revisions, I guess, of the outlook. Is there a plan to have another revisions of kind of how we're achieving the works, or meeting our goals, and then how that looks long term? I know there's a lot of assumptions that have to be built into that, but... []

MARY STEINER: Well, I think if you look at, in terms of just the money, I think if you look at Liz's, that's her attempt, when she talks about the history or--what did she say? []

GAYLE-ANN DOUGLAS: Evolution of... []

MARY STEINER: It evolves...the evolution or something. You can see that some of the first cut of the savings were pretty grand, pretty broad. And now with implementation time lines, they've been refined down to things that we think that we actually will be able to achieve. So... []

SENATOR ERDMAN: I guess my comment, or at least what I'm shooting for, is that if we projected a savings of X and we actually have a difference from that number, what does that look like, long term? []

MARY STEINER: Oh, I know what you mean, okay. Yeah, in terms of the whole expenditures, and are we going to get it down to the... []

SENATOR ERDMAN: We're widening the gap, as I would see it. []

MARY STEINER: Yeah, and I think we're going to report on that maybe every couple times or so, because the numbers just pretty much are the same when we're going out 25 years. But I can make sure that we do another estimate for next time. By then we'll have our appropriation, which we're basically going to say, that's what we're going to spend in those next two years, and we can use that as the basis, going out, and we should have some more estimates refined. I'm not sure that we've changed too much since last time. But yeah, we can do that. []

DON PEDERSON: As a follow-up comment to what Phil was saying, I've watched some on the television about what the Legislature is doing, and I've been pretty impressed with some of the...well, all of the new members of the Health and Human Services Committee. I think it's a huge task to get involved with that, and they're making good headway. But as far as this organization is concerned, our particular task force, I think we have to recognize that this is like a huge battleship, and we're only going to be able to turn little degrees at a time, but we have to go forward and keep making as many of those turns. I think we've made some real progress, but you're not going to see immediate huge results from this. They will be long-term results. []

MARY STEINER: Yeah, that will really...the big impact will be out in the future. []

PAT SNYDER: You know, one of the things--and I look at this frequently--is when we look at the savings in a grand total, and we really don't look at the detail and truly, the devil is in the detail, because frequently what is happening to us is we've made some great efforts to move forward, and then we turn around and we lose some federal funding. So basically, the steps that we have made that have affected the people we're caring for, the recipients, in terms of maybe eligibility, maybe services, whatever that may be, you know, all of a sudden, an outside component of this whole big Medicaid picture has negatively impacts us, so it doesn't look like we, in fact, are making those strides forward. One of the things I would like to see, is like to see that analysis. For instance, I do happen to know our utilization rate went up for heavier care, and you know, to me that is not an unexpected, because as we keep lower-level care individuals in community services longer, there's a point, and there's a cyclical point where, through the continuum, we're going to start seeing these folks come back into facilities, only they aren't going to be a low-cost person anymore. They're going to be the highest cost, and they've already used all of their funding--already used all of their funding, and other than the facility services. So the state has to look forward to an increased utilization rate of Medicaid. In other words, you know, for years we have a 50/50 private pay/Medicaid rate. We're seeing that change, and if you look at national statistics, we're so very lucky, when many states are seeing 75 percent institutional care, 25 percent private pay. So those are some of the things that I can tell you, they're going to happen to us, and I think those are the kinds of things we need to start looking at, what...you know, the outcome may not be all as rosy as we may think it is. And I, for one, don't want, five years from now, to say, gosh, this reform committee really didn't do its job because of...and the truth is, we probably really did, it's just that...how it's configured. []

DON PEDERSON: You're not going to see the immediate, what you might call, gratification of result. And the other thing that we have in Nebraska that makes it more difficult, I think, and I don't know how we compare with other states, but I've seen the statistics about our aging population. And our aging population is increasing much faster than our young population, and so we're going to have more demanded on our younger people, and it's just a matter of demographics. []

PAT SNYDER: The truth is, who will take care of you? []

DON PEDERSON: Yeah, that is. []

PAT SNYDER: That's the truth. And if we...and the more and more we develop of one-on-one care, which, you know what? That's exactly what I want. I want somebody to come in my home and take care of me, one on one. But the truth of the matter is, is how many kids did you have? []

DON PEDERSON: Yeah, yeah. []

PAT SNYDER: That's about it. (Laughter) You know, I mean that's just plain the facts, because we're already experiencing... []

MARYLEE FITZSIMMONS: Pat, that's why we'd better keep them healthy. []

PAT SNYDER: []

MARYLEE FITZSIMMONS: You'd better keep those kids healthy. []

PAT SNYDER: That's...we all better keep healthy. (Laugh) []

DON PEDERSON: From what I know about you, you don't want somebody to come in and take care of you. []

PAT SNYDER: That's probably true. (Laughter) I'm a little too independent. []

DON PEDERSON: Well, that's good. That's one of the things that helps the state, is a level of independence that we've always had, so. Okay, anything else for Mary? If not, I think we've probably already had our discussion, haven't we? That was the next thing on the agenda, and is there any other business that you want to take up? If not, I think the next thing that we have to determine is when we want to meet again. []

PAT SNYDER: At what point would that coincide with some of the reports that should be done,... []

SENATOR ERDMAN: That's what I was thinking about. []

PAT SNYDER: ...where we'll know where we're at with budget, so that we have... []

DON PEDERSON: Well, the session will be over at the end of May, and before that, we won't really know what the final is, because you have the ultimate budget passage and

then you have the Governor's actions, and then you have the adjournment. So nothing before the first of June, really. []

PAT SNYDER: And let me see. When do you usually the second go-round for the mid-term look at the budget? When does that start? The cycle starts when? In September, with the departments? []

SENATOR ERDMAN: Their budgeting, you mean? []

DON PEDERSON: Yeah. Yeah, really, September they have to start getting their information in. []

PAT SNYDER: I'm wondering if we need to try to coincide with some of those time frames, so we're looking at what are the potentials, you know, what progress have we made, and... []

JEFF SANTEMA: I think the council is due an October, 2007, preliminary report on (inaudible). That will be the next report, I think, due to the council. []

PAT SNYDER: I think it depends whether the group thinks...feels that we need to have a session where we might need to look at and open discussion on whether or not the reform plan continues to be maybe what we need to do, or do we have the authority to make an addendum to it? Do we need to do that? []

DON PEDERSON: I think we can do it. []

PAT SNYDER: You know, the Medicaid reform plan is nothing more than a strategic planning process to me, and when something doesn't work, you make a change in it. You just don't keep it there in the plan and say, by golly, we're going to do this whether it works or not. I would just as soon that we had an opportunity to look at that, assess that, and say, you know what? If this isn't working, maybe what we need to be able to do is make some recommendations at that time. And I would ask the department, when the department thinks that you will have a good handle on where you're at, where things are working, what (inaudible). You know, the implementation of some of our strategies may not be good. The outcome may not be as effective as we want it. []

DON PEDERSON: You don't need to limit it to good handle. If we just have any kind of a handle on it. (Laughter) []

PAT SNYDER: Oh (laugh), reasonable handle. []

SENATOR PEDERSON: Reasonable handle. []

PAT SNYDER: We want them to have that. Well, we want them to have a handle. []

DON PEDERSON: Are you talking about October, or September? []

PAT SNYDER: Yeah. []

DON PEDERSON: You look at those time lines you've got on your implementation, and you won't have a whole lot more before that time. []

MARY STEINER : Right, and a lot of them are just studies, and then, you know, we'd have to take the results (inaudible) implement, so that the plan right now a lot, is just study and figure it out. []

DON PEDERSON: Should we leave that date fluid, and you look at your time lines and see when you think it would be appropriate, in light of the budget, in light of your projections as to where you think we are? Would that be all right with the group? []

MARY STEINER: Yeah. []

_____: I think that's very good. []

SENATOR ERDMAN: And then you'd throw in your reorganization in there, as well, to... []

DON PEDERSON: Yeah, I think there's a bit to go through that. Would it be all right with you if we just left it, that they assess when they will have adequate information for us to have another meeting? And then you'll go through Jeff, and he'll contact us and see when we can do it, okay? And is there anything else to come before the meeting? []

SENATOR ERDMAN: I move we adjourn. []

DON PEDERSON: Okay, and I think everybody will agree with you, so we'll do it. Thank you very much for everybody being here. (See also Exhibit 5.) []