Health and Human Services February 23, 2018 Room 1510

RIEPE: [00:00:07] Good afternoon. This is the-- this is the Health and Human Services Committee. We welcome you here today. This is Friday the 23rd of February. I'm Merv Riepe, I'm the Chairman of the Health and Human Services Committee; I represent Millard and Omaha, along with Ralston in Legislative District 12. I'm going to ask the members of the committee who are here today, along with the staff, if they will introduce themselves and then I will proceed and go with some introductory comments. Senator on my far right--.

KOLTERMAN: [00:00:42] Senator Mark Kolterman from Seward; I represent District 24 which is York, Polk, and Seward Counties.

HOWARD: [00:00:50] Senator Sara Howard; I represent District 9 in midtown Omaha.

ERDMAN: [00:00:52] Steve Erdmann; District 47, ten counties in the Panhandle.

KRISTEN STIFFLER: [00:00:56] Kristen Stiffler, legal counsel.

CRAWFORD: [00:01:00] Good afternoon, Senator Sue Crawford from District 45 which is eastern Sarpy County, Bellevue, Offutt.

LINEHAN: [00:01:06] Hi. Lou Ann Linehan, western Douglas County.

TYLER MAHOOD: [00:01:10] Tyler Mahood, committee clerk.

RIEPE: [00:01:12] Thank you very much. We have two wonderful pages back here that help us out

on a routine basis. I would tell you their name but their supervisor told me I shouldn't, so they'll have to remain mysterious. The committee will take up the bills in the order that they're posted outside of this particular room. We'll be taking them up-- and this is your part of the legislative process here in Nebraska and your opportunity to express your positions on either side of the discussion. You'll see that some of our committee members will come and go during the hearing. That's not because they have a lack of interest in your testimony or in your bill, but they do have other bills that they either have testify on or they may have to introduce a bill in one of the other standing committees that we have in the Legislature. To better facilitate today's procedures, I want to go through a little rules of engagement here. The first one would be I request that you please silence or turn off your cell phones. That if you are going to testify, in the interest of moving the process along, if you would come to the front, I think we have eight or so chairs up here, that would help us as well. The order of the testimony goes that the introducer, the senator who is introducing the bill, has an opportunity to open, as we call it, on the bill and they are not on the clock. Following their conclusion, then we go to proponent's; we will then go to any opponents. At that time, we go then to any that are testifying in the neutral capacity. We will have a-- we will then ask the clerk to read in any letters of support or opposition that we have to officially make them part of the record. I will note at this time, if you have a letter coming in, it has to be here on the day prior to closing, before the hearing date, and it also needs to ask in the letter that it be included in the record. And I say that for those of you who on occasion come back and testify. When you come up to testify, you'll be asked to bring an orange slip along and to share that with either the clerk or probably one of the pages will get it. We will also-- we're going to ask you, when you come to the seat, to give us your name; spell your name and share with us the organization that you are with. Today we're going to be working on a five-minute clock which means we'll have four minutes on the green; we go to one then on the amber, which is a get ready; and then following that, the red light will come on. At times if you're in the middle of the thoughts, I will try not to be abrupt, but I will if it goes on for too long, I will come in and ask you to conclude your remarks. And that's done

with the interest and respect for other people who are here to testify as well. That said, you may get one of the committee members who will ask you a question that you can then continue on and finish the point that you're thinking about. We also ask you to be concise, and if you feel that your testimony is being redundant to some other that was just given, please be respectful of that. If you will not be testifying on the microphone today, but want to go on record as having a position on the bill at hand, there are white sign-in sheets at each door; these sign-in sheets will become part of the exhibits in the permanent record at the end of today's hearing. Any written material that you may have that you want to distribute to the committee and the members of this group, along with the legal and clerk, we'll need ten copies. If you don't happen to have your ten copies, please acknowledge so and our pages are wonderful about zipping out of here, and I don't know where they go, but they always come back with the ten copies. That said, I think it's magical. That said, I-- I want to open today's hearing with Senator Howard who is going to be opening on LB835. Senator Howard, it is yours.

HOWARD: [00:05:50] Okay. Good afternoon, Chairman Riepe and members of Health and Human Services Committee. My name is Sara Howard, H-o-w-a-r-d and I represent District 9 which encompasses midtown Omaha. Today I'm here to present LB835, a bill that provides for independent audits and reviews under the Behavioral Health Services Act. This bill requires uniform standards to be used by each managed care provider including standard enrollment forms, uniform credentialing, and procedures established for prior authorizations and retrospective utilization reviews processes. It establishes a grievance appeal and hearing process that complies with federal and state statutes and regulations for timely resolutions. A key component of this bill is that provider appeals have a clear structure with an independent auditor and review and resolution process. In that process, after a final decision is made, the unsuccessful party, whether it's the managed care or the provider, shall pay the external reviewer; essentially a loser pays. As a member of the Legislature and a member of this committee, I've heard all the problems over the past 15

months as a new managed care system was implemented by the state of Nebraska. Before January 1, 2017, there were two systems of managed care: one for physical health and one for behavioral health. Each had a different managed care company, but only one company. Although there were problems at the start of implementation, the MCO for behavioral health was only focused on behavioral health services and worked with providers as they had to revamp their businesses. Now we have Heritage Health merging those two systems for physical health and behavioral health into one. And now we have three companies, three payments systems, three credentialing systems, three different sets of employees, and a much longer, harder learning curve for all providers, but particularly smaller clinics and individuals. I don't think any policymaker here can deny that this fragile behavioral health system of ours is one we must protect, particularly these days when mental health and substance use treatment is so important and as we face huge problems in our child welfare system. LB835 establishes additional mechanisms for behavioral health managed care services that provide uniformity, appeals process, oversight, and transparency. These areas are where behavioral health providers have had continuous ongoing systemic problems requiring constant monitoring, persistent communications to get paid, while also trying to fight for credentialing of professional staff. And in the case of small providers, making sure they can make payroll when they do not get paid regularly. Much has been asked of our behavioral health providers who have had the most significant problems dealing with this new system. And I believe this bill addresses some of those concerns. Thank you for your time and consideration of this important matter. And I'm happy to try to answer any questions you may have.

RIEPE: [00:08:29] Okay, thank you very much. Senator Crawford.

CRAWFORD: [00:08:34] Thank you, Chairman Riepe, and thank you, Senator Howard, for bringing this bill and being attentive to how to continue to improve the system. Are any components of this bill models that have been used in other states?

HOWARD: [00:08:47] Yes, I apologize; I should have mentioned that. This has already been implemented in Kansas, and I believe while the individual wasn't able to come up because of the weather, they did submit a letter. And so if you did not receive the letter I will-- I will address it in my closing.

CRAWFORD: [00:09:04] Okay, thank you.

RIEPE: [00:09:04] Senator Linehan, please.

LINEHAN: [00:09:06] Thank you, Chairman Riepe; and thank you, Senator Howard. There's a process now isn't there?

HOWARD: [00:09:13] There is a process, but each one is different and unique for each company.

LINEHAN: [00:09:18] So, because when I usually when we get a bill there's like we change something so there's some old wording or-- I was shocked when I looked at this, this is all new?

HOWARD: [00:09:29] So the process right now lies in regs and in the contracts with the managed care companies. So this would all be new uniformity in terms of standards.

LINEHAN: [00:09:37] So are the regs not uniform now?

HOWARD: [00:09:40] Well no, because each company can do something a little bit different in terms of credentialing.

LINEHAN: [00:09:45] Okay. What about in terms of appeals?

HOWARD: [00:09:48] It's the same. Each company is different.

LINEHAN: [00:09:51] And then what happens now when the providers are not happy? Is there an appeal of last resort to HHS?

HOWARD: [00:10:00] They can tell HHS, but there isn't a clear appeals process outlined in statute.

LINEHAN: [00:10:06] Is there-- because I've had, obviously, we've all had providers with concerns, and I've heard the term, I hope I wrote it down here somewhere, fair hearing board, am I saying that right?

HOWARD: [00:10:18] I don't know; I'm not familiar with the fair hearing board.

LINEHAN: [00:10:21] You're not?

HOWARD: [00:10:22] No.

LINEHAN: [00:10:23] Oh, because one of my providers thought it was important; maybe I'm using the wrong term.

HOWARD: [00:10:28] It could be. I can absolutely look into it and follow up with you.

LINEHAN: [00:10:31] Okay. I'd appreciate that.

HOWARD: [00:10:36] Certainly.

LINEHAN: [00:10:37] Thank you.

RIEPE: [00:10:38] Are there additional-- Senator Kolterman.

KOLTERMAN: [00:10:40] Thank you, Senator Riepe. Senator Howard, would you-- I'm reading the bill here. Would you kind of walk through the process that we-- because it talks about 60 days and then there's 10 days and-- walk through what you-- what your expectations are.

HOWARD: [00:10:54] Well, I think one of the challenges was in terms of credentialing in particular. It was taking quite a long time for a provider to get credentialed with specific managed care company. And so by putting in those timelines, the expectation is that we wouldn't have that drawn out. And obviously, you want to be credentialed because you can't bill until you are. And so the timelines would give that uniformity for how long you-- it would-- it could take a managed care company to credential an individual. And then if they didn't meet those timelines, then there is an appeals process for that.

KOLTERMAN: [00:11:29] And this deals only with behavioral health?

HOWARD: [00:11:33] Behavioral health, yes, sir.

KOLTERMAN: [00:11:33] So this appeals process wouldn't pertain to the rest of Heritage Health.

HOWARD: [00:11:38] No.

KOLTERMAN: [00:11:42] Okay, thank you.

HOWARD: [00:11:43] Thank you.

RIEPE: [00:11:43] Senator Crawford and then [INAUDIBLE] .

CRAWFORD: [00:11:46] Thank you, Chairman Riepe; and thank you, Senator Howard. I just wanted to follow up on that. Why is it just for behavior health?

HOWARD: [00:11:53] When we were looking at what Kansas had done, behavioral health was really the area where they were having the most challenges in terms of credentialing and in terms of uniformity and in terms of--

CRAWFORD: [00:12:03] Okay.

HOWARD: [00:12:03] And it's also where we have the most independent providers. So where it's just one person trying to figure out a-- three different companies credentialing and billing procedures. And so this really made sense in terms of if we're going to try an appeals process, if we're going to try for uniformity, we start in mental health; and then we could consider physical health after that.

CRAWFORD: [00:12:24] Excellent. Thank you.

HOWARD: [00:12:25] Thank you.

RIEPE: [00:12:25] Senator Linehan.

LINEHAN: [00:12:28] Are these-- are the MCOs-- they're currently audited aren't they?

HOWARD: [00:12:34] I don't know. It would have to be in their contracts. I'm certain that they are audited by an external party because they're an organization and a corporation.

LINEHAN: [00:12:44] So how do these audits different from those audits?

HOWARD: [00:12:47] Well those audits would be maintained internally, and these audits would be reflected to the department.

LINEHAN: [00:12:54] So the department doesn't audit the MCOs now?

HOWARD: [00:12:57] I don't know, I'd have to ask them, yeah.

LINEHAN: [00:12:58] But surely when you wrote the legislation, you figured out what they were doing now.

HOWARD: [00:13:04] Well most of this is based on all of the hearings that we had over the summer. And so the knowledge that I have is the knowledge that the committee shares. But, yes, when we were looking at the Kansas legislation, my understanding is that we don't have an external audit system.

LINEHAN: [00:13:20] And how much would the external audit system cost?

HOWARD: [00:13:24] That is in the fiscal note--quite a lot, several million dollars, unfortunately. Vendor contractual costs for that would be about $8 million.

LINEHAN: [00:13:37] So previously you said that one of the problems, and I know there are issues that people can't get credentialed, do you know how many behavioral health providers we have credentialed right now through the MCOs?

HOWARD: [00:13:51] I do not know, but I can get that for you.

LINEHAN: [00:13:53] Okay, because it would be good- are we talking thousands and we're missing a hundred, or are we talking-- just so we have some idea what the problem really is.

HOWARD: [00:14:02] Sure.

LINEHAN: [00:14:04] Okay. Thank you.

HOWARD: [00:14:04] Thank you.

RIEPE: [00:14:04] Any other questions? Senator Crawford.

CRAWFORD: [00:14:11] Thank you, Chairman Riepe. I believe I recall from the fiscal note that quite a bit of the expense, yeah, much more than half of the expense is picked up by federal funds. So is this an initiative encouraged by the federal government to have some of these audits? I was struck by the fact we're talking one and a half million on our part and over 7 million for the federal government's part.

HOWARD: [00:14:37] You know, I don't-- I don't know.

CRAWFORD: [00:14:39] So it's striking to me it was such a large contribution on federal side compared to our side. So when you said it was 8 million--

HOWARD: [00:14:47] In vendor costs, yeah.

CRAWFORD: [00:14:48] It looks like that there's a lot of federal money available for that.

HOWARD: [00:14:51] There's a lot of match, yeah. I will look into that, because I'm not sure why, and it's not mentioned in the fiscal note specifically.

RIEPE: [00:15:00] Is it fair to say that the physical health side, people have this figured out. The behavioral health side they don't have it figured out?

HOWARD: [00:15:04] In terms of the providers?

RIEPE: [00:15:11] We're focusing on-- at the expense of the providers, other than behavioral, this is explicitly behavioral. It seems like for some reason or another they haven't been able to figure it out and the other side has. So it can be figured out.

HOWARD: [00:15:29] I'm certain every-- there's a solution to everything. But I would also note that most physical health providers, as you would know as a hospital administrator, work under large umbrella organizations, rather than being independent practitioners. And that's really what we're dealing with when we're looking at mental health-- mental health providers.

RIEPE: [00:15:47] Does that speak to the marketplace the same much like I read in yesterday's Wall Street Journal, more and more hospitals are going together with 150-bed hospital systems. Are we going to have to have more consolidation, be able-- so that we have in-- fewer people that are the heads of their own small mom and pop [INAUDIBLE] kinds of-- And I know in some parts-- in smaller communities we're going to have that, but I'm just-- you know, consolidation seems to be the name of the game. I just-- do you see that as a part of the future that's being resisted?

HOWARD: [00:16:26] In terms of mental health providers in the state of Nebraska?

RIEPE: [00:16:30] Yes, yes, specifically mental health providers.

HOWARD: [00:16:31] You know I don't know. We still have a lot of mental health providers who are still independent practitioners who still bill independently and they're able to get into areas and practice independently where there isn't a large health system. So I can't speak to the systems change in terms of consolidation.

RIEPE: [00:16:51] Well, I admit to you, I'm conflicted on them because I'm a free market kind of an individual and I'd like to see choice. The question that I have to at least address or read up front is just a fiscal note and a priority status. I mean it makes it kind of discouraging, huh.

HOWARD: [00:17:07] No, I have no-- I have no expectation that this will move this year, but I do think it's an important conversation to have.

RIEPE: [00:17:15] Okay, I thought that was important to-- not to dash hope, but at least get it-- the issues--

HOWARD: [00:17:21] Who knows, I mean there are only six FTEs, and my top has always been 98 FTEs on the Howard bill, so I'm pretty satisfied with this one. Thank you.

RIEPE: [00:17:30] Okay. Are there additional questions? Why don't we go on to proponents? We may have some, and we'll hope you will be here for closing.

HOWARD: [00:17:38] Thank you. I have two bills in Judiciary, but I will try to stay.

RIEPE: [00:17:41] Okay. Well we appreciate that. Thank you very much. I'd like to move now to proponents, people in support. How many people do we have that intend to testify, just so we get an idea.

CRAWFORD: [00:17:52] Just on this bill.

RIEPE: [00:17:56] On this bill, yes. We were here until 7:00 last night. We want to know what to expect. Okay. We have a couple. Welcome back today.

AANNETTE DUBAS: [00:18:05] Thank you.

RIEPE: [00:18:06] And thank you very much for being here.

ANNETTE DUBAS: [00:18:06] You bet. I know you did have a late, late night last night, and it's Friday afternoon and the sun is shining and--

RIEPE: [00:18:15] We love to work.

ANNETTE DUBAS: [00:18:17] It kind of grows on you, doesn't it. Senator Riepe and members of the Health and Human Services Committee, my name is Annette Dubas A-n-n-e-t-t-e D-u-b-a-s, and I am the executive director for the Nebraska Association of Behavioral Health Organizations, otherwise known as NABHO. We are a statewide association representing providers, hospitals, regional behavioral health authorities, and consumers. Our mission is to build strong alliances to ensure quality substance use and mental health services are accessible to everyone in our state. And we would like to thank Senator Howard for introducing LB835. NABHO's members are no strangers to managed care. Prior to Heritage Health, behavioral health was carved out with Magellan being the single MCO, one company whose sole focus was on behavioral health. Our association was and remains committed to the successful operations of a managed care system of service delivery. As far back as 2011, NABHO hired an outside consultant and that work produced the current managed care contract statutes that we have in place today and helped define the previous program contract requirements. When the system now known as Heritage Health was proposed, we fully understood the challenges and the complexities of implementing such an integrated program. We watched what was going on in other states. We wanted to learn from their mistakes and do all we could to help ensure that Heritage Health worked. From the very beginning, we met regularly with Medicaid and the MCOs and stressed the importance of consistency of operations between the managed care companies and the need to streamline and simplify administration for service providers. Our association worked hard to keep lines of communication open, educate our members about contract negotiations, help them connect with the appropriate people when they experience problems, and troubleshoot as much as possible. Every action we have taken wants to ensure that Heritage Health works for all involved because if it doesn't it's our patients that suffer. We appreciate the fact that things are working better and improvements have been realized. We also appreciate the attention given to health providers by Senator Riepe and his staff, Director Thompson and his staff, but we believe more can be done to make sure Heritage Health is running on all cylinders and that it achieves its goal of improving health outcomes,

enhancing integration, and quality of care, and improving the financial sustainability of the system. Establishing uniform standards for credentialing utilization reviews, grievance, appeal, and hearing processes will provide clear and consistent direction. We understand there are certain federal due process requirements, but this bill would require the state to set a standard that must be met. We also believe that including a loser pays provision in the appeals process ensures that all parties are being thoughtful and responsible when it comes to making these types of decisions. We are especially supportive of the provision that requires an independent external audit with a focus on actual claims and denials. This has been, and to varying degrees, continues to be the area with the most problems for all service providers. The current contract says the state has a right to audit financial records. But this bill requires an annual independent review of a random sample of all claims paid and denied by each MCO. This will bring an unbiased and objective eye into the process and ensure that providers are being promptly and accurately paid. This will also support the DHHS goal of improving the financial sustainability of the system. I have attached the written testimony that was alluded to from Senator Howard from my counterpart in Kansas. They're getting ready to go into their next round of contract negotiations and pass legislation similar to this bill with strong bipartisan support last year. Intention for their legislation was to create a Medicaid managed care program as streamlined and uniform as possible. He also states that they have seen improvement in both the relationships with, as well as confidence in the MCOs because of this legislation. We remain firmly committed to the successful operation of Heritage Health. We believe LB835 is a serious and legitimate piece of legislation that will keep us moving in the right direction for overall patient care. I thank you for your attention and would be happy to try to answer any questions if I may.

RIEPE: [00:23:04] Thank you. An initial question I have, what was NABHO's role in drafting this particular--

ANNETTE DUBAS: [00:23:11] We worked very closely with Senator Howard, yes.

RIEPE: [00:23:13] Are there other questions? Senator Linehan.

LINEHAN: [00:23:18] Thank you, Chairman Riepe; and thank you, Senator, for being here. How many members do you have in NABHO?

ANNETTE DUBAS: [00:23:24] We have 44 members statewide.

LINEHAN: [00:23:26] Forty-four.

ANNETTE DUBAS: [00:23:26] Um-hum.

LINEHAN: [00:23:27] So a lot of these small providers that seem to be the biggest-- or a large part of the concern are not members of your organization?

ANNETTE DUBAS: [00:23:34] I would say we're probably-- I don't have my chart in front of me, I'd say we're about split 50/50 between large providers, medium size, and smaller. So we represent a very--.

LINEHAN: [00:23:51] Do you have any members that are just one person?

ANNETTE DUBAS: [00:23:54] Well we represent organizations. So it would be like a small business that has a couple of providers in their association-- in their organization. So we don't-- we do not represent individual providers. We represent provider organizations.

LINEHAN: [00:24:07] So do you know how many providers are credentialed?

ANNETTE DUBAS: [00:24:10] I could not answer that for you for certain, Senator, I'm sorry, but--.

LINEHAN: [00:24:14] Like any-- not even a ball park number?

ANNETTE DUBAS: [00:24:15] No, I'd hate to throw something out there and be off base. But I do believe that's information we can probably get.

LINEHAN: [00:24:22] Okay. I think that would be really helpful, so we know what we're actually dealing with here. On the test-- or the-- I don't know, it says testimony in the title: The Senate Committee on Health and Human Services from Kansas.

ANNETTE DUBAS: [00:24:34] Um-hum.

LINEHAN: [00:24:36] You talk about they have 26 licensed community mental health centers. Do you know, is that-- that's certainly everybody in mental health doesn't work in one of those community mental health centers.

ANNETTE DUBAS: [00:24:47] No, their association is not-- I mean they represent behavioral health providers, but it's not the way our organization is set up.

LINEHAN: [00:24:56] So in Kansas, if you're on Medicaid or CHIP or-- and government-provided because of your situation, do you have to go to one of these 26 licensed mental health centers to get help?

ANNETTE DUBAS: [00:25:13] I think this is-- no, this isn't the only place that you can get mental health services, but they have, to my understanding, a more organized organization made strictly of community mental health centers. You know, we have community mental centers in Nebraska; again, I can't speak to how many we have. I know a couple of them are in our association, but they don't have their own standalone association, as far as I'm aware.

LINEHAN: [00:25:39] So in Kansas, are these all associated-- are they-- they're independent, evidently, they're not-- they're not government run?

ANNETTE DUBAS: [00:25:48] No, not to my knowledge.

LINEHAN: [00:25:51] Okay. Okay, it would be interesting to see how they do this because it seems 26-- and I know their population is larger than us, but it seems like-- I know in other states, you drive down the street and there's a sign and it says here's where you can get mental health, which doesn't seem like that's the case in Nebraska, from what I've seen. You have to be like-- you can be in crisis not know where to go. Right?

ANNETTE DUBAS: [00:26:14] Our association--

LINEHAN: [00:26:14] So it would be interesting to look--.

ANNETTE DUBAS: [00:26:15] Our association isn't actually an apples to apples comparison as far as who we're representing. His is very focused on community mental health centers; where we are much more diverse. I mean, we have hospitals who are members; we have, you know, the regional behavioral health authorities; we have consumers, so we're a much broader-based

organization than theirs is.

LINEHAN: [00:26:35] So is CHI a member?

ANNETTE DUBAS: [00:26:36] Yes.

LINEHAN: [00:26:36] So are they having these same kinds of problems with getting reimbursed?

ANNETTE DUBAS: [00:26:41] Yes. I mean, as I stated, things have improved. Again, being a larger organization, they probably have more resources, staff, etcetera, that have helped them navigate the system better than maybe my mid and smaller sized organizations.

LINEHAN: [00:26:55] Okay, thank you very much for being here.

RIEPE: [00:27:01] Senator Kolterman, did you have a question?

KOLTERMAN: [00:27:03] Yes, I do. Thank you, Senator Riepe. Thank you for coming, Senator.

ANNETTE DUBAS: [00:27:04] You bet.

KOLTERMAN: [00:27:07] Talk a little bit-- you've been around this place a little bit for a while and you worked with-- you probably had an opportunity to work with Magellan prior to taking a position that you have when you're on the outs here.

ANNETTE DUBAS: [00:27:21] Yes.

KOLTERMAN: [00:27:21] So tell me how is it-- do you think it's been a posi-- I mean, we knew there are going to be challenges going in, do you think it's positive to have three different providers versus one and if, if that's the case, I mean, obviously with one it would have been a lot easier to audit them. But now we're talking about auditing three different organizations, which is rolled into one. Talk about the challenges that you saw with Magellan versus what we have now and advantages and disadvantages.

ANNETTE DUBAS: [00:27:53] Yeah, and I do believe that there are advantages and disadvantages prior, you know, with Magellan it was one company whose sole focus was on behavioral health. So everything, you know, that my members had to do with Magellan, Magellan understood what they were doing, my members understood what Magellan was doing. There was-- certainly there were times that there were disagreements. When I came into this position as the executive director, was towards the end of-- no it was the beginning of moving towards Heritage Health and away from-- from the carve out. And my understanding was communication and the work cooperation had definitely improved over the course of time with Magellan. So there were more regular meetings with Magellan when problems were identified. They were able to kind of get on top of them right away. But again, the company had a very single focus. My members knew, moving into an integrated system, it would be a challenge. There's not a disagreement that an integrated system isn't a good thing because you really can't separate behavioral health and physical health, they go hand in hand. And we saw this as an opportunity to make that point even more well known. What our concern was, as behavioral health providers, we make up a much smaller part of that system. And even though we don't represent a large number or a big part of the financial pie, so to speak, our members are the cost drivers. So we can bend that cost curve for physical health care. And so we just wanted to make sure that that was always front and center with the plans as they moved forward is recognizing that while behavioral health may appear as a small component of this, we really contribute to the cost and can help contain those costs. So moving from, to get back

to your question, sorry for diverging there, you know, moving from dealing with one company to three companies and being a part of physical healthcare as well as pharmacy, making up a smaller component of that three part has been a little challenging for our members. The administration, you know, dealing with three separate companies, and I know there are steps being taken. There's administrative simplification committee, but they're again having to look at physical pharmacy, as well as behavioral health, so sometimes our issues are always at the top of the priority list. So just, you know, that was our message when we met with them throughout the entire process is it's important for our members to have the administration streamlined as much as possible just so they can manage cost and keep things on track. And I know you've heard from previous members of my members who have talked about hiring extra staff, the extra time that it's taking them to work through some of these things, which is adding to their costs, which is, you know, bottom line that impacts their ability to deliver services.

KOLTERMAN: [00:30:54] So, along those same lines, just-- and you might know, you might not have the [INAUDIBLE], do you know, of your members or in the behavioral health arena, are most of your members licensed with all three organizations? Do they-- or they just have one license with Heritage Health and they have to all, because they all have different networks.

ANNETTE DUBAS: [00:31:19] Right. Every organization contracts individually with the MCOs.

KOLTERMAN: [00:31:24] Right.

ANNETTE DUBAS: [00:31:24] And to my knowledge, I believe all of my members are contracted with all three MCOs. I could be wrong there. And if they are all, it's probably a very small number that is not contracted with all three providers.

KOLTERMAN: [00:31:39] Then one last question, and this is just kind of-- I'm just kind of testing the waters here, with behavioral health we're seeing a lot more done with telehealth. Is that working for your members?

ANNETTE DUBAS: [00:31:53] We see a lot of opportunity in the area of telehealth, especially as you get out into the more rural and frontier areas where having access to a healthcare provider, especially certain licenses like psychologists and psychiatrists, so I think there are probably still some obstacles in place, as far as really making that work well, how rates are set, etcetera, but we see that as something that has a great deal of potential for behavioral health.

KOLTERMAN: [00:32:19] Okay. Thank you, Senator, appreciate you coming down.

ANNETTE DUBAS: [00:32:20] You're welcome. Thank you.

RIEPE: [00:32:21] I have a question. Is Catholic charities part of your organization?

ANNETTE DUBAS: [00:32:28] Yes, they are a member.

RIEPE: [00:32:30] And they have psychologists do they?

ANNETTE DUBAS: [00:32:33] You know, they have gone through a big overhaul of how they do business. Their behavioral health services component of the whole organization has gotten quite a bit smaller than what it was in the past, so I can't tell you for sure what type of licenses that they have in place, but they do provide behavioral health services.

RIEPE: [00:32:56] Within NEBHO, your organization, what provision do you have for moral

objections?

ANNETTE DUBAS: [00:33:01] As an association, we have nothing in place.

RIEPE: [00:33:05] So you don't have any overall arching guidelines.

ANNETTE DUBAS: [00:33:07] No.

RIEPE: [00:33:09] Okay. Let me ask you a second question. In a given month, how many times have you met with the managed care organizations or the Department of Health and Human Services. What's an average number in any given month?

ANNETTE DUBAS: [00:33:21] You know, I can't-- in a given month, we try to meet with Medicaid every probably three to four months, more if, you know, over the last year we probably met maybe I would say every three months. We've invited the managed care companies to our monthly meetings. As an executive committee, we've met with them, gosh, we haven't had a recent meeting with them, which is on my agenda that we need to have another meeting, met with them; so, you know, I've got to say we've at least tried to meet with all of the entities quarterly. And, of course, then we exchange e-mails, and through the provider, Medicaid provider, committee meetings we, you know, interact with them in those respects too.

RIEPE: [00:34:15] Okay. I know this-- people that know me know that I like flip charts, so is DHHS your go-to number one box?

ANNETTE DUBAS: [00:34:22] It probably will depend on the situation. But I would say the majority of the time, yes, that's-- that's who we go to. Medicaid gave us-- here's the contact number

if you have issues. All three of the MCOs have given me contacts for-- so depending on, you know, if I have an individual member that's called me and said, okay, I have this problem, I can kind of determine, do I need to get in touch with the MCO or do I need to go Medicaid. So I kind of have those call numbers provided by the different entities that I will go to based on a situation.

RIEPE: [00:34:51] Is it your interest in this legislation promoting a message you think that your providers should be treated differently and maybe better than other providers?

ANNETTE DUBAS: [00:35:03] Oh certainly not, but certainly on par with the providers. And as I said, we may be a smaller component of Heritage Health, but we are-- we are a cost driver and we can-- we can support the efforts of physical health through behavioral health and vice versa. So again, my members have never disagreed with moving towards an integrated approach and get the fact that you can't separate behavioral health and physical health. But we just want to make sure that we're at the table and that our voice is being heard.

RIEPE: [00:35:35] How many member organizations do you have? Occasionally, the number is thrown out that we have 30,000 providers-- and I kind of go like, that's a lot.

ANNETTE DUBAS: [00:35:44] We have 44 organizations. Now I can't tell you to the exact number how many staff each one of those organizations have, but--

RIEPE: [00:35:53] But everybody says-- I mean, what I hear you telling me is this 30,000 providers is an exaggeration.

ANNETTE DUBAS: [00:36:03] I couldn't tell you how many behavioral health providers there are. I'm sure there's a significant number. But as far as my organization, we represent 44

organizations.

RIEPE: [00:36:12] If I was quicker, I'd take 44 into 30,000 and say how can that be.

ANNETTE DUBAS: [00:36:16] But again, we are a diverse organization; so we represent large organizations like hospitals like CHI and Bryan and Boys Town, all the way down to some very small provider organizations out in the rural areas of the state who, you know, maybe just have a couple.

RIEPE: [00:36:31] So you might be counting the guy at Bergen Mercy CHI that's working on the back dock because they're one of CHI's two or 3,000 employees.

ANNETTE DUBAS: [00:36:43] You know, again, I'm not.

RIEPE: [00:36:43] I'm not you, I'm just saying, that 30,000 number--

ANNETTE DUBAS: [00:36:44] Right. Right. Right. You know, I can't-- I can't testify to the fact of how many actual providers my organization-- but that's a good point though, it's something I probably should follow up on. And again we're diverse in that we have regional behavioral health authorities, as well as several consumer groups. So not everybody is an actual provider in our association.

RIEPE: [00:37:06] I know that when I say that 30,000 number, people look at me and like a dumb dog look like you've got to be kidding. And now I'm kind of-- maybe I better check my number. Okay. Are there other questions? Senator Crawford, please.

CRAWFORD: [00:37:19] Thank you Chairman Riepe; and thank you, Ms. Dubas. I wondered if I could talk to you just a little bit about the fact that it looks like with the, with the bill and the fiscal note, they're talking about the fact that we would-- if we put this in place, we'd have an external, independent, third-party reviewer that would do the audits. Is it your understanding that similar to what happens in Kansas that they have some external group they contract with for those audits or do you know?

ANNETTE DUBAS: [00:37:50] I don't know specifically. I believe that that is included in their legislation as well that is an external, but I can't speak to how that actually works.

CRAWFORD: [00:38:00] Okay. So do you know what the existing statute-- there's authority to do audits. Do know who would do those audits if it were done?

ANNETTE DUBAS: [00:38:09] You know, and I certainly don't know contract law by any stretch of the imagination, but just based on what I know that's in the contract, the division may-- may do an audit.

CRAWFORD: [00:38:21] Okay.

ANNETTE DUBAS: [00:38:22] And so I'm assuming that that would take place from-- from within the division.

CRAWFORD: [00:38:26] They might do it or they might hire somebody to do it, either way. It's not clear, as far as you know.

ANNETTE DUBAS: [00:38:30] As far as I can tell it's not a required thing, but--

CRAWFORD: [00:38:33] Okay.

ANNETTE DUBAS: [00:38:33] But they may be able to speak to that differently.

CRAWFORD: [00:38:35] Okay. I'll put that on my list. So then the second part, and this is the part I'm trying to understand, because I know credentialing has been an issue and timelines for credentialing, now on that part, do you know from talking to your other colleagues and other health areas if there's anything unique or more problematic on credentialing for behavioral health, in addition to or beyond the issue that many of them are small providers?

ANNETTE DUBAS: [00:39:04] I wish I could speak to that with more authority and that had been my intention to have a provider here today, but for a lot of reasons weren't able to make that happen, so I do apologize for that. I know over the last couple of years the state had contracted-- has contracted with a company called Maximus and that's who does the credentialing. So that was kind of a new process for our members. It's my understanding, I think, that all providers have to go through that not just behavioral health. But again, I'm going to rely on the experts behind me that will be able to answer that better. But then through that credentialing, the credentialing has to be submitted to each of the MCOs as well.

CRAWFORD: [00:39:45] So it's really kind of two kind of processes they have to crank through, the Maximus--.

ANNETTE DUBAS: [00:39:50] The MCOs have to make sure that the providers they're contracting with are credentialed. That's an important component of making sure that the providers are who they are and doing what they say they are.

CRAWFORD: [00:40:01] Right. Right. And you're asking for a consistent process for MCOs.

ANNETTE DUBAS: [00:40:06] Uniform stand-- right.

CRAWFORD: [00:40:06] Not necessarily saying that it has to eliminate the Maximus process.

ANNETTE DUBAS: [00:40:11] No, we—no, we're saying-- we understand credentialing is an important part of operating within the system; it's just making sure that the three MCOs have a consistent or uniform process for that credentialing. And again, I apologize for not having a provider here who can answer that, but I could certainly do some follow up on that.

CRAWFORD: [00:40:31] Okay. So it-- because the fiscal note says something about needing a centralized provider manager, like the department is supposed to be taking care of this, or someone else is maybe taking care of this. But you're saying that what the MCOs do right now we just want them to agree to do it in a similar way. Is that fair? Not something new, but let's--.

ANNETTE DUBAS: [00:40:51] Right. Right. Let's--.

CRAWFORD: [00:40:53] So how do those conversations-- so I assume that's part of what the administrative simplification committee is supposed to be about. So how are those conversations going and why has that not lead to more uniformity from your perspective?

ANNETTE DUBAS: [00:41:09] My experience with the administrative simplification committee is they have like put out what are the priority issues. And again, recognizing that this is just isn't behavioral health providers, these are physical health providers and pharmacy as well. So what are

the issues that are deemed a priority for this committee to look at and work on. And there's usually kind of a vote and then the top issues-- and the agenda for the next meeting was just sent out, and I should have brought it so I could tell you what's next. So this particular issue just has not risen to that level of attention right now. But again, that committee is in place and part what they're supposed to do is look at this.

CRAWFORD: [00:41:50] Thank you very much. That committee is everybody together, they don't necessarily have subcommittees of different kinds of providers.

ANNETTE DUBAS: [00:41:57] There is a subcommittee of that committee that really is looking at kind of troubleshooting. They have regular meetings where the MCOs and providers come together talking about what are problems that are being experienced right now. So that's a subcommittee of that administrative simplification, but otherwise I'm not remembering any other subcommittee.

CRAWFORD: [00:42:19] Not of behavioral health subcommittee.

ANNETTE DUBAS: [00:42:20] Right, right.

CRAWFORD: [00:42:20] Thank you.

RIEPE: [00:42:20] It's my understanding under the Obama Administration, one of the conditions for going to a managed care is that you had to have three providers, because if you had two, you get no competition. So the idea here was to get competition, not to get, you know, antitrust collaborative going with everybody doing everything the same way. To me it's kind of like the, call it, trauma, if you will, but moving from one provider to now three providers. Although, it flies under the banner of [INAUDIBLE], it's fundamentally three different insurance carriers, if you

could use that terminology.

ANNETTE DUBAS: [00:43:01] And we understood that-- and again with our meetings, those initial meetings, especially when we talked about, you know, what are ways to create uniformity, we get that every company operates differently and there are certain proprietary things that, you know, they aren't willing to share with their competitors. So again, we understand that. But from our perspective as how do we manage our costs and administration, if there are-- if there are areas that you can come together and create a uniform standard form for whatever it is, you know, that-- that's what will benefit my members and the system as a whole.

RIEPE: [00:43:38] What about on the appeals process, how does that, on a routine go, and how long a time line does that run on?

ANNETTE DUBAS: [00:43:48] I tried to get my finger on that process. And since we are still relatively new into Heritage Health, it's just a little over a year old, my members' focus really for the last year has been on just getting their claims paid and dealing with correcting things that were denied and what have you. So as far as I know, there hasn't been an extensive appeals process that any of my members have gone through to date. I could be wrong, but that's not what I'm-- that's not what I've heard from them so far. Right now it's kind of been the immediacy see of, let's get our claims paid and get things back on an even keel.

RIEPE: [00:44:32] In the past, I recall that with Medicare one time we had a prospective payment model fundamentally. It's kind of like they gave us our allowance, we worked against it. When we shored up, or righted up, at the end of the given period of time, helped everyone with cash flows, I'm not committing to managed care organization data, I'm just trying to discuss options about ways. And I think my other concern is making sure that-- because I am a believer if you have an oral

agreement, someone says I want to do this procedure, the MCO says yes, then if it's all the information submitted correctly then they get paid; over simplification, but I believe that you say you are going to do it then do it.

ANNETTE DUBAS: [00:45:21] And that's another one of the changes that we will be experiencing through Heritage Health moving from fee for service to more value based types of payments. Again, not something my members necessarily disagree with, but it really is a shift in how they do business, how they charge for what they do, and what they're able to collect for what they do. So just a lot of really big changes that aren't always easiest to navigate, especially if you don't have all of the infrastructure in place to help you manage those changes.

RIEPE: [00:45:51] Talking about infrastructure, have your members looked at a clearinghouse that-- to facilitate the clean bills and then-- to keep the cash flowing?

ANNETTE DUBAS: [00:46:03] I do believe that some of my members do contract with a-- with different types of clearing houses to help them with billings and etcetera. And some of those clearing houses have been beneficial in helping them dealing with, you know, late claims or improperly paid claims, some more than others. But I do know-- and that's something as an association we talk about regularly, what are the things we can do to help, you know, collectively help you navigate some of these changes or put processes in place that help you manage fiscally. So that's one of our roles as an association.

RIEPE: [00:46:36] You can allow them to continue to be entrepreneurs and yet provide them some fundamental support that they just maybe don't have the extra {INAUDIBLE].

ANNETTE DUBAS: [00:46:44] Right. Right.

RIEPE: [00:46:47] Okay, all very helpful, very interesting to me. Are there other questions? You've been very informative, very helpful; we appreciate it. Thank you very much.

ANNETTE DUBAS: [00:46:53] Thank you for your time and attention.

RIEPE: [00:46:55] Thank you. I'd like to hear more proponents or we would. Are there more speaking in favor? If not, do we have any opponents? Director Thompson, welcome.

THOMAS ROCKY THOMPSON: [00:47:20] Thank you. Good afternoon, Chairman Riepe, and members the Health and Human Services Committee, my name is Thomas Rocky Thompson, T-h-o-m-a-s R-o-c-k-y T-h-o-m-p-s-o-n; I serve as interim director, Division of Medicaid and long-term care in the Department of Health and Human Services and I'm here to testify in opposition to LB835. LB835 would provide an additional level grievance appeal rights to providers, mandate the utilization of external independent third party reviewer for provider disputes, create a streamlined standardized enrollment and credentialing process providers that participate in managed care. First, to address the process of external, independent, third-party reviewer, this appears to conflict with federal law. Federal law says that after an internal appeal with the managed-care organization is exhausted, federal law provides any further appeal is taken through the state fair hearing process. This federal requirement requires that the hearing be held before the Medicaid agency. Also the recent federal Medicaid managed care rule require that our members are only subject to one level appeal at the managed care level and an access to the state fair hearing process. As a part of the state fair hearing process, individuals also have the opportunity to a hearing in district court under judicial review. If they do not-- if not satisfied with the result from administrative hearing before the department. The managed care organizations, as well as the department, have written processes and procedures in place for all appeals. These processes are based on the federal requirement for an

appeal rights, including time of those appeals. Providers are given this information as they enroll and can access at any time from the managed care organizations or the department. Under this bill, it's unclear about how this actually external review process would work in conjunction with the state's administrative appeals process. In the handout I gave you, we have include flowcharts with the several possibilities of where this process would fit in. Also, I know Senator Dubas mentioned the current utilization of the appeals process by behavioral health providers. And we see low utilization of the state-- existing state process by our providers. So it's unknown how many providers would actually take advantage of this new process. That is why the cost of this new process is not actually reflected in the fiscal note due to limit utilization of this process by behavior health providers. There are also additional concerns this bill could interfere with the department's program and integrity functions. Our program integrity team works together with Medicaid fraud and patient abuse unit in the Attorney General's Office to investigate provider fraud and abuse. There are legal concerns where payment is made to a provider if resolutions of claims dispute is not made within a certain number of days it has listed in the bill. It's unclear what effect this may have if a providers later taken to court under the false claims act. This requirement could lead to federal disallowances, our payment using only state general funds, that the provider legitimately should not have received payment. LB835 also requires the department to streamline the enrollment credentialing process. Now I do agree that this is a good idea and would be a process improvement. However, the state does not currently have a system in place to expand a Maximus system to do both, enrollment and credentialing. So there is a cost associated with that that's reflected in the fiscal note. Just want to address a couple of other points that came up in the previous testimony. In addition to the administrative simplification committee, we do have a behavioral health integration committee that has been focused on that specific provider group's needs and they have worked on process improvements with our behavioral health providers and NABHO. Also, Kansas we mentioned. Kansas did pass a similar law last year. However it has the same timelines for implementation as this bill, and this bill says it won't be implemented until 2020 for the external

process. So they have not actually implemented that portion of the bill yet, and we did ask if they have actually operationalize it yet. Like I don't even know if there is a contractor that does that type of claims review process. They said they had not. I'd also like to add, as mentioned at the last Heritage Health briefing, we do-- we're in final stages of releasing RFP for a financial auditor for the MCOs. Additionally, we are federally required to have external quality review organization for our plans. Finally, I would like to thank our behavioral health providers and NABHO for their work and their commitment to success of Heritage Health. Now I'm happy to answer any questions that you may have.

RIEPE: [00:51:47] Thank you. Senator Crawford.

CRAWFORD: [00:51:52] Thank you, Senator Riepe; and thank you, Director, for being here and your testimony. I'd like to focus first on the area where I think there is agreement here at the bottom where it says: streamlining the enrollment and credentialing process, and that's the part of the fiscal note I was having the most trouble understanding as well, and that it's a good idea and a process improvement. So what would we need to do to get there from your perspective?

THOMAS ROCKY THOMPSON: [00:52:19] Well, thank you, Senator. The Medicaid managed care rule requires providers to actually enroll with Medicaid and also be credentialed with the managed care organizations. Previous to that managed care rule, you could actually-- not actually be enrolled in Medicaid, in some states it’s not actually enrollment Medicaid providers, it could just be crucial to the plans. But that changed with the Medicaid managed care rule. So to do that we would have to create a new system in order to-- and Indiana has a similar system, to make sure that enrollment and credentialing they actually isn't done in-house by the Medicaid division.

CRAWFORD: [00:53:00] Thank you. And so then if we-- if we did that, then we'd be telling the

managed care organizations we've-- we've taken care of the credentialing and enrollment and you take the people we tell you to take. Is that-- is that fair or is that what you mean [INAUDIBLE]?

THOMAS ROCKY THOMPSON: [00:53:14] Well we would still select which plan they would actually be enrolled in, because we can't force anybody [INAUDIBLE] .

CRAWFORD: [00:53:19] No, no, no, but I mean we would be taking care of all the credentialing, so the managed care organizations would then be not making them go through an additional training, is that fair?

THOMAS ROCKY THOMPSON: [00:53:30] That's correct. And you know the enrollment process is different than the credentialing process. Enrollment requires different things than credentialing.

CRAWFORD: [00:53:36] Could you explain that. I'm not sure about that, that's why I was having trouble understanding the fiscal note.

THOMAS ROCKY THOMPSON: [00:53:40] Sure. Okay, I can go through the particular-- okay. So the-- actually 42 CFR 455 supports B and E, go over what actually is required in Medicaid enrollment. So that's collective provider detail like names, addresses, the actual risk level of that provider, screened to make sure they're not excluded from Medicare, things like that. Now, credentialing requires-- they check to see if there's a valid license of practice, education training of that provider, malpractice history, work history, history of loss of medical license, and felony convictions, things like that. And so that's currently not done by our system.

CRAWFORD: [00:54:20] The last part--

THOMAS ROCKY THOMPSON: [00:54:22] Oh right, the credentialing.

CRAWFORD: [00:54:24] Credentialing is not done by Maximus.

THOMAS ROCKY THOMPSON: [00:54:26] Maximus, that's correct.

CRAWFORD: [00:54:27] So we do the enrollment part and then the plan-- the MCOs each do their credentialing their own way.

THOMAS ROCKY THOMPSON: [00:54:32] And I can say that if there is a new provider, they can do both process concurrently.

CRAWFORD: [00:54:37] Great. But is Indiana a good-- did you mention them as a good example of a state that's streamlined this process?

THOMAS ROCKY THOMPSON: [00:54:43] They're one state that I'm aware of; I don't know how great it is for the provider--

CRAWFORD: [00:54:46] Okay, sure. But they're one example--

THOMAS ROCKY THOMPSON: [00:54:46] --but they're one example that has a system like this.

CRAWFORD: [00:54:49] Excellent, thank you.

RIEPE: [00:54:49] Senator Kolterman, please.

KOLTERMAN: [00:54:51] Thank you. Acting director, isn't that-- but that takes away-- if we were to go to that type of a system, that really take away the advantage that Heritage Health brings, because at the present time all these three providers go out and do their own deals and they negotiate their own contracts. So if we were to do that, why wouldn't we just have one? Does that makes sense?

THOMAS ROCKY THOMPSON: [00:55:20] It does make sense, Senator; and I don't think that process would take away from the actual contract negotiations of the plans. It would just help with the same-- collecting the same information that the plans do require. And so the plans would still have to contract, they can't be forced to take a certain provider. They'd still have to contract, they would still have to work out the contract; they would still have negotiated that contract.

KOLTERMAN: [00:55:44] Correct me if I'm wrong, but each one of these three companies have gone out individually and contracted with the providers.

THOMAS ROCKY THOMPSON: [00:55:56] That is correct.

KOLTERMAN: [00:55:57] And they each one have a different contract that they pay. So one might get a bigger discount for mental health type of benefits, and on the other hand they might make more off surgeries.

THOMAS ROCKY THOMPSON: [00:56:12] That's correct. And, you know, also we're trying to go to more value-based contracts too, so more now comes now and things. And so those are individually negotiated also.

KOLTERMAN: [00:56:22] Have you-- have you-- be intriguing to see how that Indiana model is working because that's completely different than managed care that I know.

THOMAS ROCKY THOMPSON: [00:56:29] Well, I think that there's two different processes that we're talking about here. We have the credentialing process and an actual agreement that the provider has with the managed care organization, that contract between the two of them. So it's to make-- ensure that they can participate in the network, but not actually what requirements MCOs have and the provider has for their participation.

KOLTERMAN: [00:56:56] All right, thank you.

THOMAS ROCKY THOMPSON: [00:56:58] Thank you, Senator.

RIEPE: [00:57:00] It's my understanding, correct me, I'm not an expert on Medicaid.

THOMAS ROCKY THOMPSON: [00:57:04] Nobody is an expert on Medicaid. [LAUGHTER]

RIEPE: [00:57:13] [INAUDIBLE] But, you know, I think at times we forget that we have another big dance partner in that and that's the federal government. My understanding is that while the states, through the administration of Medicaid, the financing and the control financially and fundamentally come from federal government.

THOMAS ROCKY THOMPSON: [00:57:31] Well--.

RIEPE: [00:57:32] So they pull the strings and we dance.

THOMAS ROCKY THOMPSON: [00:57:35] A little less than half does come from our-- our state-- our state's taxpayers. But they do contribute the majority of the money to our Medicaid program, that's correct. And so we do have to follow the rules.

RIEPE: [00:57:47] And he who's got the gold makes the rules.

THOMAS ROCKY THOMPSON: [00:57:50] That's what my father always said.

RIEPE: [00:57:51] That's right. I guess-- sometimes I think we're in the situation where we-- we may not write the music, but we have to play it, so there you go.

THOMAS ROCKY THOMPSON: [00:58:07] Yes, sir.

RIEPE: [00:58:07] Senator Linehan, please.

LINEHAN: [00:58:10] Thank you, Chairman Riepe. I think you brought along in your handout here some question that Chairman Riepe was asking. On the back page, it says in the first three quarters of 2017 there are over 14,000 enrolled behavioral health providers.

THOMAS ROCKY THOMPSON: [00:58:28] I should point out, Senator, that's-- the 30,000 number is just for the state of Nebraska; the 14,000 number is both in the state of Nebraska and also out of state. So we do have a significant number of providers that are enrolled in Nebraska Medicaid out of state.

LINEHAN: [00:58:42] Okay, can you say that all again.

THOMAS ROCKY THOMPSON: [00:58:44] So the 30,000 number, or the number of providers that actually are in the state of Nebraska.

LINEHAN: [00:58:49] Mental health providers.

THOMAS ROCKY THOMPSON: [00:58:49] Well, those are all providers.

LINEHAN: [00:58:51] Okay, okay.

THOMAS ROCKY THOMPSON: [00:58:52] The 14,000 number that's cited right there, are all mental health providers that are enrolled in Nebraska Medicaid nationwide. So let's say there's an enrollee that is-- there is a participant-- their closest provider is in Colorado, for example, in the western part of our state.

LINEHAN: [00:59:12] I see.

THOMAS ROCKY THOMPSON: [00:59:12] So they would still be enrolled in Nebraska Medicaid, but they would not actually be in the state of Nebraska.

LINEHAN: [00:59:17] So, but we do have 14,000-- is that 14,000 individuals or 14,000 companies or--

THOMAS ROCKY THOMPSON: [00:59:26] It can be both. There might also actually be some duplication there because this is-- a lot of the providers they do move around within practices. So there might be also some duplication there, but that's the best number that we can come up with.

LINEHAN: [00:59:39] Okay, well it's an impressive number. Thank you.

RIEPE: [00:59:42] Is it common for state Medicaid to pay across lines? Because Iowa would not do that. If you were on Medicaid Iowa, you could not go to Omaha.

THOMAS ROCKY THOMPSON: [00:59:51] Yes, sir. Usually in places with just, you know, just borders on a map don't necessarily mean a lot to a person if their provider is in-- closer, especially in the western part of the state, if there's a provider that's closer and they can go to that one easier than go to Omaha or Lincoln, they would go to that provider in Wyoming or Colorado.

RIEPE: [01:00:14] At that time, it meant a lot to Iowa.

THOMAS ROCKY THOMPSON: [01:00:16] And I know that there are a lot of Iowa Medicaid patients that utilize services in Omaha.

RIEPE: [01:00:22] Okay. May have changed too. Are there additional questions? Senator Crawford.

CRAWFORD: [01:00:25] Thank you, Chairman Riepe. And thank you again, Director. I believe you mentioned contracting for an audit-- for external audit, did I hear you say that?

THOMAS ROCKY THOMPSON: [01:00:38] Yes, Senator. There is a requirement under federal law that we have an external quality review organization review our-- our program.

CRAWFORD: [01:00:50] Okay. And so is that an audit of DHHS or is that-- does that include an

audit of the-- of the-- any of the claims and how they got treated by the MCOs?

THOMAS ROCKY THOMPSON: [01:01:02] It's an audit of the contract requirements and also federal and state requirements of the contract and of the MCOs.

CRAWFORD: [01:01:10] So it's an audit of whether or not we're complying with federal law.

THOMAS ROCKY THOMPSON: [01:01:13] That's part of it, yes.

CRAWFORD: [01:01:15] That's part of it. Is there any part of it that's an audit of whether or not the-- whether or not claims might be being denied inappropriately?

THOMAS ROCKY THOMPSON: [01:01:25] I don't know if it gets that specific. We do have that financial auditor that we are in the last stages of releasing RFP for.

CRAWFORD: [01:01:34] So that's to--.

THOMAS ROCKY THOMPSON: [01:01:36] Then that's not federally required, but we decide to do that as part of best practices.

CRAWFORD: [01:01:40] Great. And so what is-- what is that auditor being contracted to work?

THOMAS ROCKY THOMPSON: [01:01:45] That's to look-- do a deep dive into the numbers that the MCO is providing to the department, and also their financial stability.

CRAWFORD: [01:01:50] Of the MCOs.

THOMAS ROCKY THOMPSON: [01:01:52] Of the MCOs.

CRAWFORD: [01:01:54] Okay. So to see if the MCOs are financially viable?

THOMAS ROCKY THOMPSON: [01:01:57] Well, that-- that's part of it and also just to see about what kind of information are-- is being reported to the state to make sure that confirms with what their actual books say to do that deep dive.

CRAWFORD: [01:02:10] Okay, so to make sure that if they say they're issuing a check, a check gets issued.

THOMAS ROCKY THOMPSON: [01:02:13] That's part of it.

CRAWFORD: [01:02:14] Okay, great. So does that audit also include the question of whether or not any claims are improperly denied? Does that auditor do that or is the auditor really just-- is the money flowing or we say it's flowing?

THOMAS ROCKY THOMPSON: [01:02:26] I would have to look into the details.

CRAWFORD: [01:02:30] I appreciate that. Thank you, and I appreciate that you're working on that--

THOMAS ROCKY THOMPSON: [01:02:32] Yes, Senator.

CRAWFORD: [01:02:33] --that integrity of the program, and include-- that doesn't have any now

I'm into added integrity to the program. Thank you.

THOMAS ROCKY THOMPSON: [01:02:40] Yes, Senator; I understand.

RIEPE: [01:02:43] Okay, are there additional questions? Seeing none, on behalf of the committee, we appreciate your candor and openness and willingness to be forthright with us.

THOMAS ROCKY THOMPSON: [01:02:51] Of course, Senator, Thank you, committee.

RIEPE: [01:02:53] Additional opponents? If you will, sir, if you give us your name and spell it and then tell us your organization.

JAMES WATSON: [01:03:06] Good afternoon. My name is James Watson, that's J-a-m-e-s W-a-t-s-o-n. I'm here representing Nebraska Association of Medicaid Health Plans and those plans include Total-- Nebraska Total Care, United Healthcare Community Plan, and WellCare of Nebraska. Thank you for the opportunity to testify before your committee here today and to respectfully express the association's opposition to legislative bill, LB835. First, the bill requires the Department of Health and Human Services to submit a random sample of all claims paid/denied by each MCO and each MCO subcontractor's to an independent auditor once a year. The MCO is to be required to pay any claim that the independent auditor determines to be incorrectly denied with no proposed recourse whatsoever. Yet each MCO is required already to undergo extensive external audits by multiple organizations, including IPRO, the National Committee for Quality Assurance, and external audits of our MCOs business transactions by a CPA. Additionally, the MCOs are contractually required to participate in audits by the Nebraska Department of Insurance. So we believe that adding yet another audit is duplicative and unnecessary expense. Further, this bill would establish a process for which a healthcare provider can request an external independent third

party review of an MCO's final decision on an individual claim, even though the contract between DHHS and MCOs already mandates that detailed and thorough grievance appeal and state fair hearing process. The bill also seeks to impose liquidated damages if MCOs do not resolve 100 percent of their appeals within 60 days. This recommendation is unrealistic and would prove difficult to achieve as resolution may not lie strictly with the MCO. An example would be the need for supporting documentation by the provider. Another example would be coordination of benefits issues which necessitates a timely response by the payer that is the primary payer. The proposal would also require managed care organizations to provide documentation to a behavioral health provider when an MCO denies any portion of the claim for reimbursement. This too is redundant to the nationally accepted practice of providing HIPAA compliant response codes via electronic transaction file called an 835 file, and by explanation of payment or remittance documents the MCOs issue to providers already. Turning out some of the new requirements that 835 would impose on the Medicaid agency, the language it requires the director of the division of Medicaid and long-term care to reproduce accurate and uniform patient encounter data creates unnecessary expense and creates an avoidable risk to members rights to privacy and it constitutes an administrative burden for the agency. Encountered data is reported in a complex electronic format intended for consumption by a regulatory agency, not a healthcare provider. Given the provider's timely filing window of 180 days for claims submission, encountered data cannot be considered complete for at least six months beyond the date of service. There's also a provision that requires the department to develop uniform standards including standardized enrollment form, a uniform process for credentialing and recredentialing, However, each MCO follows the credentialing policy requirements of the National Committee on Quality Assurance. And beginning in mid-2016, throughout all of 2017, the MCO has provided extensive credentialing training and information for providers. The training presentations in fact are still posted on the Heritage Health Web site. The association fully supports efforts to simplify processes for providers and is already working toward that in collaboration with both MLTC and providers who actively avail themselves of the existing

quarterly forum called the Administrative Simplification Committee. As noted, LB835 is comprised of several somewhat subjective proposals, all of which are opposed by the association. In an attempt to outline the expenses to each MCO, health plan actuaries estimated this bill's provisions would cost the MCOs anywhere between $3.3 million and $9.3 million annually. And the capitation rate determination process sets forth in the contract provides parameters for consideration of additional expenses into annual actuarially sound rate-setting calculations. Increased program expenses beyond those in the plan's capitation rates would directly impact future rate setting. I want to also mention that LB835 also unnecessarily places constraints on determinations of medical necessity. The inability to review readmissions for more than 15 days from discharge for the same medical condition as stated in Section 4 and 4(c), and potential increased utilization as stated in Section 4 and 4(b) will directly correspond to increased risk to program integrity. In order to smooth this line, I want to just make one comment in summary and that is we believe that there will be an implementation expense associated with this new process, if it's adopted by the Legislature as well, and our review believes that the cost of the program changes alone would range from nominal to well over a million dollars. And with that I'd answer any questions you might have.

RIEPE: [01:08:35] Are there questions? Senator Crawford.

CRAWFORD: [01:08:35] Thank you, Chairman Riepe; and thank you for being here and testifying, and for providing the details in the written testimony as well. So you're representing the Nebraska Association of Medicaid Health Plans.

JAMES WATSON: [01:08:45] Correct.

CRAWFORD: [01:08:46] Do you also represent health plans in other states?

JAMES WATSON: [01:08:50] No, I do not.

CRAWFORD: [01:08:53] Okay, thanks. So I was really interested in what you discuss on page 5, because, again, what we're trying-- well, are multiple parts of the bill that, I think, one of the issues that we're trying to really do is simplify and streamline the process. And so I was very interested when you mentioned this Council for Affordable Quality Health Care Pathway.

JAMES WATSON: [01:09:17] Right.

CRAWFORD: [01:09:19] So I just want to make sure I understand what you're saying here. Is it true that if our providers sign up with this entity that all three MCOs accept that credentialing and wouldn't have to go through additional credentialing if they have completed their profile on this CAQH, is that what you're saying?

JAMES WATSON: [01:09:45] No, but the profile information would be available to be used, it's not that the profiling information is all there is, but if-- the information is contained there, the MCOs could use it. So it would have to speed the process up is the idea.

CRAWFORD: [01:10:02] Are the MCOs committed to doing that instead of requiring that information be submitted by the providers?

JAMES WATSON: [01:10:10] That's my understanding.

CRAWFORD: [01:10:12] But then each MCO has some additional things they might require.

JAMES WATSON: [01:10:15] Yes.

CRAWFORD: [01:10:16] So this does-- is not a silver bullet; I mean this is not-- help us with this problem in terms of if we just use this then there would be some one place for them to go?

JAMES WATSON: [01:10:27] No, not in and of itself.

CRAWFORD: [01:10:28] Not in and of itself. All right. And does this entity-- does it work for behavioral healthcare-- for behavioral providers as well?

JAMES WATSON: [01:10:37] Yes.

CRAWFORD: [01:10:37] Okay. Thank you.

RIEPE: [01:10:38] I have a question. Are you from Kansas?

JAMES WATSON: [01:10:45] No.

RIEPE: [01:10:47] Oh, okay, I thought you were. I wanted to quiz you if you if you knew anything about the Kansas process, maybe it was something similar to this. Maybe you know anyway.

JAMES WATSON: [01:10:54] Well, I know a little bit about the Kansas process as it currently exists, but not as it will exist in a new contract. I mean, I know that the Kansas state agency has an office of hearings and appeals that handles the state fair hearing process and it's very, very formal and they can do discovery and all the legal things that lawyers like to do. And in the actual matter itself is handled by the attorneys for the Kansas state agency. So, I mean, the provider would be in that context against state lawyers. I think it's-- Senator, in my opinion, it's cumbersome.

RIEPE: [01:11:35] As it's being implemented or it has been implemented?

JAMES WATSON: [01:11:37] It's been in existence for a long time in Kansas and I don't know, I'm not familiar with what they're doing, the new process that was discussed.

RIEPE: [01:11:46] Who defines the word "fair" if you know?

JAMES WATSON: [01:11:51] I think there are probably federal cases that would give some insight into it, but I really couldn't tell you for sure.

RIEPE: [01:11:57] Okay, just curious. Okay. Are there other questions? Seeing none-- oh, go ahead.

CRAWFORD: [01:12:02] I have a question. Thank you, Chairman Riepe. And one more explanation just so we understand where our parameters are in terms of streamlining. On page 4, you talk about a nationally accepted practice of providing HIPAA compliance response codes with a 835 file.

JAMES WATSON: [01:12:27] Right.

CRAWFORD: [01:12:30] Now is that some kind of, again, we're looking for streamlining opportunities. What is a 835 file and how-- how does it help with streamlining as far as standardization?

JAMES WATSON: [01:12:44] It's an electronic file-- it's an electronic file that was mandated by

HIPAA, the Federal Administrative Simplification Provisions and it has standard data elements. I can't tell you off the top of my head what they are, but it's a standard process where the claim is filed electronically, the 835 is generated as a response, and the provider should be familiar with an 835 file because I think they see them all the time.

CRAWFORD: [01:13:09] Earlier and we had some discussion about there being a recognized national claim kind of standard, and the question was could we have all three MCOs use that and standardize that, so it was similar kinds of information everyone is sending.

JAMES WATSON: [01:13:27] My understanding is that all the MCOs can use and do use the 835 file as a response.

CRAWFORD: [01:13:34] So it's your understanding it similar information required from each of them.

JAMES WATSON: [01:13:38] From each of them, yes. But I'm not saying that that solves the problem. I'm not saying that all, I'm just suggesting that they do use it because it's part of the federal law.

CRAWFORD: [01:13:47] Okay, thank you.

RIEPE: [01:13:51] Okay. Are there any questions? Thank you very much for being here, we appreciate it.

JAMES WATSON: [01:13:53] Thank you.

RIEPE: [01:13:53] Are there additional opponents? Is there anyone who is testifying in a neutral capacity? Okay. Senator Howard, you are welcome to close. And while you're coming up, I'm going to ask Tyler to read any letters into the record. And please tell us, Tyler, whether they are in support of or in opposition of if you would or can.

TYLER MAHOOD: [01:14:15] I have a letter signed by Mary Sullivan of the National Association of Social Workers, Nebraska chapter in support; Liz Lyons and Pat Connell on behalf of the Nebraska Child Health and Education Alliance in support; Marc Brennan on behalf of the Nebraska Speech Language Hearing Association in support; Kyle Kessler of the Association of Community Mental Health Centers of Kansas in support; and Kristin Mayleben-Flott of the Nebraska Planning Council on Developmental Disabilities in support.

RIEPE: [01:14:42] Okay.

HOWARD: [01:14:42] And I'll waive closing. Thank you.

RIEPE: [01:14:43] Okay. Thank you, Senator Howard. That said, that concludes the hearing on LB835. And with that we will move on to Senator Kuehn's bill, LB1057; and I know Senator Kuehn is here because I saw him. Welcome.

KUEHN: [01:15:01] Thank you, Chairman Riepe. Good afternoon, Chairman Riepe and members of the Health and Human Services Committee. I am Senator John Kuehn, J-o-h-n K-u-e-h-n, and I represent District 38 which is seven counties in the south central part of the state. And I'm here today to present a fairly straightforward piece of clarification legislation to Nebraska's prescription drug monitoring program, LB1057. If I could take a quick moment before I get into the details of the bill, I would like to take this opportunity to put on the public record and also thank and

recognize a number of the stakeholders that have been part of a really integral process in Nebraska's prescription drug monitoring program over the course of the past several years. The state of Nebraska has gone from a laggard to a leader in the area of prescription drug monitoring, being a national standard not only for the breadth and scope, but also the efficacy and efficiency of our state's prescription drug monitoring program. And that did not happen by accident, that happened through careful execution with a number of partners, including partners here in the Legislature, including the senators who have been working for years, in some cases through multiple generations of senators, to conceptualize this program, the assistance and help of this committee over the years in helping to refine and develop the legislation. I think it's important as we talk about this clarification language that we need to recognize the great partners that NeHII has been in developing this program which has become a national model. Kevin Borcher, Deb Bass have been outstanding partners for me as a senator to work with. I also think we have to recognize the contribution of Blue Cross Blue Shield in the NeHII program, in hosting our PDMP in a very unique model. So as we talk about some clarification language today and some technical cleanup, I don't want us to lose sight as a body, and certainly with this committee of the excellent work that has gone into developing a really model system for the entire nation and one that I think all Nebraskans can certainly be proud of. So with that, appreciate your, your graciousness in allowing me to express that. Today with LB1057, we're providing some clarification by striking a paragraph in current statute and rewriting it to provide greater clarity for interpretation and respond to a couple of unintended interpretations of the existing statute. So as you know, the purpose of Nebraska's prescription drug monitoring program is to prevent the misuse of controlled substances and to monitor for the care and treatment of the human patient. Nebraska's current statutes require that all dispensers, for example pharmacies, report all prescription drugs to the PDMP on a daily basis. One thing to note is that Nebraska statute does not differentiate between different types of pharmacies, including for example a veterinary pharmacy, a nuclear pharmacy, a medical gas pharmacy, a nursing home pharmacy, and so on. Because of this lack of statutory differentiation, an unintended

consequence of the prior PDMP legislation interpretation requires veterinary pharmacies, and I want to be clear, we're not talking about veterinarians, we're talking about veterinary pharmacies, to report all prescription drugs for their patients regardless of their species. This has included some non-human, non-control drugs which are being reported by these pharmacies to the system. There are approximately 20 different pharmacies that dispense primarily medications to animals, and you probably know these as Pets Choice Pharmacy, Petco, Vets Source, Heartland Veterinary Pharmacy. And I have a letter I will be submitting for you to look at and just get some firsthand example from, one, Animal Health International, which has noted one of the challenges that have been associated with the current system. The complication we're seeing has arisen because many of our animal prescription drugs do not have the NDC number which is used to identify a specific drug for human use. So without this number, the PDMP cannot identify the medications reported by these pharmacies and rejects the prescriptions which is causing an error in the PDMP data. While there is a need to identify and monitor the dispensing of controlled substances for the owner-client of an animal, there is no need to have pharmacies reporting on non-controlled substances. I don't think it's the intention of the PDMP to track antibiotics or heartworm medication for pets. LB1057 also removes conflicting language regarding the reporting of controlled substances by veterinarians. You may remember that last year LB223, which this committee advanced and which was passed by the body, changed the date for veterinarian implementation to report to the PDMP to July 1 of 2018. And the paragraph that is being stricken there is a reference to that January 1, 2018, date, which we are striking, so it provides complete statutory clarification for veterinarians that they will be dispensing Schedule 2 through 4 controlled substances beginning July 1 of this year. The third clarification is regarding the definition and the exemption around the term dispenser. The statute can be interpreted that a dispenser does-- dispenser does not include a person who provides for the delivery of a prescription drugs in an inpatient hospital or for emergency department care. This interpretation may potentially prevent a pharmacist who works in a hospital from gaining access to the PDMP. As pharmacists are an integral and necessary part of our healthcare team who routinely

check and utilize the PDMP, this clarification allows pharmacists in these situations to access the PDMP and provide valuable healthcare services to all patients in Nebraska. LB1057 is designed to correct these-- these unintended consequences that happen when you undertake a process of this magnitude and size so that the data that is reported to the PDMP is meeting its original intent. It provides for a cleaner more accurate information so that all providers can know what medications their patients are receiving. It also clarifies and cleans up language that continues to enable us to use this valuable tool for prescribers and pharmacists to prevent the misuse and abuse of opioids and other controlled substances, and to continue to serve as a powerful healthcare tool for all providers. With that I'm happy to take any questions that you may have. I know we have individuals who will be talking specifically about some of the technical aspects and operation of the PDMP who will follow. So with that--

RIEPE: [01:21:43] Do we have any questions? Is this your last hearing?

KUEHN: [01:21:49] This is-- yes it is.

RIEPE: [01:21:51] I'd like to say, at least I for one am sad.

KUEHN: [01:21:54] Thank you, Senator Riepe.

RIEPE: [01:21:54] But thank you for opening. And we will see if we have other proponents. Will you stay for closing?

KUEHN: [01:22:01] Absolutely. You bet.

RIEPE: [01:22:02] Okay, thank you, Senator. If you'd be kind enough to just state your name and

spell it [INAUDIBLE]. We know you, but--

DEB BASS: [01:22:22] Good afternoon, Chairman Riepe, and members of the committee. My name is Deb Bass, that's spelled D-e-b B-a-s-s, and I'm the chief executive officer of the Nebraska Health Information Initiative known as NeHII. I'm going to keep my comments very short here because they're-- they're very much along the same lines of what Senator Kuehn just shared with all of you. But just in closing, I'm going to say that we believe that Nebraskans benefit when their healthcare providers have valid data on the medications that their patients are taking. And that's just what this bill is intended to do to clean up that data. Better data will help with identifying adverse medical events caused by med errors. And that leads to safer and better outcomes at a lower cost for Nebraska. This bill will support those efforts. And I will be happy to answer any questions that you have.

RIEPE: [01:23:10] That was about the right length. [LAUGHTER] That was [inaudible]. Are there any questions?

DEB BASS: [01:23:16] I do want to say, folks, that we have been contacted by a number of states that are looking at similar legislation. This really is just an awesome experience for all of us that are working on this. I know for certain one bill-- one state has already introduced legislation and others are looking at it so thank you, awesome work.

RIEPE: [01:23:36] I know I too was at a national meeting and they shouted out Nebraska as being leading in this, so congratulations to you and everybody else that's been involved with it. So that's good. Thank you very much. Are there additional proponents? Seeing none, is there anyone speaking in opposition? Seeing none, is there anyone speaking in a neutral capacity? Senator Kuehn, we will call you back up to close. You're waiving. And Tyler, would you read in any

correspondence, we have letters.

TYLER MAHOOD: [01:24:09] Yes, I have a letter signed by Galen Frenzen of the Nebraska Cattlemen in support, and a letter signed by Dr. Thomas Williams of the Department of Health and Human Services in support.

RIEPE: [01:24:23] Okay thank you very much. It feels like a landslide. With that we conclude the hearing for LB1057. And we will move on now to legislative bill, LB968. And I think we're waiting for Senator Wayne. Do we-- we can maybe-- yeah-- okay. We're going to-- we're going to call-- we can take a little break if-- would everyone like a break until-- maybe five minutes or six? I'll give you six.

CRAWFORD: [01:25:03] Until five after 3:00.

RIEPE: [01:25:03] Who? What?

CRAWFORD: [01:25:03] Until five after 3:00.

RIEPE: [01:25:03] Oh, that's crowding six, but okay. You're a good negotiator. We'll take-- five minutes after the hour.

[01:25:14] [BREAK]

RIEPE: [01:25:14] We're going to reconvene the Health and Human Services Committee, if you will take a seat please. I know it's a family reunion kind of deal here, but we're going to-- again this is the Health and Human Services Committee. We have one very eager senator who wants to

present. And so with that we're going to invite Senator Wayne to introduce and open on LB968. Senator.

WAYNE: [01:33:20] Thank you. I just want to note that I'm sitting lower because we had to change out chairs because that chair has a defect in it and I didn't want the Chairman of Health and Human Services to have an injury in this committee hearing.

RIEPE: [01:33:35] Would you like to have a telephone book to sit on? [LAUGHTER]

WAYNE: [01:33:35] No. It just seems kind of weird. Good afternoon, Chairman Riepe. My name is Justin Wayne, J-u-s-t-i-n W-a-y-n-e, and I represent Legislative District 13 which is north Omaha and northeast Douglas County. LB968 will increase allowances permitted for people collecting Medicaid that is necessary for several reasons. But first and foremost is the way our law is written that disincentivizes people to work and disincentivizes people to take mere promotions at their jobs. Nebraska's disabled want to work; and as testimony follows-- following behind me will tell you that many times that they often can't work or they often can't take promotions to make their lives better because it is truly a cliff effect. As it stands today, a person collecting disability in the state is on the brink of poverty and most basically live in poverty because of this work restriction requirement. We are asking this body to take a look at this this year, and at a minimum have a LR study that we can really make some changes in regarding this area. The basic allowance right now is to low. The yearly allowable income for a single person is $13,860. You really cannot live off of that, and at the end of the day we have to make it better. As this body knows, we only make $12,000 a year and we often complain about that and many of us have other jobs or other income. This bill is very simple. It adds $7,000 a year for the allowable income for a single person. For a family of two, the current standard is $18,000. This would also increase it by $11,000 to roughly 30-- or $29,000-- roughly $30,000. I do want to take a brief moment to talk about-- and I am shortening up my testimony

because one of my mentors, Judge Thomas, is receiving a Pittman Award that started at three o'clock. I missed calculating how long the last hearing was going to take, but I understand it was an important issue for Senator Howard. So I respect that, but this is such an important issue that I had to stay down here and at least open on it. And I will waive closing, just for the record, and that is the reason why I'm waiving closing. But I do want to take a minute to talk about the fiscal note. A similar bill was introduced a couple of years ago, and the fiscal note was roughly $3 million. My fiscal note has jumped up to $72 million. I don't understand. Not much has changed in three years. We still get snow here, it still gets hot here during winter. I really don't know what has changed in that moat, but that is a situation where I'm asking, because I understand fiscal notes, and I understand where we are in the legislative process that I would implore this committee to have a LR study to look at how do we incentivize people to get back on the payrolls, to work and make sure that this cliff effect is gone. The Department of Health and Human indicated 2,564 people are going to rush to jump on Medicaid and get disability. I don't find that-- and that's part of their assumption in the fiscal note. I just don't necessarily believe that to be true. That is a huge assumption that I think death by fiscal note is a reality and why it was used. Again in 2013, Senator Gloor had a very, very similar bill, and that was significantly lower. Today they are saying they need 14 new staff to do this. I just don't believe that is true. And again, $70 million price tag was Senator Gloor's bill only had roughly a $2 million fiscal note is just-- I don't think it necessarily fair and draws in skepticism to how we got to that number. Again, my bill only applies to people who collect disability, who have the desire and ability to maintain a job. Of the people collecting disability in Nebraska, this is a small number, per se, and I don't believe that 2,500 will jump on the payroll. Again, this is a huge issue that we need to address; huge issue that I see day in and day out in my district. And close personal friends of mine are the reason why this bill was brought and then-- because they fall into this category, helped me craft a bill you'll hear from Edison later because he's familiar with this area a lot more. So I just need some expertise in this area to help me craft it, but the reality is the individual I know simply wanting to work as a grocer, bagger at Baker's on 72nd

and Ames and lost his benefits this year because he made over the amount. He was not aware; he knew the amount, didn't think that he was going to hit it. Got a couple extra paychecks where he thought he was making a little extra money so he can have some fun, go out to the movies, do some things, collected his end of the year calculation and said now I'm over. That's a huge problem. And a person who has been on disability for the last 10 to 15 years and simply took a part-time job and now he's struggling to figure out how this is going to work and how he's going to be able to maintain his rent and his medical needs that he has prescriptions for. So with that I'll answer any questions.

RIEPE: [01:38:58] Okay. Thank you, Senator Wayne. Are there questions from the committee members? Seeing none, oh, I'm sorry, Senator Linehan.

LINEHAN: [01:39:05] Thank you, Chairman. I feel some freedom to ask some questions since Director Thompson said nobody understands-- or nobody is an expert on Medicare. [LAUGHTER] Like oh, okay then. So can you provide us a copy of the fiscal note that you're referring to from two years ago. That would be very helpful.

WAYNE: [01:39:25] Edison has a copy of that and we will make sure that we have enough copies for the committee.

LINEHAN: [01:39:29] And I apologize for not doing my homework before you got here, but is this just so they can stay on Medicaid, or are you-- are there other benefits that you trying to increase.

WAYNE: [01:39:39] I believe it is just Medicaid. Like I said, I believe, because I read a couple times, but you just said nobody is an expert. But working with the experts in the field, and this would be a question for Edison when he comes up, because he helped me draft the legislation, I

believe it's just Medicaid.

LINEHAN: [01:39:52] Okay, thank you very much.

RIEPE: [01:39:54] That's not necessarily a matter of just staying on it, it's a matter of getting on it too, or just staying on it.

WAYNE: [01:39:59] Well, technically, according to their assumption, people could get on it. But when I originally approached the bill and contacted Edison for help regarding this, it was because of people I know who were getting kicked off.

RIEPE: [01:40:11] Okay. Okay. Thank you. Additional questions? Thank you very much. We understand that you have waived closing.

WAYNE: [01:40:17] Yes. And I just want to stress for the record, it is not because of the issue, it is because of a mentor, why I got to law school, and why I'm a practicing attorney of mine since the seventh grade who is getting an award and that's where I need to be.

RIEPE: [01:40:29] We applaud you for it. Additional proponents? If you would, sir, we've seen you before, but if you would state your name and spell it.

EDISON McDONALD: [01:40:44] Oh good. You don't know how to spell it yet? Hello, my name is Edison McDonald.

RIEPE: [01:40:53] We wanted to see if you change it.

EDISON McDONALD: [01:40:56] E-d-i-s-o-n M-c-D-o-n-a-l-d, and I'm the executive director for the Arc of Nebraska. Again, we're a nonprofit with 1,500 members covering the state. We're advocates for ensuring the most integrated lives for people with intellectual and developmental disabilities possible. We focus on community inclusion because it ensures that we are cost effective; focus on the best treatment possible, and it brings the most back to us as a society. We strongly support LB968, the Disability Employment and Engagement Program, DEEP, because it will help to ensure that people with disabilities can work more, gain independence, and contribute more to society. The bill will adjust the formula for workers with disabilities, thus ensuring they're able to work without risking losing lifesaving benefits. The current law places them into a category where at best many can work part-time jobs making a low level income. At worst, the current law discourages people from working altogether because they risk losing their benefits altogether. The navigation of this complex system leaves many confused and unintentionally crossing lines that would be devastating to their well-being. We would like to expand their opportunities to ensure they can work without being tripped up under red tape. I've traveled the state hearing stories of individuals all over who have had this exact same problem. It's frustrating to hear these stories of people who would rather work than sit around at day programs. Yet they are unable to because they get the medications and support that enables them to be in a condition of work. The law as it stands, encourages the continued cycle of poverty. The issue is particularly difficult given that many positions the people with disabilities are offered are seasonal or short term in nature. Currently, there is a trial work period that was designed for people who are going to-- go into work and allow them a trial without losing benefits. Unfortunately, this trial period is only good for one use and is designed for people who are looking to go into a permanent position. This makes it nearly impossible for them to do short term, seasonal, or contract work because they may have a short-term increase in income, but that doesn't mean that it will continue. Prime examples include positions in parks, retail, call centers, or real estate. Today I'll also speak as a former employer who's hired people with disabilities. They are some of the hardest working and most dedicated

individuals that I've had the pleasure to manage. With one in particular, we ran across this issue on several occasions. The first time I wanted to promote her, I was shocked to hear her say I don't know if I can. What employee who is hard working, has excellent attendance, and stellar performance would even consider turning down a higher salary and a promotion. Yet this is a story I've heard from many others in Norfolk, Kearney, Lincoln, Hastings, Omaha. Let's get out of their way and ensure that they can work. Once they do exceed these income levels, they pay a premium that is reasonable. This concept ensures that they have more skin in the game without losing benefits that ensure that they can work. We are removing the disincentive. Instead it will be replaced with a moderate premium of 7 percent for unearned income and 3 percent for earned income. Now this is a clear commonsense program that enables individuals with disabilities to work more and contribute to society. However, the clear concern is going to be the giant fiscal note that was attached a few days ago. Despite discussing this with the department months ago, we see a late fiscal note that seems highly questionable. This attempts to display the program as a significant new cost. The reality is that these costs are being spent regardless. Most recipients are already receiving benefits, but they are unable to work. The administrative costs seem closer to reality, but still inflated. This also fails to take into account the massive amount of new added tax revenue, by their estimates, 2,564 workers to our economy. Even at a lower level, we're talking about 51 million in a new tax basis, and that's just from a quick back of the napkin math. The department really has a concern. We'd be open to the idea of an amendment requiring that they already be receiving benefits or that they receive benefits for one to five years so you don't have new people coming onto the program. Instead it's just limited to the people who are already on the program and ensuring that those people can work. Please support LB968. I'll take any questions.

RIEPE: [01:45:30] Are there questions? Senator Crawford.

CRAWFORD: [01:45:31] Thank you, Chairman Riepe. As I understand what you were just talking

about, about many of the people who would benefit from this program are already on Medicaid.

EDISON McDONALD: [01:45:45] Um-hum, yep.

CRAWFORD: [01:45:46] So already on Medicaid.

EDISON McDONALD: [01:45:47] Yes.

CRAWFORD: [01:45:47] And are most of them already in a buy-in situation or is it kind of a mix?

EDISON McDONALD: [01:45:52] No. Currently on the MIWD program, I think this-- like less than 100 people.

CRAWFORD: [01:45:59] Okay. And are they-- a hundred are in some kind of buy in.

EDISON McDONALD: [01:46:05] Uh-uh.

CRAWFORD: [01:46:06] And then how many others are you thinking that are in this pool.

EDISON McDONALD: [01:46:10] I mean, you know, the department's estimates are around 2,500; but from my interactions with people, I think that it could be a lot more. Everywhere I go, I see people who are running into this issue. Maybe there are pieces that won't necessarily apply, but I think the general piece of this program has huge implications.

CRAWFORD: [01:46:34] Do you see in the fiscal note where they account for the fact that more people will be paying premiums now? I mean, more people will be paying into the system now,

where now they don't work so they don't have to pay this.

EDISON McDONALD: [01:46:45] I don't think it accounts for that. I don't think it accounts for that in tax basis. I don't think it accounts for the added sales tax of these people now being able to contribute more. And it definitely doesn't account for the added life value of people being able to contribute to their community.

CRAWFORD: [01:47:02] Sure. Which We all value, but unfortunately that doesn't usually get in--

EDISON McDONALD: [01:47:05] Doesn't come across in a number well.

CRAWFORD: [01:47:09] The direct premiums back to the program as the kind of tangible or direct benefit you would hope would be reflected.

EDISON McDONALD: [01:47:16] Yes. Yes.

CRAWFORD: [01:47:17] Thank you.

RIEPE: [01:47:19] Okay, other questions? Seeing none, thank you very much. Next proponent please. If you would be kind enough to state your name and spell it and then tell us the organization you represent.

JENNIFER JAMES: [01:47:45] Good afternoon, members of the committee. My name is Jennifer, J-e-n-n-i-f-e-r, James, J-a-m-e-s. I am supporting myself and others like me. I'm in favor of LB968. Just because people with disabilities want to work more or get a raise doesn't mean they should lose their benefits. They still need them. In my situation, I worked for one month and had a temporary

job and they messed up my benefits for three months after. If I hadn't been able to stay with my mom, I would have been homeless. The landlords and other people that you give-- that you have to use for your benefits are not going to listen to-- hey I have to wait for my benefits. I was very lucky to be able to live with my mom and be able to still be independent. They did eventually give me back my benefits, but it was a lot of work and a lot of paperwork to do. So it discouraged me to find a job. I don't want to lose my benefits. And I'm disappointed that people have to have these problems. They shouldn't have to not have a job to improve their life and with the threat of losing their benefits. We have enough hoops to jump through already just to get a job and try to keep it without having these problems. So we need to not have these barriers to prevent us from being able to support ourselves and live more independently than we do now. So I ask you to move LB968 out of committee. Thank you for your time and if you have any questions, I'd be happy to answer them.

RIEPE: [01:49:42] Thank you. Thank you for stepping forward and presenting to us today. Are there questions from the committee? Okay, seeing none, thank you again. Opponents? Or proponents, I'm sorry.

AUDIENCE MEMBER: [01:49:51] One second.

RIEPE: [01:49:51] Okay. [01:49:51] The [0.0] mikes are real sensitive; are you able to state your name and spell it?

AUDIENCE MEMBER: [01:49:51] Hold on just a second. She was moving out of the way for Michael to testify. So no, Michael was going to testify.

AUDIENCE MEMBER: [01:50:36] I'm sorry, that was my mistake. Okay, can you go over that way so Michael can--.

AUDIENCE MEMBER: [01:50:36] Yeah.

AUDIENCE MEMBER: [01:50:36] Thank you. I'm sorry, I apologize.

RIEPE: [01:51:18] Michael, thank you for being with us. Are you able to spell your name.

MICHAEL WARNER: [01:51:23] Yes sir, I can.

RIEPE: [01:51:24] Okay, thank you, sir.

MICHAEL WARNER: [01:51:25] M-i-c-h-a-e-l W-a-r-n-e-r.

RIEPE: [01:51:33] Very good, thank you.

MICHAEL WARNER: [01:51:34] I am speaking as a proponent of LB968. Full disclosure, I am a board member of Disability Rights Nebraska, but I am speaking independently of them today. I am so honored to be able to speak with you today about an issue that is very near and dear to my heart. In 1986, I was born and diagnosed with cerebral palsy. At that time, my parents, specifically my mother, was given two options. Number one, institutionalize me; or number two, take me home and raise me as what I was to her, her son. She chose the latter, and in that choosing the latter she also chose to teach me that there is no barrier on what I could do for my country or for myself if I put my mind to it. I'm very saddened to say that the overall government does not seem to share that same vigor for me to want to be a contributing member of Nebraska's society, specifically, but also national society. I do not understand how it is feasible for you to say that I am fully welcomed to being a contributing member of Nebraska's society, but then you put an unjust cap on what it is that

I'm allowed to make. Therefore, making me fearful to work because I cannot lose essential benefits that I need to survive. My mother wanted me to do the best with what I could. And that is simply all I'm trying to do. With that I yield to you and would be happy to answer any question that you have.

RIEPE: [01:54:20] Thank you. Thank you, Michael. Are there questions from the committee? I don't see any. Thank you very much for coming. I know that it takes extra effort and we appreciate it very much.

MICHAEL WARNER: [01:54:32] Thank you very much.

RIEPE: [01:54:32] Thank you, sir. Now we'll take additional proponents as we get an opportunity here. Thank you for coming. Welcome. And if you'd be kind enough to spell your name for us and state it so that we have it for the record.

SHARON ORDUNA: [01:54:58] Good afternoon, senators. My name is Sharon Orduna. It's spelled S-h-a-r-o-n O-r-d-u-n-a. I am here to testify in support of LB968 on behalf of the Nebraska Planning Council on Developmental Disabilities. Although the council is appointed by the Governor and administered by the Department of Health and Human Services, the council operates independently and our comments do not necessarily reflect the views of the Governor's administration or the Department of Health and Human Services. We are federally mandated, independent council comprised of individuals and families of persons with developmental disabilities, community providers, and agency representatives who advocate for systems change and quality services. LB968 creates the Disability Employment and Engagement Program Act. LB968 will ensure that individuals with disabilities who seek higher wages and/or additional work hours can do so without losing their benefits through Medicaid that are essential to their health. The council is supporting the legislation, as employment is one of the goals of our current state plan. We

believe that systems change is needed in order to provide increased opportunities for more individuals with intellectual and developmental disabilities of diverse identities to pursue an employment path of their choice. Individuals with disabilities should not be punished for wanting to work more hours or even accept raises. As a family representative who serves on the council, I am personally familiar with the challenges and barriers that individuals with disabilities encounter as they navigate the system to find and keep employment without sacrificing their essential benefits. People with disabilities want to and they have the ability to work and contribute to their communities. Unfortunately, the current law disincentivizes that and a change is needed. I am here today to give you my voice of my family's personal journey with disability and medical challenges. Our daughter, Kiera, 23, was diagnosed at four and a half years old with autism spectrum disorder. Autism impairs the ability to communicate and also interact with others. My husband, Paul, and I are both veterans of the military. Paul served four years in the United States Navy and I served 11 years in the Air Force Reserve; three of those years in support of Operation Desert Shield and Desert Storm in the early 90s. Both of us are college graduates, but nothing, absolutely nothing could have prepared us for the journey with our daughter's diagnosis of autism. It took more than four years to get her diagnosed, and today because of the advocacy of parents, autism can be identified as early as six months. Along with the diagnosis of autism, we have faced other serious medical challenges. Anxiety has accompanied the diagnosis of depression with Kiera, but recently a neurologist in Georgia added the diagnosis of postural orthostatic tachycardia syndrome, in short it's called POTS. What POTS does, it describes that too little blood flow returns to the heart when Kiera moves from one position to another such as lying, sitting, standing. We have been fortunate to assist Kiera in finding employment to gain practice with some of the deficit scales that she has in social-- social skills. Kiera works at a restaurant in the Aksarben area of Omaha as a hostess. Her position allows her to greet guests and also clear tables after the guests have completed their dining experience. As parents, we made sure that the owners were aware of her diagnosis of autism and they pledged their assurance to us and teaching to her deficit areas. Kiera loves to work. This is

what she observed from her classmates that she was going through her high school experience. Now even though Kiera has medical conditions that demand constant monitoring, she will not allow those medical issues to keep her from her job. She is loyal and will not call out sick if she is able to go to work. Kiera works approximately 9 to 12 hours a week at a rate of pay of $9 an hour. As her parents and guardians, we are mindful of the hours that Kiera can work before she is in jeopardy of losing health benefits that we desperately rely upon. I have also advocated for a young man who works at Eppley Airfield. He loves his job and his employers love him. He has proven himself to be a valuable and a valued employee. He would work more hours if he was able to, but because of the limitations on the number of hours that he can work before losing his benefits, he becomes so anxious about not going over those hours that his anxiety literally keeps him from going to work for several days. The limitation on hours and wages has put a tremendous amount of pressure on him and his family. Individuals like Kiera and this young man should not be forced to choose between working and keeping medical benefits. As we the parents get older, please help us ensure that our children would not have to make a choice between working more hours on a job they love or cutting back on hours just to keep their health benefits. I urge you today to support LB968 so that our children would not have to make such a choice. Thank you so much for your time and consideration, and I'll entertain any questions that I can.

RIEPE: [02:01:38] Thank you very much. And thank you for your service both to the Nebraska Planning Council on Developmental Disabilities and also for wearing the uniform of the United States Military.

SHARON ORDUNA: [02:01:51] Absolutely, my pleasure, sir.

RIEPE: [02:01:52] Thank you. Are there questions from the committee? I'm especially fond of your husband, I too was a Navy sailor. You get an extra point there.

SHARON ORDUNA: [02:02:05] Oh, thank you, you don't want to go there, sir. I'm Air Force.

RIEPE: [02:02:15] I surrender. Thank you very much. We appreciate it.

SHARON ORDUNA: [02:02:17] Thank you, sir. Thank you, Committee.

RIEPE: [02:02:17] Additional proponents? Welcome. Thank you, and if you'd be kind enough to state your name and spell it.

LINDA JENSEN: [02:02:17] The chair is a little low for-- I'm Linda Jensen, L-i-n-d-a, Jensen, J-e-n-s-e-n. I'm speaking in support of LB968. And I want to thank you for your attention to this important issue. I'm currently on the board of directors for NAMI, the National Alliance on Mental Illness in Omaha; and co-chair of the Mental Health Action Team for OTOC, which is Omaha Together One Community. I won't repeat what a lot of other people have said because I definitely agree with it. I've done studies of people with various disabilities and they're all just wonderful, courageous people who really want to work, but they are so concerned about losing the medical care they need. And one of these people is my son, who has paranoid schizophrenia. He was diagnosed 26 years ago, and he's had plenty of hospitalizations and violence and whatever else that people with schizophrenia have before the medication controls the illness. He's had-- he's been on Medicaid since about 1992, and then on Medicare for a period of time. The last 15 years, he's been fairly better because his doctors found a medication that worked. However, it's very expensive and has the danger of a granular psychosis. So he has to have monthly blood tests for that because it could be fatal if it wasn't discovered in the early stages. So he's worked part time and then full time some in the mental health field. Not quite enough to earn income to become what you call self-sufficient because his medications and care would cost about $2,000 a month. We provide a lot of

functional supports: laundry, cleaning, maintenance of living quarters, cars, you know, like Orduna said, the different things that you do to help your loved ones be employed. In 2010, he was notified that Medicare would no longer cover his medical expenses because he had not received the SSI or SSDI payments. He had been on Ticket to Work and he had made-- his income was slightly over the amount that they allow, but he really wanted to work at that level. So he should have been at that time considered for the Medicaid insurance for workers with disabilities under 1619B. However, the HHS workers and the hearing officer did not understand that law and so he was without Medicaid coverage for several months. And we looked for all the free meds we could get and all the assistance. Then in 2012, the state review team decided he was permanently disabled because he would always acquire this heavy medication and he was eligible for Medicaid again. They said at that time he didn't have to be reviewed again. But in 2016 they started reviewing again and-- because now they review annually each person that has Medicaid due to a disability which must be quite a few people. So during a period of regular employment, my son became eligible to contribute to a 401(k) with matching percentages from his employer and did accumulate some funds in a health savings account. But those can only be used for medical expenses, as most of you know. However that health savings account is counted as part of his $4,000 asset limit. So it's like you give up the health savings account for-- do you have any-- or do you have $500 in your bank account and hope that nothing else happens. So that asset limit would really be helpful, because, you know, how can you buy a car or even make a down payment on a home. So actually we had to go ahead and cash out the 401(k) to keep the restriction down. We wanted to roll it over into an enable account, you know, which that was established a few years ago, but there are some problems with that. There was no way to do that, for one thing, they said there was no process. And actually there is no physical service place. There's not an office in Nebraska where you can go one open an enable account; you have to do it all online. You have to mail the checks to them. It's-- it's really a weird process, not real helpful, it doesn't seem like, not user friendly. So include that in-- in the review too. Now again, we're involved in a hearing with HHS because the state review team this

year-- last year they say he was still disabled, this year they say he's medically improved and his disability is not the severity to receive Medicaid. He still needs all the medications, still needs all the care, but it's not that severe they said. So I don't know if they think we can quit doing it or not.

RIEPE: [02:07:46] Dr. Jensen, we've reached our time limit. Can you kind of draw together in some conclusion.

LINDA JENSEN: [02:07:51] Yeah, basically that's all I wanted to say. I did-- when I went to the HHS Office, I do want to bring this out, they-- the worker said, I have never heard of this program, the Medicaid Insurance for Workers with Disability. And actually at the hearing one of the people who is an HHS personnel said I've never heard of the Ticket-- I'm not familiar with Ticket to Work or work incentive programs.

RIEPE: [02:08:19] Okay. Thank you. Let's see if we have any questions from the committee. Before you run off, just a second, let's see-- do we have any questions? Senator Linehan.

LINEHAN: [02:08:28] Thank you, Chairman Riepe. So thank you very much for being here. So your son is diagnosed with schizophrenia, but he's now on medication that seems like he's in a good place and he can work.

LINDA JENSEN: [02:08:41] Well, he's in a good place. It does not cure it.

LINEHAN: [02:08:45] I got it.

LINDA JENSEN: [02:08:46] He still has-- still has symptoms, still has, you know, he gets really tired from the medication.

LINEHAN: [02:08:52] He still has schizophrenia.

LINDA JENSEN: [02:08:54] He still needs help.

LINEHAN: [02:08:56] Right. So the good news is he's got medication, so that's incredibly wonderful.

LINDA JENSEN: [02:08:59] Yeah, good news on the medication. So, you know, keeping him out of the hospital and also out of prison.

LINEHAN: [02:09:06] Yes. So has he been able to, and I have great empathy for you being here and I really appreciate you being here. Is he-- has he looked at any of the programs, and I can't-- I'm going to-- slipped my mind what they call-- for-- the site you have-- kids who can't get insurance and then they went to the exchange, has he been able to use the exchange at all, or is that just...

LINDA JENSEN: [02:09:29] WE haven't-- we haven't looked at that yet, but we-- I'm sure will be.

LINEHAN: [02:09:34] Okay. All right, thank you very much for being here, appreciate it.

RIEPE: [02:09:38] Thank you. Thank you very much. Next proponent please. I see some hand signals being called over here. If you would, sir, please state your name, spell it for us please, and who you represent, if you represent someone other than yourself.

JOSHUA WALLACE: [02:09:55] Yes, sir. Good afternoon, Senators; my name is Joshua Wallace and-- J-o-s-h-u-a W-a-l-l-a-c-e and I represent LB986. And I am-- I am here as a concerned citizen

who lives in Omaha, Nebraska, other than Douglas County. Please support LB968. This bill would also-- sorry, what this bill would allow individuals like me to be able to work through the 40 hours a week without using medical eligibility. Right now I work 14 hours a week. Every time I work more than 14 hours a week, I lose my Medicaid. Twice I was living in an extended family home where my provider was not paid for three months and I could have lost my residential support, my aide, my day service support and my medical support so I could have been homeless. But I could have lost Medicaid, but this may not only help this-- Medicaid not only helps with my medical needs, it helps me receive support I need at home to help me live as independently as possible. DEEP would help me build on my independence. Please support LB968. Thank you for your time and I'm open to ask any questions.

RIEPE: [02:11:32] Thank you. If you'd just stay right there. Are there any questions from the committee? Seeing none, thank you very much for being here. Additional proponents? If you'd be kind enough to give us your name and spell it and tell us the organization you represent or yourself.

JASZMIN DEFREITAS: [02:12:00] My name is Jaszmin Defreitas, it's spelled J-a-s-z-m-i-n, and the last name is d-e-F-r-e-i-t-a-s. And I'm really here representing myself and other people in my situation. I'm here today in support of LB968. I don't doubt this bill is going to significantly improve the lives of many residents of Nebraska. In 2013, I completed my bachelor's degree and two majors and two minors. In 2015, I obtained a master’s degree in public administration. Presently, I work part time as a retail cashier for an hourly rate of $9.40 an hour. A part-time retail position being compensated the same amount as high school students is not a career path I chose. Years ago I was diagnosed with intractable, uncontrollable permanent seizures. Shortly after receiving this diagnosis, I was physically unable to hold any job. After years of trial and error with medications, I've managed to maintain employment in this position for two full years. In the last two years, my managers have offered me better opportunities within the company. The most recent

of which was taking on the role of manager for the store's framing department while the current manager took maternity leave. I really did want to accept this offer, but despite that I could not accept, the position would have been ideal because it would have given me the opportunity for some advancement. I don't have a way to test my abilities to see how much further I could push myself in the workforce. Unfortunately, I was uninsured and I was trying to seek approval for benefits and I knew there was no way that that would happen while I was temporarily in this position. My ultimate goal is to work full time. I do eventually want to utilize the degrees I've worked so hard to maintain-- obtain, I'm sorry. Unfortunately, I know that going from working 12 hours a week in an unskilled position to a full-time skilled position is not going to be a simple transition. The main problem I face when considering a promotion or seeking other employment is the fact that I have no way of knowing if I can physically handle the work. I'm literally forced to decide whether the opportunity is worth the risk to my health. And when I say a risk to my health, I'm not just referring to my physical capabilities. The smallest raise, promotion, new job, it can result in me losing the ability to control my medical condition entirely through lack of healthcare. Around the same time I turned down that previously mentioned promotion, I had to call my mineralogist explain to him, no, I can't attend follow up; I don't know when I'll be up to go to my next appointment because I don't have the money to do it. I'm prescribed seven medications a month. All together they cost about $600 in the generic format; and that's up to the pharmacist to apply every discount card he can give me. A one month supply of the one generic version of a prescription is approximately $200. That's more than I make in two weeks. Without health coverage, appointments with specialists, routine blood work, required medical tests, it's not financially feasible, especially with a minor promotion. So accepting a promotion would actually cost me more than I make. Furthermore, my inability to take steps necessary to control my condition would almost certainly lead to my inability to hold any job anyway. Even if I were to accept a raise, my medications would cost more per month than I earn. Additionally, the necessary testing and trips to the emergency room are not financially feasible. Every time I have a seizure,

they last around 5 minutes. I'm supposed to, according to my neurologist, go to the ER. I've not been able to comply with that admittedly because it costs too much money. It's a $3,000 bill, taking an ambulance, I can't do it. As of this moment, if I were to take every penny I earn at my job, put the funds towards paying off over $12,000 in medical debt, after years I'd still owe money. And I do want to pay off this debt ; I don't want to owe these facilities money. The passage of LB968 will allow individuals like myself the opportunity to test our abilities in the workforce, build a work history so perhaps maybe one day I can resume full-time work. The fear of losing benefits forces individuals such as myself to choose between attempting to gain independence and our actual survival. Thank you for listening.

RIEPE: [02:17:02] Okay. If you want to hold on there just a second. You look like you were going to dart out of there.

JASZMIN DEFREITAS: [02:17:03] I'd like to.

RIEPE: [02:17:04] We'll see if there are any questions from the committee. Senator Linehan.

LINEHAN: [02:17:10] Thank you, Chairman Riepe. And thank you very much for being here. So are you on the Medicaid program now?

JASZMIN DEFREITAS: [02:17:16] No, not at this moment, no.

LINEHAN: [02:17:18] You were on it and you lost the benefit?

JASZMIN DEFREITAS: [02:17:20] I've gone back and forth on it. It's been a mission.

LINEHAN: [02:17:23] Okay. Okay. All right, thank you very much.

JASZMIN DEFREITAS: [02:17:29] Sure. Anyone else?

RIEPE: [02:17:31] Thank you so much for being here.

JASZMIN DEFREITAS: [02:17:32] Yeah, you're welcome.

RIEPE: [02:17:34] Next proponent please. If you will, sir, your name and spell it.

BRAD MEURRENS: [02:17:52] Boy! Good afternoon, Senator Riepe and members of the committee. For the record my name is Brad, B-r-a-d, Meurrens, M-e-u-r-r-e-n-s, and I am the public policy director for Disability Rights Nebraska, the designated protection advocacy organization for persons with disabilities here in Nebraska. And I'm here today in strong support of LB968. While policymakers tout the individual and collective benefits of competitive employment, Nebraska continues to ignore and has refused to act substantively on ways to improve the employment of its citizens with disabilities. Many Nebraskans with disabilities want the opportunity to work, want the opportunity to take a better paying job, or want the opportunity to take a promotion or a raise. However, individuals with disabilities who rely on Medicaid for-- here in Nebraska for their essential healthcare needs face a draconian decision when seeking any of the aforementioned opportunities, either be gainfully employed and jeopardize eligibility for Medicaid or stay unemployed with no risk of their Medicaid coverage at a 45 percent cost to the state. In other words, Nebraskans with disabilities have to finesse a very fine line that is truly unique to them-- try to get a job and earn a good wage, but don't make too much money lest you be deemed ineligible for Medicaid. For many people with disabilities, Medicaid is the only healthcare coverage they can get, or is the only healthcare program that meets their unique healthcare needs. Thus many people with

disabilities who want to work, get a raise, or take a new or better job are stuck in a state of forced dependency. It is often very easy to label these individuals as takers or to just get a job. However it is often not that easy for Nebraskans with disabilities given the mix of social and employer attitudes toward people with disabilities, as well as the systemic policy structures that directly inhibit or discourage employment. Nebraskans with disabilities have an employment rate about half of their peers without disabilities, and 31.9 percent of Nebraskans with disabilities age 21 to 64 were employed full time, full year; whereas 67.6 percent of Nebraskans without disabilities were employed full time, full year. LB968 presents an opportunity for individuals with disabilities who are already receiving Medicaid benefits to get a job or a better paying job without the scare of losing their Medicaid coverage. LB968 presents a long overdue opportunity for Nebraskans with disabilities who are working or want to work to escape this forced dependency. LB968 would allow them to save and to earn a good living which has a myriad of beneficial effects both individually and collectively. LB968 allows more Nebraskans with disabilities to have skin in the game economically though through increased wages, taxes, and sliding scale premiums. Although it would seem that since Medicaid is their lifeline, they already have the most skin in the game. However, we would suggest one small change in the language on page 4, subsection G, lines 3 through 6. We would prefer that the subsection to read, quote, one representative from the designated protection and advocacy organization in Nebraska. And so to clean up the individual with disability's program created by the five federal-- so all that language just leave it at: the designated protection and advocacy organization in Nebraska. That's-- that's just the phrase that we prefer to use. So we strongly recommend that LB968 be advanced. And I'd be happy to answer any questions that you would have at this time.

RIEPE: [02:21:57] How many other states currently provide this program?

BRAD MEURRENS: [02:21:59] I'm trying to recall the data, the research, I would say of the

majority of them do, but don't quote me on that, I'd have to go back-- have to go back and look at the total cumulative number. But I think we're in the majority that have a situation like this, either a Medicaid buy in program or Ticket to Work program or have a-- have those differentiated asset limits and income limits.

RIEPE: [02:22:28] Okay. Senator Linehan.

LINEHAN: [02:22:30] Thank you, Chairman Riepe; and thank you very much for being here. So I'm just trying to get-- if you-- so you are disabled and fully disabled because that's the way you would-- you can't-- it's hard to get Social Security benefits unless you can prove you are completely disabled. Right?

BRAD MEURRENS: [02:22:46] Yes.

LINEHAN: [02:22:46] So most the people that are on Medicaid that are adults have been-- they qualify for Social Security, they're considered fully disabled. Generally? Great.

BRAD MEURRENS: [02:22:55] Well, you know, that will be-- that's a good question. I'm not sure if that holds true for everybody that's on Medicaid. I think that there might be some other folks that would come after me would have more specific definitive data on the relationship between Social Security benefits and Social Security designation of disability and Medicaid. I don't-- I don't believe that you have to have both.

LINEHAN: [02:23:16] Okay.

BRAD MEURRENS: [02:23:16] But again I'm not the Medicaid expert.

LINEHAN: [02:23:19] Okay. So--.

BRAD MEURRENS: [02:23:22] And I certainly don't hold myself out to be, and I know just enough to be dangerous.

LINEHAN: [02:23:27] Okay, I will ask-- I'll wait. Thank you very much for being here.

BRAD MEURRENS: [02:23:33] Sure.

RIEPE: [02:23:33] Okay. Any other questions? Seeing none, thank you very much for being here.

BRAD MEURRENS: [02:23:37] Thank you.

RIEPE: [02:23:37] Additional proponents? Please come forward. If you would, have a seat and tell us your name, spell it please, and the organization you represent or yourself.

RYAN NEAL: [02:24:00] Thank you. My name is Ryan Neal, R-y-a-n N-e-a-l. I am a board member of the Arc of Nebraska. I am here also representing Region 5 Services. I am a community worker incentives counselor for the Social Security Administration as a community partner, so I do have Social Security training. And that's sort of the angle I'm going to approach this from. As a work incentives counselor, I have an agenda. My agenda is I want people to have jobs. I want people to have jobs because it improves their quality of life and it also reduces their dependence upon benefits which is savings to both state and federal systems. There are a number of barriers that people face, people with disabilities face when they're looking at employment. There are perceptions of certain employers, there are perceptions about the costs of accommodations. But I

think the biggest one we're concerned about here today is the fear on the part of people with disabilities about losing their benefits based upon the unpredictability and lack of transparency of the Social Security and Medicaid systems. I think that the disability employment and Engagement Program Act really provides a more certain framework and a more fair and predictable system for people to look at and know how to operate within. One of the biggest difficulties people face is just this labyrinth of rules and regulations that you have to try and navigate when you're attempting to work and manage your benefits. And to be very clear, the way the system seems to be set up, the poverty line is the baseline, that is where people's countable income seems too often be dropped to when they're dealing with our state Medicaid system. But I want to talk a little bit about why people were-- people with disabilities and people who received benefits in Medicaid is a good thing for the state of Nebraska. Okay, I want to talk about the positives. If people begin to work, if people begin to increase their hours, and people take-- begin to increase their income, they tend to spend this in their local communities. They pay income tax at the state and federal level. They pay sales tax. All these things filter into the cost of their services. A person who receives what is called supplemental security income, or SSI, reduces the amount they draw from the general tax fund. They also add to it through the payment of income tax. Once again, paying for their own system and supports. As employees gain hours, they become eligible for benefits such as retirement and insurance if they are allowed and encouraged to work more hours and to work up to the level of their capacity. This, in turn, reduces the burden on Medicare/Medicaid, SSI, and the Social Security trust fund. They begin to pay FICA taxes. They begin to earn credits and quarters of coverage. Workers are entitled to Social Security benefits which replace their SSI. This also is an incredible benefit to taxpayers. Once a person draws SSI, they become eligible for Medicare reducing the burden on the state's Medicaid system. Additionally, they also incur Medicaid share of costs under which they pay a portion of their Medicaid, further reducing the burden; and they also will pay a Medicare copay. So basically, if people are allowed to work through this system in a more predictable way, if they're allowed to work to their capabilities, they pay for more and more of their benefit themselves. I

consider this to be an incredible, an incredible benefit to this. I can't calculate what the cost savings would be. I was really looking for the idea of how a person would be against the DEEP Act and, well, then $72 million was loaded and I guess that's a pretty good reason. But I look at this as you're going to have short-term costs; you're going to have cost increases if this law passes in the short term. This is an investment. This is an investment in the people in Nebraska. And I think it's one that will eventually pay off fiscally as a responsible choice. That's pretty much what I have to say.

RIEPE: [02:28:36] Okay. Let's see if we have any questions. Senator Crawford.

CRAWFORD: [02:28:41] Thank you, Chairman Riepe. And thank you for being here and presenting. So on the one hand, we're talking about increasing amounts one can earn.

RYAN NEAL: [02:28:49] Yes.

CRAWFORD: [02:28:49] So key benefits. But then you also mentioned the importance of transparency. So is there some other components of the bill that are important that are changing that system, or is it-- or is-- or is it mainly just the importance of making sure that line is pushed up a bit so people have more room to work?

RYAN NEAL: [02:29:11] You know, it is a little bit of both. The pushing the lineup is good. There's also of course the benefit of having a state law come out and that does tend to encourage employment, both on the part of potential employees and also on the part of employers. It seems pretty counterintuitive, but the more you protect a person's benefits, the more likely they are to take a risk and work. The more you make the system uncertain and dangerous to navigate, the more people tend to hold on to what they have.

CRAWFORD: [02:29:42] Thank you, that's very helpful.

RIEPE: [02:29:46] Okay. Any other questions? Seeing none, thank you very much.

RYAN NEAL: [02:29:47] Thank you.

RIEPE: [02:29:49] Do we have additional proponents we'd like to hear from? Thank you for being with us. If you'd be kind enough to state your name, spell it for the record please, and then proceed forward.

DAN BAUERLY: [02:30:20] Certainly. Hi. My name is Dan Bauerly, spelled D-a-n B-a-u-e-r-l-y. I'm here in support of LB968. I'm here representing myself as an individual. Here to just share my experiences with Medicaid and my employment history as well. I am a quadriplegic due to a spinal cord injury I suffered from motor vehicle accident almost 18 years ago. I've since earned a bachelor's degree in education, and then years later also earned a master's degree in youth development. Since then I've worked odds and ends part time jobs from-- with after school programs, with after school rec for the parks and rec or through family services also. Lately, for the past seven or eight years, I've been working for a nonprofit agency here in Lincoln. I started out working 20 hours a week simply because I didn't want to lose my benefits, and-- and-- although I've been offered several times from my employer to expand on those hours, as well as my wages, I was given the opportunity to expand my hours to 30 hours a week, which I did, which kicked me off Social Securities, which was something I wanted to do, was something I worked towards. I didn't want-- I did not want to receive Social Security benefits anymore. However I must maintain Medicaid simply to help me. Medicaid is a central part of my life because I require Medicaid to-- to cover benefits such as-- or not benefits, but expenses such as home health expenses which allow me to remain independent, live on my own, and am able to keep, you know, maintain my employment

that way. I need home health for my simple daily chores by getting up, getting bathed, taking care of my personal cares throughout the day. I receive four visits a day from my home health agency. Along with that, I also rely on Medicaid to cover my home medical expenses as well, for home medical equipment that I rely on to also maintain my independence. Once I was-- expanded my appointment to 30 hours and reported that to HHS, I then received a letter notice in the mail that I was kicked off Medicaid immediately. And to maintain that I was given a share of cost of over $900 a month. And then over $900 a month was more than half my income, which was not-- just not feasible. All of this-- through this I-- this happened-- the caseworker I was working was not aware of MIWD and that is why I was kicked onto the share of cost program. Thankfully, I was made aware MIWD and brought that to the attention and was able to, and I've been able to maintain it working 30 hours a week for the past several years now, However, my employer still has offered me several times, several occasions to expand my hours, as well as my wages and I simply can't do it. I have to keep turning him down. So I just ask that you support LB968, you know, for many reasons that we've already seen today, but also, you know, it really is a program that could benefit myself. I would like to earn more wages. I'd like to increase my assets and set up retirement situation, you know, a plan for myself, you know. Those kind of situations make me nervous in my long-term future, and hopefully, you know, can-- because of this we'll be able to maintain my employment and expand on that as well. So, and with that I just-- I can answer any questions you may have.

RIEPE: [02:34:51] Does your employer provide no benefits beyond full time or none at all?

DAN BAUERLY: [02:34:59] Not at all unfortunately. It's a non-profit agency and we're grant funded, so our grant-- the money that-- the funding that we receive covers my wages and a few program expenses. But, you know, you certainly is willing to pay me more, not for more money-- but beyond that my experiences in sharing my, you know, my situation with others, I've learned that

many private insurances almost exclusively do not cover home health costs through a home health agency. So what I've made aware of and if I, you know, just like I mentioned, Medicaid is the only option I have to fully cover the home health expenses that I have. And so I rely on that to remain independent.

RIEPE: [02:36:00] Thank you. Are there other questions? Seeing none, thank you very much. How many more testifiers either side do we have coming? Looks like 1, 2, 3, 4. Okay. Proponents. Let's keep on course. Additional proponents? If you would, would you mind moving the chair back. We need to get you in front of the mike here. If you'd be kind enough to state your name, spell it, and then proceed on.

ULYSSES HERNANDEZ: [02:36:58] My name is your Ulysses Hernandez, spelled U-l-y-s-s-e-s, and Hernandez is spelled H-e-r-n-a-n-d-e-z. I live in Nebraska, Omaha, Nebraska, in Douglas County. I'm here as a good citizen with a disability. I want to be able to work full time-- full time and earn more money without losing Medicaid. My family needs help teaching me important living skills. Medicaid can provide these services. Earning more money to help pay for things myself should not make me eligible for insurance and disability services. Please support LB968 so individuals with disabilities can work and continue receiving support to live importantly as possible. Thank you senators for your time.

RIEPE: [02:38:18] Okay, thank you very much for being here. Are there questions from the committee members? Seeing none, again, thank you for joining us.

ULYSSES HERNANDEZ: [02:38:27] Yeah, no problem.

RIEPE: [02:38:32] Additional proponents please. If there are other proponents that you're going to

speak, please come to the forefront so we can move along. If you would please, introduce yourself, spell your name, and if you would, your organization if you're with, if you are one, or yourself and please go forward.

RAINA GULBRANDSON: [02:39:09] My name is Raina Gulbrandson, spelled R-a-i-n-a G-u-l-b-r-a-n-d-s-o-n, and I'm with Easter Seals Nebraska. We're here today in support of the Disability Employment and Engagement Program Act, although we do-- we would like to propose that the current statute in its entirety be stricken-- in its entirety, because the language that's left in there would be even more-- providing more constraints for individuals. I would like to talk specifically about the problems created by Nebraska's buy in structure and how that ties to Social Security's Title to Work incentives create barriers for individuals at all levels of employment. The trial work period terminology creates an extensive set of problems, many of which I will explain here today. The previous adoption of this language has created significant constraints. Partly, this is because Social Security and HHS define trial work period differently. The department refers to the trial work period, they look at that on a month by month basis; whereas Social Security defines trial work period within a 16-month rolling period. I would like to cite just a few examples of individual situations in which access to the current program is denied. For example, an individual who receives an SSDI payment of $800 per month and wants to earn an additional $800 per month through work cannot use the MIWD program. Once an individual begins working, they enter into a share of cost of $755 dollars. This is because the person is not earning at Social Security's trial work period level. The share of costs represents 47 percent of the person's monthly income and consumes their entire take home pay. If this same individual wants to earn a thousand dollars per month, they're able to use the program, but only for a limited amount of time. If a thousand dollars per month represents their long-term earning capacity, they will no longer qualify once their trial work period, as defined by HHS, is over. An individual who begins full-time work and starts a retirement account will become ineligible for the program once that account accumulates more than $4,000. I

can cite an example in which one individual had to take a loan from her 401(k) to remain eligible for MIWD. An enable account was not an option for this individual because she was not disabled prior to age 26. An individual who has used their trial work period in the past is unable to use the program. And it should be noted that there are many instances where individuals have used their trial work period without their knowledge due to a lack of understanding of the Social Security work incentives and lack of access to education. There are also examples of individuals who would like to work part time while in school and want to save their trial work months for when they graduate and work full time. In addition to these examples of ineligibility caused by the program structure, there is another set of problems and barriers for those who are eligible and trying to enter the program. For example, it may take several weeks or even months for Social Security to get a beneficiary's official trial work determination on record and an additional several more days or even weeks for this information to be communicated to the department. Another problem has to do with the 36-month extended period of eligibility. During this time frame, an individual is not due a cash payment from Social Security for any month his or her work demonstrates substantial gainful activity or SGA. If benefits stop-- do stop during this time, Social Security considers this a benefits suspense due to work activity and still considers this individual to be disabled. The department however confuses this non-pay status with an unfavorable medical determination. Therefore if an individual is earning more than $1,180 per month, the individual could be found to be ineligible and therefore be penalized for working at a level which suspends their cash benefits. Gaps in coverage occur while these issues are being rectified, and unless the individual is working with an experienced benefits counselor, it is highly unlikely the issues would even be identified let alone resolved. While we're grateful to be one of the 40-plus, I believe it's 43 states, to have a buy-in program and while it is true that many people have benefited throughout the past years, change is necessary. A new buy-in structure as set forth by the Disability Employment and Engagement Program will create opportunities for individuals at every level of work whether that be a few hours a week or taking a full-time position or somewhere in between.

RIEPE: [02:44:10] Okay, we have a red light, can you kind of pull it together so we can get everyone through.

RAINA GULBRANDSON: [02:44:14] Yes. We can no longer settle for a program which in name and intent professes disability inclusion, yet in design and implementation excludes so many. Thank you for your time.

RIEPE: [02:44:25] Okay, thank you very much. If you'll hold for just a sec, we may have some questions. Seeing none, again, thank you for being here. Thank you. Additional proponents? I think I saw a couple more at least. If you'd be kind enough to state your name, spell it, and tell us who you are with please.

NICOLE BELL: [02:44:47] Hello, Senator, my name is Nicole Bell, that's spelled B-e-l-l. I am a resident of Omaha, Nebraska, residing in Douglas County. The reason I'm here today is a concerned citizen. I would like you as a-- I would like you to consider supporting LB968. Medicaid is something that is important to me because it helps me pay for medical expenses and will help-- one day help me with financial services. I would like to work more, but I'm afraid of losing my benefits. I don't want to not have a job coach. Please support LB968. Thank you for your time.

RIEPE: [02:45:35] Okay. Thank you. Any questions? Thank you for coming down here. Additional proponents? Anyone want to testify in favor? Okay, seeing none, do you see any? Okay. Is there anyone speaking in opposition? Yeah. Opponents. Director Thompson, welcome.

THOMAS ROCKY THOMPSON: [02:46:06] Senator Wayne was right about that chair. Good afternoon, Chairman Riepe, and members of Health and Human Services Committee, my name is

Thomas Rocky Thompson, T-h-o-m-a-s R-o-c-k-y T-h-o-m-p-s-o-n, and I serve as Interim Director of the Division of Medicaid and Long Term Care in the Department of Health and Human Services. I'm here to testify in opposition to LB968 based on the fiscal note. The department is committed to policies and programs that lead to greater integration of individuals with disabilities into the communities in which they live. We strive to provide independence whenever we can and when the budgets, laws, and regulations allow. I would like to express my appreciation to the Arc of Nebraska, and Disability Rights Nebraska. They met with me, I think, back in December to talk about this and I really appreciate their work and their continued support of changing this program. This is a program we need to look out-- look at for improvements. This is an important issue, as Senator Wayne said. In the current fiscal situation, this legislation is unaffordable as it is written. The bill expands the Medicaid program by increasing income limits from 250 percent to 450 percent of federal poverty level, with an increase resources limit up to 40,000, depending upon marital status and family size. The current limits are $4,000 and $6,000. So this legislation would be substantially higher, LB968 also requires premiums which are currently in place for individuals between 200 and 250 percent of federal poverty level. This bill would change the premium requirement to individuals with income above 150. However as written, the bill proposes different premium limits based on an individual's unearned and earned income. This would cause individuals in the same income level to have different premiums. It is estimated that approximately 10,000 individuals could be eligible for these new programs due to the high income and resource limits. Using conservative estimates that only 25 percent of these individuals would apply for these programs, the cost exceeds $70 million per year. The current fiscal situation sharpens our focus on sustaining our current programs to maintain services and LB968 would put additional fiscal burden on the state. The division does commit to continue working with stakeholders including Senator Wayne, this committee, Disability Rights Nebraska, and the Arc to increase awareness of the program and study possible changes in light of federal law changes over the past 20 years, when this statue was actually written. I also think it's important to look at other resources available like

subsidies and cost sharing reductions on the exchange that have come in place over the past 20 years to help those individuals with disabilities to work. Now I know that Senator Wayne mentioned the 2013 bill from Senator Gloor, and I do have a copy of it right here. And his bill has the same income limits that we have for the current program. So in Section 4 of his bill, it has accountable family income of less than 250 percent of the federal poverty level. And this bill, on page 2, it establishes the income limit to less than 450 percent of the federal poverty level. So that's a substantial part of the fiscal note and why it's different than 2013. His bill did change because of federal authority that we operate our program is based upon the Balanced Budget Act, and there were subsequent changes creating Ticket to Work program that may change about the trial work period and a lot more flexibility about the assets that individuals would receive. So that's one change that possibly could be considered in the future. But I think this is important issue that we need to continue to revisit and study. Thank you. If you have any questions, let me know.

RIEPE: [02:49:49] Are there any questions? Senator Linehan.

LINEHAN: [02:49:51] Thank you Chairman Riepe. Thank you Director Thompson for being here. I'm very happy to hear you say we need to work on this. So one of the things, I think, Senator Wayne said is we can look at an amendment-- maybe not amendment, but going forward, look at something which would just apply to people that are on the program versus worrying about bringing new people in.

THOMAS ROCKY THOMPSON: [02:50:12] I think that might be possible. You know, the current program has 250 percent of federal poverty level. Senator Gloor's bill maintained that 250 percent of the federal poverty level. So I don't think there will-- idea of getting more people in with his bill, I think it was to extend the time period that individuals could be on the program. I think if we tried to do 450 percent of the federal poverty level and try to limit coverage to certain

populations that might require a waiver authority, but I haven't looked into that.

LINEHAN: [02:50:44] And then, could the department-- because this is one thing that I don't understand, but again, I feel so free not to understand things now, with your waiver, is there a way the department could look-- at what point, especially if some of these individuals are single individuals, like many of them seem to have been today, at what point-- where could they make enough money that they could get on an exchange?

THOMAS ROCKY THOMPSON: [02:51:10] Thank you, Senator. The exchange subsidies and cost-sharing reductions begin at 100 percent of federal poverty level and extend to 400 percent of federal poverty level. Now there's a sliding scale that's in there so there's a lot less available resources at 400 percent of the federal poverty level than at 100 percent of federal poverty level. But as mentioned by some of the previous testifiers, the Medicaid benefits, they do offer additional services than offered by private insurance. So that's something that also needs to be studied.

LINEHAN: [02:51:36] So they wouldn't get the day services-- or they wouldn't get the in-home services maybe.

THOMAS ROCKY THOMPSON: [02:51:41] I'm not familiar with all the services that are available on the products on the exchange. But from my awareness of private insurance, Medicaid covers those services and private insurance does not.

LINEHAN: [02:51:53] Again, thank you very much for being here, and I'm very pleased to hear that you are willing to work on this so we can make it better.

THOMAS ROCKY THOMPSON: [02:51:59] Yes, Senator.

LINEHAN: [02:51:59] Thank you.

RIEPE: [02:52:03] Okay, Senator Crawford.

CRAWFORD: [02:52:03] Thank you, Chairman Riepe. And thank you, again, Director, for being here. And I am also thrilled and interested in working on this issue and trying to make it easier for people to engage in work and work more. So I wonder if you could talk just a little bit about two things. One is what your department is currently doing, or if you have had any changes that your department has made since you've heard some of the comments about people calling and the people that are in the department working, not knowing about this program, or not knowing how to help someone on this program.

THOMAS ROCKY THOMPSON: [02:52:39] Thank you, Senator. This program, there's two dedicated social service workers in a field office that are dedicated to this program. And so there has not been great awareness in the field about this. And there are ways that we've tried to increase awareness, but is it something that is a underutilized program. And right now there's only 84 participants in the program. So it's something that we definitely need to look at, figure out a way to make sure it's part of their training and know this is available.

CRAWFORD: [02:53:10] Right, so kind of flag or something to push to get the help they need.

THOMAS ROCKY THOMPSON: [02:53:14] Yeah, in some programs have those dedicated caseworkers, because, you know, Medicaid eligibility is complicated and so we need those skilled workers; but again, two social services workers, I don't think that's sufficient.

CRAWFORD: [02:53:27] As I understand it, one issue is the amount you can earn. But we also have some other complications or issues with our Ticket to Work and the way we define the trial periods. Is your department currently engaged in policy analysis or work in trying to move towards solutions to some of those issues?

THOMAS ROCKY THOMPSON: [02:53:45] Thank you, Senator. You know, this is something that I did have a brief done for me back in November about this program in a different-- federal authorities, Balanced Budget Act, the Ticket to Work, what other states have done with this program. As I said before, a large number of states do have this program in some way. Fifteen states use a Balanced Budget Act. Twenty-two states have the Ticket to Work program. Connecticut has both. Massachusetts has an 1115 waiver for this; and the most recent state was in 2006. So I think-- that was South Dakota; and I think-- so I think that we need to look into this about what we need to change for our federal authority for this, what is the best way that we can help encourage work by our citizens.

CRAWFORD: [02:54:36] Absolutely. And we look forward to working on this with you and your predecessor, so.

THOMAS ROCKY THOMPSON: [02:54:41] Thanks, Senator.

RIEPE: [02:54:43] Okay. Thank you very much, Director Thompson. Is there anyone else speaking-- concern for-- opposition? Okay, seeing none, is there anyone who is speaking in a neutral capacity? Welcome.

KATHLEEN EGBERS: [02:54:52] Thank you.

RIEPE: [02:54:52] We would invite you or encourage you to state your name and spell it if that works for you.

KATHLENE EGBERS: [02:55:40] Okay. Good afternoon Senator Riepe and members of the Health and Human Services Committee. My name is Kathlene Egbers, and it's spelled K-a-t-h-l-e-n-e, Egbers, E-g-b-e-r-s.

RIEPE: [02:55:50] Okay. We invite you to go forward. Thank you.

KATHLENE EGBERS: [02:55:51] I work at the UNMC Munroe-Meyer Institute and have been asked by Senator Howard to share my experiences with employment. Thank you to Senator Howard, even though she is not here. Since my testimony is representing my experiment as a state employee, my testimony is as neutral. I'm very grateful that I can share my experiences as I believe that this bill would improve the quality of life for people with disabilities in our state. I'm very thankful and fortunate to have a job working for an organization that provides accommodations for me. I have encountered issues with regards to the wages I'm earning and the financial regulations of the Nebraska Medicaid program. Currently, I'm receiving $9.51 an hour. I have had to decline offerings of higher amounts, as it would impact my qualifications to receive Nebraska Medicaid in the long run. This bill-- this bill would allow me to work more hours if I choose and receive raises without having to think about how my benefits are impacted. I believe this bill would be a great incentive for people with disabilities to work as it would increase their independence from this system and make us feel like contributing members of society. I'm a long life-- I'm a lifelong Nebraskan. I graduated high school in 1994. I lived on the farm until a spot at Quality Living opened up in Omaha in 1997. One second. Once I moved to Omaha, I was able to learn how to use public transportation and acquire more skills and attend college. One second. One second. --Metro Community College with an associate degree in human services. During college, I volunteered at

the League of Human Dignity. Then I got a position with the AmeriCorps program where I was able to do volunteer service and receive a stipend for my work at UNMC Munroe-Meyer. When my-- one second, when my AmeriCorps position ended, MMI hired me. I have worked there for 12 years, and in that time I have had to reduce my work-- my working hours, forego raises in order to-- in order that I don't lose my Medicaid benefits. If I get a raise, it's been between one and five cents per hour. The bill ensures that if I work more hours or accept a meaningful raise, I won't risk losing my Medicaid benefits because it would create a tiered system that would allow the state to collect more money and allow me to keep some of that money as well. Please build a system that helps people with disabilities be able to work, keep their Medicaid, and feel like they contribute. I really enjoy working. Thank you for considering my testimony.

RIEPE: [03:00:24] Okay, thank you. Are there questions from the committee? Seeing none, we very much appreciate you being here. Thank you.

KATHLENE EGBERS: [03:00:28] Thank you.

RIEPE: [03:00:31] Are there additional individuals that want to testify in the neutral capacity? Okay. Thank you for being with us. If you can, I'd ask you to state your name and spell it.

KRISTINA MEINECKE: [03:00:58] My name is--

KRISTINA MEINECKE: [03:01:11] Okay. Tina has asked that an accommodation be that I read her testimony.

RIEPE: [03:01:19] That's perfectly fine.

KRISTINA MEINECKE: [03:01:19] Okay. All right. Good afternoon, Senator Riepe, and members of the Health and Human Services Committee. My name is Kristina Meinecke, and that is spelled K-r-i-s-t-i-n-a, Meinecke, M-e-i-n-e-c-k-e. I too have been invited by Senator Howard to share my experiences. Since I also work at the UNMC Munroe-Meyer Institute, and I am a state employee, my testimony is also neutral. I want to thank you for having me here in on this matter and allowing me to share my story. I currently live at Quality Living. I grew up in St. Paul, Nebraska, and moved to Omaha after I graduated from high school. I attended Metro Community College where I got an associate's degree in computer programming. I volunteered in different organizations and also participated in the AmeriCorps program. After my term in AmeriCorps ended, MMI hired me. I have worked there for 11 years. Currently, I work in their business office and in their speech department. Right now I make $9.51 per hour. I have been offered more money. However, I have refused pay raises because that would require me to work less hours in order to keep my Medicaid benefits. I've had to reduce my hours and refuse pay raises simply to retain my Medicaid. I really have no choice as I need my Medicaid as it pays for services that employer-based insurance will not pay for. For example, Medicaid pays for personal assistance services, also called PAS. This service pays for someone to help me get up every morning. Traditional health insurance will not pay for this service. So as you can see, I need Medicaid, but I also need to work. I like working. I like making money. I just wish that I could work more and still have some money to show for the time that I've worked. This bill would do that. I understand that there are limited amounts of money that I can receive, but I wish it was a tiered system and not simply end Medicaid if you go over a certain amount. When I work I feel that I'm contributing. This bill would not only let me have a bit more money, but it also makes a statement that people with disabilities have a right to contribute to society like any other person. Tina wanted to let you know that she can take questions if you have any.

RIEPE: [03:04:05] We'll see if there are any. Apparently not. Tina, thank you very much for being

here, we appreciate it. It's been a long day. Are there additional testifying in the neutral capacity? Okay. Seeing none, and seeing no one to close, Tyler, I'm going to have you read in any letters that we have.

TYLER MAHOOD: [03:04:31] I have one letter signed by John Bahr, independent self in support.

RIEPE: [03:04:31] Okay. Thank you very much. Without a closing, that concludes this hearing on LB968. Thank you all very much for being here. Safe travel and thank you for making the effort.