

**Health and Human Services and Appropriations Committees Briefing
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Good afternoon, Chairwoman Howard, Chairman Stinner, and members of the Health and Human Services and Appropriations Committees. My name is Dr. Matthew Van Patton, and I am the Director of the Division of Medicaid and Long-Term Care within the Department of Health and Human Services. I am joined today by my deputy directors, Rocky Thompson, Heather Leschinsky, Jeremy Brunssen, Dr. Larra Petersen, and Karen Heng, and our legal counsel, Nate Watson.

As CEO Smith indicated, we are providing you with a packet containing several exhibits. We are providing these documents to let you know in detail about our planning efforts, as well as to provide reference materials that have shaped our thinking in designing the Heritage Health Adult Program. A copy of our slides is provided as Exhibit 1 in your packet. In my remarks, I will address most of the written questions we have received from Chairwoman Howard, and then Deputy Director Brunssen will address Chairwoman Howard's cost questions, as well as the written questions we have received from Chairman Stinner.

Pursuant to the Initiative, a copy of which is attached as Exhibit 2 in your packet, the Heritage Health Adult Program will cover all able-bodied adults between the ages of 19 and 64, who meet the various requirements, including the adult expansion and caretaker relatives populations. This program will use our existing managed care health plans to provide medically necessary care to people who cannot afford it and promote wellness and life success. In response to Administration Question Number 5, it is important to note that any legislative action that would significantly affect Medicaid, including the ability to use managed care, would inevitably delay our ability to begin benefits on October 1, 2020.

We have successfully fulfilled the first step in the expansion process – the filing of the state plan amendments with the federal government on April 1st. This was the one and only deadline in the Initiative. A copy of the submitted state plan amendments is provided as Exhibit 3 in your packet.

Benefits begin on October 1, 2020. Signups start on August 1, 2020. We understand that many people would like benefits to begin sooner, however our priority is making sure the necessary preparations have been made, the services are available, and people know how to access care. We are taking the time needed to do this right. In the packet, at Exhibit 4, you will notice a timeline of the work that needs to be done.

Furthermore, the experience of other states demonstrates the wisdom of taking the time necessary to do this right. Anything less would be letting down the people we serve and the taxpayers who pay for it. In your packets, at Exhibit 5, you will also notice news articles that demonstrate this reality.

There are several different ways to become eligible for Medicaid. Many people understandably think that Medicaid currently provides the same package of benefits to everyone enrolled, but it does not. Pursuant to federal law (for example, Sections 1902, 1915, 1920, and 1920A of the Social Security Act, copies of which are provided as Exhibit 6 in the packet), Medicaid covers a variety of persons with different needs. For example, children receive additional and different services than adults. Persons with disabilities have different services than others who are not disabled. Pregnant women have services designed for their specific needs. Residents in nursing homes receive services tailored to their circumstances. In your packets, at Exhibit 7, we have provided you a chart comparing the benefits of those persons currently eligible.

The Heritage Health Adult Program is designed for able-bodied adults on Medicaid. In short, all persons similarly situated are treated similarly, in line with federal law and the Initiative.

In response to Benefits Question Number 7 and Administration Question Number 3, to design a program that best fits the needs of Nebraska, we intend to submit a section 1115 Medicaid demonstration waiver to the federal government. This process began when we submitted a concept paper on April 1st. The concept paper, which is Exhibit 8 in your packet, covers a number of proposals that not only provide health care coverage, but also provide an innovative route to wellness and life success. The 1115 process involves negotiations with the federal government. Federal law requires at least 2 public hearings as a part of this process – we will hold at least 4, on dates and at locations to be determined, including at least 1 public hearing in each congressional district.

In response to Benefits Question Number 1, Heritage Health Adult Program participants will receive basic coverage that is comparable to the type of health insurance many Nebraskans receive through employment. The precise package of services will be defined after negotiations with the federal government, though it will be similar to the Blue Cross Blue Shield Pride Plan. A point-by-point comparison of Medicaid state plan services and this commercial insurance product is included within the Benefits State Plan Amendment, which is part of Exhibit 3 in your packet. In response to Administration Question Number 7, unlike some other states, there will be no so-called work requirements to receive basic coverage. I will say that again: There will be no work requirements to receive basic coverage.

The Heritage Health Adult Program is designed to empower people. In response to Benefits Question Number 2, to earn prime coverage – which includes additional benefits like dental, vision, and over-the-counter medication coverage – members will be required to participate in care and case management and see their health care provider within one year of signing up. In response to Benefits Questions Numbers 4 and 5, those who have participated in care and case management and have visited a health care provider within the last year will receive prime coverage at the program's start date because they are not new applicants; their situation

is different. In response to Administration Question Number 6, existing systems will let providers know whether a person has basic or prime coverage.

In response to Community Engagement Question Number 1, care and case management are the core components of the benefit package provided by the health plans today. We intend to build on this existing structure.

Care management is the professional function by which a set of supportive activities to improve health and reduce the need for future medical services is accomplished. This includes patient education, care coordination, and help managing difficult health conditions. For example, care management includes assistance with finding the right health care provider and making an appointment. People who have not gone to the doctor for regular checkups in a while might not know where to begin. Exhibit 9 in your packet contains additional information about care management.

Case management is the professional function by which a collaborative process of evaluation, planning, facilitation, and advocacy for options and services that support the social determinants of health and assists with communication and resource needs for improved wellbeing is accomplished. For example, case management includes finding and accessing other resources that are needed to be healthy, such as food banks, housing, and transportation.

Participating in care and case management is a major benefit that allows us to understand completely people's current circumstances and get them the health care and other assistance that they need.

In addition, seeing a health care provider at least once a year is really important in addressing health care needs, especially if someone has a chronic condition that has gone untreated for some time. Seeing a doctor regularly helps a person understand his or her current health and allows the person to make a plan for wellness.

In the second year of the program, members who want prime coverage will also be required to meet certain community engagement requirements. Good health is about getting regular healthcare and living a productive life. We care about treating the whole person and want them to live a full and productive life. Caretaker relatives already have more than a full-time job, so they will meet this requirement. For every other able-bodied adult, to earn prime coverage they will be expected to do things such as volunteer for a public charity; be attending a college, trade school, or apprenticeship; looking for a job through the Department of Labor; or, holding a job, for at least 80 hours a month. In response to Community Engagement Question Number 5, other options to meet this community-engagement requirement are being explored, including participation in treatment for substance abuse. In response to Community Engagement Question Number 2, we will leverage existing resources to monitor this requirement. Our model aligns with guidance provided by the federal government, which a copy is provided in your packet as Exhibit 10.

In response to Administration Question Number 4, in order for Medicaid staff to begin receiving applications and for benefits to begin, we are working hard to make the necessary changes to our existing eligibility and enrollment system, even though it will be phased out later. We are also working with the health plans to leverage their technology and processes to assist in the provision of benefits. We have provided you a chart, which is part of Exhibit 4, that goes through the timeline for technology changes to incorporate required updates to accommodate the Heritage Health Adult Program.

There are a few other remaining questions from Chairwoman Howard's list that I would like to address at this time:

In further response to Benefits Question Number 2, dental services currently include oral evaluations, re-evaluations, comprehensive periodontal evaluation, radiographs, diagnostic casts, preventative services, restorative services, endodontics, periodontics, prosthodontics, oral and maxillofacial surgery, orthodontics for children, and adjunctive general services. Vision services currently include examination, diagnostics, treatment, frames, lenses, and contact lenses when medically necessary. Over-the-counter drugs currently includes things such as analgesics, antihistamines, and cough and cold products.

In response to Benefits Question Number 3, the program will not charge premiums. Co-pays in place today will apply.

In response to Benefits Question Number 6, regarding former foster care, federal law (Section 1902(a)(10)(A)(IX), a copy of which is included as part of Exhibit 6 in your packet) does not allow this so-called mandatory group to be included in the adult expansion group.

In response to Benefits Question Number 8, some of the newly eligible Medicaid population, the medically frail, will have increased health care needs. We intend to contract with a consultant to develop a clinically sound definition to serve this population appropriately. I have provided you examples of how other states have accomplished this task, which are found at Exhibit 11 in your packet.

In response to Administration Question Number 1, redeterminations of eligibility will take place every six months instead of annually. This is to avoid issues that have arisen in other states regarding ineligible individuals receiving coverage. Information has been shared with you in your packets, at Exhibit 5, regarding the experiences of other states.

In response to Administration Question Number 2, Medicaid traditionally provides payment to providers for services rendered up to three months prior to the date of application. In order to align to private insurance and to encourage members' timely access to health care, we are requesting to shorten this period to make coverage retroactive to the first day of the month of application. Furthermore, we will be engaging with providers on processes that support increased use of presumptive eligibility.

In response to Community Engagement Question Number 3, we will use the health plans to monitor attendance at appointments.

In response to Community Engagement Question Number 4, in addition to caretakers of minor children currently covered by Medicaid, if a relative is caring, for example, for an adult child, he or she will also meet the community engagement requirement.

Now I will turn your attention to Exhibit 12, and walk you through the Heritage Health Adult Program eligibility and enrollment process.

At this time, I want to make clear that we will work to transition current adult members who will join the Heritage Health Adult Program. In addition, we are also looking at our home and community-based waivers to allow the newly eligible adult group access to those services, when appropriate.

In addition, I want to point out that we have provided helpful scenarios about basic and prime coverage as Exhibit 13 in the packet. Exhibit 14 is a copy of the fiscal impact of the Initiative, and Exhibit 15 is a copy of our press release regarding the Centene and WellCare merger.

Thank you for allowing me to come speak with you again today and answer many of your questions regarding Medicaid expansion through the Heritage Health Adult Program. I would be remiss in not acknowledging this team's work and professional competency. I would also like to thank this group of public servants for their work and commitment to building and implementing the Heritage Health Adult Program.