Health and Human Services Committee
LB 1011
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Good afternoon, Senator Campbell, and members of the Health and Human Services Committee. My name is Calder Lynch (C-A-L-D-E-R L-Y-N-C-H). I am the Director of the Medicaid and Long-Term Care Division of the Department of Health and Human Services. Today I am here to testify in support of LB 1011. Thank you, Senator Campbell, for introducing this bill which will allow additional flexibility for the Department in contracting for behavioral health managed care programs.

Neb. Rev. Stat. §71-831, passed in 2012, prescribes financial and operational requirements for the administration of Medicaid behavioral health managed care. This statute was implemented in the context of a stand-alone behavioral health managed care program. As Nebraska Medicaid moves toward a fully-integrated delivery system for medical, behavioral health, and pharmacy services under the Heritage Health Managed Care Program, the provisions required by the statute pose significant administrative challenges for the state and its contracted health plans. LB 1011 will remove these administrative challenges.

I want to start by thanking the leadership and members of the Nebraska Association of Behavioral Health Organizations (NABHO) for working collaboratively with us to draft this legislation. The original statutory language was put in place in large part to their efforts and I very much appreciate their willingness to revisit the language in the context of our evolving program.

I want to assure the Committee that the spirit of the original language remains. What is more, the Heritage Health plans will be required to meet the proposed requirements of the Centers for Medicare and Medicaid Services (CMS) for medical loss ratio and actuarially sound rates that provide further protections regarding the dollars we invest in these services.

However, there are three provisions required by the current statute that inhibit our full ability to realize the financial and health outcome advantages of integrating benefits and services through the implementation of Heritage Health. These provisions include the incentive requirement, the cap on administrative spending, and the cap on profits and losses.

1) Currently, the statute includes a requirement for a <u>1.5 percent withhold</u> of the premium payments. This is also referred to as an incentive requirement. The statute requires that any unearned portion of these funds, in addition to other performance contingencies

imposed on the plans by the Department, be spent exclusively on behavioral health related services. We have worked to revise these requirements to give the Department greater flexibility regarding the amount of the incentives, clarify that reinvestment funds also include any remittances under the new medical loss ratio requirements, and, given the nature of the fully integrated contracts that include physical health, pharmacy and behavioral health services, permits the use of reinvestment funds to address a broader array of health care needs.

2) The administrative cap as written in the current statute is out of sync with the new medical loss ratio requirements and restricts the ability of health plans to invest in care management programs. The proposed language aligns the cap with the MLR provisions and ensures that health plans are able to adequately invest in quality improvement activities, while still providing the necessary protections to ensure that taxpayers are protected and expenses are appropriate.

3) Under current law, the insurer is guaranteed that profits can be up to three percent per year and losses will not exceed three percent per year. In addition to the profits, health plans would be able to earn incentives of 1.5% of all income. The total costs of the Heritage Health program will exceed $6.9 billion over five (5) years. Profits over 1% for comprehensive integrated contracts is a significant amount and will artificially inflate the overall costs to the Medicaid program. This provision is also redundant to the medical loss ratio requirements. This bill recognizes this in allowing the Department additional flexibility is setting caps on profits at amounts lower than 3% but no greater. It also allows us to remove the cap on losses, as this may not be appropriate after the first year of the contract.

Thank you for the opportunity to testify before you today regarding LB 1011, which we believe will help us continue our mission of helping people live better lives. I look forward to future conversation with this Committee as we work to improve the care of the most vulnerable in our State.

I'm happy to answer any questions you may have.