

Medicaid Managed Care Listening Tour

January 2022

Feedback Summary

FEBRUARY 1, 2022

**Division of Medicaid &
Long-Term Care**



NEBRASKA

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DEPT. OF HEALTH AND HUMAN SERVICES



February 1, 2022

Thank you to everyone who was able to join the Medicaid team throughout January to share their experiences with Medicaid's managed care program. People's willingness to share their experiences means a lot to the program as we look to develop new managed care contracts.

The procurement process for Medicaid's managed care health plans is currently underway. As part of this process, Medicaid held listening sessions throughout the state in January to learn about the community's experiences with the current health plans. Across these sessions, Medicaid's seen a need to focus on improving member experiences, provider experiences, and program accountability. Medicaid is currently working this feedback into our request for proposal (RFP) and will share how this feedback is reflected in the RFP when it is released.

Medicaid's RFP process is continuing along its original schedule, with the RFP expected to be released in April 2022 and DHHS announcing who will be awarded the contracts in July 2022. DHHS is planning to share more details about the implementation of the new contracts when it is announced who will be awarded these new contracts.

In an effort to be transparent with all our stakeholders, all the written feedback we received on our January listening tour (through 1/31/22) is attached. If you would like to share additional feedback with our program, please feel welcome to contact us at DHHS.HeritageHealth@Nebraska.gov.

Sincerely,

A handwritten signature in black ink, appearing to read "Kevin Bagley".

Kevin Bagley, Director
Division of Medicaid & Long-Term Care
Nebraska Department of Health and Human Services

Summary of Comments

The Office of Public Guardian (OPG) submitted various written comments, which include details about some of the very vulnerable persons they serve.

Generally speaking, these comments relate to:

- 1) Alleged issues of access to care by, and reasonable accommodations of, individuals with significant comorbidities;
- 2) alleged denials of parity between behavioral health and physical health concerns; and,
- 3) alleged denials of medically necessary services by the current managed care organizations.

Additionally, the Nebraska Chapter of the American Physical Therapy Association submitted comments with recommendations for the next managed care contracts. Their recommendations for these contracts include:

- “1. Establishment of a clinical advisory board to include rehab services representative
2. Ongoing education to providers through on-demand and live webinars, digital "how to" resources
3. Significant penalties if delays in payment occur.
4. Establishment of population health outcomes expected to be achieved with penalties if not achieved. These population health outcomes will be reported yearly with a plan of action if outcomes not being met.
5. Payment based on the Medicaid fee schedule.
6. Publication regarding their decision-making algorithm for prior-authorization decisions.
 - a. Must cite resources and have resources available
7. Pre-authorization process should take no more than 5 minutes to submit.
 - a. Platform must be easy to understand and does not require undue hardship to the provider.
8. Expedited reviews when asked and needed
9. Encouragement and payment for essential wellness activities for the beneficiaries.
10. Development and research on how to best serve our developmentally impaired children when "skilled" therapy is not required but still need ongoing therapy interventions.”

Additional comments received by Medicaid are attached.



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EMPOWERING CHILDREN, FAMILIES AND OUR COMMUNITY.

January 11, 2022

To: State of Nebraska / DHHS
From: Pediatric Therapy Center, P.C.
RE: Medicaid MCO Listening Sessions

To Whom It May Concern,

I am here today as an occupational, physical and speech and language therapy provider and owner of Pediatric Therapy Center, located in Papillion, Nebraska. Pediatric Therapy Center has provided care to Medicaid members since 2008 and have served over 1000 Medicaid recipients in the past 14 years. Since the state of Nebraska moved to Medicaid MCOs, I have seen a significant negative impact on all types of providers across the state. When the use of MCOs began, providers anticipated that there would be bumps in the implementation process. Unfortunately, the state of Nebraska greatly underestimated those bumps and the corresponding administrative burden on providers, as well as the negative impact on Medicaid recipients.

In the past 5 years, providers have had multiple issues with each Medicaid MCO and these issues are too numerous to list and read to you during this testimony. The summary of these issues focuses on prior authorization, timely payment, and access to care for Medicaid recipients. The combination of these issues has led us to realize there is little accountability to the MCOs when providers encounter issues such as the ones I just mentioned.

The first issue is that the MCOs have all required various degrees of prior authorization, which has significantly increased the administrative burden on all providers. At one point, a MCO required a double level of authorization from a primary care physician for therapy providers to be able to see a patient for therapy. During this time, my company required 1.5 FTEs per week to manage all of the authorizations. This is a three to four time increase in the number of FTEs we previously required for prior authorization. More recently, a MCO outsourced their prior authorization to an outside vendor, for which, submitting and authorization takes an average of 20-30 minutes for my facility. This is four to size times the amount of time it requires for us to submit for an authorization for other MCOs. I currently have had to hire 1.5 FTE to manage all the Medicaid authorizations. This increase in administrative burden means that we are providing Medicaid services below what the reimbursement is. To state it plainly, we lose money each time we see a patient with Medicaid.

The second issue with the MCOs is timely payment and appropriate processing of claims. Repeatedly the MCOs have had errors in their claims process, which results in providers having to refile and fight to prove the error by the MCO. Frequently, providers have been the ones to identify errors in the claims process. Again, this results in additional administrative burden, resulting in providers providing care below what they are reimbursed by Medicaid.

The third issue is that the increase in administrative burden with Medicaid MCOs results in a delay in care or a reduced level of care for Medicaid recipients. When providers were subjected to the double authorization requirement for one MCO, we had patients waiting 14-28 days to schedule a follow up appointment after the evaluation. When providers have to submit for authorization after an evaluation, the rules and regulations allow the MCOs a 14-day response time. MCOs have taken the entire 14 days to approve therapy authorization, again, resulting in a significant delay in care for Medicaid recipients.

What can the state of Nebraska do to help work towards a more efficient and fiscally responsible approach to MCOs? First, involve providers in the RFP process. Thank you for the opportunity today to voice our concerns. Please continue to keep these lines of communication open and reach out to providers to clarify issues we are bringing forth. Ideally, I would like to see a committee of providers that are directly involved in the RFP process with the Department of Health and Human Services.

Secondly, please take into consideration the significant amount of change providers has been subjected to since the implementation of MCOs. Providers have established positive working relationships with some of the MCOs and would like to see those MCOs continue with contracts for the state of Nebraska.

Third, establish some parameters for accountability for the MCOs when they do not meet the requirements of the rules and regulations. Previously, DHHS held weekly, then monthly meetings where members of each MCO were required to be present to report on known issues and be available for providers to ask questions. Those meetings were beneficial for all involved and we would like to see those meetings initiated again.

Fourth, please continue to keep the maximum number of MCOs at three. Managing the changes and administrative burden for three MCOs is enough for all providers.

Fifth, if DHHS decides to change to a new MCO, consider running beta testing for claims and authorizations with providers. Using this method will help decrease the number of errors that occur once a MCO goes live.

Lastly, consider the administrative burden on all providers from each MCO. Providers want to continue to meet the needs of Medicaid recipients, but this is becoming increasingly difficult with the added costs associated with a greater administrative burden.

Pediatric Therapy Center is committed to serving all members in our community including Medicaid recipients. Unfortunately, if we continue to lose money on each Medicaid patient that we service, this is not sustainable for our practice.

Thank you for the opportunity today to voice our input.

Candice Mullendore MS, OTR/L

Candice Mullendore, MS, OTR/L

President, Pediatric Therapy Center

candice@ptcne.org



January 10, 2022

To: State of Nebraska / DHHS
From: Central Nebraska Rehabilitation Services, LLC
RE: Central NE Rehabilitation Services 81-0653461/1184627911

To whomever it may concern,

I am here today as I am concerned with the direction the state Medicaid program has been heading in the past couple years. We have been treating Medicaid patients for over 30 years at our clinics and I have never encountered the issues like we have experienced in the last year. The issues we have experienced in the last 5 years more than quadruple the issues we had in the prior 20, which makes us question the longevity of being able to provide quality treatment to this population. Typically, the benefit of seeing a Medicaid patient was that you could provide care and get reimbursed quickly, with little hassle. I knew what we would be reimbursed by reviewing the Nebraska fee schedule. Today, it is an entirely different story.

We are forced to fight for care on the front end before the beneficiary is even seen for therapy, then after providing the care we fight on the back end for payment. Delays in care are regular occurrences while waiting for authorization – sometimes greater than 14 days. We are forced to touch our claims repeatedly, (national statistics indicate it cost the provider \$25 every time a claim is touched), which results in care being provided at less than cost. Furthermore, we have claims that we have 'touched' greater than 10 times as we are still waiting for payment. All of them are clean claims but are still waiting for payment due to technical difficulties within the MCO. We experience short pay, inappropriate denials (the most common being denials for no authorization when we have authorization). There seems to be little accountability to get these issues resolved timely as we have handfuls of claims dating back to early 2021.

We have established monthly meetings with each of the MCO's and work directly with them to resolve our issues. This has proven to be extremely beneficial but has taken considerable time and perseverance to ensure these meetings occur. I feel they have helped us tremendously, however when I look at our internal tracking board – we have more issues with the 3 MCO's than any of our other 3rd party payers. The hard reality is that we have more paperwork, more regulations, more hassles than we do with any other payer and yet we receive a fraction of the reimbursement. I have always felt we need to care for those in our own communities so have continued to accept Medicaid but wonder how long is this sustainable with the current functioning.

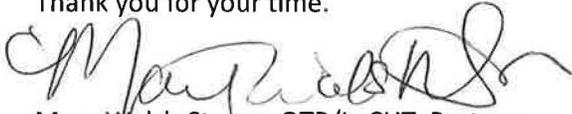
Nebraska Medicaid needs to get back to a healthy relationship with all providers. Open up meetings, similar to those that were held when Heritage Health first started, where providers could discuss issues with the state and the MCO's all in the same room. The MCO's were held accountable to get resolution and report back by the next meeting.

In an ideal world – it would be nice if all the MCO's followed the state regulations and fee schedules without adding more authorizations, more paperwork and figuring out ways they could further reduce payments. Beneficiaries should receive similar benefits with each MCO and should not have to switch plans or fight to get services covered.

Finally, I think a significant amount of progress has been made with each MCO since they started in Nebraska. I urge you strongly consider this when moving forward with an RFP process. Seek provider input. Work with the MCOs to have transparency as well as accountability. Please consider the amount of administrative burden that is transferred to the provider each time there is an MCO change.

I am open for any conversations as want to help improve the process. I have lots of examples if you want them or need further clarification.

Thank you for your time.



Mary Walsh-Sterup, OTR/L, CHT, Partner
Central Nebraska Rehabilitation Services, LLC
308-398-5170

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Good afternoon. My name is Tami Lewis-Ahrendt. I am the Chief Operating Officer at CenterPointe, one of Nebraska's largest non-profit Behavioral Health agencies and Medicaid Providers.

I am speaking today to provide the Managed Care RFP (Request for Proposal) writers and developers with some ideas that would result in greater provider satisfaction and potentially a better overall system.

Claims Payments:

Issues:

- Currently, MCO's are not paying claims in a timely manner. They incorrectly deny claims pushing payment out beyond 45 days and causing a significant administrative burden.
- Payments are often not issued at the correct rate, requiring retraction, reissuance and additional administrative burden.
- MCO's struggle with getting rate changes made to their systems resulting in delayed or unpaid rate increases and months of retractions, resubmissions, and ongoing claims projects.

Suggestions:

- Provide MCO's with incentives for paying claims on time (within 30 days of claim date) and at the correct rate. Create penalties for unpaid claims, unnecessary or incorrect denials or rejected claims. Create penalties for claims unpaid over a certain period or date range (i.e., over 90 days).
- Establish timeframes and expectations for MCO's to accommodate changes to their systems for things like rate increases or CPT code changes.

Supervision of the System:

Issues:

- There is no system of reporting or accountability for MCO's. There is no mechanism to report contract violations like delayed payments, repeated or patterned inaccurate denials, or for things like poor communication and bad customer service from contract reps.
- Providers carry the burden of MCO deficient performance, unpaid claims, inefficient processes and MCO staff turnover.

Suggestion:

- Implement a quality assurance and oversight program for the MCO's. Develop a process for management of concerns related to inconsistent practices, non-payment of claims, claim retraction errors, incorrect rates, etc. Managed Care Organizations should have a standard compliant resolution process, timeframes,

and expectations for things like known issues, claims projects, and other repeated provider facing problems.

- Conduct provider satisfaction surveys, collect data on average A/R days for providers or volume of dollars outstanding. Develop and utilize a provider or stakeholder committee to engage with the MCO's and the service system to provide feedback and data regarding ongoing issues and to provide feedback and suggestions for improvements.

Consistency and Standardization:

Issues:

- Lack of consistency in the process of provider credentialing. Lack of consistency in MCO provider portal functionality. The lack of consistency in the processes and tools used causes varying timeframes for provider credential completion. Because each MCO has different processes and varied credential expectations by clinical provider type, agencies are carrying a financial burden while they wait for credential confirmation. There are also redundancies with generating credentials for each MCO AND for the state through Maximus.

Solution:

- Develop and utilize a single credential standard, process, and portal. The State could utilize Maximus, sharing data and provider information with MCO's to allow them to pull or push rosters from the state system into their own.
- At a minimum, require a common process with established timeframes for successful credential completion.

Issue:

- There is no standardization or consistency in the service authorization process which results in inconsistent communication and differing processes for authorizations and reauthorizations.
- Service definitions are interpreted differently across MCO's. This inconsistency creates a system where individuals are denied needed services or discharged earlier than expected from necessary levels of care. It also creates an additional administrative burden in unnecessary appeals.
- Inconsistent application and understanding of medical necessity results in unnecessary denials and appeals. For example, medication compliance is pointed to frequently medical necessity determinations regardless of the level of care, which is not an accurate measure to determine continued stay or reauthorization for rehabilitative and residential levels of care.

Solutions:

- Create a standard authorization process across all MCO's.

- Define standards for length of stay by service type. Enforce service definition adherence.

Specialty Behavioral Health Care knowledge:

Issue:

- MCO's lack staff who understand behavioral health, evidence-based models of care, or standards of practice for our service delivery. This creates issues on all fronts from authorizations to appropriate payment. It creates disruption in services and outcomes for their members.

Solution:

- Require MCO's to employ or train adjudicators and staff in Behavioral Healthcare systems, levels of care, assessment tools, service types, and state-approved and supported evidence-based practices.

Innovation:

- RFP should require system innovations and room for Mobile Crisis Teams, Certified Community Behavioral Health Clinics, Care Coordination, and Integrated Health practices with payment models that support them.
- Require MCO's to invest in technology, creating online tools for authorization requests, provider credentialing or rostering, claims denial information, and appeals processes.



Building strong alliances that ensure quality behavioral health services, including substance use and mental health services, are accessible to everyone in our state.

Introduction

The **Nebraska Association of Behavioral Health Organizations (NABHO)** is a statewide organization representing providers, regional behavioral health systems, and consumer groups. Our 52 member organizations appreciate the opportunity to provide input into the pending managed care procurement for Heritage Health. This briefing provides a summary of issues and offers recommendations for managed care organization (MCO) contract language.

Issue #1: Inadequate integration of behavioral health

- Behavioral health is a key part of overall health, and NABHO supports integration. Medicaid expansion and the COVID pandemic have resulted in more people seeking behavioral health care. People with behavioral health needs such as depression and psychosis are among those at highest risk of COVID morbidity and mortality. Our goal is to extend existing resources by reaching people with mild to moderate conditions in primary care settings and those with more serious conditions in specialty care. Yet, the integrated management of physical health and behavioral health for people with behavioral health conditions has not worked well. Most integration initiatives have occurred through the efforts of behavioral health providers rather than changes to the primary care system.
- Evidence-based practices, such as Collaborative Care for mild to moderate conditions, are not supported by Medicaid or the MCOs. Other insurers have seen the value of Collaborative Care through offsets to overall health costs of 6 to 1.
- The recent infusion of federal funds under the American Rescue Plan to ramp up integrated behavioral health services because of the COVID pandemic cannot be sustained without access to insurance for those who are eligible. Most of the integrated care initiatives for people with serious behavioral health conditions in Nebraska are funded by the Substance Abuse and Mental Health Services Administration (SAMHSA). These grants are time limited and require that grantees bill Medicaid for covered services that become available as a result of the grant. The MCOs and behavioral health providers need to plan for sustainable funding of integrated care services for Medicaid enrollees.
- There is a behavioral health benefit knowledge gap. Not enough experienced behavioral health professionals are in decision-making roles at the MCOs. Many MCO staff are not familiar with Nebraska's behavioral health Medicaid benefits or the broader system, especially specialized evidence-based practices such as Assertive Community Treatment (ACT), Multisystemic Therapy (MST), and Functional Family Therapy (FFT). MCOs also have a knowledge gap about specialized treatment for people with alcohol and opioid addictions, including approaches such as Medication Assisted Treatment (MAT), and those dependent on methamphetamine or other stimulants. Knowledge about the American Society of Addiction Medicine (ASAM) criteria is not adequately integrated into care management and service authorizations. This lack of knowledge results in more time spent by providers explaining available services, covered benefits,

eligibility criteria, and length of stay—activities that are costly and impede time available for direct care.

Recommendations

1. Require the MCOs to develop a plan with goals and timeframes for integration of behavioral health care into their delivery systems. These plans should include primary care. For individuals with mild to moderate conditions, require the use of Collaborative Care in primary care settings. Collaborative Care is a well-established evidence-based practice available to many Nebraskans who have Medicare or private insurance. Implement the billing codes developed by the American Medical Association and used by Medicare.

For individuals with more serious conditions, require the MCOs to work initially with providers who deliver integrated care in behavioral health settings, most of whom have developed integrated care models with SAMHSA grants. The focus should be on sustainability of these services through Medicaid for those eligible, as well as strategies to expand capacity for specialty behavioral health integrated care models within specialty care settings.

2. Include language in the RFP that requires senior psychiatric leadership and advisors (board-certified adult and child psychiatrists and addictionologists) and other senior behavioral health clinical staff to be knowledgeable about the Medicaid behavioral health benefit and broader behavioral health system. This scope of knowledge should include people with lived experience, the ability to oversee and advise on care management, utilization review and medical necessity decisions, quality improvement goals and outcomes, and provider network management.
3. Require each MCO to submit a staff training plan to increase knowledge of current Nebraska behavioral health benefits and services, especially evidence-based practices and peer services, across the spectrum of mental health and substance use treatment and rehabilitation services. Training should begin with services that are detailed in Medicaid coverage documents, such as ACT, as well as the ASAM levels of care and related programs.
4. Require MCOs to offer training sessions on behavioral health evidence-based practices for providers at no cost. The Medicaid Division should coordinate the number and topics of the training with each MCO, with the goal of filling network gaps and improving outcomes.

Issue #2: Different and lengthy MCO utilization review standards and provider credentialing processes

- Each MCO has implemented a different utilization review process and criteria, adding to the already existing burden of providers to untangle procedures and obtain authorization. Providers spend too much time calling on prior authorizations and multiple reauthorizations, tracking phone messages, and repeat requests for information. The time burden created by this lack of standardization takes away from direct care, adds costs, and adversely impacts quality.

- Further, MCOs have inconsistent interpretations of “medical necessity.” The MCOs do not appear to maintain uniform standards nor understand how to apply “medical necessity” to specialty behavioral health services as defined by the State, especially rehabilitative services and substance use residential treatment programs. For example, one MCO used medical detox criteria for denying care for residential treatment, an inappropriate application of medical necessity.
- MCOs have no standardization of credentialing, and they take far too long to credential new staff, causing delays for licensed professionals and other staff who are qualified to deliver services when billing MCOs for services provided. Often, providers are not necessarily informed when credentialing is granted and completed. These issues have a destabilizing impact on providers’ budgets and their ability to serve the increasing number of people who are seeking behavioral health care because of Medicaid expansion and the COVID pandemic.

Recommendations

1. Require all MCOs to adopt a standardized set of national best-practice standards for utilization review that recognizes covered evidence-based practices, and tailor criteria to the Medicaid service definitions defined by the State. Require the use of ASAM criteria, the national best-practice standards for substance use treatment and rehabilitation. Limit the number of reauthorizations required when Medicaid services define the length of stay and/or the service has specific time frames for length of treatment, such as ACT, MST and FFT.
2. Require MCOs to adopt a uniform credentialing application and clearly defined process approved by Medicaid, and set the expectations that the MCO credentialing process will not exceed 30 days from receipt of a clean application. Further require that MCOs inform providers in a timely manner when their credentials are approved via written communication. Also require that MCOs include the newly credentialed provider in their claims payment system within the same timeline (30 days) to ensure timely payments for services. Require MCOs to report on the completion of the credentialing and technical claims denials quarterly, and implement performance incentives and penalties if required time frames are not met.

Issue #3: Extremely slow claims payment and limited Value-Based Purchasing for behavioral health

- Clean claims payments typically take between 30 and 90 days, with many claims taking longer than several months. For example, one provider has an outstanding accounts receivable balance of \$1.3 million, with \$981,060 beyond 120 days. Slow payments add costs and force providers to obtain lines of credit and pay interest, which unnecessarily depletes their resources. This situation applies to other providers, as well as behavioral health providers. Further, the MCOs have significant technical systems glitches related to claims payment. For example, some MCOs have not set up the code modifiers in their claims payment systems to address covered Medicaid services. Providers are at a loss to determine how to address this without improved oversight and accountability. MCOs

often do not respond to provider inquiries about how to address the MCO technical systems issues.

- Value-Based Purchasing, a goal of Heritage Health, is extremely limited for behavioral health. MCOs have made few attempts to include behavioral health providers in Value-Based Purchasing efforts, even though many larger providers have capacity to demonstrate good outcomes and share some risk. The lack of Value-Based Purchasing impedes access to key services because claims-based reimbursement often does not cover the cost of team-based evidence-based practices, such as NAVIGATE, first episode psychosis services supported by the Centers for Medicare and Medicaid Services (CMS).
- The use of “in lieu of” services option under managed care does not appear to be available to behavioral health providers. Further, alternative payment approaches for services known to have effective outcomes and costs savings are not available for BH services.

Recommendations

1. Include a requirement in the RFP for the MCOs to pay clean claims within 30 days to improve provider cash flow. Add MCO incentives and penalties to ensure compliance for timely claims payment and reporting.
2. Add language to the RFP that requires MCOs to respond within two business days to provider inquiries about technical challenges encountered with the MCO claims system. As noted above, lack of code modifiers for Medicaid covered services result in claim denials, without any ongoing resolution. Require the MCOs to track and submit quarterly reports on the number of denied claims resulting from technical challenges. Implement incentives and penalties if the MCOs do not have a plan of correction with a reasonable completion date and a plan to address previously submitted unpaid claims. Identify a Medicaid Division contact for providers to notify when claims payment issues are not addressed timely by the MCOs.
3. Require the MCOs to meet with behavioral health providers, especially Community Mental Health Centers, Certified Community Behavioral Health Clinics, hospitals, and specialty substance use treatment providers. These meetings should focus on developing and implementing a Value-Based Purchasing plan for a percentage of specialty behavioral health services dollars across the spectrum of care. The plan should also offer incentives for NABHO members delivering integrated care that demonstrates effective outcomes. Include the use of “in Lieu of” services option available to MCOs under management care and alternative payment arrangements.

Issue #4: Non-emergency transportation for individuals discharged from hospitals and outpatient settings

- Transportation is not available for individuals discharged from inpatient or outpatient procedures.

- This lack of transportation is especially troubling because staff spend significant time trying to organize transportation and schedule rides to clients' homes.

Recommendation

1. Clarify the language in the RFP about financial responsibilities and arranging non-emergency transportation for individuals discharge from inpatient and outpatient settings.
2. Address the requirement that transportation should be available timely, or within 30 to 60 minutes for individuals discharged from inpatient and outpatient procedures.



Heritage Health Listening Session
Kathy Nordby, CEO
Midtown Health Center
January 20, 2022

Good afternoon Director Bagley and members of the Medicaid team. My name is Kathy Nordby and I am the CEO of Midtown Health Center, located in Norfolk and Madison. I am here today on behalf of Health Center Association of Nebraska (HCAN) and Nebraska's seven Federally Qualified Health Centers. Thank you for the opportunity to provide input as you begin this contracting process.

In 2020, Midtown Health Center served over 7,000 patients across 22,000 visits. Like all of Nebraska's seven community health centers, Midtown is a nonprofit, community-based organizations that provide high quality medical, dental, behavioral, pharmacy, and support services to persons of all ages regardless of their economic or insurance status. Health centers are a critical component of the safety net in Nebraska, providing comprehensive, culturally appropriate primary care to over 107,000 patients statewide at 70 different servicelocations. Nearly 47% of health center patients are uninsured and 93% are low income.

Thirty percent of Midtown's patients are Medicaid recipients. Medicaid plays a critical role in our patients' lives and for our health center. We appreciate the opportunity to participate in this listening session. As you consider the RFP and contracting process, we request that you consider the following:

First, transition to new MCO providers or change of ownership of existing MCO's has caused significant credentialing issues, with delays as long as 60-70 days in completing the credentialing process. Credentialing timelines and processes should be streamlined and consistent across all MCOs. This includes provider eligibility retroactive to the application date, a 30-day timeline that is strictly enforced.

Second, we encourage the Department to continue to work with providers to clarify and improve the value-based contracting process across all MCOs. Value-based contracting can play a critical role in enhancing quality and driving down the overall cost of care. The Department should consider implementing a core set of quality measures across all value-based contracts as well as incorporating social determinants of health into value-based arrangements.

The integrated care model utilized by health centers rests on the ability to use behavioral health warm handoffs conducted during medical visits. Currently these services are considered add on services since Heritage Health was implemented. Going forward, community health centers would propose working together to find a solution that will remove limits on the number of integrated visits that can be billed in a year, as well as enable those visits to be billed as a health center encounter.

Finally, I would strongly encourage the Department to consider past MCO performance when awarding new contracts. Ongoing delays, improper denials, and ineffective systems do little to further the goals of Heritage Health.

We appreciate the opportunity to share these comments with you and look forward to working with the Department and MCOs to enhance the Medicaid program in Nebraska.

Thank you.



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To: Kevin Bagley, Director of the Division of Medicaid and Long-Term Care (MLTC)
From: Nebraska Psychological Association
RE: Comments for DHHS Listening Tour for Medicaid's Managed Care Program
Date: January 27, 2022

Thank you for the opportunity to submit written comments regarding DHHS' listening tour for Medicaid's managed care program. We have enclosed a list of concerns and possible solutions. NPA will have a representative in attendance at the virtual meeting Thursday, January 27, 7:00-8:00 p.m. (Central) for the purpose of communicating any comments or questions from the Medicaid team back to NPA Board Member psychologists.

Psychological Evaluations:

1. Problem: Time and resource intensive efforts for clinicians, office staff, and presumably MCO staff for psychological evaluation preauthorization requests (e.g., CPT codes 96130, 96131, 96136, 96137). Additionally, subsequent to submitted requests, clinicians rarely and inconsistently receive feedback regarding authorization status.

Proposed solution: Allow 8 hours of psychological testing, per year, per client with no preauthorization required but still within medical necessity standards. Psychological evaluations consistently warrant this much time, and the 8 hours of approved evaluation time will save time, hassle, and ultimately money (e.g., MCO staff managing initial requests, appeals, paperwork).

2. Problem: Relatively short timelines occur, wherein on-line account access for providers is rendered inactive. When providers attempt to log-in, they receive a message advising they request access again or contact their administrator. This unnecessary delay, with no links/contact information provided, is inefficient and necessitates more time and effort for clinical and MCO staff. Preauthorization status checks, for example, are delayed.

Proposed solution: Consider implementing longer periods of time prior to terminating access to on-line resources and send a user-friendly, efficient reminder to providers with a link and easy renewal options provided to their email addresses as deadlines approach. Most payors, outside of the Heritage Health system, have significantly longer periods of account access timelines, and they prompt clinicians with easily accessible solutions as deadlines approach.

3. Problem: Out-dated preauthorization evaluation requests have continued with one of the three MCOs. Two of our NPA psychologists spent over an hour in a meeting with multiple representatives from the company to support updates including specific links provided to MCO staff members that reflected up-to-date/accurate prototypes. While the problem was acknowledged by MCO staff, the psychologists were told no change could occur. MCO staff appeared to concur that the outdated form contributed to related denials that otherwise would not be happening had the form been currently consistent with relevant CPT codes. Nothing changed.

Proposed solution: Consider having a standard preauthorization form and approach across the MCOs for extended psychological testing requests, if more than 8 hours are required for the calendar year. For

example, UHC's form is easily accessible on-line with an option to save the request, clear with clinically relevant questions, manageable to complete, and up to date with current industry standards (e.g., <https://electronicforms.force.com/PsychTesting1/s/>).

4. Problem: During these past several months, two of the three MCOs appeared to begin partially authorizing psychological testing preauthorization requests. Providers are experiencing "shaving" of units (e.g., 5 hours granted from an 8 hour request), with no consistent rationale provided and inconsistent with similar past requests but with different authorization outcomes.

Several of our psychologists can provide examples of the capitated authorizations, with one of our psychologists citing the following experience. She received full pre-authorization for psychological testing during the Spring of 2021. However, the client was unable to participate until the Fall of 2021. At that point, the authorization was expired, and the psychologist re-submitted the same exact request. The request was deemed for unknown reasons to "not be medically necessary," and the number of units were diminished from the original authorization.

Proposed solution: The prior proposed solution of allowing 8 hours yearly, prior to requiring preauthorization, would likely improve staff time efficiency, foster increased differential diagnosis and effective treatment for clients and clinicians, and minimize inconsistency and denials. Nebraska Medicaid staff sponsoring this listening tour and being responsively accountable to the types of requests presented here provide hope and potential for targeted improvements.

5. Problem: Payment denials for CPT codes 96138 and 96139 (technician codes) appear to be occurring for unknown reasons. Providers are subsequently required to resubmit authorization requests for reconsideration before getting paid correctly. Concerns include poor time efficiency for providers, clients, and MCO staff, inconsistent processing of claims, and denials for legitimate and allowed CPT codes.

Proposed solution: Require consistent approvals and proper claims' processing across MCOs for CPT codes 96138 and 96139.

Mental health crises are escalating in our State, our country, and around the world. Providing thorough, competent, tailored evaluations is a unique and valuable skill set for psychologists. Differential diagnosis is at the forefront of providing individualized, sensitive, effective care that ultimately decreases cost because treatment becomes more efficient when informed by diagnostic clarity via evaluations by psychologists. Evaluation requests have likely decreased over the course of the past few years because of the "tip of the iceberg" concerns listed above, in this document. Providers having to struggle with partial authorizations with unclear authorization status has been an obstacle to clients accessing quality services. Even if evaluation numbers are relatively diminished, the cost to clients, providers, and very likely MCOs have likely increased because of less informed and thus cost-inefficient care. Incentivizing MCOs and providers to utilize psychological evaluations is absolutely indicated for good clinical care and for ultimately for fiscal responsibility.

Mental Health Services beyond Psychological Testing:

6. Problem: MCOs appear to no longer be covering interpreter services which significantly impacts access to care for our most vulnerable populations. As the issue stands now, our understanding is that providers are faced with using the majority of the contracted mental health service rate they receive for paying interpreters when needed.

Proposed solution: Collaborate with providers and clients who have experience, historically, with this issue given interpreter support was a covered service at one time. Improvements can be made with good communication and proactive planning.

7. Problem: Provider credentialing timelines appear to have been extended from 30 days to 90 days with poor communication about progress. Disrupting timely access to mental health services, especially with psychologists-in-training and new clinicians, is particularly disruptive during this national mental health crisis. Also, ambiguity exists for the level of credential required for a person finishing their last year of their doctorate degree in terms of credentialing and reimbursement. Limiting access to care as well as presenting inconsistent reimbursement rates across agencies then requires agencies to keep up to date of the requirements of each MCO.

Proposed solution: Present clear and consistent guidelines regarding the credentialing of psychology interns via collaboration with internship sites leaders and the Behavioral Health Education Center of NE. Pursuing a collaborative effort using programs already in place to bring early career providers to the state in a manner that is beneficial to the community, while reducing undue burden to the agencies and providers providing the opportunities, is suggested.

8. Problem: Healthy Blue's lack of payment issues have been catastrophic for participants in care – mental health and other clinics – and for providers.

Proposed solution: The ultimate solution to this protracted series of challenges historically involved escalated communication via State Senators who took action, providers, staff people involved with a variety of professional organizations, and even clients. Tireless and vocal advocacy to collaborate via a “collective voice” moved stalled payments after months of inaction and for some practices, termination of Medicaid contracts and even bankruptcy. Clients experienced significantly disrupted, and often abruptly discontinued, care.

Nebraska Medicaid staff continuing to actively seek provider input and endeavoring to be functionally and visibly responsive to the types of requests, as presented here, is helpful. Impacting future contracts for MCOs via detailed and recurrent reviews of experiences and suggestions is imperative for all stakeholders committed to improving Nebraska Medicaid services.

cc: dhhs.heritagehealth@nebraska.gov



January 27, 2022

Department of Health and Human Services
Division of Medicaid and Long-Term Care
Attn: Medicaid Communications
301 Centennial Mall South
P.O. Box 95026
Lincoln, NE 68509-5026

Re: Feedback from Quality Living Inc. (QLI) regarding our experience with Medicaid's current managed care system

Dear Director Bagley,

Thank you for your sincere interest in gaining feedback from the numerous entities impacted by Nebraska Medicaid's use of a managed care system. QLI has been a fixture among the Nebraska healthcare community for over 30 years, serving a uniquely complex and resource-intensive population: individuals who have suffered catastrophic brain and spinal cord injuries. QLI was born from a creative and collaborative relationship developed between our organization and the State of Nebraska Department of Health and Human Services, in an effort to answer the significant health service challenge of caring for this specialized population of Nebraskans. Nebraska Medicaid recipients have been a fixture among the patient population served at QLI since we opened our doors, and we have been committed to continuing to serve these patients for as long as possible.

This commitment has not come without its challenges, however; most recently and significantly Medicaid's transition to a managed care system. Our experience thus far in working with Medicaid managed care in Nebraska is that the system is not capable of appropriately managing the specialty population QLI serves.

The specific issues QLI has faced are summarized into the following categories:

- There is no mechanism in place to ensure Managed Care Organizations (MCOs) manage to the best long-term outcome. They are incentivized to manage to the lowest short-term cost.
 - MCOs are less incentivized to consider the long-term costs of patients with incomplete rehabilitation outcomes, because the likelihood of that MCO bearing the lifelong cost of caring for that member is miniscule. Whereas the likelihood of the State of Nebraska bearing that long-term cost is almost a sure thing.
 - Misinformed length of stay decisions have adversely affected patients' likelihood of achieving recovery milestones that would significantly decrease long term costs to the state (i.e. tapering off medications, decreasing caregiving needs, increasing likelihood a patient will return to work or driving)
- MCOs often have an individual medical decision maker lacking the requisite expertise in the specific population they are reviewing to effectively manage it. This results in inappropriate and inconsistent utilization decisions, depending on the reviewer.
 - QLI has had to add staff specific to meeting the reporting requirements of MCO's, including completing the lengthy and cumbersome appeal process when these inappropriate denial decisions are given. These are costs that we have then been forced to reflect in higher rates for services.
- Similarly, the guidelines employed to make utilization management decisions lack specificity to a very unique population of patients being served. It is not appropriate to utilize standard Milliman, Medicare, FIM or other traditional skilled care management guidelines to determine authorization or progress at a Special Needs Nursing Facility like QLI. As a Special Needs Nursing Facility, QLI

operates under a distinct set of regulations, and again and again since the transition to managed care, MCOs have proven both ignorant of and resistant to complying with these regulations

- Failure to consider non-traditional criteria for coverage leads to a lack of attention to important cognitive or behavioral issues that can significantly contribute to long-term costs when not appropriately addressed.
- MCOs are either unwilling to be collaborative in their utilization decisions or do not retain people in individual positions long enough to make the necessary collaborative processes sustainable. This necessitates constant re-education and advocacy by providers for previously established effective processes.
- The appeals process is too slow and weighted against patients and providers to be an effective tool to hold MCO decision makers accountable.
 - This issue is exacerbated for providers, as there is no accountability for the MCO when they deny a patient who has no appropriate or available discharge location.
 - As MCO's have decreased the number of days they are willing to authorize for a patient and their team at QLI to establish a safe and successful discharge plan, this has forced QLI to assume costs of unfunded days until such a plan can be established.

With a desire to continue to be a collaborative partner to NE DHHS, we would submit the following suggestions for changes within the Medicaid managed care system that could address some of the issues noted above.

Overall, we would like to see changes implemented that support a collaborative process between a provider with the highest degree of expertise in the client population it serves and a funding source that is invested in the long-term success of both that client and the State. Two specific suggestions to that end are:

- 1) Support from DHHS for implementing a method by which the MCO's are made to abide by the existing "Special Needs Facility" regulations when managing cases at QLI. This includes providing at least an initial 90-day authorization (which the current regulations dictate).
 - We would also propose updates to the regulations including that patients are allowed to remain in the facility, and the MCO's reimburse the facility, for no less than 30 days from the date of the notice of continued stay denial or until a safe discharge can be completed.

OR

- 2) Exclude Special Needs Services from the scope of managed care contracts through a contract amendment. Thus, Special Needs Facilities, such as QLI, would be subject to fee for service utilization review and claims payment. This would enable QLI to partner directly with DHHS on achieving the most financially beneficial long-term outcomes for a very complex population of Medicaid recipients. Not to mention the benefits to consumers in being afforded the most appropriate access to highly specialized services to achieve their highest potential following catastrophic injury.

The healthcare landscape in which QLI was born into existence over 30 years ago has changed dramatically. We recognize and truly appreciate that the system for managing the costs associated with healthcare must adapt and evolve in response to those changes to effectively serve its beneficiaries. QLI remains a committed partner to Nebraska's DHHS in navigating a path forward that is most effective for those beneficiaries, providers and the State. We appreciate your consideration of the information presented herein toward that effort.

Sincerely,



Michelle Ploeger
Provider Relations Coordinator

D: (402) 573-3723 F: (402) 573-2170
mploeger@QLIomaha.com

Heritage Health Listening Session
Health Center Association of Nebraska Comments
By Andrea Skolkin, CEO
OneWorld Community Health Centers, Inc.
January 18, 2022

Good morning Director Bagley and members of the MLTC team. My name is Andrea Skolkin and I am the CEO of OneWorld Community Health Centers, located in Omaha. I am here today on behalf of Health Center Association of Nebraska (HCAN) and Nebraska's seven Federally Qualified Health Centers. Thank you for the opportunity to provide input as you begin this contracting process.

Nebraska's health centers are nonprofit, community-based organizations that provide high quality medical, dental, behavioral, pharmacy, and support services to persons of all ages regardless of their economic or insurance status. Health centers are a critical component of the safety net in Nebraska, providing comprehensive, culturally appropriate primary care to over 107,000 patients statewide at 70 different service locations. Nearly 47% of health center patients are uninsured and 93% are low income.

We appreciate the openness of Medicaid leaders at the state to listen and address issues. Medicaid is a critical program for both health centers and our patients, with nearly 30,000 health center patients receiving health insurance coverage through Medicaid. When Heritage Health launched in 2017, health centers worked closely with the Department and managed care companies to address the initial bumps and challenges. As you consider parameters for the new Heritage Health contracts, we ask that you consider the following:

First, transition to new MCO providers or change of ownership of existing MCO's causes tremendous credentialing and billing issues and we would like to see MCO accountability for the process incorporated into the Request for Proposals.

Next, credentialing timelines and processes should be streamlined and consistent across all MCOs. This includes provider eligibility retroactive to the application date, a 30-day timeline that is strictly enforced, and standardized credentialing processes across service lines.

Second, the value-based contracting process is inconsistent across current MCOs. The utilization of a core set of quality measures across all value-based contracts will provide a more robust quality management program for the entire Medicaid population. In addition, the Department should consider how the social determinants of health value-based contracting standards to ensure that the drivers of health are considered.

Next, behavioral health warm handoffs, conducted during medical visits as part of the health center integrated care model, are not currently counted as authorized services. They have been considered add on services since Heritage Health was implemented should be able to billed at the health center encounter rate, and not limited to five per patient per year.

A few additional thoughts to share as the RFP is written and published:

Pharmacy: We would like Medicaid to cover Vitamin D Drops (used for Vit D supplement for nursing babies), Saline nasal spray (for kids/babies), chewable multi-vitamins and chewable multi vitamins with iron (kids), Vitamin B6 and Doxylamine (both used for nausea/morning sickness).

Heritage Health Listening Session
Health Center Association of Nebraska Comments
Page Two
January 18, 2022

Language: Language is a barrier for many members of Medicaid Managed Care. We would encourage communication by Medicaid Managed Care in methods in addition to written language and want to note that that some Medicaid enrollees are not literate and language let alone English.

Random Patient Assignment: The Company that randomly assigns primary care providers needs optimization. Often times patients are not assigned to the correct primary care provider, this often causes additional work for the MCO's and providers, and particularly impactful in value based care contracts.

Finally, the Department should strongly consider past MCO performance when awarding new contracts. Ongoing delays, improper denials, and ineffective systems do little to further the goals of Heritage Health – to provide high quality service efficiently and in a cost-effective manner.

We appreciate the opportunity to share some of the lessons we have learned over the last five years and we look forward to working with you to enhance the Heritage Health experience for both providers and patients.

Thank you.



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facebook.com/aarpnebraska

January 18, 2022

Nebraska Department of Health and Human Services
Kevin Bagley, Director
Division of Medicaid and Long-Term Care (MLTC)
Lincoln, NE 68509-5026

RE: Nebraska Medicaid Heritage Health Program – community feedback on programs

Director Bagley:

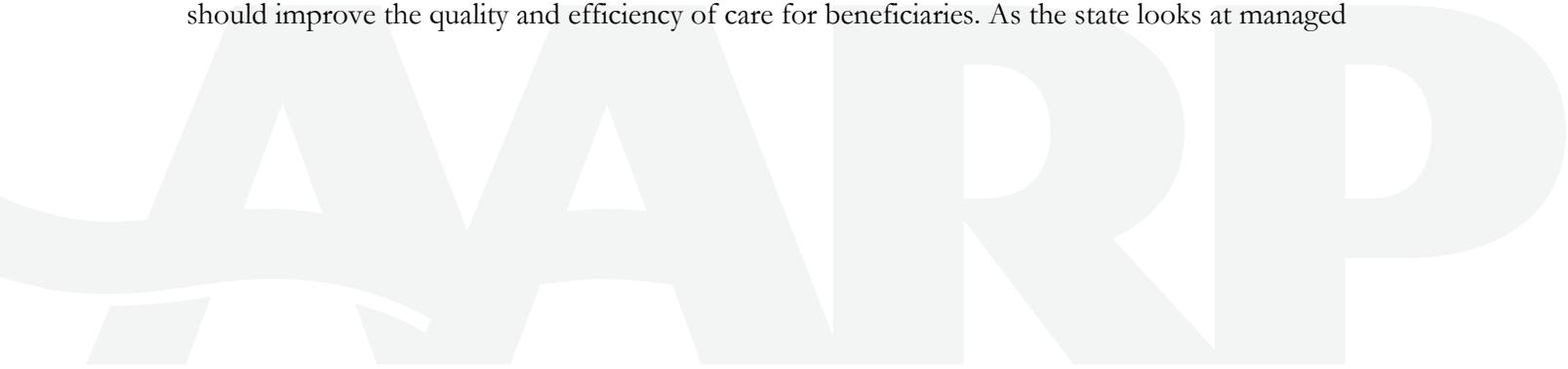
Thank you for the opportunity to comment on the Nebraska Medicaid Heritage Health program ahead of the contract procurement process for 2022.

AARP Nebraska is a non-profit, non-partisan organization that works across Nebraska to strengthen communities and advocates for the issues that matter most to families and those 50+ such as caregiving, healthcare, employment and income security, retirement planning, affordable utilities and protection from financial abuse.

Between 2015 and 2050, the age 85+ population in Nebraska is projected to nearly triple, from 42,000 to 121,000 which is a change from 2% to 5% of the US population. People age 85+ are the most likely to need assistance with activities of daily living, such as bathing, eating, transferring, and toileting. Additionally, nearly 1/3 of this population has dementia, often requiring higher levels of care and assistance. The “Silver Tsunami” is upon us and with that comes the need to review and makes changes at all levels.

AARP Nebraska has been following the implementation of Medicaid Managed Care since its debut in January 2017. Our concern has always been and will continue to be ensuring adequate access to providers and services across the state for consumers utilizing such programs. We certainly agree that progress has been made with Medicaid Managed Care since the inception of the program and appreciate and recognize the Department’s continuous work to identify and address such issues.

AARP believes that Medicaid should remain a vital safety net that guarantees adequate and affordable health care that meets the needs and preferences of beneficiaries. Further, Medicaid should improve the quality and efficiency of care for beneficiaries. As the state looks at managed



care contracting for 2022, improving accessibility, quality, and affordability of care for beneficiaries should be a top priority.

While there appears to have been progress made in addressing many of the challenges with the program, we continue to hear from provider groups that issues are still very relevant and that many providers are still struggling overall to make the program successfully work. As examples: prior authorization delays and denials, payment delays or denials all of which trickle down to the consumer. The longer a patient waits to begin services such as therapies the further the setbacks can be to their recovery which in the long run will further extend their need for ongoing, higher paying services. We are fortunate that many providers who have or continue struggling with the program continue to provide and maintain services and relationships to Medicaid consumers, many struggling to keep their doors open. We are concerned, however, that many providers are no longer able to continue allowing that extended access and are and will continue to provide less services to those that qualify for these programs and services. It is critical that all Nebraskans, regardless of where they reside, have the ability to access all of the contracted plans without limitations.

For adults 50+, containing costs and maintaining accessibility is especially important, in both rural and urban parts of the state. AARP's Public Policy Institute has found that for adults age 50-64, 14.7% in rural areas and 13.1% in urban areas had to forgo health care due to cost.¹ We encourage the state and Nebraska Medicaid to conduct an annual review of rules for paying providers and MCOs to ensure that they do not undermine health care access. The state should consider payment incentive systems that reward high quality and improvements in care. Additionally, beneficiaries should have reasonable and adequate access to providers, especially in our most rural parts of the state.

AARP recognizes that the state, supported by federal guidance and oversight, has the flexibility to innovate and strengthen the Medicaid program in ways that do not cause harm to beneficiaries. We ask that Nebraska continue to strive to improve Medicaid managed care in order to provide greater affordability and access to care for Nebraskans across the state.

Thank you for the opportunity to comment and be part of this process. We look forward to working with you through this process and would be happy to assist you in any way possible. Please do not hesitate to contact Jina Ragland, Associate State Director of Advocacy, at 402.323.5424 or jragland@aarp.org, if you have questions or concerns or need additional information.

Sincerely,



Todd Stubbendieck
State Director, AARP Nebraska

¹ <https://www.aarp.org/content/dam/aarp/ppi/2021/10/rural-urban-health-disparities-among-us-adults-50-older.doi.10.26419-2Fppi.00151.001.pdf>

DHHS MLTC Experience Management Provider Relations

From: judi scott
Sent: Thursday, January 27, 2022 11:27 AM
To: DHHS MLTC Experience Management Provider Relations
Subject: The impossibility of using the Medicaid system

Hello Mr. Kevin Bagley,
I've received the nice letter that you sent to the Medicaid Providers wishing us well and giving us a opportunity to share our experience with Medicaid. I could not pass the opportunity to share my experience with trying to utilize Medicaid as a way of assisting the precious people who I call clients. I started the process of registering as a provider in February 2021 it took about 4 month averaging about 10 hrs. per month to realized I needed additional assistance with the process of getting registered. So I reached out to a super nice man name Nic Zajac with Nebraska Total Care. Mr. Zajac worked with me each day for about 4 days averaging about 4 hrs. per day until finally I got registered and received my registration info. Then, I realized I had only done apart of what was needed to be able to bill Medicaid (for Total Care only). So, for the next 2 months I worked on the registration through NPPES, MAXIMUS, DHHS, CAQH, PaySpan, Total Care, Availity/Healthy Blue and a couple other sites then I received my Nebraska Medicaid Provider ID # on 8/20/2021. It took a lot of time and tears with frustration to get to that point. It is now 5 months (1/27/2022) since receiving my ID# and I am no closer to participating in the Medicaid program because navigating the various different websites are an impossibility! The UHC website is a living nightmare! And you go round and round on the Total Care and Availity sites. I've had to save myself from the pain called Medicaid billing and I have to settle for providing service only to those with vouchers, cash and I give up to 2 Medicaid clients free service per month (because that's all I can afford) since I had to give up trying to access Medicare, for my own health (stress) and sanity. Well that's my Medicaid experience, thank you for your statement "One of our priorities at the Medicaid program is to ensure providers' perspectives are taken into account in all our decisions." This allows me/us who feel that the process of getting registered/approved and

utilized the Medicaid program, is way to difficult and a easier method of trying to be a Medicaid provider is needed, Thanks for your time and if you know of any worker who may be able to help me figure out what I can do to be able to use Medicaid as a billing source I would greatly appreciate it.

Judi Scott, PLADC

Healing Stone IOP/OP Service

Preston, Drew

From: DHHS Heritage Health
Sent: Monday, January 31, 2022 12:54 PM
To: Preston, Drew
Subject: FW: Follow-up Info as Requested Regarding NE PHRDH codes

From: Kerri Dittrich
Sent: Monday, January 31, 2022 10:54 AM
To: DHHS Heritage Health <DHHS.HeritageHealth@nebraska.gov>
Subject: Follow-up Info as Requested Regarding NE PHRDH codes

Good morning!

I want to thank the staff from DHHS who participated in the Medicaid Managed Care Statewide Listening Tour in Norfolk. The meeting was very productive and I felt like concerns were readily accepted.

I was asked to provide follow-up information on the comments I gave at the meeting. I spoke on behalf of local public health dental hygienists. Currently I work for a local health department and provide preventative dental services to children in schools and childcare centers in my area. In the past 6 months I have provided services to over 1300 children (43% of those served indicated they do not receive regular dental care). A major component of my program is referring children to local dental providers to establish a dental home and to receive further treatment as needed.

Several years ago, Public Health Dental Hygienists were able to be reimbursed by NE Medicaid for conducting oral health screenings. Currently there is no reimbursement for such services. With the shortage of dental providers that accept Medicaid patients, my program and the oral health screenings I can offer are so important for the oral health of the patients I serve. Below is some information about the screening codes along with several other codes that if reimbursed for Public Health Dental Hygienists would greatly improve oral health care access and outcomes.

The following codes are reimbursed for a Dentist, but NOT for a Public Health Dental Hygienist:

- D2940 (\$33.96) Protective Restoration
- D5410 and D5411 (\$21.23) Denture adjustment (upper/lower)
- D4355 (\$48.82) Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis

In 2013, two new CDT codes were added to address occasions when a comprehensive dental exam is not conducted by a dentist—D0190 (screening of a patient) and D0191 (assessment of a patient). Reimbursement has already been adopted in more than 16 states for these codes.

[Rules of Reimbursement - Dimensions of Dental Hygiene](#)

As noted above NE Medicaid does NOT reimburse Public Health Registered Dental Hygienists for either of these codes (D0190 or D0191).

Below is some more information to support the Public Health Dental Hygienist workforce:

Public Policy Recommendations Following an executive order from President Trump, in December 2018 the U.S. Departments of Health and Human Services (HHS), Treasury and Labor, in collaboration with the U.S. Federal Trade Commission and White House offices made public policy recommendations in a report titled Reforming America's Healthcare System Through Choice and Competition. Relevant to the issue at hand, the report said, "dental hygienists can safely and effectively provide some services offered by dentists, as well as complementary services." It also recommended:

- "The federal government and states should consider accompanying legislative and administrative proposals to allow non-physician and non-dentist providers to be paid directly for their services where evidence supports that the provider can safely and effectively provide that care."

[Facts about the Dental Hygiene Workforce | ADHA - American Dental Hygienists Association](#)

Thank you very much for your consideration in adding these codes as reimbursable procedures for Public Health Dental Hygienists. The need for such reimbursement is supported by the Nebraska Dental Hygienists Association, several local public health departments, and other organizations. Formal support statements can be provided upon request.

If you have any questions, or would like to request further information, please feel free to contact me directly.

Thank you again for your time and consideration.

Kerri Dittrich, PHRDH

Preston, Drew

From: DHHS Heritage Health
Sent: Friday, January 28, 2022 8:47 AM
To: Preston, Drew
Subject: FW: Thoughts

From: Ariella Reeves
Sent: Thursday, January 27, 2022 10:01 PM
To: DHHS Heritage Health <DHHS.HeritageHealth@nebraska.gov>
Subject: Thoughts

I wanted to talk at the meeting but my dogs kept barking.

As a provider who takes mostly Medicaid clients, I have found it very challenging to get paid. I was working with another practice and paneled under them. When the cost of rent became too great I decided to find a cheaper place to practice. What I did not realize was how difficult it was for me to be paneled on my own and now to get paid. As a provider we have a responsibility of continuation of care. I took all my clients with me to my new practice. 30 individuals 16 have Medicaid I could not just tell them "sorry I can't see you until I know for sure I am going to get paid." My paneling should have been finalized and done by October 1, 2021 when I moved. I started the process in June of 2021 so everything would be ready to go.. Instead it has been a nightmare. Changes that could make it easier:

1. The process should be simplified for practitioners who already have an individual NPI number and practice under a group tax ID number to go out on their own. This was my third move since going into private practice. It seems to get more difficult every time I moved.
2. Paneling should be easy and transparent and streamlined. When you go to the website to apply to be a Medicaid provider there should be a "this is what you need to complete for each MCO". A check list should be provided so that steps are not missed and paperwork should be easily found. The one thing my biller ran into was different MCO's telling her she forgot a form and because of that, payment would be delayed even after the contract was signed. When looking for the form it was hidden on the website and difficult to find.
3. I did have clients who had Healthy Blue and I found them a new provider because at the time I started my independent paneling process Healthy Blue said they were not accepting new providers. I wasn't really a new provider because I had been paid by them using my NPI number and the group tax ID at my old practice. I was a new provider though because I now had a new tax ID number and had to get a new NPI number. Healthy Blue should not have been able to say they were not accepting new Medicaid providers for mental health. That was a very big disservice to clients in Nebraska. I had a healthy blue waiting list, which now I am starting to work through because I finally was able to be in their network.
4. Currently Nebraska Total Care and UHC community continues to decline many of my claims saying I am not in network or I need preapproval. This is interesting because they do pay some of my claims. Every time they decline a claim I have to pay .25 to resubmit it. .25 is not a lot of money but it adds up. I have on average 90 claims a month. If I have to resubmit half of those claims over and over again I could end up paying a lot just to resubmit my claims.

I am part of a Facebook private practice group and I have seen other providers ask why they need to get pre approval before seeing their Medicaid clients. So this is not just an isolated incident.

5. Providers have a lot of requirements to make sure we are being ethical. What tools are holding the insurance companies accountable? Who do we call when insurance companies are not being ethical? There are no numbers that are easily found where we can report shady insurance practices.

Thank you for taking the time to have these community meetings. I don't think we need a new Managed care company for Mental Health. We just need to fix the ones we have.

Ariella Reeves MA LIMHP

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Preston, Drew

From: DHHS Heritage Health
Sent: Thursday, January 27, 2022 2:45 PM
To: Preston, Drew
Subject: FW: feedback re: MCOs

From: Robin Claussen
Sent: Thursday, January 27, 2022 2:22 PM
To: DHHS Heritage Health <DHHS.HeritageHealth@nebraska.gov>
Cc: Robin Claussen
Subject: feedback re: MCOs

Hello! I attended the meeting in Norfolk on 1/20/22. Since the meeting, I have been gathering data regarding our experience with the three MCO's. Overall, I heard three main concerns by other providers at the meeting- outstanding claims, the time it takes to get providers credentialed and the time it takes to complete the auth/reauth process. Below is the information regarding Liberty Centre Services experience with each MCO regarding the above referenced information.

Credentialing: the time it takes to become credentialed with each MCO

UHC- 6 weeks

HB and NTC- 4 months

Outstanding claims as of 1/26/22

	Less than 30 days		30 days		60 days		90 days or more	
Nebraska Total Care	\$	116.59	\$	116.59	\$	162.03	\$	1,331.3
United Healthcare	\$	349.77	\$	5,914.60	\$	4,604.72	\$	5,297.6
Healthy Blue	\$	233.18	\$	594.57	\$	927.27	\$	5,468.1

Grand Total:

Initial authorizations and Re-authorizations: the time it takes to complete an auth with each MCO

For all three MCO's, it takes an average of 1 hour to complete an auth or reauth for community support, psychiatric day rehab and psychiatric residential rehab services.

HB- don't notify provider if/when approved, have to call for the info and it takes an average of 30-60 minutes to get this information, are not providing timely responses for initial auths- this has recently been taking two weeks to get an approval and in the meantime, we are providing services to the person served (yet we don't know if we will be paid for the service provided). Initial auths are supposed to take up to three days, not two weeks.

UHC- most of the time they are only approving partial authorizations; therefore, we are completing authorizations twice as often as the other two MCO's and that takes additional time, the website to get auth info is not working for our staff and the tech staff have not been able to get it to work so staff have to call UHC to get the auth info and that takes an average of 30-60 minutes to complete.

It's difficult to keep track of three different MCO's processes. One or two would be much easier and appreciated.

If you have any questions, please don't hesitate to contact me at 402-750-7650.

Thank you!

Robin Claussen, LIMHP, LADC
Liberty Centre Clinical Director



Preston, Drew

From: DHHS Heritage Health
Sent: Thursday, January 27, 2022 2:44 PM
To: Preston, Drew
Subject: FW: Feedback on current Medicaid Plans

Drew,

I confirmed this is for the for the Medicaid Listening Tours. She was unable to attend virtually but was told she could email in feedback.

Thanks,

Doug Bauch | *DHHS Program Manager II*
MEDICAID & LONG-TERM CARE

Nebraska Department of Health and Human Services

OFFICE: 402-471-4547 | CELL: 531-530-7302

DHHS.ne.gov | [Facebook](#) | [Twitter](#) | [LinkedIn](#)

From: Rachel Andersen
Sent: Wednesday, January 26, 2022 11:42 AM
To: DHHS Heritage Health <DHHS.HeritageHealth@nebraska.gov>
Subject: Feedback on current Medicaid Plans

Hello,

I am currently working as a Social Services director for one of the largest nursing homes in Omaha. My background is a Master's in social work and LCSW licensure. I have worked as a medical social worker, specifically in the nursing home setting, for around 10 years. I'm heavily involved with everything related to Medicaid: applying for Medicaid, renewing Medicaid, Medicaid payment to facilities and Medicaid coverage for things like therapy, counseling and DME equipment.

The purpose of this letter is to specifically share my experience with the current Medicaid plans and how I feel they support our nursing home facilities and how well they serve the low-income elderly in our state.

Two primary areas I want to focus on is approvals for physical, occupational and speech therapy sessions and approvals for DME, such as wheelchairs.

United Health Care Community Plan does a good job of allowing the facility therapy team to provide treatment sessions for our long term care residents, as it is needed. Out of the three plans, they are the most reasonable to work with to be able to order customized manual and power wheelchairs for our residents who can no longer walk or self-propel a wheelchair.

I would also like to add that UHC offers additional services to their members such as social workers who will help with housing and community resources. I have personally worked with their housing specialists for a couple of my short-term residents and was blown away by their level of knowledge, expertise and compassion to assist their homeless members.

NE total care is one of the worst Medicaid plans I have ever worked with. They routinely deny therapy services, even for cases where it is blatantly obvious that my resident would benefit significantly. Or they will approve just a couple

sessions and then deny going forward. They are especially reluctant to approve speech therapy. Speech therapy is so necessary in the nursing home setting. It is very common for our dementia residents to develop significant swallowing issues as the dementia progresses. Without speech therapy to do treatment and/or recommend appropriate diets, the risk of aspiration (and subsequent hospitalizations) goes way up.

Another area that I am troubled by is their denials of wheelchairs. We have many residents who are unable to propel their own w/c, often due to strokes or chronic illness such as MS. They need power wheelchairs to be able to maintain independence and quality of life. NE Total Care always denies these wheelchair requests and states that the nursing home can push them in a regular chair. They seem to feel the nursing home should also provide the wheelchair themselves. Nursing homes don't have stock piles of wheelchairs to just give out. We've also tried to get custom items on regular chairs, such as a pressure relieving cushion to prevent sores and have been told "use blankets or towels".

Every year during open enrollment, the therapy department provides to my social work department a list of residents with NE Total Care, who need wheelchairs. We then work with the residents and their families to switch to the UHC Community plan. Rarely does UHC ever deny wheel chair requests- the same requests that are sent to NE Total Care and denied.

While I am so thankful for the UHC Community Plan, I also find it very unfair that they are likely paying out more for DME claims than anyone else due to NE Total Care's complete disregard for nursing home residents. I am sure we are not the only facility to be playing this game.

With Healthy Blue being a newer plan, I do not have any positive or negative feedback at this time.

Thank you for taking into consideration our facility's experience with the current Medicaid Plans.

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