[LB765 LB782 LB793 LB796 CONFIRMATION]

The Committee on Health and Human Services met at 1:30 p.m., Thursday, January 24, 2008, in Room 1510 of the State Capitol, Lincoln, Nebraska, for the purpose of a public hearing on LB765, LB782, LB793, LB796, and gubernatorial appointments. Senators present: Joel Johnson, Chairperson; Tim Gay, Vice Chairperson; Philip Erdman; Tom Hansen; Gwen Howard; Dave Pankonin; and Arnie Stuthman. Senators absent: None.

SENATOR JOHNSON: Let's go ahead and get started. I'm Senator Joel Johnson. This is the Health and Human Services Committee. Let me tell you who we've got here, and we'll soon have the rest of our group. On my right is Senator Tim Gay; we have our staff on both sides of us, Jeff and Erin; and then Senator Tom Carlson off to my left--Hansen; excuse me. There is a Tom Carlson. He is about twice as big so I don't want to get him mad at me. At any rate, Tom is from North Platte, a freshman senator down here, but doesn't act that way at all. And here comes the late Gwen Howard. And one of the things, just to warn you a little bit, you might have seen me coming in here kind of gimpy, so. They've got me on some medicine for some back and leg pain, and the--I'm so dry that I don't think I could spit if I had to. So if I sound a little funny, that's the reason for it. At any rate, here's Senator Pankonin, as well. Now, let's just go through a few things that are necessary. First of all, the cell phones: When the cell phones go off in the recorder's or transcriber's ear--there we go--they get very upset. One other little thing that they just really get mad about is some people will come up to the desk when they testify, and have a pen and do like that (tap-tap) on the glass surface, and it's kind of like tapping Morse Code. And we don't use that anymore, by the way. So at any rate, let's avoid doing that. The other thing, again for the record, would you state your name and spell it. It helps the people a lot when you do that. Now, there's also a page here that will help distribute any materials that you have; so anyway we can help you that way, fine. Now, one of the things--and it's probably my fault for not being a little bit hard-nosed about this to start with--is that yesterday we didn't get done until after 6:00. And, you know, we're here to listen until your done, but I think that the people that testify and talk first, if they go at this very slowly and use up the time, the fact of the matter is, we're not being very nice to the people that may have driven many miles just to talk at 5:00. There comes a point of diminishing returns of how much we can stand and take in, in one day, as well. So don't think that you need to think of being kind to us, but be kind to the person--you might be the one at 5:00 or 6:00 the next time, so. Be complete. I would ask that, please do not come up and read a three-page statement. We will ask you not to do that. Now, if you've got a one-page we might tolerate that, or whatever, but really be to the point. You're doing yourself and your cause a disservice by going on and on and on. All right. With that, we have two appointments, gubernatorial appointments. And Scot Adams, you want to be first? [CONFIRMATION]

SCOT ADAMS: Sure. Age before brains and beauty. [CONFIRMATION]

SENATOR JOHNSON: All right. Welcome. What Scot is doing is filling out a form there. And if you...when you get ready to testify, you might actually come up and do that before you sit down on the next one, so. Scot, welcome; glad to have you here. [CONFIRMATION]

SCOT ADAMS: (Exhibit 1) Thank you so much. It's good to be here. Good afternoon, Senator Johnson and members of the Health and Human Services Committee. My name is Dr. Scot Adams, S-c-o-t A-d-a-m-s. I began as director of the Division of Behavioral Health Services for the Department of Health and Human Services on July 1, and I'm honored that Governor Heineman appointed me to this position, and I will appreciate your confirmation of his appointment. Let me share a little bit about my career background. I served as executive director of Catholic Charities in Omaha for 13 years, and have more than 31 years experience in organizations that serve families in the area of substance abuse treatment and poverty. I've experience in strategic planning, operations, fund-raising--glad that's over, and public relations, and began my career work providing individual group and family therapy. I've also taught social work and social justice courses at Creighton University, Metro Community College, Methodist College, and the University of Nebraska at Omaha. I'm a licensed mental health practitioner and a certified master social worker, both in inactive status; and a member of the National Association of Social Workers, and Catholic Charities USA. I was appointed a member of the Community Corrections Council several years ago, from it's beginning. My bachelor's degree is in sociology and philosophy and a certificate of social work; these are from Creighton University. My master's degree is in social work from the University of Nebraska at Omaha, and I hold a doctorate in community and human resources from the University of Nebraska at Lincoln. And on a personal note, my wife Rita and I were high school sweethearts. We have been married since 1975 and have four children: Rebecca, Brian, Katie, and Emily. As director of the Division of Behavioral Health, my responsibilities include the regional centers in Norfolk, Lincoln, and Hastings; monitoring of community-based mental health and substance abuse services; and a new focus on children's behavioral health. All adult behavioral health services are now closed at the Hastings Regional Center, however we operate the 40-bed chemical dependency program there for adolescents. I'm encourage by the successes that we are seeing as a result of the behavioral health reform. Since LB1083 passed in 2004, we have redirected over $60 million in regional center funds to community-based services; increased community mental health services from serving 13,000 and more people in 2004, to nearly 26,000 in 2007. [CONFIRMATION]

SENATOR JOHNSON: Scot, give those numbers again, would you please? [CONFIRMATION]

SCOT ADAMS: All right. I will go with detail. Mental health services, serving 13,567 in fiscal year 2004, to 25,898 in fiscal year 2007. [CONFIRMATION]

SENATOR JOHNSON: Thank you. [CONFIRMATION]

SCOT ADAMS: We've increased community substance abuse services, as well, from serving 19,557 people in fiscal year 2004, to 26,254 in fiscal year 2007. We have closed 232 adult and 16 adolescent mental health beds at regional centers. We have collaborated with the regions to hold a series of emergency protective custody "road shows" for law enforcement and providers last summer. We have decreased the waiting list for regional center services to an all-time low in November and December. We've developed relationships for the development of a Lasting Hope Recovery Center in Omaha. We have supported and expanded opportunities for living situations outside of hospitals. In 2006, 127 people received housing-related assistance, and in the last fiscal year that number increased to 557. In addition, we have recently established the Office of Children's Behavioral Health and submitted the LB542 Department of Health and Human Services plan for behavioral health services for children and adolescents, on time, on January 4, 2008. We know there are many challenges to be faced, and some of those involve: supporting the option of assisted living in communities when appropriate for persons with mental illnesses; increasing emergency protective custody rates; increasing access to crisis care; and among the more important ones, increasing consumer involvement beyond the few and at all levels of our processes; integrating a recovery focus appropriately with other treatment visions; focusing in on special populations like individuals who are elderly or who also are developmentally disabled; and fully integrating mental health and substance abuse into behavioral health phraseology and terminology. Over the next year, my focus will be on completing behavioral health reform and integrating children's behavioral health services into the Division of Behavioral Health. The department submitted its new strategic direction for behavioral health for children and adolescents on January 4, in response to LB542 passed in 2007. My intent is to work with all of the stakeholders to ensure that we move forward together to create a comprehensive system of care for behavioral health, especially for children and adolescents. I believe that safety, dignity, and recovery are real, and are possible for individuals with mental illness. My vision for the division and for Nebraska's behavioral health system includes: completing behavioral health reform set out in LB1083; integrating children's behavioral health into the division; nurturing the behavioral health system; and helping Nebraska become recognized as a top-five state in providing behavioral health services, especially in the areas of consumer involvement, safety, accessibility, and effectiveness of treatment. That brings me to my priorities and where my focus will be during the next year and beyond: enhancing Nebraska's emergency protective custody procedures; balancing the role of the regional centers, both in relation to one another and in relationship to the behavioral health system as a whole; integrating children's behavioral health so that there's a single point for information, and improving the system's quality and accountability; and great inclusion of consumers in all aspects of the behavioral health system. I look forward to improving the quality of life in Nebraska through our mission of helping people to live better lives. And if I might take a quick moment to also make mention of a couple of

recent incidents at the Lincoln Regional Center. I'm sure we are all familiar with those. And I want simply to say that safety is our primary concern. There were two incidents of recent note: one involved the elopement of a person, a patient at the regional center; the other was a recent Joint Commission accreditation report. We have taken actions to address this and to ensure that this will not happen again, as safety is our most important concern with regard to patients and with staff. In the case of the elopement, we are conducting a root cause analysis to identify all of the dynamics that go into this process, and to fix those that happened. [CONFIRMATION]

SENATOR JOHNSON: Can you tell us exactly what that...you know, the nice 50-cent word, but what are we talking about? [CONFIRMATION]

SCOT ADAMS: A root cause analysis is formal terminology--it's from the Joint Commission or accrediting body, that requires us to look at the equipment, facility, environment, staffing, policy, procedure elements that go into any incident such as this. So we will be looking at those. We have had, as part of that, conversations with others and external folks, and we are looking at discipline, if that's a necessary outcome of the analysis. We expect the analysis to be done yet this week. We also will be looking at equipment needs or other procedural elements that might be improved to ensure that this doesn't happen again. [CONFIRMATION]

SENATOR JOHNSON: Okay, such as? Equipment needs or whatever? [CONFIRMATION]

SCOT ADAMS: Pardon me, sir? [CONFIRMATION]

SENATOR JOHNSON: Such...equipment needs or whatever, whatever you are kind of talking... [CONFIRMATION]

SCOT ADAMS: Equipment needs could include electronic communication devices or other methods. Policy needs might look at a review of the number of...the ratio, for instance, of patients to staff, on an outing; those kinds of things. [CONFIRMATION]

SENATOR JOHNSON: Okay. Now, you had the headline of the one incident, and so on. Is this representative of many problems that the accrediting people found, or is this somewhat of an isolated incident? [CONFIRMATION]

SCOT ADAMS: Thank you for the question. What you speak about is that the Joint Commission recently completed its site visit at the Lincoln Regional Center. The Lincoln Regional Center completed 386 out of 397 of the standards; passed them successfully. Words that were used at the exit interview included words such as "outstanding," "national model," and "exemplary performance." At the same time, while they were on site, they observed a situation in which there were no particular consequences, but the

situation involved a nurse in the medication area, where she was alone, and a patient approached her. They had an encounter, a discussion, a conversation, and the observer from the Joint Commission felt that this was a potentially dangerous situation because she was alone, had no panic button, and so in response to that they placed us into what's known as immediate threat. A determination...a preliminary determination of...preliminary denial of accreditation has been entered. This is a first step. And I want to assure the committee that we have not, at this point, lost accreditation, but have begun the step to ensure that we take necessary steps to improve the situation. What we have done today so far is this: We have ordered the development of cameras throughout S-5. This incident occurred on the unit known as S-5. It is the most secure unit at the Lincoln Regional Center. No other unit was identified as a need or in trouble, from the Joint Commission, so it was isolated to that single unit. In addition to the cameras, we have ordered panic buttons so that people can call immediately for additional assistance. Thirdly, we have had conversations with both the Nebraska State Patrol and with the Department of Corrections for additional security measures that can be of assistance to us, and we are involved in those discussions. We expect to have additional security personnel available probably within the next few days. We have also instituted a policy change or procedural change that each staff must remain in line of sight with another staff member so that there can be at least two people observing any single situation that can go on in the unit. We think we are taking actions that will improve the safety for staff and for patients, both on site at the Lincoln Regional Center and on outings in the community. Finally, let me say that outings to the community have largely been suspended at present while we go through the root cause analysis of the causes. Medical appointments will continue to occur, but we hope to come back with refined procedures, and as I said, the changes necessary to ensure safety. I appreciate your attention. I'm sorry for having taken so long. I would be happy to respond to any questions you may have. [CONFIRMATION]

SENATOR JOHNSON: I think it is necessary, and that's why I asked rather pointed questions about that and other instance, so. Senator Hansen. [CONFIRMATION]

SENATOR HANSEN: Thank you, Senator Johnson. Dr. Adams, thank you for being here today. On your first page of your resume--not your resume, but your testimony today--down at the next to the last bullet point there it says, closed 232 adult and 16 adolescent mental health beds at regional centers. Explain to me why that is a success--and just go ahead; sorry. [CONFIRMATION]

SCOT ADAMS: Sure. LB1083, passed in 2004, was a significant policy change for the state of Nebraska. One...the parameters of which were a move from reliance upon state regional center hospital care for those with mental illnesses to community-based care. In there, LB1083 specifically directed the reduction or closure of services, and we are working in line with that directive. The reason and rationale for the change in attitude and approach in Nebraska rests with the improved effectiveness of community-based

care as a result of people being able to be closer to jobs, to family, to friends, to the natural supports that occur. And so the reduction of those beds accompanies the development of additional community-based services to care for people who suffer from behavioral health disorders. [CONFIRMATION]

SENATOR HANSEN: Do you think that this is the best outcome for those citizens? [CONFIRMATION]

SCOT ADAMS: Long-term picture, absolutely it is the best outcome. In any transition there may be moments or individuals for whom the outcome may be problematic. We have worked, I think, extremely diligently in patient by patient by patient, to minimize individual impact to the extent possible and to move forward with the new paradigm set forth in LB1083. [CONFIRMATION]

SENATOR HANSEN: Thank you. [CONFIRMATION]

SCOT ADAMS: Thank you, sir. [CONFIRMATION]

SENATOR JOHNSON: Senator Pankonin. [CONFIRMATION]

SENATOR PANKONIN: Thank you, Senator Johnson. Scot, about a year ago you came before us and started this new position, obviously probably somewhat knowing the challenges, but yet as we...as I've learned over this last year, this area and so many of the areas that this committee oversees are very challenging and deal with people that are vulnerable or have serious issues and this sort of thing. Over this year's period of time I just would be curious about what you feel is your greatest satisfaction professionally, and also what area you think is the greatest challenge for us--for you and us as a state? [CONFIRMATION]

SCOT ADAMS: Well, just one? I have to tell you, I...in terms of personal satisfaction with regard to things, I have to tell you that the awareness of the scope and breadth of the state's involvement in the way that we touch lives in, I think, helping ways, has been very reassuring and encouraging. I am proud to be part of a team of people who really care deeply about the, as you said, the very vulnerable people with whom we are entrusted. I wouldn't...I say that not only about the state workers with which I am proud to work, but also about the colleagues and professional associates with whom we partner throughout the state. There are some great folks in Scottsbluff who care and go the extra mile in crisis situations and in noncrisis situations--the things that sort of keep a person going, keep a person alive, and keep them out of crisis. I am very proud of that kind of thing. Challenges, whew, boy, there are a lot of those. There are tensions that seem to be at odds with one another at times. For example, there is an inherent tension within the Division of Behavioral Health. On the one hand, to fund community-based services my job is to close another portion of what I'm responsible for: to downsize the

regional centers. There is an inherent tension in the fact. The electricity around the political dimension about almost anything in Lincoln is a fascinating experience, sometimes encouraging, sometimes startling, but always present. And that is for a guy from Omaha who worked at Catholic Charities, I was used to church politics. I thought I had those down pretty well. But this is a different breed of cat, and so that is another personal challenge on that side of things, and so I hope to become better at those kinds of things. From the systems point of view, I think in my testimony you see a couple of major challenges. Special populations. I've spent much of my morning with a young woman who experiences both developmental disabilities and mental illness. These folks are difficult because oftentimes the cross-training necessary to effectively and appropriately fully support her in her life may not be present on either side of that line. We have to have greater conversations and communication, training, and that kind of thing to help move that forward. [CONFIRMATION]

SENATOR JOHNSON: All right. Scot, I see no further questions. We'll also introduce Senator Arnie Stuthman from Platte Center, and that's on the grounds that you won't ask any questions, but...anyhow, Scot, thank you very much. [CONFIRMATION]

SCOT ADAMS: Thank you. [CONFIRMATION]

SENATOR JOHNSON: Okay. Next, Vivianne. [CONFIRMATION]

VIVIANNE CHAUMONT: Good afternoon. [CONFIRMATION]

SENATOR JOHNSON: Good afternoon and welcome. [CONFIRMATION]

VIVIANNE CHAUMONT: (Exhibit 2) Good afternoon, Senator Johnson and members of the Health and Human Services Committee. My name is Vivianne Chaumont, V-i-v-i-a-n-n-e C-h-a-u-m-o-n-t, and I began as director of the Division of Medicaid and Long-Term Care for the Department of Health and Human Services on May 14. I'm honored that Governor Heineman has appointed me to this position, and I would appreciate your confirmation of his appointment. I want you to know that I'm excited about the opportunity to lead Nebraska's Medicaid program and to be part of the team implementing the restructuring of the Department of Health and Human Services. Advancing the efficient and cost-effective delivery of healthcare services to Nebraska's children, elderly, and disabled is my primary goal, and I look forward to working with CEO Chris Peterson and the other directors in improving the quality of life in Nebraska through our mission of helping people live better lives. Let me share a little bit about my work background. For more than 20 years I've had a lead role in developing and implementing policy that impacts the daily lives of children, the elderly, and others in need. From 2001 to 2005, I was the Medicaid director for Colorado's Medicaid program and was responsible for establishing and managing the policies of Colorado's Medicaid program. During that time, I authored a rewrite of the state's managed care statutes; I

developed a review process to help ensure that rules and regulations were understandable to clients and in compliance with state and federal standards; I created a centralized data system to improve the efficiency and consistency within the department; and I brought efficiencies and accountability to Colorado's home and community-based services programs. From 1985 to 2001, I served as an assistant attorney general in the Colorado Office of the Attorney General. I was chief counsel for the state's Medicaid program and the children's basic health plan, which is like the CHIP program here, along with other public assistance and public health programs. From 1980 to 1984, I was counsel for the California Department of Health Services, advising the department on programs relating to environmental health. Most recently, I served as CEO of ValueOptions of Arizona, Inc., a company that contracted to manage the care and delivery of services to Medicaid clients and individuals with mental illness in Arizona. I received my bachelor's degree in psychology in 1975 and my law degree in 1978 from the University of California at Davis. On a personal note, I have three wonderful children: Jonathan, who graduated from Colorado State University, lives in the Washington, D.C. area; he will graduate from law school in a year. My son Colin just graduated last month from the University of Northern Colorado; and my daughter Katie is in her junior year at the University of Denver. Please note that none of them are Colorado Buffaloes (laughter) for which I am very happy. All three are political science majors. They keep me laughing, growing, humble, and poor. I want you to know that I returned to state government because I enjoy public sector work. I feel that policymaking is a great way to make a real difference in people's lives. Leading Nebraska's Medicaid program is a great opportunity and I'm excited to be a part of the team implementing the restructuring of the department. Making the department more accessible to all those we serve is an essential goal that I believe can be accomplished through good management and decision making. During the past eight months a number of things have been accomplished. The drug rebate collection for single-source, physician-administered drugs was implemented; a contract for the Medicaid Management Information System, know as the MMIS, has been awarded; a request for a proposal was released to study a defined benefit Medicaid reform proposal; a state plan for the Unit on Aging was approved by the Federal Administration on Aging; and a long-term care insurance partnership program was implemented. Over the next few months my focus will be on monitoring the progress of the Medicaid Management Information System contract, often referred to as the MMIS, and implementing the recommendations submitted by the department...by the Medicaid Reform Council, as well as exploring other ways to keep the Medicaid program sustainable. My goals are to facilitate the building of a new MMIS contract on time and on budget: to complete the Medicaid reform initiatives, such as providing intensive home visitation services to high-risk pregnant teens, aligning benefits with commercial insurance and care management for high-utilizing clients; continue to provide persons in institutions the option to live in the community; continue to evaluate processes to streamline or eliminate obstacles for providers to participate in the Medicaid program; and review and redraft regulations to clarify and update requirements. Accomplishing these goals will be

the next important steps in meeting two of the top priorities identified by the Governor for the department, and those are: continuing to slow the growth of Medicaid expenditures, and implementing the new MMIS on time and on budget. I look forward to improving the quality of life in Nebraska through our mission of helping people live better lives through effective health and human services. I would be happy to answer any questions you may have. [CONFIRMATION]

SENATOR JOHNSON: Senator Stuthman. [CONFIRMATION]

SENATOR STUTHMAN: Thank you, Senator Johnson. Welcome to Nebraska, Vivianne. [CONFIRMATION]

VIVIANNE CHAUMONT: Thank you, Senator. [CONFIRMATION]

SENATOR STUTHMAN: Do you find your past work with the Medicaid in Colorado is similar to what you're doing here? [CONFIRMATION]

VIVIANNE CHAUMONT: Yes, in a lot of ways. You...it's kind of like the same issues, different state. The issues, I think, are the same throughout the states, and that's how to make a program sustainable and yet available to the people that really need the program; how to keep providers invested in the program participating in the program; how to improve the delivery of services to clients. So a lot of the issues are the same. What they say about Medicaid is, if you look at Medicare--50 states, 1 Medicare program; with Medicaid, it's 50 states, 50 Medicaid programs. So there are differences, but a lot of the core issues are the same. [CONFIRMATION]

SENATOR STUTHMAN: Do you find the issues in Nebraska are better, easier to manage, than they were in Colorado, or vice versa? [CONFIRMATION]

VIVIANNE CHAUMONT: No. (Laugh) No, I don't think the issues here are any easier. I think Nebraska is ahead of Colorado in some areas and probably behind...one difficulty, I think in Nebraska, is how old the MMIS system is. That system is 30 years old and it's really being held together with Band-aids and gum. I think that once we have a system that's more up-to-date and viable, we will be able to have...to effectuate some changes in a lot simpler fashion. So that's one area where I think that we have some serious issues. On the other hand, I think that Nebraska has been very up-front, and ahead, in looking at Medicaid reform and how to control costs while still making the program sustainable, and that's an issue where I think we're doing well. [CONFIRMATION]

SENATOR STUTHMAN: Okay. I just have one comment. I just feel that you will be a real asset to the wonderful team that we have working with HHS. Thank you. [CONFIRMATION]

VIVIANNE CHAUMONT: Thank you, Senator. [CONFIRMATION]

SENATOR JOHNSON: Yes, Senator Hansen. [CONFIRMATION]

SENATOR HANSEN: Thank you, Senator Johnson. It's good to have you here again today. I just want to comment on your willingness to...and I think you have the willingness and the wherewithal to continue to slow the growth of Medicaid in Nebraska, while at the same time making sure the services that are needed get there. But your...the phone call that we had several weeks ago and the visit we had in my office looked like you are on the right track of slowing the growth of Medicaid, yet getting the services to the people who need them, especially children, and I appreciate that. [CONFIRMATION]

VIVIANNE CHAUMONT: Thank you. [CONFIRMATION]

SENATOR JOHNSON: Let me just kind of follow up on that just a little bit. You know, basically what we've talked about is lots of nuts and bolts-type of issues within the system. How about if we look at that whether we now have the nuts and bolts in place. If you were driving the car, what avenues would you have the people of Nebraska pursue in order to live healthier lives at less cost? [CONFIRMATION]

VIVIANNE CHAUMONT: I think we need to pursue the community alternatives for the elderly and disabled, and we need to have programs in place from early on so that people know, are aware of what their options are, and have the choices to stay in the community, stay in their homes, and be cared for in a less expensive manner, as well as a better quality of life for them. I think they need to be educated on those issues. That's...a big portion of the Medicaid budget goes to the elderly and disabled, and that would be one area where we need to continue to expand those services. [CONFIRMATION]

SENATOR JOHNSON: I guess one thing that's always come to thought, mind, with me is, you know, basically you're talking of a lower economic income here who are going to want these services. And what I see as we have an aging population, we then would also have a greater number of these people, but I'm also concerned about the other end of the economic scale, that they then go to Arizona or Florida or whatever, so that we don't...we lose those that may help our economy that way, and continue to expand the demand for the services, percentagewise. Is that a logical statement or not? [CONFIRMATION]

VIVIANNE CHAUMONT: I don't know that the Medicaid program would really see that. The exodus of older people to other states wouldn't, I don't think, what you're talking about, affect the Medicaid program in either way. It might affect the tax base that funds the Medicaid program. [CONFIRMATION]

SENATOR JOHNSON: Yeah, and see that's...well, like I say...yeah, and that's what I'm getting at. [CONFIRMATION]

VIVIANNE CHAUMONT: But...right; right. [CONFIRMATION]

SENATOR JOHNSON: So, all right. Well, any other questions? Vivianne, I see none. Thank you very much. I am also one of the people that believes that at this point in time the reorganization has been quite successful and the appointments that the Governor has made have been quite outstanding. [CONFIRMATION]

VIVIANNE CHAUMONT: Thank you. [CONFIRMATION]

SENATOR JOHNSON: Keep up the good work. All right. Now, we have a bit of a problem in that one of the people that one of our senators would like to make sure is here to testify, and so on, has to leave for an appointment before too late in the afternoon. So we're going to switch two bills. And what it is, is let's go with Senator Gay on LB765 first, and this is "change provisions relating to certificates of need," will be first. Tim. [CONFIRMATION]

SENATOR GAY: Thank you, Senator Johnson and senators of the committee, and thank you very much, Senator Howard, for allowing us to do this. I appreciate it very much because I know your bill is very important, too, and you have people that want to testify on behalf of that. But let me start. LB765 is a small bill with a big impact. It clarifies the certificate of need law in Nebraska for long-term care and rehabilitation beds. Just a little bit of a history on certificate of need, is in the '70s we had a certificate of need law in place from the '70s to 1997. In 1997, that was repealed but it was in place...it remained in placed for rehab beds and long-term care beds. So there was a reason they decided to do that, so if you grow at a moderate rate without the certificate of need approval, but any growth beyond that rate would have to go to a certificate of need program. This growth rate has allowed the certificate of need approval. And what it reads is, what we thought it did, the lesser of 10 beds or 10 percent of either the total rehab beds or long-term care beds of the facility over a 2-year period. So if I'm a Papillion hospital, let's say, and I currently have 20 rehab beds, I could add the less of 10 beds or 10 percent of my 10 rehab beds, or 2 beds over a 2-year time period. At least that was the way the department interpreted the language over the past ten years, and this was a method that controlled the growth. Unfortunately, the statutory language is ambiguous. It's unclear right now whether that 10 percent refers to the total bed capacity in all of your facilities or just a specific versus long-term care or rehab. So there is a substantial difference there and how it was intended. This bill would clarify that language a little bit. So because this law is ambiguous, a Nebraska hospital asked the department for its interpretation of the law. The department reiterated its position that it was 10 percent of the total rehab or long-term care beds; not 10 percent of the total

beds at the entire hospital. The hospital took the state to court to interpret the language, and the court ruled in favor of the hospital. The result though, right now, is a greatly expanded possibility of growth in long-term care and rehab beds, which could be very...obviously it could be very expensive for the state. I need to make clear that this bill in no way prevents the growth of rehab or long-term care beds in any healthcare facility under subsection 5 initially can create a long-term care or rehab unit by converting up to 10 beds in this 2-year period. Any healthcare facility can increase its rehab or long-term care beds by up to 10 percent of the current rehab or long-term care. And if you wanted to, you could go to certificate of need if you could prove that you needed more beds, is the way that we felt we understood it. The one point that I...before I decided to introduce this legislation was, is this hindering competition in the marketplace? I mean, of all the things, I don't want to do that. I do think patients have the information they need to make informed decisions, but until the patients have the ability to direct their care and make decisions as to where they're treated, there really isn't a competitive marketplace in the healthcare industry. It's a very regulated industry and continues to be to this day. Now, if things change down the road, we could look at this again. So behind me we'll have testifiers from Madonna Rehab here, and hospitals, as well as others who will talk a little bit more on the bill, and then I will stick around and answer any questions that you may have on closing. Thank you, Senator. [LB765]

SENATOR JOHNSON: Okay. Any questions of Senator Gay at this time? I see none. One thing, Senator Howard, is we will do your bill second, and then go through the list, as well, and not flip-flop. [LB765]

SENATOR HOWARD: Thank you. [LB765]

SENATOR JOHNSON: All right. How many people do we have that are going to speak in behalf of this bill? Could I have...? One, two, three, four. And how many opposed? One, two, maybe three back there. Okay. Welcome. [LB765]

MARSHA LOMMEL: (Exhibit 1) Thank you. Senator Johnson and members of the Health and Human Services Committee, my name is Marsha Lommel. It's M-a-r-s-h-a L-o-m-m-e-l, and I have been the president and CEO of Madonna Rehabilitation Hospital since 1989. I have a clinical master's degree actually from the University of Minnesota, and also an MBA, and 40 years of experience in rehabilitation. I currently serve on the board of directors of the American Medical Rehab Providers Association, which is our national association for rehab hospitals and units. For 13 years I was a survey consultant for the Commission on Accreditation of Rehabilitation Facilities, which is the accrediting body similar to JCAHO, the accrediting body for rehabilitation. I'm here to testify in support of LB765. First of all, I'd like to just give you a little background from Madonna. I think all of you know a little about Madonna Rehabilitation Hospital, but maybe you don't know that it is one of the three major freestanding rehabilitation hospitals in the region. The others are Craig Hospital in Colorado and the Rehabilitation

Institute of Chicago. Of our 1,400 employees, over 225 are highly specialized therapists in specific areas of rehabilitation. Our research institute collaborates with many universities across the country, as well as with other rehab hospitals, to create the future for rehabilitation for our industry. I've passed out a book that I'm going to refer to. The very first tab has a few exhibits, and I would direct your attention to the first one, which shows the 28 states, besides Nebraska, from which Madonna receives its patients. We have 17 units and houses on our campus for family members to stay while the patients are in rehabilitation, so we have a very large geographic area. A little bit about the rehabilitation industry, because it is a very small industry. I think it represents 2 percent of the whole Medicare budget, so it really is a very small part of healthcare as a whole. But it's critical to analyze this CON law in relation to the current and the future status of rehabilitation. First of all, there are really two levels of acute rehabilitation. The first is what I call a Level II rehabilitation facility. There are about a thousand units, rehabilitation units of acute care hospitals in the country. They generally are 10 to 20 beds, and they serve a less complex level of patient than the Level I rehabilitation facilities. They are accredited by the Commission on Accreditation of Rehab Facilities for general rehabilitation. The Level I rehabilitation facilities are usually freestanding rehabilitation hospitals like Madonna. There are 217 of them in the whole country, and they generally are accredited by CARF for very specific diagnoses. I'll refer you to the second page, which shows the accreditation standards for Madonna, as well as the other six facilities within Nebraska. You can see that Madonna holds the highest accreditation in brain injury rehabilitation, stroke, spinal cord system of care, pediatric rehabilitation, and outpatient medical rehabilitation. Alegent is second largest. They have 40 beds and are accredited in 4 specialized programs. The others are smaller units around Nebraska that provide access to rehabilitation for people on a geographic basis throughout the state. There is a letter in the third exhibit from the accrediting body, CARF, that really outlines what the difference is between general rehabilitation and the highly specialized rehabilitation for brain injury and spinal cord injury in pediatrics. And the basis for that is that a rehabilitation hospital, in order to provider services for that high level of care, really needs a critical mass. With our sparse population in Nebraska, that's kind of hard to get. It's not like in the city of Chicago or New York or some of the more populous areas. But a critical mass is necessary because you can't really be good at providing services, nor could you economically afford to provide services for patients with spinal cord injuries, for example, if you only had three of them a year. You have to have a critical mass. I know that at the beginning of this week, I can tell you that at Madonna we have 18 patients who had newly acquired spinal cord injuries on one unit. So that's quite a bit of expertise that goes into that. The other thing that has been happening in the rehabilitation industry as a whole, is that Medicare has changed the rules. About four years ago they began to eliminate certain diagnoses as eligible for acute rehabilitation, wanting them to go to a lesser level of care or skilled care service. And that has significantly impacted the whole nation, as well as Nebraska. The next three exhibits just demonstrate that fact that we have lost a number of rehabilitation units in the country; that the number of patients treated in rehabilitation facilities has

decreased by about 100,000 just between 2004 and 2006; and the third one shows that the discharges from rehabilitation hospitals and units in Nebraska has also begun to have a downturn. So that makes it really even more imperative that we have a rational policy in Nebraska so we make sure we keep what we have in terms of rehabilitation. The best example that I can give you is in Kansas City, which is very close by. You only need to look that far to see an example of what happens when a state, in this case Missouri and Kansas, because Kansas City sort of straddles both, don't have... [LB765]

SENATOR JOHNSON: Ma'am, I would ask this of you, if you could stick to the facts rather than saying that Kansas City isn't very far away and so on. This is the type of things that repeated over and over again, do cause the delays that we are talking about. So if you would please... [LB765]

MARSHA LOMMEL: I'll try to do that, Senator. The Rehab Institute of Kansas was a freestanding Level I rehabilitation hospital in Kansas City for many years. Like Madonna, it served brain injury and spinal cord injury. During the 1990s, the other acute care hospitals in the Kansas City metropolitan area decided to add rehab units. The effect of that on the Rehab Institute of Kansas was obviously they lost that critical mass, and they closed in 2001. What happens in Kansas City now is that none of those smaller units in the acute care hospitals are able to provide the services for complex patients, and they're all sent out-of-state. I have a letter in the exhibits from Dr. Steve Hendler who was the director of the Rehab Institute of Kansas, talking about having to send his patients to either Madonna or Craig. The other thing that I guess I would like to address is the two issues that I have heard in connection with this discussion, and one is that Madonna should just compete in the free market environment. And I think we don't believe at this point that healthcare is a free enterprise-kind of system because the information is not available. There is not transparency. And in most cases, particularly in rehab, there really is no price discrimination. But I think even more than that, in my 40 years in rehab, I have not found that people either prepare for or want to know about or even think about what they would do if they had a serious illness or injury. If you think about if your mother had a stroke tomorrow, or if your child was in an automobile accident, would you know how to choose a rehabilitation hospital, or would you even know what to ask? The next exhibit in the book is a list of the speciality services that are available at Madonna for the more complex rehabilitation patients. And as you look through that list, I'm not sure that any consumer would either understand the difference or know why any of those were important in a rehabilitation facility. The other issue that I've heard is that Madonna has refused admission for patients qualified for rehabilitation. And I would tell you that that simply is not true. Madonna's mission is rehabilitation. We've spent 30 years developing a nationally recognized rehab hospital, and we certainly want to admit any patient who is qualified. There are a lot of regulations that are involved here about who is qualified for rehabilitation. We have, as I said, a regional marketing effort, and admit patients from all, especially the five surrounding states, so we want to serve people who are eligible for rehabilitation. I think there's a place for

Level I and Level II rehabilitation facilities in Nebraska. I think we want to make sure that people have access to good rehabilitation services in as wide a geographic area as possible. And Madonna's concern is that we maintain the critical mass to be able to continue to provide in Nebraska the very complex and high level rehabilitation services that we've built. So I thank you for your time and I'd be happy to answer any questions. [LB765]

SENATOR JOHNSON: Any questions? Seeing none, thank you. Next please. Just kind of reemphasize to everybody, in lots of other committees you have five minutes, and a red light goes on and you're done. And so, you know, we just used 15 minutes, and so again be as brief as you can. Let's be nice to the people that are last, as well as first. [LB765]

BRADY BERAN: All right, thank you. [LB765]

SENATOR JOHNSON: Would you proceed. [LB765]

BRADY BERAN: Good afternoon, senators. My name is Brady Beran, B-r-a-d-y, space, B-e-r-a-n. And I'm going to take you back to September 24, 2004. I was playing a football game at Seacrest Field, and in the third quarter of the football game I got hurt on a kickoff return. I had a helmet-to-helmet collision with a Southeast player, and got knocked on my backside. A coach came and helped me walk...get up off the field and walk off. When I got to the sidelines I collapsed, my eyes rolled into the back of my head, I started foaming from the mouth, and it wasn't looking good for me. So I got rushed to BryanLGH West Hospital, and when they did a scan of my brain they saw that there was a lot of bleeding. And after the surgery we found out that I had less than a 10 percent chance of surviving the surgery. The doctor had done the surgery three times before; none of those patients ever made it. Well, they put me into a drug-induced coma because I was starting to move on the surgery table, so Monday I was supposed to wake up, but I didn't. I didn't wake up for another five weeks, and in that time period I had four more major surgeries. Then I was taken to Madonna Rehabilitation Hospital as soon as I started coming out of my coma. When I woke up from my coma I was unable to walk, talk, read, or even eat. At Madonna Rehabilitation Hospital I learned to do all of those things, and it was just such a great experience for not only me but also my family. After I became an outpatient, I went back to school the fourth quarter of my junior year, and (inaudible) continue (inaudible), and then my senior year I took a full schedule. I graduated with my class, but while I was going to school I was also going to Madonna. And currently I am at Southeast Community College as a human services student there, and I still go to Madonna three days a week. And now I'm going to give it over to my mother. [LB765]

SENATOR JOHNSON: Okay, thank you. I remember seeing about you on television and so on, and it's nice to see you here, and we appreciate your coming. [LB765]

CAROL BERAN: I am passing around a picture of Brady when he was coming out of his coma, and also... [LB765]

SENATOR JOHNSON: You've got to identify yourself other than Mom. (Laugh) [LB765]

CAROL BERAN: (Exhibit 2) I'm sorry. I'm Carol Beran, C-a-r-o-l, and B-e-r-a-n. And I'm passing around a picture of Brady, what he looked like coming out of his coma; you can see the difference from then to now; and what Madonna...a letter about what Madonna has meant to us. When Brady was coming out of his coma, he was pretty much a vegetable. He was unable to sit up, and as you can see, he couldn't even hold his head up when they first stood him up. We were at BryanLGH, and had we been told that we could stay there for therapy, we probably would have seriously considered it on the grounds that we had been there five weeks already and felt very comfortable there, getting to know the staff. And luckily we ended up at Madonna. Toward the end of his stay at BryanLGH, they came to do therapy with Brady, and they wouldn't wake him up if he was sleeping. Well, of course, he was sleeping most of the time, so they would come for therapy and bill us, but he really didn't get much therapy. It's not like that at Madonna. You get up and you learn to live life again. The therapy there is completely coordinated by a team of therapists, psychologists, ministers, nurses, and doctors, and they communicate daily about every aspect of the patient. The therapy had...Brady was able to use a free-weight harness machine that would help him to regain his walking. He was on a moving balance machine, which they still use today, to help him with his balance. He had electrode brain wave retraining for memory issues, which is a big problem on brain injury; and he used a numerous amount of vision therapy to help with eye problems, which is also a problem with brain injury. A patient is able to experience all of that and much, much more. Brain injury recovery is an art; it's not a science. And it's tailored differently at Madonna for each patient. One of the most important aspects that Madonna has is the therapeutic learning center, and it's one-room for the patients there. Very few rehab centers have this luxury. It's headed by Nova Adams who has been there over 25 years and has experience with the students and helps them ease back into the classroom. She was able to help Brady. When he was injured, he was reading at a kindergarten level after his injury, and she was able to get him from that point to where he's keeping up very successfully at a community college, Southeast Community College, now. I feel it's very important to have brain injury, the patients, in one unit altogether. It's a big support for the families and for each other. Lifetime contacts and friendships are formed from this. There is no other program like Madonna. Behind these doors many miracles are taking place. These miracles take hard work and a loving, caring atmosphere that Madonna supplies. We're so proud of the work being done there on the cutting edge of rehab. It's been a blessing to our family and the many, many others. [LB765]

SENATOR JOHNSON: Thank you. [LB765]

CAROL BERAN: Thank you. [LB765]

SENATOR JOHNSON: Any questions of Mom? I see none. Thank you very much for coming. [LB765]

CAROL BERAN: Yes, thank you. [LB765]

SENATOR JOHNSON: Next please. [LB765]

ROGER LEMPKE: (Exhibit 3) Senator Johnson and members of the committee, my name is Roger Lempke. That's Roger, R-o-g-e-r, Lempke, L-e-m-p-k-e. I'm the former adjutant general of the Nebraska National Guard, but I'm not here today in that capacity, obviously being retired. I'm here on my own capacity to...in support of the soldiers that I took part in sending to Iraq. Some of them came back injured. And I'm here today to testify in favor of LB765, which relates to the certificate of need requirements for rehabilitation and long-term care capabilities in Nebraska. Now, I absolutely do not claim any healthcare management expertise, however I do have some very practical experiences in dealing with wounded Nebraska soldiers, and I think that's germane to discussion regarding this bill. In working to obtain the best care for our wounded heros, I discovered the importance of focusing resources on the issue, in this case many times brain trauma incidents, which are prominent coming out of Iraq, and also being close to home during a rehabilitation period. I've always believed that recovering soldiers respond more quickly and positively to treatment when families are nearby. The Department of Defense basically uses military hospitals around the nation for rehabilitation needs. This works fine if you've active duty. Typically, you wind up back at the base that you came from, and that's where your family generally is. It doesn't work that way for the reserve component. Nebraska National Guard soldiers have had to go to places like Walter Reed, a hospital in D.C.; the Brooks Medical Center in San Antonio; and the Eisenhower Army Medical Center in Fort Gordon, Georgia. The treatment at these locations is adequate, but our soldiers are isolated from their families for extended periods unless families can make costly relocations to be near their soldiers. Eventually we were able to convince DOD to transfer soldiers to reputable civilian facilities for treatment. That's when I discovered the unique and renowned capabilities at the Madonna Rehabilitation Hospital for treating traumatic brain injury. And let me give you an example of that: Specialist Jeromy Dillman. I met Jeromy and his family a little over a year ago at Walter Reed. Jeromy had been seriously injured in an IED, improvised explosive device accident in Iraq; suffered severe injury to a nerve in his leg. So he basically had, among other injuries, a very limp left leg. It was clear, when I visited him there, and his family happened to be there at the time, that even though he was undergoing treatment and Walter Reed was doing the best they could for him, it was going to be a long process, and unfortunately a process that could not be directly supported by family because they couldn't afford to stay. We were able to

convince the Army to transfer him to Madonna because of its reputation in rehabilitation services. Jeromy is now in Lincoln with him family and he actually works at the Military Department performing duties at headquarters while he is undergoing his rehabilitation. Last year, in talking with Jeromy and the staff at Walter Reed, many predicted that he would never walk without assistance. Recently I ran into Jeromy. He's not only walking, but running. So none of this would have been possible without Madonna's dedication to traumatic injury rehabilitation. I've learned recently that Nebraska has applied some very prudent management practices to rehabilitation and long-term care to avoid diluting quality of treatment and care with excess unmanaged capacity. In 1997, the Legislature wisely enacted reasonable controls to manage the growth of these kinds of facilities and capabilities. However, recent debates over the intent of the law and a recent court ruling risk disrupting the balances between supply and quality that has served Nebraska, and indeed soldiers like Jeromy so well. About a year ago, a solider living in Kansas--a Nebraska solider living in Kansas--incurred severe head injuries from a civilian incident. Medical professionals in Kansas referred him to Nebraska to Madonna for rehabilitation. I'm told...I was told then that Kansas simply did not have the same capabilities as Nebraska because they had not managed their rehabilitation limits as Nebraska has under the law that exists. By the way, that soldier today is doing fine and he's functioning back home, and he is still a Nebraska soldier. Currently, about half a dozen soldiers from Nebraska are in rehabilitation at Madonna at some level. So on behalf of them, and unfortunately others that will undoubtedly come along the line as we continue our struggles in Iraq, I would ask this committee to support and advance LB765 that will clarify the language intent for certificates of need, thereby continuing Nebraska's prudent management of this vital capability. Thank you, and I'd be open to any questions that you might have. [LB765]

SENATOR JOHNSON: Yes. Senator Hansen. [LB765]

SENATOR HANSEN: Thank you, Senator Johnson. General, it's good to see you again. I know you have a commitment to families of soldiers, and now to the soldiers who have come back and then this medical need, and I appreciate that. Are there...you said Kansas was lacking in rehab hospital beds then? [LB765]

ROGER LEMPKE: Not beds, capability. And I believe Marsha probably expressed it best when she talked about Level I capability. And in this...if I recall, this particular soldier, he had very severe head injuries from a beating, and it was because of that that he was sent up here. So I believe it was in that acute, what I would call acute care--probably not the right term--that they were lacking. [LB765]

SENATOR HANSEN: I appreciate your commitment to the families. [LB765]

ROGER LEMPKE: Thank you. [LB765]

SENATOR JOHNSON: Anyone else? General, let me just say something. This is a, I think... [LB765]

ROGER LEMPKE: Five minutes or less, Senator, okay? [LB765]

SENATOR JOHNSON: Right, yes. Well, (laughter) it's...I very, very much appreciate what you're doing. I think on a national basis, it's a disgrace what our federal government has done to ask these families to go through what they have, and then give them less than optimal care. So it's great that people like you are out there calling this to everybody's attention. I think you got an award the other day... [LB765]

ROGER LEMPKE: I did. Thank you. [LB765]

SENATOR JOHNSON ...and it was well-deserved. [LB765]

ROGER LEMPKE: Thank you very much, Senator. Appreciate it. And thank you very much, everybody. [LB765]

SENATOR JOHNSON: Next please. Any other proponents? Well, there comes one. [LB765]

MICHAEL MUNRO: Good afternoon, Senator Johnson, members of the committee. [LB765]

SENATOR JOHNSON: This guy looks a little bit like a Boy Scout I had once upon a time. [LB765]

MICHAEL MUNRO: Longer than either one of us care to admit, Senator. My name is Michael Munro, and the last name is spelled M-u-n-r-o, and I am general counsel for Madonna Rehabilitation Hospital. And I would just like to add a couple of comments to Senator Gay's initial comments regarding the effect of the lawsuit. As he mentioned, there was a lawsuit between a hospital and the state of Nebraska, and the case is currently on appeal. And the effect of the current interpretation by the court of the Certificate of Need Act is illustrated in your packet behind Tab 4. And this shows the growth of rehabilitation beds in Nebraska over time, in a typical 100-bed hospital with a rehab unit. And as you can see, with the blue line here, the growth is rather dramatic under the current interpretation by the court. And it seems to us that it's counterintuitive that we have a Certificate of Need Act in the first place if we were going to have that type of exponential growth of rehabilitation beds. So that's an important point to make. The second point is that the Certificate of Need Act, as it stands, is not terribly restrictive. We're not here asking that rehabilitation beds be...growth and rehabilitation beds not be eliminated. We're saying that there is a process, and if a facility wishes to add to their rehabilitation unit, they may do so; and if they want to add more than the

law allows without a certificate of need, they can go through the certificate of need process. So that is available. And then finally I want to clarify a point from Ms. Lommel earlier in the hearing. Patients who do not meet acute rehabilitation criteria but are eligible for nursing home admissions may not have been admitted to Madonna. There are...she indicated there are two levels of care. And the acute rehab criteria, the Level I that Senator (sic--General) Lempke referred to, those patients are certainly admitted to care at Madonna, however the lower level of care is a nursing home bed under the licensure, and there may be some patients, over time, that have not been admitted to nursing home beds because Madonna simply does not have the space. We have 25 nursing home beds available for those types of patients, so I want to make that point clear. And I'd be happy to answer any questions, if there's any additional questions. [LB765]

SENATOR JOHNSON: Any questions? I see none, thank you. [LB765]

MICHAEL MUNRO: Thank you. [LB765]

SENATOR JOHNSON: (Exhibit 4) Any other proponents? All right. I think we had three or four opponents. And while you're coming to the fore, let me say that there is a letter here from Joann Schaefer, chief medical officer, of the Division of Public Health, and this is basically a letter that we would qualify as neutral testimony regarding this. Welcome. [LB765]

BRAD SHER: (Exhibit 5) Senator Johnson, members of the committee, my name is Brad Sher, S-h-e-r. I'm the vice president of managed care and public policy at BryanLGH Health System. I'm a registered lobbyist working solely on behalf of BryanLGH, and we would like to state our opposition to LB765. And we just ask the question, how does the bill improve patient care or serve the citizens of Nebraska? We have had a 20-bed rehabilitation unit for a number of years, and we sought to convert 10 existing acute care beds recently. We were responding to what the market was demanding in that, in that we have been asked by payers and so forth of dealing with shorter lengths of stays, tighter admission criteria for inpatient stays, and so forth--an increase in the number of patients potentially for rehabilitation services of an aging population, trauma services, strokes, etcetera. And other providers were not responding to that from a market perspective. We attempted to convert the ten beds to rehab in order to meet the needs of the community, and were opposed by the Nebraska Department of Health, as well as other competing providers. Last August, we received a declaratory judgment from the Nebraska District Court that 100 percent upheld and enforced the current statute to allow the 10-bed conversion. So the issue of total bed capacity is what the law had and what the law intended. The court rejected arguments that it was the Legislature's intention to restrict rehab beds, as argued by the state and other providers. And we're moving forward to open those 10 beds, and we should be 100 percent Medicare-certified by June 1, which is our fiscal year. The current law,

this...or the proposed law, LB765, would have prevented our ability to respond to the patient needs by preventing the opening of our 10-bed unit. It was important to open 10 beds because that's the configuration of our unit. It makes us as efficient and effective as we possibly can on the west campus, and the 2-bed incremental increase that would have occurred under LB765 as proposed would be inefficient and ineffective. Also in December of this year, the U.S. Congress acted to change what was called the 75-percent rule to 60 percent, and led by Senator Ben Nelson, helped to allow facilities to take more rehab patients and expand the capability in the marketplace. So we have the ability to have an expanding marketplace for rehab beds at this point in time. And as you know, BryanLGH does a lot of very high level tertiary services. We're a trauma center. We do...we're a neurosurgical center, cardiac, orthopedic, and mental health services. And our biggest challenge right now is to produce a safe destination and discharge for our patients. And we want to do this by doing good quality care. And CMS and other payers want us to move people on to the next level of service in an appropriate and timely manner. We develop a discharge plan within 24 hours of admission, and ask the question of our physician, where are we going while we're in the hospital, and where do you want to go with the patient, what's appropriate as we move forward? With over 20,000 inpatient admissions per year, 30-plus percent of these patients need some kind of postacute care service. Our biggest challenge, as a hospital, is executing an appropriate and safe discharge plan, and to simply put it, get the patients transferred out of the hospital to the facility of their choice. Let's be very clear, we want them to go where they want to go. It isn't all about trying to put them into our units or something with us. It's where does the patient want to go or where the physician wants them to go--in an appropriate facility and the right level of care, and in a timely manner, and according to what payers expect, an appropriate level of care and what physicians expect, and so forth. We offer and seek, first, the patient's choice or preference for the facility. And if or when rejected by the patient's first choice, we seek the next best alternatives. Currently, based upon our experience and a variety of data sources, we estimate that 40 to 50 percent of the referrals that BryanLGH makes to skilled nursing homes, rehabilitation facilities, and long-term acute care facilities are initially rejected. And it's true both locally and throughout the state: Patients are rejected from the facilities they request and prefer, and facilities decline business on almost 1 out of every 2 referrals. So we have...I don't know, it's capacity, or what happens. And the facilities have the simple ability to say no to a referring hospital without any reason or rationale. Unlike acute care hospitals with emergency rooms which must take all patients, skilled nursing and rehabilitation facilities can say no to any referral or patient. So what are the reasons for this? We believe or are told by facilities that, number one, do you have a payer? Is somebody paying the bill? So these facilities rarely take no-pay patients or charity patients. We have, on our rehab units, 9-10 percent of our patients right now are no-pay or charity patients. And they can also be rejected based upon the quality, what I define as the quality of the payer source. Can some payers pay better than others? So that's a decision of which we believe facilities do. So over 50 percent of our rehab patients are either no-pay, Medicaid, or Medicare patients. They get rejected

because they're too complex or too expensive. The patient has a real or perceived level of complexity that the facilities do not want to take. Respiratory problems, size of the patient, excess number of medications, psychological problems, these are all issues of why we get turned down. And we can't distinguish a pattern of rejection by an individual facility because one day they may take a patient with a given set of complications, and the next day reject a similar patient with the same set of complications, and we don't know why. The power of rejecting patients, once again lies with the receiving facility. And there are also social issues, such as family dynamics, patient behavior, or other factors that lend to a potential disruptive environment at the referring facility. We also see factors that after 12 noon on any given day they don't want to take a patient, or on a Friday, on weekends, or they delay acceptance of a patient over a weekend and wait a few days while waiting for better patients potentially coming their way. We experience long delays in response to accepting patients, when we call and they say, well, we'll get back to you, we'll let you know. So we wait and we wait and we wait. Our care management department, which has had cases where the department has called over 50 different facilities on a single patient, looking for placement of a patient. It is very common that we have to call 3 to 10 facilities for every patient before finding an accepting facility. We're trying to address the ongoing changing needs of the marketplace. We're being rejected by existing facilities for half the patients being referred. We utilized the existing law to expand our services to meet patient needs and demand. And we're being asked to control our costs from all sides. Okay, everyone wants the acute care hospitals to control costs and be efficient and so forth. So if a single day of acute care costs, costs $1,000, and we can...and rehab costs approximately $500 for us to move patients along, that's efficient and effective, okay. So we have to have the ability and the flexibility to move patients efficiently and appropriately. The proposed change in law will limit acute care hospitals' abilities to meet these changes, and we ask the committee not to restrain our flexibility. Passing this bill will, in effect, stop any expansion of beds or facilities on a practical basis. And if we lose the appeal, which is currently going on at this point in time, who will take the patients and serve the population? BryanLGH asks the committee to please not forward this bill; please do not constrain acute care hospitals' ability to adapt and change to meet current and future patient needs. Any questions? [LB765]

SENATOR JOHNSON: Thank you very much. Any...Senator Stuthman. [LB765]

SENATOR STUTHMAN: Thank you, Senator Johnson. I have a real concern with the facts that you've given, that 40 to 50 percent of your referrals are turned down. That really disturbs me that...is there no place for them, or is it just because of personal things, which you did mention in here? [LB765]

BRAD SHER: I can't tell you why it occurs, I can just tell you it occurs. And I could bring our 40 to 50 members of our care management department, individually, and talk to them, and tell them what in a typical day they do, in calling, calling, calling, trying to find

placement for patients. And it's...and there's a lot of complicating factors. I can understand why facilities don't want to take no-pay patients. Nobody wants them. But if we have to have them, I've got to get the most appropriate level of care to move them along because clogging up acute care beds with patients, we don't want to do that. You want us to be effective and efficient in that. And if they are kind of complex or they've got a little bit of behavioral problems, and so forth, we've got a lot of difficulties getting patients moved along in the system. And it's pretty common. It's not just us that has that issue. We've got more of them because we're trauma and other issues, but... [LB765]

SENATOR STUTHMAN: It's not that I don't believe these figures, but I'm under the impression that there's probably not a bed anywhere else for them? Would that be something? Because when an organization or a center has (inaudible) 50 beds, and they're only 20 of them there, then here we're hearing that 40 to 50 percent of them are rejected, that would tell me that those other beds are all full already. [LB765]

BRAD SHER: Or they don't have the staff for the beds. I'm staffed because my average census is 30 and I can't take 1 more. I have the physical capacity; I might not have the staffing capacity. I may have a certain level of complexity of patient that I could do, and if you've got a simple patient, I'll take a simple one. If you've got one with a little bit of problems, they could be on a ventilator, additional medications, it may be beyond what I'm getting paid by that payer. There are a variety of factors that go into that decision-making process, and that's our challenge as a hospital to try and move people along. We have to give them all the facts. We have to tell them the condition of the patient. We give them all the clinical information of what's going on with the patient, what the payer source is, and so forth, and then they tell us yes or no. And they don't tell us...sometimes they do say, well, we're not going to take them for this reason or that reason, but they don't have to do that. [LB765]

SENATOR STUTHMAN: Okay. Thank you. [LB765]

BRAD SHER: Sure. [LB765]

SENATOR JOHNSON: I've got a question. Don't leave yet. Well, you know, to me it kind of comes down, and I certainly appreciate what you're talking about, to hear, with the inability to find the places and so on, and that's kind of a sad commentary, too, I guess. But I guess the real question in my mind that is raised by the proponents here, and so I'd like to have your response to it, is I think they used the term "critical mass." In other words, for these really difficult cases that apparently...I mean, their concern was that you had to have so many before you could justify all of the services for that number. Any comments about that and so on? [LB765]

BRAD SHER: I understand that. But you have to look at what we're trying to provide, what Madonna provides, okay. And I believe that BryanLGH is the largest referral facility

to Madonna, by a lot, and we refer patients with them, we have a working relationship with them, and so forth, that we deal with each and every day. They provide a much higher level on some of their units of services and patients that we're never going to do. That's what they specialize in; that's what they're nationally known for; that's why they're with Craig and the place in Chicago and all that other kind of stuff. We're trying to provide rehabilitation care that is taking care of our level of patients, and some of our, what we might see more typically from a trauma perspective or a stroke perspective, and so forth, that we have to be able to address those patient needs, okay. And I don't...we're not planning...BryanLGH is not planning on getting into that level of Madonna's business. So I've got 20 beds and soon to have 30 beds, assuming the appeal doesn't stop things, that addresses one component of Madonna's beds, set of beds, but not all of the capabilities and services and so forth, okay. So I'm just trying to expand and be efficient that way. I agree, you have to have levels of efficiency. And what's inherent in this CON law and what allows now based on total bed capacity, allows acute care hospitals to open a unit that's efficient and effective. And if you've been on our west campus, we have these sections where there are 10 beds. So if I lose the appeal, I have to go through CON or whatever the...or I only want to open up, I can open up 10, I've got 20 beds; I can open up 2 beds. Well, 2 beds on a 10-bed unit is not efficient; it's not effective. You just can't develop the critical mass or the economies of scale you need to, that if I could just open up a 10-bed unit would do for me. And that's what we did. We opened up 10 more beds. We were just...we have been reaching capacity of the unit of our 20 beds recently, and especially now since December when they went from the 75-percent rule to the 60 percent, that gives you more ability and flexibility. And we think there is an increasing demand in the marketplace, so there's plenty of business for everybody to sustain themselves. We don't need a change in the CON law, because I don't personally think everybody is going to willy-nilly, just start opening things up. We need to do it and have that flexibility, and we're asking not to constrain that. As a large tertiary provider that we've been asked by the community and by the state--maintain the trauma center, maintain mental health, maintain these tertiary level services for Lincoln and the greater area, and we need to have the flexibility to move people along, because that's what CMS wants us to do and state Medicaid and everybody else, to do what's right for the patients and for the community. That's our sole mission. That's what we think is right. I'm not sure this bill does that, really thinks about the patients. You can predict the facilities, but if you've got to grow in the market, and the market doesn't address it, then we've got to let that...keep that flexibility and that ability to go on. [LB765]

SENATOR JOHNSON: All right. Thank you very much. [LB765]

BRAD SHER: Thank you. [LB765]

SENATOR JOHNSON: Okay. Do we have...how many more that are opponents? And are you the only one, or was there someone else back there, as well? (Inaudible.) Okay.

Welcome to you. [LB765]

RHONDEL McCANN: (Exhibit 6) Hello. My name is Rhondel McCann, R-h-o-n-d-e-l, McCann M-c-C-a-n-n. I am currently the medical director at Bryan Rehabilitation Hospital and I previously was practicing at MidAmerica Rehabilitation Hospital in Kansas City, Overland Park, in charge of the...it was the medical program director for their traumatic brain injury specialty unit. And so there is a TBI program in Kansas City, alive and well, and it was a very good program. Currently, I'm against the bill because I think the bill would limit access of care for patients. As you know, BryanLGH Medical Center is a not-for-profit hospital and a sole provider of trauma care to the local residents of Nebraska. Many of the patients that are treated there are indigent, brought by ambulance or flown by emergent treatment for...by life-flight with severe devastating injuries. They are not able to return to home directly due to deficits in independence of mobility, ambulation, disease management, and self-care. For the majority of patients, BryanLGH Medical Center provides the sole option for acute inpatient rehabilitation for these non-funded individuals. And I would argue that I do have patients currently on my unit that have not been accepted by other places in town. The success of the BryanLGH Medical Center as a tertiary care Level I trauma hospital is in part dependent upon the capacity and success of the rehabilitation unit itself. By providing a continuum of care, transitioning patients off the acute care units to acute inpatient rehabilitation, the hospital is able to maintain its high level of medical care for all Nebraskans. And that's what the last speaker was talking about is trying to transition patients off the acute care, get them to the next level of care. There are constraints governed by Medicare as to the diagnoses of patients admitted to acute rehab. Many of the trauma and indigent patients are appropriate candidates for acute rehab, but they do not fall into that 60 percent criteria. By diluting the ability of BryanLGH to expand the number of rehab beds in the future, I have concerns that we will be unable to meet the needs of this population secondary to the percentage of patient mix categories to maintain a Medicare exempt status. As the numbers of indigent patients climb and non-funded patients, BryanLGH will need to have a greater number of beds to admit people that are compliant up to the 60 percent rule in order to compensate for the 40 percent of people that are indigent that don't qualify. Also, I feel that the bill supports a paternalistic approach to your personal healthcare decisions and choice, limiting care options of patients. The BryanLGH Medical Center Acute Inpatient Rehabilitation Unit is a viable option as a provider of excellent acute inpatient rehabilitation care in the region. It recently was audited by the Commission on Accreditation of Rehabilitation Facilities and received seven commendations for excellence. Having personally practiced at many acute rehabilitation hospitals, I personally can attest to its quality of rehabilitation care and nursing care of its patients. As the BryanLGH Medical Center Acute Inpatient Rehabilitation Unit is physically attached to the acute care hospital, it is able to provide seamless acute care services that no free-standing rehabilitation hospital can offer. It offers patients who have catastrophic injuries the option of rehabilitation in a setting of acute care. Clearly stated, if you stay at Bryan for acute inpatient rehabilitation, you are

provided a continuum of care where your trauma surgeons and your other specialists continue to follow you at bedside. If you have a complication or need emergent evaluation, you have access to all specialists, tests, and radiological studies without delay or a ride in an ambulance back to the acute care hospital. And, if you have been really sick and have had a lot of medical complications, you may choose to stay close to your specialist, under their watch and direct access to acute care services. Many patients do prefer this option. This right to choose should be protected and not politically mandated by limiting future growth of the Acute Inpatient Rehabilitation Unit at BryanLGH. [LB765]

SENATOR JOHNSON: Okay, thank you. Any questions? [LB765]

RHONDEL McCANN: Okay, thank you. [LB765]

SENATOR JOHNSON: You must have covered things pretty well. Thank you very much for coming. Any other opponents? Seeing none, let's call that a day on LB7...what? Oh, I'm sorry. [LB765]

BRENDON POLT: Senator Johnson, I wanted to testify neutral. [LB765]

SENATOR JOHNSON: Absolutely. And I read that letter and have that in my...so I apologize, and welcome. [LB765]

BRENDON POLT: No problem. And I won't read my testimony, but just to make a quick point. I'm Brendon Polt... [LB765]

SENATOR JOHNSON: You take your time, Brendon. [LB765]

BRENDON POLT: ...okay, from the Nebraska Health Care Association. My last name is spelled P-o-l-t. And the Nebraska Health Care Association, as you probably know, represents about 200 nursing homes and long-term care units of hospitals. And since the certificate of need impacts long-term care facilities, I felt like I should at least explain why we're taking a neutral position on the bill. But first of all, I do want to thank the bill sponsors and Senator Gay for including us in open dialogue about this bill. And so I wanted to make sure I mentioned that on record. We've determined that the proposed amendment, specifically, should not affect nursing homes or long-term care units of hospitals. And that's because under the certificate of need there is a definition of rehabilitation beds that's very narrow. And therefore a nursing home bed, although it provides rehabilitation services under Medicare, for Medicare A services, under the act that's not a rehabilitation bed, it's a long-term care bed. In order to qualify as rehabilitation bed under this act, it has to be part of an acute hospital and excluded from payment under Medicare, called PPS payment. But none of our facilities, no nursing homes, are included in that definition. So because this doesn't affect nursing homes,

we're neutral on the bill. And so I just wanted to get that on record. Any questions? [LB765]

SENATOR JOHNSON: Any questions? Brendon, thank you very much. You usually have quite thoughtful considerations. Thank you. [LB765]

BRENDON POLT: Thank you. [LB765]

SENATOR JOHNSON: All right. Anyone else from a neutral standpoint? Senator Gay, why don't you wrap things up. [LB765]

SENATOR GAY: I'm going to waive my closing. I would thank Senator Howard again for letting us go first. Thank you very much. [LB765]

SENATOR HOWARD: You're welcome. Absolutely. [LB765]

SENATOR JOHNSON: Okay, thank you. That being the case, let's close on LB765 and, Senator Howard, let's go ahead with you on LB782, allow disclosure of child abuse and neglect information. Let's just take about 30 seconds and let people clear the room, and we can kind of stretch at the same time here. [LB765]

SENATOR HOWARD: Thank you, Chairman Johnson and members of my committee. I am Senator Gwen Howard, that's H-o-w-a-r-d, and I'm here to introduce LB782 at the request of Governor Heineman. LB782 will allow additional public disclosure of child abuse and neglect information to the public. I was pleased Governor Heineman had asked me to introduce this important piece of legislation. Current Nebraska law allows the Department of Health and Human Services to release very limited information to the public. This information includes whether a child is a state ward, or was previously a state ward, when a child became a ward, and when custody was terminated, adjudication type, status of parental rights, and if other children in the family are in state custody. In the event of a death or a near fatality of a child resulting from child abuse or neglect the department will provide additional information if a person has been criminally charged and has been convicted or acquitted, or a county attorney certifies a person would have been charged prior to that person's death. In this situation the department can disclose a written summary containing information about actions taken and services rendered by the department, confirmation of reports received by the department, and information about the investigations conducted by the department. With LB782 the Department of Health and Human Services will be able to provide more information to the public, specifically the chief executive officer, CEO of the Department of Health and Human Services or Division of Children and Family Services Director may disclose information regarding child abuse or neglect and the investigation of such services if in the best interest of the child and if any of the following factors are present: the alleged perpetrator has been charged with a crime relating to the child abuse or

neglect report; a judge, law enforcement official, county attorney, or other local investigative agency or official has publicly disclosed the services related to the investigation; an individual who is the parent, custodian, foster parent, provider, guardian, or child victim over 14-years-old has made disclosure; the information is related to a child fatality or near fatality; the information is released to confirm, clarify or correct information concerning an allegation of actual instance of child abuse or neglect made public by sources outside of the department; or a child who's in custody of the department is missing in placement, in which case the CEO or director may release the name and physical description of the child for reasons of safety for the child or for the purposes of community safety. The public has a legitimate interest in knowing more when such tragic events occur. The ability to confirm, clarify or correct information concerning an allegation or actual instance of child abuse or neglect which has been made public by sources outside the department will address the public's need to know by providing substantive and accurate information. This greater transparency will increase confidence in the work of the department in fulfilling their role in protecting the children of Nebraska. And Todd Landry will be here to address any questions that you have regarding this bill. I'm going to try to spare my voice and my coughing, if that's all right with you. [LB782]

SENATOR JOHNSON: Okay. That certainly is. Let's proceed then with proponents. [LB782]

SENATOR HOWARD: Thank you. [LB782]

SENATOR JOHNSON: And how many proponents and opponents do we have? An opponent back there? Pro? Okay, two. Any opponents? Okay, thank you. Welcome, sir. [LB782]

TODD LANDRY: (Exhibit 1) Thank you. Good afternoon, Senator Johnson, members of the committee. My name is Todd Landry, that's T-o-d-d L-a-n-d-r-y and I serve as the director of the Division of Children and Family Services within the Department of Health and Human Services. I'd like to start by thanking Senator Howard for introducing this bill on behalf of Governor Heineman. I'm here today to testify in support of LB782 which proposes to expand the information that can be provided to the public under certain circumstances dealing with child abuse and neglect. As Senator Howard indicated, current Nebraska law allows the department to currently release very limited information about child welfare cases to the public. In 2001, the department requested introduction of LB642, which passed in 2002, and expanded our ability to share information in the event that child abuse or neglect results in a fatality or near fatality. And Senator Howard shared what we are currently able to release. We routinely and currently comply with requests from the media in those situations. We believe, however, that the public has a legitimate interest in knowing more and on a more timely basis when tragic events occur. In October, a toddler died while in the custody of the department. I was

frustrated that we were so limited in the information that we could release and that we were unable to fully correct inaccurate information in the media. We again saw the need for public disclosure in December, related to the Von Maur shooting. One of the things that we learned from these situations is that going through case records and court files can be very time consuming, but it must be done in order to gather the information necessary to respond to very legitimate questions about the department's action or inaction in these cases. Because it does take time, we may not always be able to respond immediately to a reporter or media question, but we will always do our best to respond as quickly as we can with accurate information. In drafting this bill, we reviewed child abuse and neglect confidentiality laws in other states. We looked closely at Colorado, Maine, Florida, Arizona, Michigan, and others. We also considered the federal Child Abuse and Prevention Treatment Act, otherwise known as CAPTA, which has confidentiality requirements that must be met in order to receive certain federal funding. Our legal staff has reviewed LB782 and believe it fits within CAPTA. We have also sent it to our federal HHS Administration for Children and Families regional contact person for review. Senator Howard covered the circumstances under which we may release information. What I'd like to do is share with you a little bit about the kind of information that under this bill we would be allowed to disclose. This includes information about a child placement, whether in-home or out-of-home; terms of a provider's contract if a provider is involved; hearing dates; the reason for removal from parents or family; the number of placement and types of placement; the permanency objectives for the child; the status of the court proceedings; and court ordered services or other services provided by the department's Division of Children and Family Services. Also, the CEO or director may release the results of criminal history record checks that have been completed by the division. Now information that shall not be released by the CEO or director, absent of a court order, include: date of birth; Social Security number; protected health information, including psychiatric records; the name of the person who made the child abuse report; and the name of foster parents unless a foster parent is the alleged perpetrator. The ability to confirm, clarify or correct information concerning an allegation or actual incidence of child abuse or neglect which has been made public by sources outside the department, will help satisfy the public's need to know by providing substantive and accurate information. This greater transparency should help the public better understand the child welfare system and the involvement of the court, guardian ad litem, county attorney, and others in the process, as well as the department. Providing information, as Senator Howard said, should also increase confidence in the work of the department in fulfilling our role in protecting the children of Nebraska. In summary, we believe that LB782 is necessary to allow the department to share important, accurate information with the public about suspected child abuse or neglect cases, related deaths or near fatalities. Thank you for your continued support for the protection of Nebraska's children. Be happy to answer any questions that you may have. [LB782]

SENATOR JOHNSON: Any questions? Todd, I see none. How about that? [LB782]

TODD LANDRY: Thank you. [LB782]

SENATOR JOHNSON: Thank you. Welcome. [LB782]

JENNIFER CARTER: (Exhibit 2) Good afternoon, Senator Johnson, members of the committee. My name is Jennifer Carter, C-a-r-t-e-r, and I am the director of the Health Care Access Program at Nebraska Appleseed, formerly the director of our Child Welfare System Accountability Program and I'm a registered lobbyist as well, solely on behalf of Nebraska Appleseed. And I'll be brief because we're handing out written testimony. But we just wanted to come and testify in support of this bill. Nebraska Appleseed has been working for four and a half years to investigate and identify problems in the child welfare system and potential solutions for positive reform. And we think that this is...one of the main potential solutions we saw was greater accountability and transparency in the system might be most helpful. And we think this is a great first step in that direction, and that it actually strikes a very good balance between the confidentiality needs of parents and children and also the needs to be more accountable and transparent for the public. The only issue I would raise, actually maybe two, was just in terms of there's a lot of good reasons in the bill to...when HHS might be allowed to release information. And we would just like to see continued oversight or maybe a reevaluation in a year's time or more, just to look at how that's working, what reasons are we releasing information for? Only because there's a great deal of discretion in the bill, which I think might be necessary, but we want to make sure that it's really being used for the most transparency and accountability and not solely to correct information or misinformation, which I think is critically important and will help with the credibility with the system with the public. But we also want it to be as open as possible while watching people's confidentiality and all of that. And my only other concern was that allowing a statement of why children were removed from a home, I think, is a piece of information that would be good to release. I think there could be some risks to biological parents confidentiality there, depending on whether that was proven in court or where we...what the facts actually are. But I...we're very excited. We've enjoyed working with Mr. Landry in the past, before he came to HHS, and we're excited that he...we think he's really dedicated to positive reform in the system. So I trust that this will be used wisely and well, but we still would like to make sure that that's actually happening. And maybe there are other positive improvements we could make in the future once we know how this is working. So we'd ask the committee to advance the bill. And I'm happy to take any questions. [LB782]

SENATOR JOHNSON: Thank you. Any questions? I see none. [LB782]

JENNIFER CARTER: Thanks. [LB782]

SENATOR JOHNSON: Thank you very much. Any other proponents? Any opponents?

Any neutral testimony? Senator Howard. [LB782]

SENATOR HOWARD: I think we're picking up time now. [LB782]

SENATOR JOHNSON: Looks like it, doesn't it? [LB782]

SENATOR HOWARD: Just briefly. Thank you for your attention to this matter. I think this will go a long way in encouraging best practices that we all want and will also provide information to the media so that they can do the best job that is possible in providing information to the public on situations that are very difficult to deal with. Thank you. [LB782]

SENATOR JOHNSON: You bet, thank you. With that...conclude the hearing on LB782. Next is LB793, with Senator Burling. And let me apologize to you for the shifting that we had to do. It was kind of a critical nature that we do them in a different order, but it may have inconvenienced you. So thank you. [LB782]

SENATOR BURLING: Thank you, Senator Johnson. And it was no problem for me. And so if that accommodated someone else, that's just fine. Members of the committee, thank you for your time today. I'm Carroll Burling, that's B-u-r-l-i-n-g. I represent District 33 in the Nebraska Legislature. I'm here today to introduce LB793. I introduced LB793 to begin a discussion on the proper procedure to pay for the cost of EPCs in the state of Nebraska. When we passed...before LB1083, which created the behavioral health reform, there was apparently nothing in the statute about who pays the cost of EPC people. And it was apparently done basically the same all over the state. But when LB1083 was introduced it was put in statute how this process of paying the cost of EPCs and subsequent procedures were to be paid. The bill says that the cost of EPCs in Nebraska now should be paid by the county where the patient is picked up. If law enforcement picks up a person and they determine that that person needs to be EPCed they're taken to the facility and then the county where the person was picked up is billed for the cost. Now as most of you know, since the implementation of behavioral health reform changes, and there were major changes in behavioral healthcare addressed by that bill. Changes present challenges and we've faced many of those and we've been facing and addressing many of those challenges. And I just thought this was a subject that needed to be discussed. And so LB793 proposes to pay for emergency protective custody patients the same as we've done in this state for years and years and years regarding general public assistance. If you are a poor person in Nebraska receiving general public county assistance you can move from one county to another and the county you move to can continue to provide general public assistance, but bill the county of legal settlement, which is the one where you came from, the one where you had residency established. In today's society people move around a little more than we used to. And I'm not sure if it was the intent of the authors of behavioral health reform that the county in...where this person was picked up pays the bill for that or whether it

was just assumed that you're always picked up in the county where you live? But people do move around. You can be in another county for a various number of reasons. You need to be EPCed, they take you in, and that county where you happen to be picked up now pays the bill. And so I'm just suggesting in LB793 that we do it the same way with the EPCs as we do it with general county public assistance. That's basically what it says. And there's a number of options here that the committee might want to consider. Residency establishment doesn't include penal institutions or nursing homes or care homes or homeless shelters, and those kind of facilities you can't establish residency that way, those are exempt. But I think that this would be a fairer way to do it. And I'm sure that the committee will hopefully discuss maybe some other options of how to address this situation. For instance, I didn't address the situation in my bill where you might bill the patient themselves if they have resources. But right now with it in the last...the county where they are picked up shall pay the bill, why would any patient be billed or pay for their EPC services even if they had the resources? So I'd be willing to work with the committee on a number of options on how to approach this situation. But I need...I think it needs some clarify. I think there's confusion out there about who pays and who ought to pay, whether they have resources, whether they don't, where they're a resident, where they're not. So if the committee sees fit to advance this bill, I'd be happy to work with them on any other ideas you might have. But I just think it's a...a discussion that needs to be had. And I appreciate your time. And there are those following me that know more about it than I do that will give you some more information. And so before I sit down, are there any questions for me? [LB793]

SENATOR JOHNSON: You've got one over here from Senator Hansen. [LB793]

SENATOR HANSEN: Thank you, Senator Johnson. Senator Burling, can you, on Section 5, can you clarify Section 5 or do you have someone behind you that can, because that looks like a shell game to me. [LB793]

SENATOR BURLING: Section 5 in the green copy. [LB793]

SENATOR HANSEN: Yes. Page 7. [LB793]

SENATOR BURLING: This is the way general public assistance is done now, Section 5. And I'm just suggesting we put into the current law, which was LB1083, this same wording for EPC. I think...did you have a specific question about... [LB793]

SENATOR HANSEN: No, the whole section, it just sounds like a county is going to pay, but we don't know which county. It still doesn't clarify it to me which county is going to... [LB793]

SENATOR BURLING: If it can be determined where the person had a residence, that county would pay, if that can be determined where the...and that means if they were in

the state a year and in the county six months or if they were in the county a year that establishes residency. And I already had said the facility is exempt, residency establishment. So... [LB793]

SENATOR HANSEN: Yeah. Somebody is going to have to tell me what that means, Section 5. I'll ask if someone behind you... [LB793]

SENATOR BURLING: Okay. [LB793]

SENATOR HANSEN: Are you going to be around for closing? [LB793]

SENATOR BURLING: I plan to. [LB793]

SENATOR HANSEN: Okay. I'll get clarifying on Section 5 or ask you again. [LB793]

SENATOR BURLING: Okay, okay, okay, okay. [LB793]

SENATOR JOHNSON: Okay. Any other questions? [LB793]

SENATOR ERDMAN: Just a question for Senator Hansen. What specifically is your question? How it works? [LB793]

SENATOR HANSEN: I can't understand what that says. [LB793]

SENATOR ERDMAN: How it works? [LB793]

SENATOR HANSEN: Yes. [LB793]

SENATOR ERDMAN: Okay. [LB793]

SENATOR JOHNSON: Okay. Let's kind of keep that in mind as we proceed. Senator Burling, thank you very much. [LB793]

SENATOR BURLING: Thank you. [LB793]

SENATOR JOHNSON: How many proponents do we have? One, two, three, am I missing anybody? Opponents? I see one back there. And neutrals? Couple of neutrals, so we got about eight or so. If we take ten minutes apiece, why it will be moving right along. (Laugh) So I would ask you to be as brief as possible. State your point, that's what we remember anyhow rather than rambling discussion. Sir. [LB793]

SHANE PERKINS: Thank you, Senator Johnson and members of the committee. My name is Shane Perkins, P-e-r-k-i-n-s. I am a deputy Adams County Attorney and I am

here in support of LB793. Part of my duties as the Adams County Attorney is to represent Adams County in mental health commitment proceedings. Adams County also contracts with 13 other counties in Region III to provide mental health services for them. As part of my duties in dealing with 14 counties with mental health proceedings I am often called upon to interpret unique situations that arise due to the mental health statutes. I can tell you, in my dealings with other county attorneys, that complete understanding of the significant changes that have occurred in mental health is quite varied, particularly in who is responsible for payment of the costs associated with mental health proceedings. One of the real issues is the...is that the Mental Health Commitment Act, the EPC proceeding itself really envisions a single incident. It is not focused on long-term mental health care. Oftentimes, we know that people do move around, are placed in other facilities in other counties and have to again be EPCed. And as we've...and I can answer questions about any confusion about the issue. But Section 71-921, as written, is open to interpretation as to what county actually is responsible for payment. One of the issues is that the easiest way is to say that the county that does the EPC is responsible. The problem is with the transition to more community-based mental healthcare much of the costs of maintaining the long-term mental health is falling on the counties. As those costs rise, counties are forced to examine the statute more closely. What happens is they read Section 71-921 and realize that the language is quite ambiguous as to who really must pay. This bill is an effort to give some structure to the counties so that the counties know what their obligation is. Unfortunately, what is happening in the current language of 71-921 is that counties are able to find loopholes to allow them to say that another county is responsible and therefore avoid paying for continued mental healthcare for people that they originally committed. What is happening is this is placing burden of payment on certain counties and others are getting off with less of a burden than they might originally have had. The efforts with this bill is to at least give us a beginning where we can come to a more equitable understanding of mental healthcare and who is responsible for paying. I think that I can, you know, go on further about this. But I think my real value here is to be available to answer questions that you might have regarding the mental health process and what the practical application of the Mental Health Act is. Are there any questions? [LB793]

SENATOR JOHNSON: Yeah, I think you're going to have a few. Thank you very much. Senator Erdman. [LB793]

SENATOR ERDMAN: Shawn,... [LB793]

SHANE PERKINS: Shane, Senator. [LB793]

SENATOR ERDMAN: Is that Shane? [LB793]

SHANE PERKINS: Yes, sir. [LB793]

SENATOR ERDMAN: I think I should know you from somewhere, but I'm going to figure out where that is. I apologize. The question Senator Hansen asked, as I understand it is this, an EPC, an individual who was previously a resident or is a resident of a county for one year is the first scenario. If they have not been a resident of the state, but they've been the resident of another county for six months, that would be the second scenario. And the third scenario is if they don't meet case one or case two, it's wherever you find them or wherever they've been EPCed, that's the county that's responsible? [LB793]

SHANE PERKINS: Yes, sir. [LB793]

SENATOR ERDMAN: Fantastic. I can read. Thank you. [LB793]

SHANE PERKINS: And I would like to point out that some of the reason for that is if you turn to I believe it's Section...Section 3, paragraph (2), that section is currently really our only guide in the Mental Health Act as to who is responsible for mental healthcare. And again, the problem is this is really only appropriate for an initial EPC. It does not envision paying for mental healthcare that goes beyond when a person is perhaps placed in a residential facility and is then EPCed again. What happens is any county that has a residential facility that is taking people is then...could then be placed...could be responsible for all further mental healthcare from that person. It simply switches it. Unfortunately, that's what is happening. The interpretation of this section is allowing some counties to say...they're interpreting it as they weren't EPCed in our county, it's not our responsibility anymore, we're done. What this means is that certain counties, for example, Webster County, four-fifths...four out of every five of their EPCs are actually people who have been placed in residential care from another county. What this is doing is that small counties that do have the mental health...the community-based mental health facility are suddenly becoming responsible for other county's EPCs, other county's mental health patients. This is coming to the point that, as in Adams County, we're in Region III where I do 14 counties, I'm able to police some of that and not burden, you know, these counties, because they're impression for most of the counties is that the county of residence is the county that pays. And the way the statute is written, certain counties, because of the increase in costs, are learning that they can simply refuse to pay, you know, because they read it as only the county where the person is EPCed rather than the county of residence. Prior to the change in the Mental Health Act, HHS basically had dictated that the county of residence was the county that the person was counted from. Essentially, the state was paying a lot of the cost. It didn't matter where the person was placed in emergency protective custody, or at least the costs were quite minimal. When...when they're...now with this change and the costs being placed on the individual counties more and more, certain counties are being forced to find creative ways to not pay. And that's essentially what that change is trying to address. [LB793]

SENATOR JOHNSON: Senator...I'm going to go for Senator Howard here, first. [LB793]

SENATOR HOWARD: Thank you. This is intended to apply to adults, correct? [LB793]

SHANE PERKINS: Yes, ma'am. [LB793]

SENATOR HOWARD: What about adolescents, youth? [LB793]

SHANE PERKINS: Adolescents fall under the juvenile system. [LB793]

SENATOR HOWARD: So that would be separate from the bill? [LB793]

SHANE PERKINS: So that is separate from this. [LB793]

SENATOR HOWARD: Okay. [LB793]

SHANE PERKINS: There is a...because of the way the statute is, the age of 18, there's a little bit of a gray area that we kind of have to deal with as it comes up. [LB793]

SENATOR HOWARD: Nineteen is the age of majority. [LB793]

SHANE PERKINS: Correct, but the age of 18 is where I think the commitment to...for juvenile ends. Hospitals will not take anyone who is, I believe, 18 or younger. But some hospitals are willing to take people who are 18 and treat them as a full EPC. It's an issue that's come up only a couple of times for us, but... [LB793]

SENATOR HOWARD: Okay. So for this bill it would be 18 and older? [LB793]

SHANE PERKINS: Well, for this bill, I believe, yes, 18 and older. [LB793]

SENATOR HOWARD: Thank you. [LB793]

SENATOR JOHNSON: Senator Hansen. [LB793]

SENATOR HANSEN: Thank you. Shane, I guess it's becoming more clear how you establish residency. But one example we have with an EPC this past year in my district, a male was found close to a junior high wearing only a trash bag. So he didn't have any ID on him. The police refused to EPC him, but did transport him to Lancaster County, who also refused to EPC him. And he should have been in some type of care. But it's just...well, it's not my problem, hand it off, hand it off and so I don't know whether this is counterproductive to the EPC process, because nobody wants to pay. And they are becoming creative, as you said earlier. And I'm not sure that's good for the patient who actually should be getting some good. Just because counties are strapped for funds and it's up to the police department to EPC. [LB793]

SHANE PERKINS: Yes, sir. Unfortunately, that's one of our major problems is that police departments and sheriff departments are becoming unwilling to EPC and people who should be EPCed aren't. Our hope is that if we can establish that the county of residence is going to be the county that is liable, that the police will be willing to EPC when it's necessary rather than thinking about the money side of it. There have actually even been even more egregious cases where counties have had knowledge of people who were suicidal and needed to be EPCed, no doubt about it, waited until the person crossed the county line, called another county sheriff and informed them to EPC the person. That's simply unacceptable in my opinion. That is bordering on criminal. We're trying to avoid those confrontations between the counties. We're trying to find a way that the counties can cooperate and work together rather than basically pulling into their own camp and saying, it's us against the rest of the state. We really want to establish a procedure, a way that the counties don't feel that if they EPC someone that it's going to be their problem. But that's it. [LB793]

SENATOR HANSEN: Thank you. [LB793]

SENATOR JOHNSON: I see no other questions. Thank you very much. Next, please. Welcome, sir. [LB793]

LARRY WOODMAN: Thank you. Senator Johnson and members of the committee, my name is Larry Woodman, W-o-o-d-m-a-n. I'm chairman of the Adams County Board of Supervisors. I'm here to testify in favor of LB793. We feel there is a need to establish residency requirements for the billing of EPCs as in other HHS programs. Since the dismantling of the mental health program that we had worked with for years, we have faced steadily increasing costs. We were assured at the time it was not the intent to shift the cost of treatment to the counties. It's bad enough to provide services for our own county residents, but with the influx of residents from other counties we are asking for help. The response from Region III has been minimal. The director told us we have too many community-based programs, that's the reason we have so many people. Just a couple of examples. Recently we've had clients from Lancaster and Douglas Counties moving to Crossroads, this is our homeless shelter. The one from Douglas County had been EPCed 19 times there. The one from Lancaster County, 7 times. Does that sound right and reasonable for those clients to be our responsibility? We've had two cases in the last six months with a cost of approximately $10,000 each. Mary Lanning Hospital takes our EPCs when they have an empty bed, but many times they are full. One client last year was placed in Bryan Hospital mental unit at the cost of $3,500 a day, besides the cost for transportation. In the year ending 2006, we paid Region III $37,000 and other institutions $8,000. This year, two years later, so far we've paid Region III $50,000, $15,000 to other institutions, and we have $29,000 pending. In a two year period that's going to more than double our costs. We need help. There are several issues here, but we need to start someplace and we think that LB793 is a step in the

right direction. I can tell you out in Adams County there is sure a different looking picture than what Dr. Adams painted. It looks a whole lot different where the rubber meets the road. Thank you. [LB793]

SENATOR JOHNSON: Wait one second and see if we got any questions of you. [LB793]

LARRY WOODMAN: Sure. [LB793]

SENATOR JOHNSON: I don't see anything. But you kind of remind me of an old saying. Be the job large or small, if you do it well, you'll do it all. (Laughter) Next, please. [LB793]

JON EDWARDS: Good afternoon. My name is Jon Edwards, J-o-n E-d-w-a-r-d-s and I'm with Nebraska Association of County Officials and we are here today in support of the basic underlying principles of LB793. I think as testimony goes along, you'll hear some discussion about maybe a few problematic areas within the definition. And we're certainly open to those concerns and believe that there may be some things that the committee can address there. But just as a general principle, as an organization we do support the underlying idea here with LB793. So I won't take any unnecessary time. [LB793]

SENATOR JOHNSON: Any questions? I see none. Thank you very much. [LB793]

JON EDWARDS: Thanks. [LB793]

SENATOR JOHNSON: Any other proponents? I see none. Any opponents? You have some things to pass around? [LB793]

C.J. JOHNSON: Yeah. [LB793]

SENATOR JOHNSON: He'll catch them for you. Welcome, sir. [LB793]

C.J. JOHNSON: (Exhibit 1) Good afternoon, Senator Johnson and committee members. My name is C.J. Johnson, C-period, J-period, J-o-h-n-s-o-n. I am the regional administrator for Region V Systems, which is one of the six behavioral health regions in Nebraska, primarily serving southeast Nebraska. I'd first like to start my testimony by saying that I've heard several comments in the proponents talking about the underlying principles of the bill. And the reason I'm here in opposition of LB793 is, as I read the bill, it is very specific to identifying who is responsible for the payer of an emergency protective custody hold. It did not seem to lend itself to a discussion regarding a lot of the issues that have been generated in relation to emergency protective custody hold. So that's why I'm up here in opposition, specifically around the payor source of

emergency protective custody. Currently, it is very clear, whether we're a region or a provider, who is to be billed for the costs of an emergency protective custody. I want to make it very clear that those costs are specific to an emergency protective custody hold. They are not in relation to who pays for any mental health treatment or substance abuse treatment following that emergency protective custody hold. It is specific to that time in which that person is placed on emergency protective custody. Either once they are released from that care or there is a Mental Health Board commitment of either out-patient or in-patient, other payor sources kick in, and it's not on the county as far as those payment dues. LB793 would create a number of significant challenges in relation to counties and providers alike. In addition to the current interlocal agreements established within the behavioral health regions, in relation to the emergency systems the current EPCs are set up in relation to those parameters and how those are billed and who would bill. LB793 would significantly compromise the current interlocal agreements established and processed to address EPCs in each of the behavioral health regions. Additional challenges that would be created by LB793 that do not exist under the current statutes include, but are not limited to, the following: LB793 places the burden of proof to determine residency on the provider of services seeking compensation. So in other words, whether you're a hospital or us as a region or any other provider, you would have the burden of proof first of all to identify the residency of that person. It was answered, as far as transitional residential situations. However, I would like to point out that there was comments made about individuals from a variety of other counties and going to other counties. The reality is behavioral health reform was identified to allow individuals, whether they were leaving regional centers or anywhere, to seek treatment in whatever place they want. Region V, because we have the Lincoln Regional Center, we do see a lot of individuals who go to the Lincoln Regional Center, even correctional facilities. And when they come out they make a decision that they want to continue to...they want to live in Region V. And so they go into treatment services there. That doesn't imply to me that they aren't residents. In fact, we treat them as they are residents because that's where they want to end up living. Under the current statutes that would not imply that people are making their own choices about where they want to live and establish residence. Counties would have to spend a considerable amount of time and resources verifying the county of legal settlement once a provider of services establishes the county of legal residence. Determining legal residence, for many purposes, can be very complicated as our experience in the area of general assistance and tuition. And I think you might hear about that later on other testimony. An emergency protective custody hold is, in all legal sense, an arrest. And I think that's very clear. This is...emergency protective custody hold is an arrest by all legal terms. It is a criminal justice issue at that point, it's not a mental health service issue at that point. The county of legal settlement should not be responsible for the costs associated with the person's incarceration if another county's policies, procedures, or actions result in the decision to EPC an individual, especially if that arresting county chose not to utilize other potential options such as crisis response teams. Throughout the state now we have crisis response teams. I do have concerns

and I wasn't even going to present this, although it's already been presented in testimony that law enforcement officers make decisions, not based on the best interests of the individual but rather based on money. That is an unfortunate reality if that is true reality. It would be equally concerning that if I was, say, a law enforcement officer, say, in Adams County and I'd met with somebody and I had crisis response teams available to me but, because I knew that person was from Lancaster, I wouldn't utilize those crisis response teams to seek an alternative rather than EPCing that person, knowing that Lancaster County then would subsequently have the bill. So I would be concerned about those kind of decisions being made. The current bed allocation at the Lincoln...at the regional centers is based on actually where the person was EPCed from. This would greatly compromise these agreements that we've had and understanding who's responsible and whose bed is being utilized at any of the state hospitals at any time. So in other words, if somebody was from western Nebraska but was EPCed in Lancaster County or in our region and then subsequently placed on a Mental Health Board commitment, we would recognize that those individuals were part of our bed allocation and we would not try and shift that burden to western Nebraska. It's very clear where an EPC occurs these are the lines of responsibility in relation to payment, process, Mental Health Board commitments, and those kind of things. There is probably a lot of other ones as I begin to look at this, but again I wanted to come and testify in opposition to this as I see there are, based on the language of the bill specific to who is responsible for paying HCIC, there are numerous complications in relation to identifying that and then subsequently holding people accountable for the payment of those emergency protective custody holds. I'm ready to answer any questions at this time. [LB793]

SENATOR JOHNSON: Senator Erdman. [LB793]

SENATOR ERDMAN: I appreciate your testimony. I guess what I gathered from your comments was that there is no problem. [LB793]

C.J. JOHNSON: It's...what the statement is it's very clear who is responsible for the costs of an emergency protective custody hold. I mean, if that was not the case, I think hospitals...hospitals are very clear who...which county to bill based on emergency protective custody hold. And I believe the legal situation is very clear about who would be accountable for dealing with those costs. I don't think there's any question about who's responsible based on the current statutes. [LB793]

SENATOR ERDMAN: So help me understand then. There are arguments being made by the individuals from Adams County, in Region III,... [LB793]

C.J. JOHNSON: Um-hum. [LB793]

SENATOR ERDMAN: Are there...are they not able to understand it? Are things being done differently than are being done in Region V? Is it an issue of understanding the

application of the law? I would think Mr. Perkins is capable to understand the law. [LB793]

C.J. JOHNSON: Well, what I heard in the testimony was that counties can refuse to pay or acknowledge, okay, their responsibility. Currently, it's very clear if a law enforcement officer from a county EPCs that person, that county is responsible. I actually see the bill that is being introduced allowing a county to say, well, they're...nope, they weren't our legal resident; and then somebody says, nope, they weren't our...I mean, I think it just would allow whatever they are experiencing to even complicate it even more, because at least at this point, based on the statute, there is no question about who is responsible, it says, where the EPC...I mean it's about where the EPC occurred and which county it is. [LB793]

SENATOR ERDMAN: And again just so that I'm clear, your opinion is that the existing circumstances, regardless of how they are being done, for example, in Region III, are better than the alternative here? And then the same point, you have no other alternative that you would offer that would even make the system better? [LB793]

C.J. JOHNSON: I think, you know, I think the issue really comes down to is not necessarily who is responsible based on the issues that are at hand, because I don't think there's any question about that. I think the issue comes down to how much counties feel they are responsible for those emergency protective custody bills, how much is the state paying, what are obvious...what are reasonable rates for an emergency protective custody hold to have to pay? You know, I think that's the real issue is when you get a bill, you know, as a county where somebody has been on...under an emergency protective custody hold for $15,000, I would question that, too. Why would I have to pay $15,000 for this person's stay on emergency protective custody? And I think that's where the real question comes in is those kind of things, not who's responsible. I think that's pretty clear in the statutes. I know it's clear, because... [LB793]

SENATOR ERDMAN: But is it...just a last question. Whether it's clear or not, is it the right solution? Because if it's clear the question is, the individual gets EPCed in Bayard, Nebraska,... [LB793]

C.J. JOHNSON: Um-hum. [LB793]

SENATOR ERDMAN: ...who's a resident of Scotts Bluff County, which is actually western Nebraska,... [LB793]

C.J. JOHNSON: Um-hum. [LB793]

SENATOR ERDMAN: ...which I'm assuming you meant when you said western

Nebraska. [LB793]

C.J. JOHNSON: Um-hum, um-hum. [LB793]

SENATOR ERDMAN: Not like York or (inaudible) (laughter). [LB793]

C.J. JOHNSON: Right. [LB793]

SENATOR ERDMAN: But the individual gets EPCed under the current law. [LB793]

C.J. JOHNSON: Um-hum. [LB793]

SENATOR ERDMAN: The county that EPCs then, the county in which the EPC occurs is responsible? [LB793]

C.J. JOHNSON: Um-hum. [LB793]

SENATOR ERDMAN: Regardless of where that individual resides. [LB793]

C.J. JOHNSON: And the reason is, is because an emergency protective custody hold is essentially a criminal justice issue. This person is being arrested. And from my perspective if I commit a crime in Lancaster County and I'm arrested for that crime, and if I lived in another county, that other county isn't responsible for my jail costs and everything else. I committed the crime in there. An emergency protective custody hold is an arrest. It is violating where you are dangerous to yourself or others and you are arrested, you are placed in custody, you are handcuffed and you are transported to a secure facility for that. And that's the issue. It's not at that point a mental health treatment issue. It's...you are dangerous to the public and you are being arrested. [LB793]

SENATOR ERDMAN: And I'm glad I kept asking questions so you could get to the connection. [LB793]

C.J. JOHNSON: Okay. [LB793]

SENATOR ERDMAN: And I think you did that. [LB793]

SENATOR JOHNSON: Well, and, Senator, I have kind of a little bit of the same thoughts is one of the things that often happens when there is legislation passed, and Jeff and I were talking about this, is that there is the unintended consequences that come from legislation so that you end up with situations like the gentleman from Adams County was describing. And so I guess the question in my mind is there some way that we can, for want of a better word, make things more equitable rather than just allowing

the unintended consequences to stay that way? [LB793]

C.J. JOHNSON: Well, you know, I think the issue is, I think, if you really delve into that there would be...I just think it would be so complex. I mean Region V has a significant number of correctional facilities. We have the Lincoln Regional Center. And I think if you began to...you know, there is just a level of understanding that because of the nature of...that you have those facilities, Region V actually has more individuals discharged from the Lincoln Regional Center into our region that were not residents of our region prior to them coming to the Lincoln Regional Center. And you're not hearing myself or you're not hearing the other counties, like Lancaster County coming up here in opposition to this because I think we all understand there is a clarity in the current bill of who is responsible for the costs of an EPC. There is lots of other issues around EPCs, but I have not experienced any lack of clarity in relation to who is responsible for the costs of an EPC. [LB793]

SENATOR JOHNSON: Yeah. I think that Hudkins had a bill last year or two of somewhat of a similar nature and so on,... [LB793]

C.J. JOHNSON: Yeah. [LB793]

SENATOR JOHNSON: ...again by unintended consequences apparently are there. Any other questions? C.J., I see none. Thank you. Any other opponents? I didn't know if the gentleman stood up or not? If not, I kind of like his tie, if nothing else. (Laugh) Any neutral? You have some things to pass around, sir? [LB793]

KERRY EAGEN: Yes, I do, Senator. [LB793]

SENATOR JOHNSON: Yeah. Matt will help you out over there. [LB793]

KERRY EAGEN: (Exhibit 2) Good afternoon, Senator Johnson, members of the committee. My name is Kerry Eagen. I'm the chief administrative officer for Lancaster County and I am appearing in a neutral capacity. Lancaster County does have several concerns about the way the bill is written now. And I did have an opportunity to speak with Senator Burling before the hearing. He was very receptive to some of the concerns we have. And I appreciate that. And I also appreciate the issue being brought to the floor in this manner. One of the sheets that I've passed around is the definition of legal settlement in the General Assistance statutes. And as Senator Burling indicated, he thought maybe we ought to look at the EPC process, excuse me for using that acronym, the emergency placement custody, but EPC is a little easier to say, like a general assistance hearing, where you look at the county of residence as the primary payor for the responsibilities. If that is the standard, I have highlighted in the provisions that have been handed around, we would want the toll anytime that is spent in either a penal institution or a mental health or behavioral health treatment facility because, as C.J.

pointed out, Lancaster County and Region V in general, we are a magnet for these types of facilities. So we get a lot of mental health patients. And with community-based mental health treatment we're going to get a lot of behavioral health issues in the community. We don't believe there is ambiguity with the statute now either. Certainly where the EPC takes place that county is responsible for paying, so we don't think there really needs to be clarity in that regard. But one of the philosophical issues that again C.J. raised, and I did talk to him before the hearing too, is, is the EPC process more like the criminal justice system or is it more like the general assistance system? EPCs are all about the public health, safety, and welfare. That individuals who are a danger to themselves or a danger to others need to be apprehended and we don't want to keep them in jail, so we try to keep them in, you know, a Crisis Center, as we have in Lancaster County. And we deal with a lot of other counties by agreement. So certainly I think if you look at it philosophically, it probably is a question that...it's an immediate need, it's a public safety need. And the county where it occurs needs to take responsibility for it, contract with healthcare organizations, if you don't have a facility, but it has to be done right now. And you can't look around at who...where the patient is from and whether you're going to treat them if they're from another county or not. It is immediate...needs to be taken care of immediately. So I think that is appropriate. Regarding administration, I've passed around a score sheet. And I didn't solicit this, but Scott Etherton, the director of our Crisis Center, sent this to me shortly before I came over to testify today. And he was looking at, over the last seven months, some of the statistics. And Lancaster County would probably come out better, you know, if we started doing a head count of...these are our clients, they're from our county, and these patients are from other counties. We're going to come out ahead and we know that because one of the major prison facilities is here, regional center is here. Clients or patients from other counties are going to come to us and we know that. But keeping track of this can be an administrative nightmare. And I can testify to this from administration of the general assistance system. I'm the hearing officer for Lancaster County and that's an issue that comes up. We spin our wheels a lot trying to track where this client came from. By nature the population has a tendency to be itinerate, they move from place to place, plus they are drawn here because this is where the treatment facilities are. So when you start keeping score, it becomes...you know, we come out ahead. But what are we really gaining? Administering such a system would add a lot of strain to the EPC system, and I don't know for how much benefit. But I can guarantee you, if you match us against any other county, we're probably treating more of their residents than they are treating of our residents. But that's really not the issue. So we would be concerned about that, some of the administrative cumbersomeness that would result from trying to track down another county to pay. I guess another issue that we had, which I don't think is a real issue but maybe needs clarification, there's another way that patients can get into the system is through the Sex Offender Confinement Act. And by definition they're in prison or in a facility already, and 180 days prior to release they are evaluated to determine if they are a dangerous sex offender. If this act is passed without additional clarification, and I'm not sure if it's necessary, by

definition if these people are in prison and you're not tolling that time that they are in prison, then they become Lancaster County's responsibility, regardless of what county they are from. So it creates an unfair situation and maybe more liability flowing to us. Presently, what happens is the prosecuting county, the county of release, the Attorney General, everyone is notified on those sex offender confinement issues and it's the prosecuting county that takes responsibility for that. And we wouldn't want to see that changed. And perhaps we could clarify that. I think underlying all of this is the concern with the fact that we're trying to move towards community-based mental health treatment. And with that you're going to have more emergency placement custody, it's just going to happen. And you want to be able to deal with that and make sure you have the resources for that. So maybe it needs to be looked at as a statewide issue. We certainly appreciate the cooperation we have with the other Region V counties. Our contracts are working very, very well and I wouldn't want to upset that. And I think C.J. did address that issue and that could be a possibility with this act that all of a sudden they would say, well, under contract maybe we're liable, but the statute says this, so we're not going to pay. So I think that could cause some concerns. So I'd be happy to try to answer any questions, if there are, from the committee. [LB793]

SENATOR JOHNSON: Any questions? Just one comment. I guess there was a senator that turned in a bill the other day to make it easier for counties to unify. And so we end up with less or fewer counties. I wonder if that would be of help? (Laughter) [LB793]

KERRY EAGEN: The region system is a basis for this, when you look at it. And the cooperation that you see with counties, and maybe that's a solution, too, is just more cooperation by contract between the counties to address the issue. [LB793]

SENATOR JOHNSON: You bet. [LB793]

KERRY EAGEN: It's clearly a county responsibility. [LB793]

SENATOR JOHNSON: Thank you. [LB793]

KERRY EAGEN: Thank you, Senator. [LB793]

SENATOR JOHNSON: All right. Any other neutral testifiers? If not, Senator Burling. [LB793]

SENATOR BURLING: Thank you, Senator Johnson. Assuming that you just made your last statement in jest, I have an idea too. If the state paid all of the general assistance and the EPCs, maybe that would help the situation, too, we wouldn't have to be talking about this. I said I introduced the bill to start a discussion. I think we've done that and it's all been good. It's been informative. And it wasn't my intent to put the provider in a position of burden of proof of residency. I understand now the county where the person

was picked up receives the bill. And then they could, if they wanted to, try to determine residency of that patient. Maybe you want to change the wording in the bill so that the county could have the option. If they don't want to spend the money to try to determine residency, they'd rather just pay it, maybe the committee wants to go that route. I just think the thing that really has given rise to this problem is the community-based services. Where before, you know, mental health...mentally ill people, which comprises most of the EPCs, they were scattered all over the state. Well, now you have facilities that open up in one county, well, it was mentioned in one of the testimonies that Webster County is a pretty small county. If they open up a community-based service, the people from other counties come to their facility, and under the way the law reads now they are stuck with the EPC bill. They might choose to want to try to determine residency of some of these people and bill some of their residents...where they came from. Maybe you want to look at changing the wording to give some options. So I'm willing to work with the committee in any way that we can to improve it, if the committee thinks it's something that should be addressed. And I do think it is something we should address. So for that reason I urge you to advance it to General File. And I'd be happy to work with you on solutions to testimony you've heard today. Thank you. [LB793]

SENATOR JOHNSON: Thank you, Senator Burling. With that, that concludes the hearing on LB793. The next one is LB796. And I'm the official carrier of the ball on this one, so we'll ask Senator Gay to take over. [LB793]

SENATOR GAY: Go ahead, Senator Johnson, open on LB796. [LB793]

SENATOR JOHNSON: Senator Gay and members of the committee, I'm Senator Joel, J-o-e-l Johnson, J-o-h-n-s-o-n and I'm representing the 37th District. I'm going to be brief here about this bill because it does get complicated. And there will be other people behind me that will get into the difficult nature of some of these problems. This is introduced at the request of the Department of Health and Human Services and the Division of Public Health. What this deals with is the Radiation Control Act. And what we need to look for here is this--a medical radiography licensure category; (2) radon measurement technicians and radon mitigation specialists requirement; registrations to allow them to be completed on the Internet; x-ray machine inspection fees, and consider increasing them and how; and requirements for radioactive material licenses by authorized...by authorizing fingerprinting in this process. So with that, Senator Gay, I'll hand the ball off to Dr. Schaefer. [LB796]

SENATOR GAY: All right, thank you, Senator Johnson. We'll hear from proponents. Dr. Schaefer. [LB796]

JOANN SCHAEFER: (Exhibit 1) Thank you, Chairman Johnson. Thank you, Senator Gay and members of the committee, this late afternoon. My name is Joann Schaefer, S-c-h-a-e-f-e-r, M.D., chief medical officer and the director of the Division of Public

Health, Department of Health and Human Services. I would like to thank you, Senator Johnson, for introducing this bill on behalf of the department. I'm here today to testify, obviously, in support of LB796 that makes five changes to the Radiation Control Act. It's a little complex. I'll try to simplify things as I go on. The Radiation Control Act regulates sources of radiation for the protection of occupational and public health and safety of the environment. The first section, 38-1915, limits the operation of x-ray computed tomography, what we commonly refer to as CAT scans, equipment to medical radiographers. Fairly recently a new type of medical imaging equipment has been developed that combines both CAT scans and nuclear medicine imaging systems. These are the colorful images that you may see one example of that. This new machine can combine both of those pieces, both of those capabilities into one image, which is tremendously fantastic for patients. Under the act, the medical radiographer must operate the system during the CT part of the procedure. The Nebraska regulations for control of radiation requires that the nuclear medicine imaging part of the procedure must be performed by a nuclear medicine technologist because of the use of the radioactive materials. Since medical imaging equipment has changed dramatically since the department began licensing the operators of this medical x-ray equipment, this bill is needed. Appropriately trained individuals will be allowed to operate the modern equipment that combines CT or CAT scan technology with nuclear medicine imaging. Second, Section 71-3503 subsection (11)(c) lists four radon licenses that the department may use. Under LB796, there will only be two. This is largely in part because one license has never been issued since the beginning of the Radon Act. And recent changes to the radon program rules and regulations have made the measurement technician and the specialist license equal to one another; there is no difference in the qualifications. So that's just a simplification in what we're doing there. Third, Section 71-3507 subsection (3) refers to both radon measurement and mitigation technician licenses. Changes to this section make it consistent with 71-3503(11)(c), which I just described above. This additional language is added here to change existing radon measurement technician licenses to a measurement specialist status, until such time the license expires. That's just some additional language in there to cover the gap until the law passes or that change is made. Fourth, Section 71-3507 subsection (9) requires the department to provide forms for the registration of sources of radiation. This change allows the application for registration to either be in writing or by electronic means. This would allow the applicant flexibility in how the information is provided to the department. In other words, when they register with us a piece of equipment, instead of having to go through a form, a specific form, grab it, fill it out for us, we're just allowing them to do it either by e-mail or in any written form, as long as the appropriate information is on the form; just taking the bureaucratic details out of that. It would also allow the department the flexibility of listing in the regulations the necessary information items that must be included in that without using a specific form, per se. Fifth, the current annual fee for registration and inspection of x-ray radiation-generating equipment used to diagnose conditions in humans or animals is limited to $70. The category of equipment is quite broad, ranging from complex CAT scans and angiogram

units to less complex and dental and veterinary and radiographic units. The fee cap of $70 for registration and inspection of all x-ray machines was established in 1990. In 2002, this language was modified so that the fee cap only applied to radiation-generating equipment used to diagnose conditions in humans and animals. The current fees are not adequate to cover the department's cost to register and inspect all x-ray radiation-generating equipment and General Funds have been needed to offset the cost. The proposal would set up a three-tiered fee cap system for registration and inspection of radiation-generating equipment used to diagnose conditions in both human and animals. The fee cap would be increased to $250 for the least complex types of x-ray machines, such as dental and intraoral and veterinary radiographic systems. The fee cap would be increased to $500 for moderately complex types of x-ray machines and the fee cap would be increased to $750 for the most complex types of x-ray machines, such as CAT scans and angiography or, I'm sorry, angiographic systems. The proposal would generate $48,800 in cash and the funds revenue replace the $42,000 currently used in General Funds. Finally, the proposal would be...would provide the department the authority to require radioactive material licenses with access to radionuclides of concern under the federal criminal background check and fingerprinting. This change is needed for the department to remain compatible with the Nuclear Regulatory Commission's program as outlined in 71-3505. And on the fingerprinting issue, we have contacted all the licensees that this affects. It's a federal fingerprinting program. And because of the secure nature of the nuclides that they handle they are aware of the issues. And we've contacted them all individually and are aware of this and are fine with being in compliance with it. That ends my testimony. I'd be happy to answer any of your questions. [LB796]

SENATOR GAY: Thank you, Dr. Schaefer. Any questions from the committee? I have a quick question for you. [LB796]

JOANN SCHAEFER: Sure. [LB796]

SENATOR GAY: When you're talking about inspection of this would generate $48,000, what is the overall cost of doing this? How many people do it, and what's the overall cost of inspecting these machines and... [LB796]

JOANN SCHAEFER: Let me pull out my book here. The overall cost for x-rays, currently in this fiscal year, is $398,000 for x-ray. We also have radiological materials and then another emergency program with radiologic health as well. So the total, that's a three component, the total program is $1.2 million. That's largely federal and cash funded. [LB796]

SENATOR GAY: Okay, and how many inspectors are doing that? How many employees? [LB796]

JOANN SCHAEFER: On the x-ray side... [LB796]

SENATOR GAY: Just overall, the whole thing... [LB796]

JOANN SCHAEFER: ...I have staff here. Can I turn around and ask just how many do that? [LB796]

SENATOR GAY: Sure. [LB796]

JOANN SCHAEFER: Julie, how many are on the x-ray side only? Okay. Currently, we have the two. [LB796]

SENATOR GAY: Okay, two. And we need one more? [LB796]

JOANN SCHAEFER: And we annually inspect 10 percent of the units. [LB796]

SENATOR GAY: Okay and then this is more of a generalized question though, too, because you're looking at the whole thing and the whole...so we're talking about $1.2 million. That's some substantial money. [LB796]

JOANN SCHAEFER: Um-hum. [LB796]

SENATOR GAY: The $48,000 here on these fees, I commend you for trying to get to a level where we're cost-efficient, break even. [LB796]

JOANN SCHAEFER: Right. [LB796]

SENATOR GAY: But is there other, like I say I don't want to shoot it down. Is there other things going to be coming where you're coming to us and saying, well, we're underfunding this, that and the other thing, other fees that you're going to be asking for to help offset the General Funds? [LB796]

JOANN SCHAEFER: In this or in... [LB796]

SENATOR GAY: Other places that...is this the first one of many, or is this just one thing we found last year that you thought you could go find a solution by doing this? [LB796]

JOANN SCHAEFER: This is one. [LB796]

SENATOR GAY: Of many? [LB796]

JOANN SCHAEFER: This is one of...well, no. This is one of several. [LB796]

SENATOR GAY: Okay. [LB796]

JOANN SCHAEFER: Not all of them have been accepted. [LB796]

SENATOR GAY: But you're finding... [LB796]

JOANN SCHAEFER: We're finding many. [LB796]

SENATOR GAY: Okay. That's what I was kind of getting at... [LB796]

JOANN SCHAEFER: Yeah. [LB796]

SENATOR GAY: ...is, what's the long-term plan here? Is that we're going to come back with... [LB796]

JOANN SCHAEFER: No, we're trying to shift...oh, no. We would love to do one big omnibus fee. (Laugh) And it just unfortunately, with the way we time our regs and the way we time the fees that are needed to generate the cash for the program, for ongoing, we can't always do it all in one big fee package. We were able to do that on the licensing side for health individuals. And we have one large fee restructuring. That is being done through regulation, however, because we already have the statutory authority and we're (inaudible) the caps. This is just to adjust the caps accordingly, because just to generate that $42,000 we will already be above the $70 cap. [LB796]

SENATOR GAY: Okay. So, I guess, the point that I am getting to is if you ask us to do this and increase a fee, I understand these things are coming at different...are you also looking to get rid of things that are no longer necessary? [LB796]

JOANN SCHAEFER: Yes. [LB796]

SENATOR GAY: It looks like you made some changes here to make it more efficient. [LB796]

JOANN SCHAEFER: Absolutely. [LB796]

SENATOR GAY: So you're going to continue to look for things that... [LB796]

JOANN SCHAEFER: Absolutely. [LB796]

SENATOR GAY: Because I'm sure these people don't like all this regulation. [LB796]

JOANN SCHAEFER: Regulation, no. [LB796]

SENATOR GAY: So you're actively looking for that as well? [LB796]

JOANN SCHAEFER: Actively looking at every way we can to deregulate. [LB796]

SENATOR GAY: Okay. [LB796]

JOANN SCHAEFER: And where we don't compromise safety to the public... [LB796]

SENATOR GAY: Right. [LB796]

JOANN SCHAEFER: ...at the same time that we're, you know, they have to be smart regulations. But, you know, every time we go through a set of regulations or through a program, we're trying to look where does it make sense to take it away. You know, the form was a nice change. That was something that makes it more user friendly. [LB796]

SENATOR GAY: Um-hum, you know the Internet and...yeah. [LB796]

JOANN SCHAEFER: Yeah, Internet. We've been taking as much stuff as we can online to make it more user friendly for the folks. But, you know, technology, this is one where we have not been able to keep up with the technology. Right now as the regs are even written we license the machines according to what the types of machines are. It doesn't make sense to do that anymore. The machines change,... [LB796]

SENATOR GAY: Right. [LB796]

JOANN SCHAEFER: ...the technology is so fast, we need to put it in there more broad. But we're struggling and we're willing to work on any language that meets, you know, anybody's interest... [LB796]

SENATOR GAY: Right. [LB796]

JOANN SCHAEFER: ...to, you know, come up with the right language so that everyone is comfortable with how we regulate those machines. And ultimately we're just protecting the patients. [LB796]

SENATOR GAY: Yeah, and it's very important on radiology. [LB796]

JOANN SCHAEFER: Right. [LB796]

SENATOR GAY: Yeah, I can see the importance of this. [LB796]

JOANN SCHAEFER: We don't want to be a burden to the hospitals, nor do we want to be... [LB796]

SENATOR GAY: Right. [LB796]

JOANN SCHAEFER: ...a burden to the people that have to be inspected all the time. [LB796]

SENATOR GAY: It's a happy medium. [LB796]

JOANN SCHAEFER: Yes. Yeah, absolutely. [LB796]

SENATOR GAY: Okay. Thank you, Dr. Schaefer. [LB796]

JOANN SCHAEFER: You're welcome. [LB796]

SENATOR GAY: I don't see any other questions. All right. [LB796]

JOANN SCHAEFER: Okay, thanks. [LB796]

SENATOR GAY: Other proponents? Go ahead and state your name for the record and spell it out. [LB796]

TOM BRENNAN: (Exhibit 2) My name is Tom Brennan, B-r-e-n-n-a-n. Good afternoon. I'd like to thank the Health and Human Services Committee members for allowing me to speak with regard to LB796. I am service leader in radiology for Nuclear Medicine Hospital in Omaha. My areas of responsibility include both the CT department as well as the nuclear medicine department. I've been a certified nuclear medicine technologist since 1987 and I received my bachelors degree from the University of Nebraska Medical Center in advanced radiation science in 1991. In addition, I am a current member of the Radiation Safety Committee for Methodist Hospital and we are fortunate to have cutting-edge technology including two hybrid scanners. It's this type of technology that LB796 addresses in part and with which I would like to make comment on. I am in support of LB796 but would like to address the wording in the bill which impacts the qualifications necessary to perform hybrid spec PET/CT scans in Nebraska. PET/CT scans are used primarily in the detection of cancer, as well as Alzheimer's and cardiac imaging. PET is short for positron emission tomography. These scans use radioactive materials and are performed by certified...CT is short for computerized technology and the scans utilize x-rays that are performed by registered radiologic technologists or x-ray techs trained in CT. Thus, PET/CT fuses two distinct technologies into one hybrid machine or scanner. Most tumors use sugar as a source of energy to help them grow, and PET scan patients are given a radioactive sugar that can be detected by the PET scanner to identify such tumors. CT scans show tumors differently. They rely on x-rays to create accurate anatomical images of the body to identify masses or enlarged lymph nodes. PET uses function and CT uses anatomy. Fusing these two

creates a very powerful diagnostic tool. However, along with the many benefits of this new technology come a set of complex training, logistical, and legal concerns that require your careful consideration and cooperation to determine the appropriate solutions. Never before have two completely different imaging modalities been combined like this. The question for us is, who is most qualified to safely and accurately run these machines? Is it the nuclear medicine technologist who is already familiar with handling radioactive materials and PET imaging or the CT tech who is already familiar with CT imaging and licensed to administer x-rays? My concerns are LB796 recognizes this dilemma and is making the attempt to provide an educational pathway for both disciplines. However, I am concerned there is no language in the bill that confirms that a nuclear medicine technologist can proceed directly to CT training as the bill suggests. Current state regulations prohibit nuclear medicine technologists from administering an x-ray, yet to become trained in CT imaging, as the bill suggests, a nuclear med tech must go through two years of training to become an x-ray...before beginning training in CT. Nuclear medicine technologists have extensive training in radiation safety, and experts in the safe handling of radioactive material and thus understand radiation safety practices at a very deep level. It's appropriate to allow a nuclear medicine technologist to perform CT exams while learning CT. They already understand radiation safety. I support the concept of cross-training in CT, but highlight the need for additional language in this bill to eliminate the need for an additional two years of x-ray training. In fact, by current law, if a nuclear medicine technologist were to go back to x-ray school and become a registered x-ray technologist they would be able to perform CT without training anyway, thus unraveling the intent of the bill in the first place. So my main point of concern with LB796 is not providing an exception for nuclear medicine technologists to bypass the required two years of x-ray tech training required by law to go on to become a certified CT tech. And bear with me on the next part, it does get a little technical. I'll try to be concise. [LB796]

SENATOR GAY: You're beyond that. [LB796]

TOM BRENNAN: Uh-huh. [LB796]

SENATOR GAY: I say, you're beyond that already. (Laugh) [LB796]

TOM BRENNAN: I know, I'm sorry. (Laughter) In addition to PET/CT, there are also nuclear medicine hybrid scanners called SPECT/CT, an acronym for single photon emission computerized tomography. This type of camera also combines nuclear medicine with x-ray, but uses extremely low doses of x-rays to improve the nuclear medicine image that are used as an integral part of a nuclear medicine exam. These devices are dedicated nuclear medicine cameras and are routinely...they're located in nuclear medicine and they are physically not capable or designed to perform standard CT exams. The CT portion alone is considered non-diagnostic, meaning that it's not helpful alone, but simply used to enhance the nuclear medicine SPECT scan. I would

state that not all SPECT/CT cameras are this limited, but certainly most in use today are. It is these types of scanners that pose concern to me both as a technologist and as a manager. This bill is encouraging in that it provides an educational pathway for nuclear medicine technologists to learn CT and apply their knowledge on hybrid scanners that have the ability to perform diagnostic, high quality CT, but what does it do to address the SPECT/CT cameras that use such low radiation amounts and are not capable of performing a diagnostic CT study and are only used for image enhancement. There needs to be an exception made, perhaps a limited scope license option for just these types of cameras so nuclear medicine technologists can perform their duties independently. Why ask a nuclear medicine technologist to learn every aspect of CT imaging so they can operate machines that cannot even perform the most basic diagnostic CT exam simply so they can legally press the x-ray button? Nor does it make sense to ask a registered technologist from another department to stop what they are doing, come to nuclear medicine to press the button when they don't know the first thing about nuclear medicine or how the scanner works in any way. For example, an ultrasound technologist can press the button and be in compliance with today's regulations as long as they are a registered technologist. It makes no different evidently that they are not trained in either CT or nuclear medicine. I ask the committee, does this sound logical? And of course it does not. That is why there needs to be an exception for this type of scanner. I would like to stress that I am not asking for something beyond the nuclear medicine technologist's scope of practice. The Society of Nuclear Medicine's Presidential Task Force addresses this exact topic by saying their scope involves the operation of cameras with x-ray tubes for transmission imaging when performed as part of SPECT/CT or PET/CT. I would propose we give the nuclear medicine technologist some additional training in basic ionizing radiation or perhaps a mini course in basic CT for SPECT/CT cameras with limited capabilities. Therefore my second suggestion is to create a limited scope license to allow nuclear medicine technologists to use x-rays with hybrid SPECT/CT only. I'll answer any questions you might have. [LB796]

SENATOR GAY: Okay, thank you. Any questions from the committee? I don't see any. [LB796]

TOM BRENNAN: Thank you. [LB796]

SENATOR GAY: We'll take that under advisement and look and see if we can do some amendments. Thank you. [LB796]

TOM BRENNAN: Thank you. [LB796]

SENATOR GAY: Any other proponents to speak on this? This is a very technical bill. If you could summarize these things, too, we do read these, you know, when we're not here and we have staff that helps too. But summarizing helps as well. So thank you very much. [LB796]

MARCIA HESS SMITH: (Exhibit 3) I have handed you copies of my testimony. And I will not read verbatim from that. [LB796]

SENATOR GAY: Okay. Go ahead and state your name too. [LB796]

MARCIA HESS SMITH: My name is Marcia Hess Smith, that's M-a-r-c-i-a Hess, H-e-s-s Smith, S-m-i-t-h. Thank you for allowing me to testify. I am a proponent of LB796. I am a nuclear medicine technologist and I am employed as the program director for the Nuclear Medicine Technology Education Program at the University of Nebraska Medical Center. I am also an executive board member for the Society of Nuclear Medicine, Technologist Section. And I also have as part of my testimony a letter of support from Dr. Jordan Hankins, the medical director at the Nebraska Medical Center, who also is in support of this bill and in points of my testimony as well. I won't go into detail about how this field works and these two fields came together because, I think, we're all starting to get the grasp of that. But understanding that we do have these two sides of radiology that have come together from the nuclear medicine and x-ray world, and we are talking truly about kind of two different levels of pieces of equipment as well--nuclear medicine technologists being able to perform full CT diagnostic images, and other pieces of nuclear medicine equipment that just use very low dose pieces of...or very low dose delivery of CT to only enhance the image quality of a nuclear medicine image without actually performing CT in the standard way that we would think. As a little bit of background. When these two fields started to come together in 2002, the interested parties from all sides of the radiology world, such as the Society of Nuclear Medicine and the American Society of Radiologic Technologists and the physician's side, the American College of Radiology, and many other interested parties all came together to try to figure out who the best person was to run this piece of equipment. And at that time all interested parties said, you know, we don't really care who runs this, as long as they are educated and they have the proper training and credentials to run this. And at that time, in 2002, the ARRT, which is our credentialing board, allowed the CT board certification to be opened up so that nuclear medicine technologists could actually sit for CT boards. However, in the state of Nebraska, almost six years later, we still are not able to perform and train in CT as nuclear medicine technologists because the current law very specifically says that you must be a medical radiographer to do CT in this state. Most all states, as a matter of fact every state that borders Nebraska and many other states across the country, most all states that I can find, are either...have already solved this problem, or are in process of solving this problem. So Nebraska truly is behind the curve. As an educator in this field, the Society of Nuclear Medicine mandated that all nuclear medicine programs institute CT curriculum into their programs by the year 2010. And we are teaching curriculum in our education programs, but our students can't actually do the clinical component because they can't push the button and perform those CT duties. We have CT hybrid pieces of equipment in our departments and we're calling people from the ultrasound department, from the

radiography department into our department, as Tom described, literally to push the button on our machines, though they have no idea what nuclear medicine imaging is all about. So essentially what we're trying to do is establish an appropriate pathway so that we can sit for boards and show that we are credentialed in these imaging technologies that have already infused in our departments, and that we have been recognized as a profession to cross-train into. I started receiving phone calls in my education department from managers across the state way back in 2002, asking me how they could start doing this training. So this problem has been going on. A bill came up two years ago; we weren't successful in kind of ironing out all of the issues at that time. We do have issues because we have licensure for radiographers and not licensure for nuclear medicine technologists. It is complicated. This is a pathway that solves that problem so that nuclear medicine technologists can attain this goal so that we can move forward with patient care issues, and so that we do not have to pay two technologists to sit at one scanning console so one can push one button and one can push the other button. There are staffing issues, there are patient care issues, there are progression of technology issues. And what we're asking for is that we are able to pass this bill so that we can perform the duties within our department. We do have this low dose type of equipment that doesn't actually require a full CT scan to be done because it's an integral part of the nuclear medicine camera. All seven states that surround Nebraska also have an exemption so that you do not have to be full CT certified in order to perform that type of technology within your department. We would like to see some type of distinction between the two levels of certification. We are completely on board with having our technologists be fully educated and certified to the degree that they need to be certified. But to ask somebody to be fully CT certified, which requires a lot of training, you have to sit for 125 procedures before you can even apply for your CT boards, be fully competent in CT, and to never use those skills for this type of piece of equipment is complete overtraining. And it does inhibit managers from purchasing this type of equipment because the training that would be required to have your technologists leave your department to go get that training and then come back to your department and never use it for this particular type of equipment is just not realistic. So we have department managers who are not buying this equipment because they don't have the right kind of technologist in their department. So we have seen most other states that are providing some type of an exemption. And I have provided verbiage in my testimony that might be helpful. We have had conversations with the State Radiation Department that we would like to work on this. We have a meeting set up next week. We're hoping we can work out some of these issues, because we definitely are in favor of this. We're behind the curve. It's inhibiting our practice, we need to address this. So this is great. It's a wonderful bill. We're happy for this. We just want to tweak it a little bit. [LB796]

SENATOR GAY: Okay. Are there any questions from the committee? [LB796]

MARCIA HESS SMITH: Oh, there is one other piece that is missing in this. And Tom addressed it just briefly. The way that it's written right now it actually does state that you

would have to go back to radiography school, which doesn't make any sense. If we went back to radiography school we wouldn't need this bill at all. I think it was just a copy and paste out of some other...out of the other law. We need a training period so that we would be able to be covered while we get our requirements so we could sit for the CT boards. So before we could apply for this licensure, we need some sort of temporary training coverage period. And we've talked about these issues. [LB796]

SENATOR GAY: Okay. I've got a question for you then. [LB796]

MARCIA HESS SMITH: Sure. [LB796]

SENATOR GAY: You said, next week we have a meeting. Who is all we? I mean, who is in the meeting? [LB796]

MARCIA HESS SMITH: Well, so far it would be Julia Schmit (phonetic) from the department of radiation, health and other interested parties who, I believe, there will be a representative from the Nebraska Society of Radiologic Technologists. [LB796]

SENATOR GAY: Okay. [LB796]

MARCIA HESS SMITH: And that's all I'm aware of at this time. [LB796]

SENATOR GAY: Okay. All right. Well, this is a good chance to air these concerns. So appreciate you doing so. I don't see any other questions. Thank you very much. [LB796]

MARCIA HESS SMITH: Thank you. [LB796]

SENATOR GAY: Any other proponents that would like to speak on this? Any opponents? Let's go ahead and...why don't you go ahead and come on up and then we'll get right to you. Okay, so opponents then. Go ahead and state your name. [LB796]

DAN GILBERT: My name is Dan Gilbert, D-a-n G-i-l-b-e-r-t. Senator Gay and members of the committee, I'm from Scottsbluff. I'm an employee at Regional West Medical Center. I have a couple of points that I am concerned about in regards to this bill. First of all is in regards to the two fees. We in our facility have been, prior to this point, paying about $35 per year for routine tubes, which are diagnostic tubes. And in reading the current rules and regulations that cap is set at $70. So we are being asked to increase the cap by a considerable margin when we haven't even reached the cap that is set by the rules and regs. We have concerns about the definition of the three tiers listed: simple, moderate, and complex. From the communication that appears to be coming out, the majority of the x-ray tubes would be in the moderate level, which would be $500 for the cap. We don't necessarily disagree with the need for an increase in fees. The question that we have is, what are these fees going for? Dr. Schaefer commented about

the fact that they were used for registration and inspection. On a routine basis our facility is already paying a physicist to inspect our equipment on a yearly basis. Then...so we have to pay that physicist and then we have to turn around and pay the fees from the Department of Health. Now the physicist comes to inspect our equipment because of the requirements from the Joint Commission, I believe. So we are concerned about the fact that we're almost paying...like paying double time for an inspection and, as Dr. Schaefer commented about, that is only happening...10 percent of the facilities are being inspected each year. So we could be...ten-year interval in between when...in between inspections, but during that entire time...ten-year period be paying the cost of an inspection. I don't think that our facility is, as I said, opposed to an increase in fees. We just need a better understanding of why the limits were set at...or the caps were set at what they are now? And maybe a better explanation of where this money is going to support two individuals to come out and inspect our facilities. The second issue I have is in regards to the combining of CT and nuclear medicine, or fusion imaging. Our facility is not opposed for the need of having a person in nuclear medicine being able to do CAT scan. We're not opposed to a nuclear medicine...or I mean, a CT person being able to do nuclear medicine studies. The question we have is the terminology that is used to describe this. Right now the bill proposes that we identify this person as a medical radiographer/CT. Well, the majority of the profession would interpret this to mean that this person does CAT scans, whereas the bill is leaning towards the fact that this person is a nuclear medicine technologist who also can do CAT scans. So we have proposed that this terminology be changed so that it more accurately reflects what this person actually is. We have suggested this person be called fusion technologist so that it actually describes what this person is capable of doing. We have an issue right now in terms of nuclear medicine and medical radiography. Medical radiographers are licensed by the state, nuclear medicine technologists are not. So here we are trying to combine two different entities together, which don't have...each do not have a license. So it brings up the question up...is, why is this not undergoing a 407 process? It sounds to me like we are taking individuals who are not licensed and trying to make them licensed without identifying the need for those people to have a license. And I don't doubt in the least bit that a nuclear medicine technologist...there's a need for them. But to try to explain what a nuclear medicine technologist is doing in terms of medical radiography is really confusing to me and confusing to the people in the profession, at least on the radiography side of the profession. The bill also does not address any alternatives. It sets some very specific requirements for this individual to meet. And there are already present an alternative examination of what is listed here for both CT and nuclear medicine technologists to meet the requirements of PET scanning. But that's not identified in this. There are alternatives for radiation therapists, and even sonographers to do be able to do PET scanning, but those are not identified here, even though they are identified at the certification level or national certification level, the American Society of Radiologic Technologists. So it's not that I'm opposed to what this concept is saying, it's just that this procedure, this mechanism is very, very complex. And I do not think that the

wording as this bill is currently listed adequately describes all of the...or takes care of all of the issues associated with what we are trying to accomplish. Thank you. [LB796]

SENATOR GAY: All right, thank you. Any questions from the committee? [LB796]

DAN GILBERT: Thank you. [LB796]

SENATOR GAY: I don't see any. Thank you very much. [LB796]

DAN GILBERT: Thank you. [LB796]

DAVID O'DOHERTY: Good afternoon, senators. My name is David O'Doherty, O apostrophe D-o-h-e-r-t-y. I'm the executive director of the Nebraska Dental Association, which represents about 80 percent of the Nebraska dentists. The NDA has opposed LB796 in its present form as it relates to Section 71-3508 and the three-tier fee cap. Approximately 4,800 units are registered in the state of Nebraska and about half of those are dental equipment. When we met with the...when the NDA met with HHS, a few weeks ago, we were told that other programs that have inspection requirements are funded with a mix of General Funds and program fees. For example, food safety has a 50-50 mix, 50 percent General Fund, 50 percent fees. We would propose something similar. We understand the need to adjust fees that have been in place for some time, however, when we requested additional information that would explain this drive in higher fees we received no information. Although this statute does not specifically address individual units, the current annual fee for four dental diagnostic machines would be $45, under the proposed statute and the fee structure it would be $60 per unit, or $240, which is a 433 percent increase. Dentists are concerned with the high costs of healthcare. And as small business owners, dentists have higher overhead costs, and this fee increase would only increase the cost of oral healthcare. The NDA believes that LB796 in its present form, modifying 71-3508 and the fee cap, is unreasonable and therefore request that this committee does not advance this portion of the bill. Thank you. [LB796]

SENATOR GAY: Thanks, David. Are there any questions from the committee? I don't see any. Thank you. [LB796]

BRAD SHER: (Exhibit 4) My name is Brad Sher, S-h-e-r. I'm with BryanLGH Health Systems and I'm actually speaking on behalf of Sharon Harms, who unfortunately had to leave. She's our director of radiology and I will be very brief and I will submit the testimony when I'm done. On licensure I'm just going to ditto what happened...what my compatriot from Scottsbluff said. It's confusing and/or we believe right now we're taking care of the equipment, and according to the terms we don't believe these changes are necessary. One that hasn't been mentioned if the radionuclides, okay get that term right, when it says they want to have fingerprinting and federal criminal background checks of

concern, and we have no idea what "of concern" means at this point in time. And we have not been contacted. And I asked Sharon about whether she's been contacted from Health and Human Services, what that means, how does it apply to BryanLGH and so forth. We do know we have something called a gamma knife, which has a big honking source of radiation. It's locked down with (inaudible), we do that. But depending upon how far "of concern" goes, are we going to have to have 4,000 employees get fingerprinted and background checked because maybe some environment services people come near it, or food service, or something like that? It's just...we just need to have that tightened up or defined better, which I think is a concern. And then lastly on fees I'm just very concerned that the cases...the case has been made for $48,000 and I guess about $1.2 million of revenue right now, let's argue. That's what? Five percent? But they're asking for fees of $250, $500, $750, which is just a little bit more from a percentage perspective, and we don't think it's justified going up there. And we also do not agree on the tiering aspect of it. And I would just argue from an actual time motion study and expense perspective, if you come to BryanLGH you're going to get 50 pieces of equipment inspected in about 2 hours because we're going to hand you the paperwork of the physicists that are doing all the work, you're going to verify it, and you'll take it back and you're going to load it in, and you're going to be done, where you could spend six days trying to find out in different parts of Nebraska, getting to different locations and so forth. We just don't think the tiering, just because a machine is bigger means it translates to a cost element for the element. I just don't think that's a good fee structure idea. And just because we're bigger or whatever that we should be...have more costs associated with that licensure, we just don't think that's appropriate. And we would be willing to work with the department on trying to deal with some of this stuff as we move forward. Thank you. [LB796]

SENATOR GAY: Thank you. Any questions from the committee? I don't see any. Thank you. Other opponents? [LB796]

LINDA COSTER: Good afternoon, Senator Gay and the remainder of the committee. Thank you for the opportunity to speak before you today. My name is Linda Coster, L-i-n-d-a C-o-s-t-e-r. And I'm sitting here very conflicted as to being an opponent because of the plain and simple fact the only aspect of this that I'm going to talk about is the nuclear medicine and CT aspect of this bill. We have in the past actively supported legislation to make sure that anyone who does any radiation studies in the state of Nebraska knows what they are doing. We were the driving force in the 407 process behind x-ray techs being licensed 20 years ago. So we understand as well the importance of radiation and people knowing what they are doing. We have absolutely no problem with nuclear medicine technologists learning to do the CT aspects of hybrid imaging. However, we also think that the opportunity needs to be afforded to the CT technologist to do the same thing. All of our national organizations, the NMTCB, the ARRT, the alphabet soups of the radiology world on the national level have all gotten together and everybody agrees that this is necessary, that there's a lot of qualified

people out there, both on the nuclear medicine side and the radiology side, that can do this. They are using the term fusion imaging. Where we're having problem with this, and I'm not going to go through all the details and pick apart the language because that's kind of a moot point. But a couple of things that I do want to bring up as far as the language goes, in one portion of the language there is a definition of medical radiography. Medical radiography is defined as the application of radiation to humans for diagnostic purposes, including adjustment or manipulation of x-ray systems, with a medical radiographer being the one who may practice medical radiography. That's defined in the rules and regulations at this point in time or in the statute, excuse me, at this point in time. What's happening is that this current definition does not address nuclear medicine technologist. Medical radiography is widely understood in the radiology community to mean those who operate x-ray systems, including CT scanners, not those who operate nuclear medicine systems. It's very widely understood. However, in the proposed language the definition of medical radiographer/CT is a person who may practice medical radiography only as it relates to a CT system. Based on the above definition, it would appear that this addresses those who operate x-ray systems, specifically CT. But in this particular definition this isn't the case. In this particular definition the intent is to mandate that a certified nuclear medicine technologist also be certified in CT with the ARRT in order to do this previous mentioned fusion imaging because of the established definition of a medical radiographer is being those who operate x-ray systems. And because there's no reference to the nuclear medicine technologist in the new definition, there's a great deal of confusion and misinterpretation of the proposed changes. I'm not going to give you all of the ways that they can be misinterpreted, but you can see with the current definition and the second definition being very similar, you can see where that confusion can arise. And so that's part of our problem. Previous testifiers have also alluded to the fact that the CT tech is under the Uniform Licensing Law and is licensed, the nuclear medicine technologist is not. From what I understand, there is different sources of authority here, and that's been part of the problem of why we're addressing only the nuclear medicine technologists, from what I understand. And I don't even pretend to understand all of this and why the CT technologist is not included and why we're not using the term fusion imaging technologist to encompass the entire fusion world. So there's an issue as there. Once again, Dan alluded to the 407 process. One of the things that has been common in the medical community anytime someone wants to change a scope of practice or add or subtract, not necessarily subtract but add duties to a medical profession is that they do go through the 407 process. I don't know that that's the answer here. I think that if that can...I just don't know. I don't know if that's something that's necessary. But I do think in the past that that's the mode and the method that people have gone through in this...these situations. I want to provide some information as well, and I can provide the details to the committee if they would like me to do so. My sources through the ASRT tell me that there are 11 states who address fusion imaging. All of these states...and the closest ones to us are Iowa and Minnesota. All of them do have rules that include both the CT technologist being able to do nuclear medicine and the nuclear medicine

technologist being able to do CT. And they do have alternate pathways, as well, besides the full CT exam that Marcia alluded to. They also have the pathways of other education and the NMTCB PET exam as well. So we really want to support this as the Nebraska Society of Radiologic Technologists, except for the fact that we don't know what this says, we don't know what this means. We are concerned that there is a mechanism and a pathway for one group to obtain this and not a mechanism or a pathway for another group who could be just as qualified to do this. And we're also concerned that there hasn't been a need demonstrated that indicates that procedures and patients are not being done because this isn't being accomplished at this point. So with that being said, if there's any questions, I'll be more than happy to address them as soon as or as quickly as I can. [LB796]

SENATOR GAY: Thank you. Are there any questions? I don't see any. [LB796]

LINDA COSTER: Okay. [LB796]

SENATOR GAY: Thank you. [LB796]

LINDA COSTER: You're welcome. [LB796]

SENATOR GAY: Any other opponents? Anybody who would like to speak in the neutral capacity? I don't see anything. Senator Johnson, you want to close? [LB796]

SENATOR JOHNSON: Senator Gay, not a whole lot to say, except looks like this bill has got a lot of work to be accomplished. And I think we're just going to have to roll up our sleeves and start working on it. Whether we'll get it in shape in time for this year or not remains to be seen. But I was sitting back there thinking that the IQ level in this room (laugh) is pretty high about now. So with that, thank you very much. [LB796]

SENATOR GAY: Thank you, Senator Johnson. That will conclude the public hearing on LB796. [LB796]

Disposition of Bills:

LB765 - Advanced to General File.
LB782 - Advanced to General File.
LB793 - Held in committee.
LB796 - Advanced to General File.

Chairperson

Committee Clerk