[LB489 LB601 LB603 LB661]

The Committee on Health and Human Services met at 1:30 p.m. on Thursday, February 19, 2009, in Room 1510 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public hearing on LB603, LB489, LB601, and LB661. Senators present: Tim Gay, Chairperson; Kathy Campbell; Mike Gloor; Gwen Howard; Arnie Stuthman; and Norman Wallman. Senators absent: Dave Pankonin, Vice Chairperson. []

SENATOR GAY: All right, we'll get started. Welcome to Health and Human Services Committee; I appreciate you being here today. We're going to get started on time. For the record, my name is Tim Gay, I'm from District 14, which is Papillion, Nebraska, and we'll introduce ourselves.

JEFF SANTEMA: My name is Jeff Santema. I serve as committee legal counsel.

SENATOR GLOOR: Senator Mike Gloor, District 35, Grand Island.

SENATOR CAMPBELL: I'm Kathy Campbell, District 25, Lincoln.

SENATOR STUTHMAN: Arnie Stuthman, District 22, Columbus area.

SENATOR WALLMAN: Norm Wallman, District 30, Beatrice.

ERIN MACK: Erin Mack, committee clerk.

SENATOR GAY: And also on the committee, Senator Dave Pankonin, who is gone today on another commitment he had, and Senator Gwen Howard, who will be joining us a little later. Our pages Justin and Blair are here to assist you in any way, as well, if you have any copies or things that need to be done. They're right over here and you can just direct them there. We do...a few rules that I just want to go over quickly is we have testifier sheets. If you're going to be testifying, please fill out one of the sheets that is over in the...on the corner. Print your name and then when you come up, if you could state your name and spell it out for the record, that's very helpful when they transcribe these later. We have a timekeeping system, here. The reason why, we do four to five bills a day, and sometimes, if you are the last bill of the day, it starts at 5:00 and that's not too good for that person. It's not fair to the person who is, you know, waiting all day to testify. So we have a five-minute rule. We have a light system. The green light will be on up until four minutes. At four minutes the yellow light will come on. At five minutes when the red light is on, if you could wrap it up, we would appreciate it. We don't like to cut people off midsentence, but you get the hint if the red light is on, time to wrap it up. If you can be precise and nonrepetitive, that helps. Many times we will get a lot of proponents for one thing or a lot of opponents for one thing and, you know, if you are more concise or have something to add or just want to be on record, feel free to come

up. But I think the best testimonies are concise in covering different areas. If you have a cell phone, if you'd turn that off out of courtesy of everyone else, we would appreciate that. I'm going to turn this over to Senator Stuthman.

SENATOR STUTHMAN: Okay.

SENATOR GAY: And I'll introduce LB603.

SENATOR STUTHMAN: Thank you, Senator Gay. Senator Gay, as Chairman of the Health Committee, is going to introduce LB603, and this is a committee bill. So good afternoon, Senator Gay. [LB603]

SENATOR GAY: Thank you, Senator Stuthman, members of the committee. For the record, my name is Tim Gay, representing District 14. I'd like to thank you each for signing onto this bill. There are many critical issues before the committee but, in my mind, this is one of the most...one of our priorities. Work force shortage as it relates to behavioral health professionals is common and a repetitive theme whether the subject matter is safe haven, Beatrice State Development Center, or the next steps on behavioral health reform. Although it is hard to measure the cost of the behavioral health shortage, we know that it is huge. To ignore it would guarantee more crises comes our way and even higher costs are involved. As you know, I purposely felt it was important that this be a committee bill so we send a strong message to our colleagues and to the individual families, providers, and many others who are impacted by behavioral health. As we deal with the difficult economy, we will hear there is no money for this in the current budget. I would argue that we must find the money before yet another crisis hits. Investing now will save us money and crisis later on and the time is now. The individuals here today who brought us this bill bring a great deal of expertise to the table. They have spent years in this business. They have looked for models that work. They come with a plan that I believe is in the right step. I would ask we not get hung up on the funding source here today, whether it be tobacco settlement dollars from the non-General Fund or General Fund dollars. Bottom line is we need to figure out and we need to work closely with our colleagues on the Appropriations Committee. In my mind the question is not if but how. My investment hat would share that the tobacco settlement fund makes sense, given the history of the fund and its uses. Endowments are by and largely created to make a difference now. Many like the well-known Buffett and Gates Foundations are by design endowments that will eventually run out of money. The tobacco funds will eventually run out of money; that is a given. The current economy would tell us that it would be sooner rather than our original estimates. This may or may not be correct. One thing I know for sure is the cost of doing nothing now is very high. Given the current economy, the tobacco settlement funds will be depleted by 2042. If you factor in our request at roughly $2 million per year, it is estimated this fund will be depleted by 2035. These numbers will of course change next year and the year after and the year after as the economy and the markets change. There are just a lot of

unknowns in this fund. But separate from this issue yet connected I would also ask that this committee take a hard look at the current expenditures that are being made by the tobacco settlement dollars. We need to make sure that the investments we are making today are still wise for today. I want us to know exactly how these dollars are being spent and, in simple terms, whether they are nice-to-have programs or need-to-have programs, as is the case with behavioral health as we all know. In terms of the bill before you, I will let the testimony begin and let the experts share with you the details of this plan. And let me add that anytime we have a private sector involved at the table, especially in this case where the private sector has invested significant millions of dollars in a facility that normally would fall on the state's back to fund, we are lucky because they will demand outcomes and will scrutinize the investment and work closely with us to help ensure that this plan works. In this case, LB603, measurable outcomes are required. I know I don't need to convince you that shortages of behavioral health professionals exist. What we do need to do as a committee is decide the best way to move forward and find a way to do it this year. I am going to turn this over to those that are here to testify, and they will share more details with you. [LB603]

SENATOR STUTHMAN: Okay. Thank you, Senator Gay. [LB603]

SENATOR GAY: Thank you, Senator Stuthman. [LB603]

SENATOR STUTHMAN: Are there any questions from the committee? Seeing none, thank you, Senator Gay. [LB603]

SENATOR GAY: Thank you, Senator Stuthman. [LB603]

SENATOR STUTHMAN: At this time I would like to have a show of hands in how many plan to testify as proponents. We have one, two, three, four, five, six, seven, eight, nine, ten. Any in the opposition? Any neutral? Okay, we do have quite a few that are going to testify. I would remind you that, you know, keep your comments short. We would like to allow an hour for this and hopefully we would like to get this bill concluded in an hour. So with that, the first testifier, please. Good afternoon. [LB603]

RHONDA HAWKS: (Exhibit 1) Good afternoon. Thank you very much for allowing me the opportunity to testify before you today. My name is Rhonda Hawks, spelled R-h-o-n-d-a H-a-w-k-s. I am here today as one of the founders of the Behavioral Health Support Foundation. It is also my honor to serve as chairman of the Behavioral Health Oversight Commission, and I am testifying on behalf of both of those entities in support of LB603. In addition to that, I am also offering support from advocates for Behavioral Health Community Alliance, Nebraska Community College Association, Alegent Health, Nebraska Hospital Association, Nebraska Community College Association, Lutheran Family Services, and the Nebraska Association of Regional Administrators. I know that there are some new members on this committee, so I apologize to those of you who

have heard some of these comments before, but I think it is helpful for the committee to know the background from...where I come from today. One in four families is affected by behavioral health issues. My family was one of those. As many of you know, my father suffered from schizophrenia, was hospitalized multiple times for months at a time. Despite his commitment to stay on medicine, he was blessed with tremendous support from my mother, and died at age 49, largely due to the side effects of psychotropic drugs he was taking. The financial burden caused by the hospitalizations, medicine, and loss of employment were enormous. The good news is that research 21 years later has yielded much more success in treatment of the disease, including psychotropic drugs that are much more effective without all the grave side effects. I am sure all of you know someone who is affected by schizophrenia, bipolar, or chronic depression. Ken and Ann Stinson, my husband Howard and I founded the Behavioral Health Support Foundation and have been committed to encourage and assist Region 6 healthcare providers, including community-based agencies and hospitals, the region itself, and the state to work together to maximize opportunities for access to services in an underfunded system. For the good of those who struggle with behavioral health issues in their lives, the communication and engagement of community-based agencies, hospitals, and regions is the best I've seen in the five years since I began working on these issues. We are concentrating on what the...what services are necessary along the continuum of care with an emphasis on recovery and sustained wellness, thereby avoiding a hospital stay which can be traumatic for the consumer as well as very expensive. The Behavioral Health Support Foundation raised about $25 million from the private sector to create Lasting Hope Recovery Center and provide capital support to community-based agencies in Region 6, to provide for continuity of care to a patient, keeping them connected to services and hopefully avoiding long waits for care. As you know, if a person has to wait to get help, the problem can escalate and eventually the person becomes hospitalized, which everyone certainly wishes to avoid. While the Omaha area is not a federally designated shortage area for behavioral health workers, we have been recruiting for five psychiatrists for nearly two years with very limited success. It is a shortage area. We have three of our complement of five psychiatrists on staff and will not be fully staffed until August of this year. Three of the five psychiatrists we are hiring are recent medical school graduates from UNMC and Creighton's joint residency program. In the past about one year that Lasting Hope has been open, we have hired locum tenums, commonly referred to as "rent-a-docs," that stay about two months at a time and it costs about two times the salary of a staff psychiatrist. We are begging community psychiatrists to help cover weekends, evenings, etcetera, until our full complement is hired and several have been great about helping us temporarily with this coverage. Recruitment has been a frustrating experience and the locum tenum situation has been frustrating and expensive. A shortage of workers can be seen everywhere. The recent safe haven controversy certainly highlighted lack of children's services and the adult system is also underfunded. The social cost of not treating those with serious mental illness can result in homelessness and multiple brushes with the law, commonly resulting in incarceration for minor crimes. Dr. Steve Wengel from

UNMC's psychiatry department is here today to discuss the details of a plan to add psychiatrists to the residency program and to require rural experiences for residents and the ability of residents and their staff to deliver health services in outstate Nebraska. We also have a guest here from the state of New Mexico, Dr. Helene Silverblatt, who will share some of the success they have had with a similar program in their state. The geographic challenges are similar to Nebraska, so we are excited. Two more people...I know I am on a red light so I will really go fast. I am also pleased to have Robb Paulk from Faith Regional Hospital in Norfolk who is a nurse and a front-line behavioral health professional and can share firsthand the impact of the shortage on the rural community; and finally, Topher Hansen, who has a lot of expertise, firsthand knowledge, and passion who will represent CenterPointe and NABHO. I also carry with me the unanimous consent from the Behavioral Health Oversight Commission for this plan. I thank you very much for this and appreciate you all signing on to it and appreciate your recognizing the shortage of workers in our state. Thank you very much. I'll be glad to entertain any questions if you have them. [LB603]

SENATOR STUTHMAN: Thank you, Rhonda. [LB603]

RHONDA HAWKS: Okay. Great. [LB603]

SENATOR STUTHMAN: First of all, I would like to add that Senator Howard has joined us here. [LB603]

SENATOR HOWARD: Thank you. [LB603]

SENATOR STUTHMAN: And does the committee have any questions? Senator Howard. [LB603]

SENATOR HOWARD: Thank you, Senator Stuthman. For the record, I really want to thank you so much for all you have done. I mean, if more people would be willing to stand up and, as your husband had said, put their money where their mouth is... [LB603]

RHONDA HAWKS: Oh, thank you. [LB603]

SENATOR HOWARD: ...I think we would...it would make such a difference for all of us, for every town across Nebraska that we live in. I wanted to bring you the message...I was a little late because I was talking to some folks in the graduate school of social work, and the social workers are more than willing to stand with you on this issue and do whatever it takes to do the combined...the cross-training and the provision of service. [LB603]

RHONDA HAWKS: Great. [LB603]

SENATOR HOWARD: Thank you. [LB603]

RHONDA HAWKS: Thank you very much. I appreciate that. [LB603]

SENATOR STUTHMAN: Any other questions from the committee? Seeing none, thank you, Rhonda. [LB603]

RHONDA HAWKS: Great. Thank you. [LB603]

SENATOR STUTHMAN: (Exhibits 11 and 12) I would like the next testifier, please. And while he is coming forward, I would like to add into the record we do have letters of support from the Nebraska Hospital Association and the Nebraska Pharmacists Association. So good afternoon. [LB603]

STEVEN WENGEL: Good afternoon. I would like to thank the...excuse me, my voice is giving out just a little bit here. But I would like to thank the committee for their time and attention and for the privilege of being able to address you this afternoon about what I think is an incredibly important issue. My name is Steven, S-t-e-v-e-n, Wengel, W-e-n-g-e-l, and I am the chair of the University of Nebraska Medical Center Department of Psychiatry. I am here representing myself, and I also represent Dr. Daniel Wilson, W-i-l-s-o-n, who is the chair of the Creighton University Department of Psychiatry, and we are in support of LB603. Dr. Wilson and I co-manage a combined residency program in psychiatry and that is why he is...why I listed his name also along with my own here. You already know, of course, about the behavioral health crisis so I won't waste your time going through things that you already know. But I would like to remind us all that untreated mental health problems have a cost in terms of producing other general medical problems such as worsening of heart disease and other factors, so there is a literal cost that way as well as lost productivity, but not to mention the human suffering, of course, that comes from inadequate or just a lack of treatment for these. How do we propose to help with this problem? LB603 has three major components that we believe will help address this situation. The first component is expansion of psychiatric residency training. The second piece is the establishment of new community training sites. Then third is development of new coursework to support current behavioral health providers. So let me briefly address all three of those things. The first piece, residency training, we are proposing to increase the residents, the number of residents in our program so that we will graduate two new board-eligible psychiatrists each year. We also propose to train all of our residents, not just the two new funded positions but all of our residents, to rural mental healthcare. This will start in the second year when they will make a week-long site visit to a designated rural community, and then in their third and fourth years of training they will then have a rural outreach clinic through both personal visits to those communities and then also telemedicine healthcare serving those communities for that entire two-year period. That

was part one. Part two is the development of community-based training sites. Right now much of behavioral health training is still done in silos. Medical students train with medical students, nursing students train with nursing students and so on. And we propose to develop over a several-year period six interdisciplinary training sites around the state, interdisciplinary referring to the different disciplines like nursing, pharmacy, social work, psychology, psychiatry, working together and training together, working as a team, which is the way to train because that is the most effective way to also provide the care. So we need to match the training with the real-world experience they get when they're actually out in practice. We plan to use a hub-and-spoke model, using the effective principles already in use by the Rural Health Education Network, or RHEN program. And these training sites will allow student rotations in areas of the state where we cannot currently do it because of lack of local supervisors, as well as allowing the students, again, to train in this multidisciplinary fashion, which is really quite unique. The third piece, the third and final piece, is the support network for existing providers, and we propose to develop what is called a learning collaborative. And what that means is we plan to bring together educators, agency personnel, consumers, family members, and a variety of other stakeholders together to develop new coursework to better train our existing providers. Mental healthcare, behavioral healthcare has changed dramatically in the last 10 to 20 years. And we now need to adapt the training that we do for people that are already out there in the trenches so we can better support them. Right now, people that are out there, particularly in the rural areas, often experience professional isolation, burnout and turnover, and we want to help support those people so that they feel more empowered and feel more successful in their jobs. The way we propose to do that, again, is to bring everybody together to help develop these courses and again doing it in a multidisciplinary fashion. So we bring people together from different disciplines to work together, and then we'll disseminate that information through a variety of creative means, much of it using the existing infrastructure of the state through the Telehealth Network. Nebraska has an extraordinary resource in the Telehealth Network which is grossly under-utilized. It can be used for clinical care but it can also be used for education. We have only looked at the tip of the iceberg of that wonderful resource, and this plan proposes to make much better use of that, both for clinical care as well as for long distance education and bringing people together from various disciplines. And at that, I will stop and see if there are questions. [LB603]

SENATOR STUTHMAN: Okay. Thank you, Steve, for your testimony. Any questions? Senator Gloor. [LB603]

SENATOR GLOOR: Thank you, Chairman Stuthman. Dr. Wengel, I've got a number of questions and I hope you understand that my questions aren't that I am not supportive of what we are talking about; I did cosign the bill. But if we don't vet these issues here, we are ill-equipped to deal with them when we get up...if it finds its way up onto the floor. How long will the residency last in these rural outreach clinics? Did you say two years? [LB603]

STEVEN WENGEL: The residents will spend two years of their training doing rural outreach the third and fourth years of their training. They will..but they'll actually start making the site visit in the second year. It's a four-year training program. They will make their first site visit in the second year of training to start to get to know the communities a little bit, to do some education out there, mostly kind of, again, just to get to know them and them to get to know us a little bit. But then the third and fourth year is where they really start doing more clinical work in those rural areas. [LB603]

SENATOR GLOOR: Will this be like the Family Practice Program where they actually reside during that time, for the most part, in those rural communities? [LB603]

STEVEN WENGEL: Right now, no. For the most part it will be making visits for several days to, again, establish contact with the community but then doing most of the clinical work when they return back to the main program. And the reason for that is that, in psychiatry training, residents are not allowed to practice without a faculty psychiatrist literally in the same area, you know, where they can have direct access to them. So that limits our ability to send residents to communities where there are not psychiatrists right now. We certainly expect that if this program is as successful as we think it will be, and that eventually our graduates go to rural areas to practice, they will in turn become future faculty members where we can send residents down the road to actually practice for more extended periods of time. We will certainly work very hard on that, and we will also, in the fourth year of training, we will establish elective rotations where we can, where there are psychiatrists in more rural communities who are willing to serve as supervisors. We will work very hard to establish attractive elective experiences where residents would go for a month, two months, perhaps even longer. [LB603]

SENATOR GLOOR: Okay. You mentioned the RHEN program, which clearly has been a very successful program in my own personal experience in outstate Nebraska. But part of the challenge has always been training people in outstate. How do you keep them in outstate? How do we avoid spending the dollars to train professionals who then take that experience, that training, that education and go to the highest buyer of their professional services, which may be in a different state? [LB603]

STEVEN WENGEL: Thank you. Yes, I think, Senator, that's an excellent question. Retention I think is...you know, recruitment is the first issue but retention is an equally important issue, and the person that comes after me, Dr. Silverblatt, I think will have some ideas to share with you that may address that. But I would say that the third piece of the discussion I had with the learning collaborative is one of the strategies we have developed to try to improve the support network for existing providers, that they...somebody in a...even in a remote area can become a virtual faculty member and actually help write coursework and also just get the support of being part of a bigger system. I think right now many people in the trenches really just do not have that and it

really is isolating. So I think the isolation is one piece. It won't fix all the problems, but I think it's a significant step in the right direction. And...well, let me just stop at that point. [LB603]

SENATOR GLOOR: Okay. The part of the responsibility under the RHEN program I think is some of that expense being borne by the local community when the individuals go out there for training purposes. With some of what makes the news recently, with a lot of those medical communities, specifically the hospitals having to go through some layoffs, trim their own budgets, how comfortable are we that we can find those six locations or at least four of the six, I think, are intended to be rural, how comfortable are we that we can find those communities willing to come up with the monies to help uphold their end of the training responsibilities or covering the expenses associated with this? [LB603]

STEVEN WENGEL: Right. I think one of the areas that we're...one of the pieces of information we have been using is of the experience of our New Mexico colleagues, and my understanding is they have been very successful that way. And the communities, actually, it almost becomes a competitive situation where you have many people vying for those opportunities. So we have to...there's certainly no guarantees there but we would hope that this would be an attractive enough option that people would really want to be part of that. But... [LB603]

SENATOR GLOOR: Okay. Thank you. [LB603]

SENATOR STUTHMAN: Thank you. Any other questions from the committee? Senator Howard. [LB603]

SENATOR HOWARD: Thank you, Senator Stuthman. Well, it sounds to me like what you would like to do is deliver a quality product, provide a service that we certainly need. Just a couple of quick questions: Do you see a place where the licensed mental health practitioners will fit into this, this team of providers that would be in place? [LB603]

STEVEN WENGEL: Yes, yes. Absolutely. I think they are certainly a key part of the team. [LB603]

SENATOR HOWARD: Good, good. Well, I appreciate that. And then, in terms of training, when we talked the interdisciplinary training, are you saying...maybe this is getting to minutia for what you're at right now, but are you saying the professionals from the other, say, social work, coming in and working with the doctors, working with the entire group, and then the physicians coming in working with the entire group? Is that kind of what you envision? [LB603]

STEVEN WENGEL: In those multidisciplinary training sites, yes. [LB603]

SENATOR HOWARD: Right, right. Cross-information. [LB603]

STEVEN WENGEL: Absolutely that we would certainly expect that. That's really the... [LB603]

SENATOR HOWARD: So you'll draw from the professions to come in and do the training of the group. [LB603]

STEVEN WENGEL: Correct. [LB603]

SENATOR HOWARD: Good, good. [LB603]

STEVEN WENGEL: And in our discussions with other disciplines, nursing, social work, and psychology, pharmacy, PA schools, we have had just an incredible amount of support and enthusiasm to do just that. Because they also are experiencing the same kind of isolation and silo sort of training. So they...so far we have knocked on a lot of doors and we've gotten a lot of very welcome answers. [LB603]

SENATOR HOWARD: Thank you. That is kind of...when we were talking about it earlier, that was kind of my vision, too, and so I appreciate the clarification on that. Thank you. [LB603]

STEVEN WENGEL: Thank you. [LB603]

SENATOR STUTHMAN: Thank you. Any other questions? Seeing none, thank you for your testimony. [LB603]

STEVEN WENGEL: Thank you. I really appreciate the opportunity to talk to you and I would like to now introduce my colleague, Dr. Helene Silverblatt. [LB603]

SENATOR STUTHMAN: Okay. Good afternoon, Doctor. [LB603]

HELENE SILVERBLATT: (Exhibit 2) Hi, good afternoon. Thank you so much for inviting me to be here. My name is Helene Silverblatt, H-e-l-e-n-e S-i-l-v-e-r-b-l-a-t-t. I am a professor of psychiatry and family and community medicine at the University of New Mexico where I am the codirector of our Center for Rural and Community Behavioral Health and I am the director for Behavioral Health for the Office of Community Health at the Health Sciences Center. And having said all that, I think I was asked to come here because we have an experience in New Mexico training psychiatry residents to do rural work which we feel has been very successful in that our statistics show that over 70 percent of our graduating residents stay on and do rural work in one way or another,

and that includes doing rural work through telehealth or actually living in rural communities. I think that what seems most exciting to me is that there are many similarities between Nebraska and New Mexico demographically, geographically but also that Nebraska in many ways is ahead of where we were 14 or 15 years ago when we started this program. And you're ahead because you have one of the most well-recognized telehealth telecommunication networks in the United States, and it's just crying out, you know, for an opportunity to be used to both work with our consumers with mental illness, to work in our agencies with our providers who provide services, and to provide interdisciplinary, cross-disciplinary training. Taking advantage of this amazing network of community colleges, other universities, high schools, I mean, you know, the pipeline can go on, can go back forever, introducing Nebraska citizens to really the interest and value and commitment possible in providing behavioral health services. I think that there is a tremendous opportunity here for a successful residency program where residents who come here to do rural training will come because this program offers it. You know, it is very hard to recruit psychiatry residents into medical school and yet our program has filled every year since we have begun this rural program. And we have not only filled in adult psychiatry, but we have filled in child psychiatry. And we filled because we offer an opportunity for residents to do something that they are not able to do in other programs. This program which involves all of the residents learning how to use tele-equipment to become part of new communities, and, believe me, when our residents go to rural communities they are welcomed. They feel a kind of acceptance and, without wanting to be too touchy-feely, but they feel that they get a kind of love from the community that they are in that they don't always experience in training, and it's very meaningful for them. And that experience draws them into staying in those rural areas. And I think that is why we have been successful. So this program that you're considering not only allows for, I think, an attractive program that will attract more psychiatry residents in the state. It is well-designed in terms of providing the latest instruction in cross-disciplinary training, which is the way to go, as well as the latest instruction in new technology. But it also statistically will probably...you know, I can't...none of us can predict the future, but I can certainly say that all of the evidence supports the fact that residents who work in rural areas or come to train in a state stay there. I am an example. I from Philadelphia. I went to New Mexico 30 years ago to start my training and I never left. I can also say, on the other side of that, that we have one of your great graduates, Chandra Cullen, who is a graduate of University of Nebraska Medical Center, who is just completing this year the last year of her child psychiatry fellowship. And I think she will probably stay in New Mexico, and I think you people would want her back in Nebraska right here, right? And she came because of our program. So I feel that this program offers a significant benefit, you'll get a great bang for your buck because you'll get residents coming here who will stay, you'll get residents who will become core faculty around the state. The residents who will then and faculty who will be able to teach, consumers, participate in work force development, across disciplines. I think you sort of couldn't go wrong. In addition, our program, because it is successful, has been able to attract other federal dollars, we've gotten other funding

from the state, we have funding originally from Human Services and then we were able to get funding from our children...I mean, the funding may be a little different here, but we were also able to get funding specifically for child residents so we have been able to expand our program to include all psychiatric subspecialty services as well, with funding. So I think this is a very good investment. I am very honored to have been asked to speak with you, and I certainly welcome any questions you might have. [LB603]

SENATOR STUTHMAN: Thank you, Dr. Silverblatt, for your testimony. [LB603]

HELENE SILVERBLATT: Thank you. [LB603]

SENATOR STUTHMAN: Any questions from the committee? Senator Campbell. [LB603]

SENATOR CAMPBELL: Thank you, Senator Stuthman. Dr. Silverblatt, I must have missed this in the time that I was listening to you, but how long has the program been going on? [LB603]

HELENE SILVERBLATT: In New Mexico, we have been going on 15 years so it's a long-term commitment. Fifteen years. Um-hum. [LB603]

SENATOR CAMPBELL: Were you the first in the country to kind of combine all of these elements together? [LB603]

HELENE SILVERBLATT: We were the first in the country to have a rural residency track, and we have won, you know, national recognition for it. I think you may be the first in the country here to have a telehealth rural track, and you'll win national awards for that too. But I think what you are asking, most importantly, is that it involves a commitment and a vision, and I think it is very impressive to me that the vision here is matched by both the private sector commitment, the state, your committee's commitment, and the university's, both universities' commitment. I mean that's extraordinary. [LB603]

SENATOR CAMPBELL: Thank you. [LB603]

HELENE SILVERBLATT: Um-hum. [LB603]

SENATOR STUTHMAN: Thank you. Any other questions? Senator Gloor. [LB603]

SENATOR GLOOR: Thank you, Dr. Silverblatt... [LB603]

HELENE SILVERBLATT: Sure. [LB603]

SENATOR GLOOR: ...for taking the time to come up here and spend a not an insignificant amount of time on this. And you may have noticed or may not have noticed we turned the thermostat up for you since you were coming up from New Mexico. (Laughter) [LB603]

HELENE SILVERBLATT: I appreciate it. I appreciate it. I just want a tour of this beautiful building and I would love someone to explain your artwork here to me. [LB603]

SENATOR GLOOR: There are many who can do that, and it is a treasure. It certainly is a treasure. We're very proud of it. Let me go back to a theme that I will probably bring up off and on with different witnesses and that has to do with retention rates because it is one of those areas that concerns me. No disrespect for my native state that I love but trying to keep retention in New Mexico versus Nebraska is probably a little dissimilar. And so I'd be curious as to what have your retention rates been and the number of your residents who are native New Mexicans who stayed in the state after they went through the training. That to me may be a key for us... [LB603]

HELENE SILVERBLATT: Um-hum. [LB603]

SENATOR GLOOR: ...trying to make sure we have better retention rates. [LB603]

HELENE SILVERBLATT: I think that's a very important point. In terms of our own program, most of our residents have not been from New Mexico because the majority of the psychiatry residents who come to UNM are not from New Mexico. [LB603]

SENATOR GLOOR: Sure. I...you're... [LB603]

HELENE SILVERBLATT: The residents who are from New Mexico are the most likely to stay because they have chosen to do their residency in New Mexico because they have family commitments or that kind of thing. The reason that residents who are not from the state stay is that often residents are in a life stage where they meet partners and make, you know, those kinds of commitments, have families, and then stay on because of that. Our...we are...part of our group involves a research component, and we're doing kind of outcomes research on the effect of what we have been doing. And so far it looks as if between 75 and 80 percent of the residents who have been in a rural program are doing some sort of rural work and most of those are doing rural work in New Mexico, not all of them but most of them are doing rural work in New Mexico. I think you bring up a very real point, and that is Taos, New Mexico, is not Clovis, New Mexico. I mean Lincoln, Nebraska, isn't, I don't know, you know, another place, another part that's just not as sexy, that's what you're talking about. [LB603]

SENATOR GLOOR: Yeah. [LB603]

HELENE SILVERBLATT: So how do we get...right. So...and the rural communities that are like Taos that, you know, suffer in some ways but certainly thrive compared to other communities where children are leaving and, you know, the high schools are having diminishing numbers, etcetera. I know that's what you are talking about. [LB603]

SENATOR GLOOR: Yep. [LB603]

HELENE SILVERBLATT: The reason that I think that your plan has the potential to be so successful, this plan, is not only in terms of the residency component but this very brilliant idea of having six hubs for training is crucial. Although you did mention the important fact that the economy is not fabulous and everyone is cutting back, it is true that in many parts of rural America the largest employer is the healthcare industry. [LB603]

SENATOR GLOOR: Yes. [LB603]

HELENE SILVERBLATT: And that what often happens is that trainees, high school graduates and then those who go on to community college or to university, have to leave to get their training. And then they don't come back. Now you can't expect everyone, you know, you can't get everyone to do what you want them to do. But the actual numbers that we need aren't in the thousands. You know, if we could get 12 more psychiatrists in rural New Mexico, we would be doing well. That's not huge numbers, right? So the fact that you have designed a behavioral health work force plan that incorporates what's already going on in community colleges, that because it's located in these rural hubs can start with pipeline development, nurturing students. I mean really, you could nurture them in elementary school, but kids who maybe wouldn't see themselves in health fields or behavioral health fields, being interested in it and showing that the outreach is real, that the connections are real that people who live in, say, Clovis, New Mexico, who didn't have any psychiatrists five years ago now have two, and there are two people who are committed to Clovis. Everyone doesn't want to live in Clovis, but we found two people who did, for example. And in addition, where there are communities like Carlsbad, New Mexico, which has, you know, the caverns but is not...has often had trouble with work force retention in New Mexico, when they had not had psychiatrists, we have been able to provide telehealth services, including our residents and our attendings who go to Carlsbad on a regular basis to maintain their relationship with that community but provide a lot of their care on-line. So that these are communities that sometimes have people and sometimes don't, but we are trying to fill the gaps so that there is not these glaring holes in services. [LB603]

SENATOR GLOOR: Let me ask one more question that I think maybe segues into some of what my concern is about retention, and that is most of the outreach clinics you're going to pick, if you're going to pick four sites and...if we're going to pick four sites

in this state outside of Omaha and Lincoln, there may or may not be inpatient psych beds in those communities. [LB603]

HELENE SILVERBLATT: Right. [LB603]

SENATOR GLOOR: Can we keep psychiatrists engaged... [LB603]

HELENE SILVERBLATT: Absolutely. [LB603]

SENATOR GLOOR: ...and staying in a community if they haven't got that portion of their medical training to be able to exercise? [LB603]

HELENE SILVERBLATT: You know, I think it's like family medicine training. Some people do acute care and like emergency medicine, and some people who train in family practice like to do surgery and do obstetrical deliveries, and some people don't. So I think what's most important for most psychiatrists is the opportunity to know that if they have a patient who needs psychiatric admission that there's a place for them to go. But having psychiatrists in the community, as Rhonda Hawks said, allows for a very much more sophisticated kind of community treatment that's often not available. And it's that kind of sophisticated treatment that's very satisfying because it works, and there is an opportunity to develop all kinds of networks of rural resources that are kind of there but untapped. Telehealth also allows for the psychiatrists, both regionally and statewide, and all the other...as well as with other behavioral health providers, to have a network where they can problem solve with each other. And one of the things we have done also is set up a network of rural and community psychiatrists who can talk about state needs. We meet with legislators also to say we don't have this. We say, well gee, there's a small hospital in Fort Sumner that has 5 beds or 15 beds at the most--that varies--but can we have 3 of those beds become psych beds? Is that possible or not? And at least to involve the people who provide the front-line care the opportunity to problem solve with the rest of the community to figure out how to address these problems. So you don't...most of our communities do not have inpatient psychiatric beds. [LB603]

SENATOR GLOOR: Okay. Thank you very much. Thank you. [LB603]

HELENE SILVERBLATT: Um-hum. Um-hum. [LB603]

SENATOR STUTHMAN: Thank you. Senator Wallman. [LB603]

SENATOR WALLMAN: Thank you, Senator Stuthman. Thank you, Doctor, for coming to our house. [LB603]

HELENE SILVERBLATT: Sure. Yes. Thank...oh, yes. It's a beautiful house. [LB603]

SENATOR WALLMAN: And I'm always interested in, like, school-based. Do you have, like, school... [LB603]

HELENE SILVERBLATT: Um-hum. [LB603]

SENATOR WALLMAN: Do you deal with public schools? I've noticed you must have some Native American schools also. [LB603]

HELENE SILVERBLATT: Um-hum. [LB603]

SENATOR WALLMAN: So do you deal with the school, train school nurses also so that they can use telehealth? [LB603]

HELENE SILVERBLATT: Yes, actually we have, on several levels, we have school-based services where we have telehealth in many schools throughout the state where we actually see students as patients. We also consult with everyone who is a potential provider in the school, including teachers and policemen and, you know, cafeteria people, everyone. We also feel very strongly that developing our rural pipeline is a crucial way to keep the work force that we need, and we do a lot of work around that and including in Native American communities. [LB603]

SENATOR WALLMAN: Thank you. [LB603]

HELENE SILVERBLATT: Um-hum. [LB603]

SENATOR STUTHMAN: Thank you. Any other questions? Seeing none, thank you, Dr. Silverblatt. [LB603]

HELENE SILVERBLATT: Well, thank you very...thank you again. [LB603]

SENATOR STUTHMAN: Thank you very much for coming here, today. [LB603]

HELENE SILVERBLATT: You bet. Thank you. [LB603]

SENATOR STUTHMAN: So next testifier, please. Good afternoon. [LB603]

ROBB PAULK: (Exhibit 3) Good afternoon, Mr. Chairman, members of the committee. For the record, my name is Robb Paulk, R-o-b-b P-a-u-l-k. I am here to testify in support of LB603, and thank you for allowing me to speak on this issue that I believe is a critical piece of helping solve the complex puzzle of behavioral health reform. I first want to say that I work in the beautiful city of Norfolk, Nebraska, home of Speaker Mike Flood, who is a friend of our hospital, and certainly we are all proud of him. I am employed at the Faith Regional Health Services and am the director of a 20-bed locked and secure

inpatient psychiatric facility, and I represent them today. Faith Regional has a contractual agreement with Region 4 Mental Health and Substance Abuse Services to provide care for patients in northeast Nebraska under the emergency protective custody as described in the DHHS Commitment Act. And the 20-bed unit also services voluntary patients. I am a registered nurse...excuse me, and have been...and I am also an emotional slob, I apologize for that. And I have been in the nursing field for 34 years and the past 28 I have been in psychiatric care; served in all capacities of not-for-profit, for-profit, and state-run facilities and served from child and adolescent up to geriatric population, drug and alcohol treatment, dual-diagnosis treatment, which are those patients that have addiction issues complicated with mental illness and vice versa; currently the treasurer and serve on the executive board of the Nebraska Association of Mental Health Organizations, NABHO, and I believe a representative from NABHO is here today to testify on this bill. Today I want to share with you the crisis in our region due to the shortage of psychiatrists, and certainly we don't hold the corner on the crisis; it is across the state. And our behavioral health unit, since it was opened in 1995, we were a 13-bed unit serving patients under emergency protective custody in Region 4, the 22 counties. We didn't have our own psychiatrist. We employed psychiatrists from the Norfolk Regional Center. After two years that contract was suspended, and then our struggle really began to have coverage of services. And the next 11.5 years we have been...after that, we were unable to obtain and sustain adequate psychiatric coverage for the needs, and relied on locum tenum psychiatrists to cover our inpatient needs, which the locum tenums are agency psychiatrists that come to us to work short term. Over the last 11.5 years, we have employed between 50 and 60 individual psychiatrists, not to count that some of those came back on multiple visits. In 2008 we have moved up to a 20-bed facility from 13 in compliance and in conjunction with LB1083, to help that issue. And...but I don't want to talk about 11.5 years, I want to just talk about 2008. In 2008 we had five individual locum tenum psychiatrists to fulfill our needs of our department. Those five psychiatrists filled what I would call a .65 full-time employee, 170 of 260 days, and we paid them $316,200. That is an average of $1,860 a day. A $316,200 could pay a psychiatrist part time and a full-time psychiatrist for a year, not to count a psychiatrist and some mid-levels or any combination of that. Not only this high struggle of...our struggle with the high cost of temporary psychiatrists but the lack of temporary and permanent psychiatrists, we also share our psychiatrists from the inpatient facility with our clinic that is in the same building. But who really suffers in this, what I want to say, is the consumer. We used to call them patients, we have called them residents, but it is the consumer with an inconsistency of care and that...those are the people. And it is the most important item, and I brought that up earlier today, is that, you know, we talk about money but it is about the consumer. Everyone in the room has been affected by mental illness, I would guess, in one way or another, and I have written down some other things about some issues that I have had in the past of making a statement about a woman at a state facility, and a psychiatrist put his arm around me and pointed to her and says, do you know who that is? And I said, you know, I thought he meant name. And he said, no, that's somebody's mom, somebody's brother,

somebody's sister. He said that could be your mom. How do you want to take care of her? And I need...I think we need to remember that when we think about this bill, is these are people. LB603 is an important first step in this solution to this...to solve this crisis and we support this. But again, the consumer. My final remarks are that I hope that, you know, I work with a great staff at Faith Regional...excuse me. We are shorthanded of psychiatrists all the time. We struggle with this. At the present time we have two wonderful psychiatrists. I also have had great mentors in this field and friends: Dr. George Barthelow from the Norfolk Regional Center who was gunned down at his office, who had a dream of a residency program in Norfolk, and Dr. Louis Martin at the Lincoln Regional Center who was killed by blunt trauma who also was a friend of mine and a mentor. I hope that their deaths aren't in vain. We really have a crisis. I'm asking for your help, and I thank you for listening. Any questions? [LB603]

SENATOR STUTHMAN: Thank you very, very much for your testimony. Are there any questions from the committee? Senator Campbell. [LB603]

SENATOR CAMPBELL: Thank you, Senator Stuthman. Mr. Paulk, I am very proud to say that Norfolk is my hometown, also. [LB603]

ROBB PAULK: That's great, thank you. [LB603]

SENATOR CAMPBELL: My question is...and I'm familiar with the hospital, obviously. [LB603]

ROBB PAULK: Thank you. [LB603]

SENATOR CAMPBELL: Have you used telehealth in Norfolk for any other services or linked up with another hospital? [LB603]

ROBB PAULK: We're not using telehealth enough. I, you know, I'm not...I don't use it a lot in my department. We use it sometimes for interviews for referring facilities when the patient goes over and sits and visits with a referring facility for a lesser level of care. But using it out in the community, I don't believe we are doing that at this time. [LB603]

SENATOR CAMPBELL: Okay. But you don't have any reservations at all that this wouldn't work for you as a hub? [LB603]

ROBB PAULK: Oh, ma'am, no. I have no reservations. You know, at this point I guess I think the bill needs a lot of help. It's...Senator Gloor is right. You know, how do you get people to stay? We have psychiatrists come and they leave. And how do you get somebody to stay? Presently we have a psychiatrist that is there because he grew up there, you know, and we are really grateful for Dr. Mayberger being there. So something is better than nothing, and right now we are struggling with that. [LB603]

SENATOR CAMPBELL: Thank you. [LB603]

SENATOR STUTHMAN: Okay. Any...Senator Howard. [LB603]

SENATOR HOWARD: Thank you, Senator Stuthman. I just wanted to say thank you for recognizing Dr. Barthelow, I was in graduate school with his wife, and Dr. Martin, and I knew him well when he worked for the department. [LB603]

ROBB PAULK: They are wonderful people. [LB603]

SENATOR HOWARD: Both good people. Thank you. [LB603]

ROBB PAULK: Very good, yeah. You're welcome. [LB603]

SENATOR STUTHMAN: Any other questions? Seeing none, thank you for your testimony. [LB603]

ROBB PAULK: Thank you. [LB603]

SENATOR STUTHMAN: Next testifier? Good afternoon. [LB603]

TOPHER HANSEN: Good afternoon, Senator Stuthman, and thank you. But first my comments to say thank you for introducing the bill and for really saying it is a matter of how we do this, not whether we do it. I think that's good recognition from a representative body of the state and says a lot about the state. I am Topher Hansen, T-o-p-h-e-r H-a-n-s-e-n. I am the president of the Nebraska Association of Behavioral Health Organizations and executive director at CenterPointe. And we, that is NABHO, are in strong support of this bill. Let me refocus again where Robb touched and that is on the consumers. This is about a family up in north-central Nebraska in a rural/frontier area who has a family member that is out...seemingly out of control. We don't know what to do with them, drugs and alcohol and behavior that is uncontrollable and trying to get in one counselor and another but you can't get access and you have to drive and the doctor doesn't know what to do and tries to prescribe the drugs and it goes on and on and on. And in one particular case then, it only began to get better when the family finally, after years, literally, of trying to deal with what was in their face, which was basically substance problems, got to a hospital in Kearney and got a level of professional that could understand and diagnose what the issues were and get them connected to the place. I had the good fortune to know that family and the second I ran into them and introduced myself, because I represent the agency, they got help, the parents started crying. They started crying because that is how big this was. It ripped their family apart. So what we have to do then, in my mind, is respond to that family and to the other families by creating a system that is going to be more responsive. This is

kind of a critical pathway system, as I think about it, critical pathway being in building a building you put the foundation up because then many things are dependent on getting that job done. Well, we have telehealth as part of our initial critical pathway, but if we are going to get the level of intervention that we need in so many arenas in the state of Nebraska, we have to have the medical expertise and we need to have the licensed therapists available in locations. Now that doesn't mean we have to put them in every single place. The hub-and-spoke model is a great system to employ people in wide areas that can access services; that is, in the north-central community the primary care physician can identify some issues and, through telehealth, begin to consult or have the patient-consumer consult with the psychiatrist in the community they might be in. This kind of hub-and-spoke model in carrying the expertise is what we need to do in Nebraska. As was described in New Mexico, we have to think creatively on how we can bring services to people all throughout the state of Nebraska. And certainly, as I mentioned just a second ago, the provisional licensure issue, we can't shoot ourselves in the foot and carry out surgery with a blunt instrument. We have to think sharply about what we do in these matters so we maximize the use of professionals and maximize the quality that goes with that. Everybody wants the high quality system, we've all talked about that before, but we cannot sacrifice a whole system of individuals, the licensed mental health professionals, in order to carry it out. It's a layered system. We have to do it one step at a time, so getting telehealth, getting the medical professions in, expanding that, maybe getting the communities to think of ways they can incentivize people to remain in the community who come out to do rural healthcare, those kinds of things. The last thing, I'll close, is we have to understand what the consequences here will be if we don't do this, and we got a snapshot through safe haven. We saw what happened in Von Maur, and we have just witnessed what underfunding and undermining an organization's system over time will do through Beatrice State Developmental Center. We have to learn these lessons, and this is a critical component of the bigger system for behavioral healthcare. [LB603]

SENATOR STUTHMAN: Thank you, Mr. Hansen. Any questions from the committee? Senator Gloor. [LB603]

SENATOR GLOOR: Thank you, Mr. Chairman. It's Dr. Hansen. Is it Dr. Hansen? [LB603]

TOPHER HANSEN: No, it's not. [LB603]

SENATOR GLOOR: Mr. Hansen, help me with the telehealth piece, and maybe somebody who follows up can help with this also. I understand how telehealth works when you can connect a fiber optic and perhaps an ENT specialist 100 miles away can look in someone's ear that is seated in an exam room 100 miles away. But I don't quite understand how we use this the same way when it comes to a psychiatric evaluation or whatnot, above and beyond being able to pick up the phone and have the same

dialogue. I mean, are we actually talking about therapy sessions that go back and forth with the camera on someone? [LB603]

TOPHER HANSEN: Yeah, that's done. There's different capacities in different areas and the wiring of a state is critical to carrying that out, and I think we are on the front edge of what's going on in that arena, and we have not taken advantage of it. But certainly telephone access is one way. If the primary care physician is saying, I need help on this, and can make the calls to somebody they know is available in their area or the next step where it's an audiovisual contact made where we, again, create our system to facilitate that sort of clinical intervention. [LB603]

SENATOR GLOOR: Okay. Thank you. [LB603]

SENATOR STUTHMAN: Thank you. Any other questions? As always, thank you for your testimony. Next testifier, please? I would like to mention that I would hope that each one of the next testifiers and the continuation of the testifiers, if you got new information, please share that with us because we want to hear from you. We do not want to have a lot of duplication. We're running a little short on time so I'd appreciate your attention to that. Thank you. [LB603]

TERRY WERNER: (Exhibit 4) I understand. I, too, would like to thank Senator Gay and the committee for bringing this bill forward, and Mr. Hansen mentioned about not whether we do it but how we do it, and I hope to offer some how's in my testimony. My name is Terry Werner, T-e-r-r-y W-e-r-n-e-r. I am the executive director and registered lobbyist for the Nebraska Chapter of the National Association of Social Workers. Mental disorders are one of the leading causes of disability for people age five and older, with major depression leading...the leading cause of disability in the United States. Clinical social workers are the nation's largest providers of mental health and therapy services, outnumbering both psychologists and psychiatrists. They provide mental health services in both rural and urban settings where there may be only one license...they may be the only licensed provider of mental health services available. I have attached some information that gives you the breakdown of licensed mental health practitioners and some maps showing the current shortage in Nebraska. Currently, we have 2,400...about 2,400 licensed mental health practitioners, 551 licensed independent mental health practitioners, and 910 provisional license mental health practitioners. The need is very great, however, there are often policies in the Department of HHS that are counterintuitive to providing access to care for those in need, such as Medicaid not reimbursing provisional license practitioners, not providing necessary rate increases, and continual limits on services by Medicaid. My point being that there needs to be coordination between training more providers and their ability to provide services. An additional concern is the lack of recruitment for LMHPs in the bill. Since they do most of the work, then most of the focus ought to be on the development on LMHPs. Additionally, LMHP services can be provided at much less cost to the state than a

psychologist or psychiatrist. Former state senator and chair of this committee, Senator Joel Johnson, was supportive of another master of social work school in Nebraska. Currently, there is only one school and many students are going out-of-state or utilizing expensive on-line programs. And all social work schools are nationally accredited by the Association of Social Work Education. This raises another concern that the University of Nebraska Medical Center administering the program and the emphasis on trained psychiatrists...we certainly do not oppose that and recognize the need and are very supportive of that so don't misinterpret my comments here. We would recommend that a board be made up of multiple disciplines, such as NASW and the Nebraska Psychological Association, to be established to administer the program and provide oversight. It is critical that this bill develop more LMHPs. In conclusion, NASW strongly supports the concept of behavioral health work force development. There is an incredible need to increase practitioners to the public. But we offer the following ideas for amendments to the bill: First, we'd like to see established a multidisciplined oversight and policy board. Secondly, increase the emphasis on the development of LMHPs. Third, establish a master of social work program at the University of Nebraska at Kearney. And finally, coordinate policies of the department so that providers are better able to maintain themselves and provide the needed services. Thank you for your consideration, and I encourage you to advance this bill. In closing I would like to just quickly mention about telehealth. We, as an organization on a monthly basis, originating either out of Norfolk or out of Grand Island, do workshops to our membership and to anybody who is interested in continuing education. But we do that on a monthly basis utilizing telehealth. We have some...there...it's not perfect but it's a good system. I'd also like to mention that when I go out to Chadron to the school of social work out there, western Nebraska really has an edge on eastern Nebraska in their, not telehealth, but their videoconferencing and their holding of classes and things. They do a really, really good job. So thank you. [LB603]

SENATOR STUTHMAN: Thank you, Mr. Werner. Are there any questions from the committee? Seeing none, thank you very much. [LB603]

TERRY WERNER: Thank you. [LB603]

SENATOR STUTHMAN: (Exhibits 9 and 10) Next testifier, please. When the next testifier is coming forward I would like to also add to the record that we have received letters of support from the Nebraska Advocacy Services and Alegent Health. Good afternoon. [LB603]

CHERYL BUDA: (Exhibit 5) Good afternoon. My name is Dr. Cheryl, C-h-e-r-y-l, Buda, B-u-d-a, and I am a private psychiatrist in Omaha, Nebraska. I am here as the legislative representative for the Nebraska Psychiatric Society and the rep to the Nebraska Medical Association. Given that we do not have a lot of time, you know, I presented a letter here. Not much new; we support the bill. NPS strongly supports it,

and the NMA, I have talked to them multiple times and they strongly support it. So you have two professional organizations in Omaha that support this bill. So that's that. On a personal note, though, I want to let you guys know that I am a recent graduate from the Creighton University Nebraska Med Center in the psychiatry department. I graduated in 2007. It was the first and it was the number one and only residency program that I applied to. Now I grew up in south Omaha, my family is here, my husband's family is here, so you know it was natural that you're going to stay. And I think that's very important to keeping recruitment of doctors here. I can attest that the University of Nebraska Med Center Creighton Psychiatry Program develops a good program. The residents that come out of there are...they typically go on to get board certified, and at least most of the residents that were with me in training decided to stay here. So I think you have a good foundation with the University of Nebraska Med Center and Creighton providing the education for these residents. I myself did not have any rural training. Telemedicine wasn't really part of my training, and I wish that it would have been. And I think if those kind of options would have been available, who knows what I might would have done, you know? As a private psychiatrist in Omaha, my group has already been contacted by Norfolk to try to do telemedicine, and we are trying to figure how to do that. Telemedicine is very important. I have done a little bit in residency working with one doctor that did it, and I know that every time we had time to do this our schedules were booked. I mean, people need that service and they very much wanted us to do that. So with that being said, I will just leave it open for any questions. [LB603]

SENATOR STUTHMAN: Okay. Thank you, Dr. Buda. Any questions on the committee? Senator Gloor. [LB603]

SENATOR GLOOR: Thank you, Chairman Stuthman, and I'll be brief. Dr. Buda, I want to thank you for anticipating and answering my question before I had a chance to ask it. I was going to ask where you were from and where you went to school, and I appreciate your being forthright with that. That, I think, helps with some of my questions. [LB603]

CHERYL BUDA: Um-hum. [LB603]

SENATOR STUTHMAN: Any other questions from the committee? I have one. Have you any interest in moving to Columbus? (Laughter) [LB603]

CHERYL BUDA: No, but I have several patients actually that drive several hours to come to our clinic, and it's really kind of sad because I can't see them as much and as frequent as I'd like to because of the transportation issues. But they are coming in droves. And, and, you know, I think just getting that exposure to those places is what gets our patients to us. You know, I didn't know anybody in Norfolk, and I went to a lunch one time and I met some family doctors and the referrals started coming in. And so when people know that there is someone out there that will take care of their patients, they just gravitate to it. And so by doing these hubs, oh, I can't see how, you

know, this is not going to be just great because people are going to gravitate to someone that wants to take care of their patients. Um-hum. [LB603]

SENATOR STUTHMAN: Okay. [LB603]

CHERYL BUDA: Okay. [LB603]

SENATOR STUTHMAN: Thank you, Dr. Buda. Thank you very much. Next testifier, please. How many more testifiers are there? We see one, two. So good afternoon. [LB603]

ALAN GREEN: (Exhibit 6) Good afternoon, Senator Gay, Senator Stuthman, members of the Health and Human Services Committee. My name is Alan Green, A-l-a-n G-r-e-e-n, and I am executive director of the Mental Health Association of Nebraska, which is a consumer-run education and advocacy organization that also provides consumer-delivered services to other consumers. First off, I want to say that we...that I agree with just about everything that everyone of the earlier speakers has mentioned. However, I guess what I would like to add is that we would like to see it expanded also. In Nebraska, the word "professional" is synonymous with a license or a state certification. It is also directly associated with the expansion...it's also directly associated with illness-based medical model services. However, if we truly desire an expansion of effective and efficient services across the behavioral health spectrum, we must go beyond the traditional reactive models of care. Prevention, wellness, and recovery are possible for persons experiencing symptoms associated with a mental illness. And these services are effective because they are provided by people who themselves are mental illness survivors. A number of peer-to-peer services are recognized by the federal government as being evidence-based practices, and many others are currently considered emerging best practices because they offer great promise and yet are so new that the evidence has not been collected or evaluated. These services are generally provided outside traditional medical or clinical...medical or treatment clinics, and they are not directed by physicians, therapists, or technicians, yet they work side by side with treatment specialists as partners in a unified effort to provide appropriate level of service and individual needs when and where the individual needs it. This being said, again, MHA supports LB603 and its goal to increase availability of trained behavioral health specialists. However, we also encourage you to consider including the expansion of effective and efficient nonmedical services, like peer-to-peer support. The best offense is a good defense, and there is no better defense than early intervention and outright prevention. Thank you. [LB603]

SENATOR STUTHMAN: Thank you, Mr. Green. Are there any questions from the committee? Seeing none, thank you for your testimony. [LB603]

ALAN GREEN: Thank you. [LB603]

SENATOR STUTHMAN: Next testifier, please. Good afternoon. [LB603]

CONSTANCE ZIMMER: (Exhibit 7) Good afternoon. To all the members of the Health and Human Services Committee, I am a consumer and a member of the board of directors of NAMI Nebraska, and I am speaking in support of LB603. [LB603]

SENATOR STUTHMAN: Would you state your name and spell it, please? [LB603]

CONSTANCE ZIMMER: Constance Zimmer, C-o-n-s-t-a-n-c-e Z-i-m-m-e-r. We vitally need community mental health services in the community, especially in rural communities, to help people on the road to recovery. We support LB603 to provide funds for a behavioral health education center. We know of the need for more psychiatrists, especially in rural areas and for children and adolescents. People call our NAMI Nebraska office daily looking for ways to access psychiatric care without waiting for several months or going to the emergency room and facing hospitalization. Due to the scarcity of mental health professionals and the lack of peer-run services, there are no easy answers. The interdisciplinary training sites across the state are important in the transformation to recovery-oriented services. Equally important is the inclusion of consumers and families in planning and delivering the training for the professionals. Research has shown that family members are the one support that continues while caseworkers, psychiatrists, and other providers may change. Consumers in peer-support roles in each of the behavioral health regions serve as liaisons to professionals, to teach recovery, and to develop complementary services that are peer-run. Consumers need to design a curriculum of training leading to certification for peer specialists and could use these training sites to deliver the curriculum. These interdisciplinary training sites, especially in the rural areas, could offer a network of training and support for providers, peer providers, families, and consumers. NAMI Nebraska urges the Health and Human Services Committee to support LB603 to assist in the transformation to recovery-oriented behavioral services in Nebraska. [LB603]

SENATOR STUTHMAN: Thank you for your testimony. Are there any questions from the committee? Seeing none, thank you very much. [LB603]

CONSTANCE ZIMMER: Thank you. [LB603]

SENATOR STUTHMAN: Next testifier, please. Good afternoon. [LB603]

PATTI JURJEVICH: Good afternoon. My name is Patti, P-a-t-t-i, last name is Jurgevich, J-u-r-j-e-v-i-c-h. This afternoon I am here to testify on behalf of the Nebraska Association of Regional Administrators. Chairman Gay, members of the Health and Human Services Committee, on behalf of the administrators of the six regional behavioral health authorities, I want to offer our strong support of LB603. By way of

background, the Nebraska Behavioral Health Services Act clearly identified that efforts were necessary to recruit, train, and retain a quality work force for the behavioral health system. We as administrators have seen the challenges of the work force shortage most acutely over the last four to five years as we worked to promote the development of additional behavioral health resources necessary to serve persons in their home communities. This work force challenge, regardless of whether you are in an urban, rural, or frontier setting of the state, is very real. The Behavioral Health Workforce Act is an important investment in our behavioral health system, an important first step to address the work force shortage in our system, and we look forward to the opportunity to collaborate to help ensure the success of this effort. Thank you all for your support and leadership in this area. [LB603]

SENATOR STUTHMAN: Thank you very much. [LB603]

PATTI JURJEVICH: Thank you. [LB603]

SENATOR STUTHMAN: Any questions from the committee? Seeing none, I want to thank you for your testimony. [LB603]

PATTI JURJEVICH: Thank you. Thank you. [LB603]

SENATOR STUTHMAN: Are there any other ones that want to testify? Seeing none, are there any in the opposition, any opponents? Seeing none, is there anyone in the neutral capacity that wants to testify? Seeing none, Senator Gay, would you like to close? [LB603]

SENATOR GAY: Just for a minute. [LB603]

SENATOR STUTHMAN: Okay. One minute, time him. (Laughter) [LB603]

SENATOR GAY: You run a tight ship, there. Well, I'd like to thank everyone who came to support this bill. And as you can see, I think it makes a lot of sense. There has been a lot of thought put into this. It's a program that I think is needed and now. But to me, when I was listening to this...and you're looking at the bill, it just doesn't make sense that we go back clear to Senator Jensen and LB1083 and implementing health, you know, behavioral health reform. And we spend millions of dollars on this reform, and yet we continue to ignore a fundamental fact that we just are short, and this is a solution, I guess. Like I said in my opening, it's a combination of a lot of people getting together and coming to us with a solution, and I think that is the way we need to look at it. Earlier this summer...Senator Flood also has been involved as well, and I'd like to thank him and his staff for taking time to understand the program and looking out for, you know, how does this work throughout Nebraska, and he did a great job at that. I'd also like to thank the committee. I think when you ask these questions, Senator Gloor, that's exactly

right, we need to ask tough questions now because if we are going to defend this in, say, the vetting process, that's the way it works. We ask tough questions now, we send it out to the floor. So I appreciate your interest in this, and of course we are all committed to this, and that's a good sign as we saw from the turnout. That's great. Another thing, I looked at this telehealth and many of you, we've seen the Telehealth Network. In some places it is being utilized, in other places not at all. So we have made a huge investment, and I just learned today that we are one of the top 10 networks in the whole country on this and we're underutilizing that Telehealth Network. So I think this is let's go out, find the solution and go utilize that network. I like the idea that we are talking about inclusion here. This is not just silos, and there was some good testimony there of how we can include other people in the end result, and more than open for some of those. But I like the idea of collaboration here instead of the silos. I do think that this is an opportunity. Someone had mentioned don't expect this to solve all your problems next year. I think Dr. Silverblatt mentioned this. That is exactly right; they have been at it for 14 years. It's an ongoing thing. But as we know in all these health situations where we need providers, you know we are all aging and the population is aging. We need to...I was enthused to see I think it was Dr. Buda come up, and what a story there. If we had a lot more of those, you know, throughout the state, boy, we'd be so fortunate. So as we look at the future, I think this is something that we can make a difference now. We...none of us are going to be here for a long time, obviously, but this is one of these bills I think we look at and say, hey, you know, I was involved in that and I helped create this down the road, and we could leave and have a real legacy here and be forward thinkers. So, I appreciate all your questions and everyone coming out today. Thank you, Senator Stuthman. And any questions, of course. [LB603]

SENATOR STUTHMAN: Thank you, Senator Gay. Senator Gloor. [LB603]

SENATOR GLOOR: Thank you, Mr. Chair. This probably is a suggestion and something that I would bring up only because I'd like it on the record. The training sites talk about doing those in counties under 50,000, and I have a pretty good idea of why we picked that, why that number was picked. But with the census coming up, I also have a strong suspicion there may be some counties that we would expect to have within this that might fall out because they would creep just over 50,000. So we might want to relook at that number before this goes much further and plump it up just a little bit, worth taking a look at so that we don't inadvertently exclude counties. [LB603]

SENATOR GAY: Absolutely. I think that's a very good suggestion, of course, bring that up now and let's remember for any amendments or something like that. I did hand out another shortage area map. (Exhibit 8) I'm sure someone else did along the way, but that's a good point. And where we do that, it's open. [LB603]

SENATOR STUTHMAN: Okay. Thank you, Senator Gay. I would just like to make a comment, you know. I was involved in the building of the new Columbus Community

Hospital and we have the telehealth, the telemedicine in there and, you know, and that's...with technology, you know, this needs to be expanded. And I'm very supportive of the fact that, you know, if we can educate the kids that are from the rural areas, they're going to stay in the rural areas. Then we don't have the problems of trying to attract people back from the urban areas into the rural areas and I think that is very important, just as the one testifier stated, you know. She was from the community, she's staying in the community and she's a real asset to the community. [LB603]

SENATOR GAY: Yeah, absolutely. I just think it makes sense, of course. And I think those bonds that I think Dr. Silverblatt or somebody mentioned, you know, that's another thing too. I think once you start, you're in the formative years and you think this is great, let's keep doing it. We need to be optimistic that we can do this. [LB603]

SENATOR STUTHMAN: Yeah. Yeah. Okay. Thank you. (See also Exhibits 9, 10, and 13.) And that will close the hearing of LB603 and I will turn it back over to the Chairman, Senator Gay. [LB603]

SENATOR GAY: Thank you, Senator Stuthman. We'll move to Senator Sullivan. Oh, there she is. Welcome, Senator Sullivan. [LB489]

SENATOR SULLIVAN: Senator Gay and members of the Health and Human Services Committee, I'm Senator Kate Sullivan from Legislative District 41. That's Kate, K-a-t-e, Sullivan, S-u-l-l-i-v-a-n. LB489 establishes the area health education centers, or AHECs, in statute. It recognizes AHECs as the primary resource for connecting Nebraska elementary and secondary students to health careers and it asks the state to make an investment in the future stability of Nebraska's healthcare infrastructure. Healthcare employs thousands in Nebraska. But we are experiencing a severe shortage of healthcare workers. Rural healthcare worker shortages impact healthcare quality through reduced access, as well as increased stress on providers. The most severe shortages are in rural areas and in medically needy and underserved population groups. Forty-nine Nebraska counties are federally designated either in full or in part as primary care health professional shortage areas; 71 Nebraska counties are designated as medically underserved areas. The shortages contribute to higher healthcare costs for everyone. Healthcare worker shortages in rural areas are caused by a variety of things: an aging work force, an aging population, recruitment and retention issues, high turnover rates, lack of career advancement opportunities, lower pay, and less benefits, and increased workload. By way of background, in the 1990s the Legislature and the University of Nebraska Medical Center established the Rural Health Education Network, known as RHEN. RHEN was charged with the development of a statewide network of volunteer medical faculty members to provide medical training rotations in rural communities for UNMC students. At that time, UNMC also determined that a program to develop and nurture future health professionals in Nebraska by educating elementary and secondary students about careers in healthcare could serve as a pipeline to recruit

students into healthcare careers. The program would also focus on retaining the students as practitioners in Nebraska once their education was completed. As part of UNMC's long-range plan then, in 2001, they sought core funding from the federal Health Resource Administration, or ERISA, Title VII funds to establish the area health education centers across the state. An area health education center, or AHEC, is a private nonprofit organization. AHEC's have cooperative agreements with the University of Nebraska Medical Center to identify and implement strategies and activities that address healthcare worker needs in federally designated rural and nonmetropolitan communities and underserved rural communities. Nebraska has five independent AHECs. They serve all 93 counties. There are four rural AHECs and one urban AHEC. In Grand Island it was established in 2002; a Norfolk AHEC established in 2003; Scottsbluff in 2005; and one in Beatrice and one in Omaha, both established in 2006. Nebraska AHECs focus on a variety of things--health career promotion, all the way from kindergarten through college; health professions development and student services; continuing education for licensed healthcare professionals and special community needs. My proposed legislation will ensure that AHECs are able to continue their work to network and collaborate with communities and community-based healthcare providers so that AHECs can continue to serve communities with demonstrated need for healthcare professionals. And AHECs will be able to continue to address the healthcare worker needs of the communities that they serve. AHECs do not currently receive any state support. With this bill, LB489, I'm asking the state to invest approximately $900,000 over the next two years to enhance what already exists as a federal, local and private funding partnership that's already in place. UNMC will administer the funds and provide the Legislature and the Governor with an annual report on their compliance with their statutory duties. So why is it important to keep AHECs in place? Well, let me give you just a few examples. In short, AHECs are the work force development and training education machine for Nebraska healthcare. AHECs concentrate on improving the quality, geographic distribution, and diversity of the primary healthcare work force, that means our doctors, our physician assistants, our nurses, dentists, behavioral and mental health providers, and other public health professionals. AHECs also connects students to healthcare careers in elementary and secondary schools. And they do this through a variety of different ways--through summer camps, through healthcare career fairs, through science meets, and after-school programs and job-shadowing opportunities. AHECs also coordinate clinical rotations for college students in cooperation with physicians who practice in rural areas. And I've been able to see this firsthand with Boone County Health Center. AHECs also connect health professionals to communities. For example, you've heard earlier about the Nebraska Telehealth Network. There was a major investment on the part of AHECs in that. So AHECs really do provide a very important service for this state. They have continued to work diligently to educate elementary and secondary students in healthcare and science career opportunities. AHECs have nurtured an environment that encourages young healthcare providers to serve in rural and underserved areas of our state. The four rural AHECs work closely with RHEN to develop and maintain student

training in rural locations. And the Omaha AHEC places an emphasis on minority students and the unique healthcare needs of the metropolitan area. I really believe AHECs are effective. They provide vital services that support Nebraska's statewide health infrastructure. They connect students to health careers. They connect health professionals to their communities and, in short, they connect communities to better health. As senators, I believe we're obligated to address the critical shortage of healthcare workers that's really looming over this entire state. AHECs provide the link to future healthcare workers through their existing partnerships. I encourage you to support LB489 and invest in the future of Nebraska healthcare. I'd be happy to answer any questions. But you should also know that there is a group of technical testifiers that are coming in back of me that I'm sure will be able to answer your questions as well. So thank you for your time and most of all your consideration. [LB489]

SENATOR GAY: Thank you, Senator Sullivan. Senator Wallman has a question. [LB489]

SENATOR WALLMAN: Thank you, Chairman Gay. Yeah, thanks for coming here. You know if this a nationwide problem or just Nebraska? [LB489]

SENATOR SULLIVAN: Oh, I would venture to guess that there are probably shortages of healthcare workers all across the nation. And I should say, too, that the majority of the states do have similar situations of AHECs just like here in Nebraska. And in many cases, they are funded more substantially than they are here. [LB489]

SENATOR WALLMAN: Okay, thank you. [LB489]

SENATOR SULLIVAN: Um-hum. [LB489]

SENATOR GAY: Any other questions? I don't see any. Thank you, Senator Sullivan. [LB489]

SENATOR SULLIVAN: Thank you. [LB489]

SENATOR GAY: How many people would be proponents and speaking? Okay. Any...about five or so. Any opponents? Anyone neutral? Okay, so we have five proponents and no opponents and looks like no neutral. So if you, again, not be repetitive and share information with us, we'd appreciate it. So come on up. We'll hear from proponents. [LB489]

MIKE SITORIUS: (Exhibit 1) Senator Gay, members of the Nebraska Legislature Health and Human Services Committee, I want to thank you for the opportunity to talk with you today about the impact of AHECs. My name is Mike Sitorius, that's M-i-k-e S-i-t-o-r-i-u-s. I serve as the director of the Nebraska AHEC center program office and also as the

Milton Waldbaum Endowment Chair of Rural Health at the University of Nebraska Medical Center, Department of Family Medicine. Today, as a Nebraska citizen that has been involved in rural healthcare issues for more than 30 years, I would like to express my support for LB489. Having grown up in Cozad, my heart still focuses on the needs of rural and underserved communities and how we as a state can provide access to healthcare for all of our citizens. I really appreciate Senator Sullivan's comments. It's almost like she read my comments or I read hers prior, but I'll tell you we didn't. And I'm also going to take an aside and state some of the testimony that you heard for LB603 really illustrated the need for a network like the AHECs when comments were made about growing your own, exposure to careers, and development of healthcare interests from the beginning. Through your support the Rural Health Education Network began in 1990s, and you've heard about that. It's a statewide network. In 2001, UNMC AHEC program received federal funding, and today there are five centers. You've also heard about those. Following the success of RHEN and AHECs across rural Nebraska, the Omaha urban AHEC was developed in 2005. Connecting students to careers, professionals to communities, and communities to better health is the national and statewide goal of AHECs. Through partnerships, AHECs, Nebraska has become a leader in recruitment and retention of health professionals that serve your constituents. AHECs are a federal, state, and community partnership in collaboration with the University Medical Center. And since its inception in 2001, federal support to Nebraska has exceeded $10 million to develop and implement this AHEC system. With the system now in place, resources are needed for sustainability, and I think you've heard why that would be the case. The university program would not receive direct funding from UNMC, nor are the centers asking to be part of UNMC or the Nebraska university budget. UNMC is allocating 10 percent of the state funds in this bill to provide a compliance oversight communication and to provide that yearly report that is so necessary for long-term development. We know that we're in a shortage time and a shortage area. We know that we've had successful programs that have retained health professionals in the state of Nebraska. The AHEC network has become an essential part of building Nebraska's healthcare work force. Eighty Nebraska counties our Governor designated shortage areas in family medicine, dentistry and/or mental health. And you heard that in the previous bill's testimony. We must maintain and increase our pipeline of future health professionals and the natural conduit to do so is to support a program that has developed a strong base of success in Nebraska in a short seven years, and that is the Nebraska AHEC centers. With your support, the federal, state, and local partnerships that have been developed will continue to enable rural and underserved areas of Nebraska to sustain their viability and vitality through local healthcare resources. I'd be happy to entertain any questions. [LB489]

SENATOR GAY: Thank you. Senator Gloor. [LB489]

SENATOR GLOOR: Thank you, Chairman Gay. And I should tell the committee that Dr. Sitorius and I go a ways back. Had I known how important he would come, both within

this state and the university system and in some cases nationally, I certainly would have treated him with a lot greater respect over the years. (Laughter) This is a chance to make amends for some of that. In all seriousness, Dr. Sitorius, you were and have been intimately involved with the RHEN program, as it relates to family practice, roll out in rural communities. And so we've just gone through this discussion on doing the same thing to a large extent with psychiatric training. Tell me, I mean give me some specific examples of how you see the AHEC linking together that training piece on a daily, weekly, monthly basis, however you're comfortable, of that training that those psychiatrists and behavioral specialists are going to need, how that will help fill a gap that may be in there or piece that needs to be in there. [LB489]

MIKE SITORIUS: Well, when I was listening to their testimony, not only could I see that AHEC and RHEN could help with identification of these as future careers for young people, but it would also help existing practitioners who are in practice to get continuing education, to get resource identification, and to provide some support for them to provide the mental health services that are already existing. And I... [LB489]

SENATOR GLOOR: Behavioral health specifically. [LB489]

MIKE SITORIUS: ...think that many of the primary care practitioners in this state could also be utilized in this network as to providing some of those mental health resources. [LB489]

SENATOR GLOOR: Okay. And the AHEC would help link all that. [LB489]

MIKE SITORIUS: The AHEC would be critical to help provide those resources. [LB489]

SENATOR GLOOR: Okay. Thank you. [LB489]

SENATOR GAY: Any other questions? I have one for you. So you've been overseeing this project for some time, I take it? This is your position, right? [LB489]

MIKE SITORIUS: Yes, it is. [LB489]

SENATOR GAY: Okay. I'm just looking and you don't have to answer this if you don't feel you could adequately answer it because it deals with the fiscal note that we receive. But it shows $400,000, $500,000; $400,000 next year, $500,000, then $900,000, going up like that. On the...then it has a...we're going to follow, in this bill it says we're going to follow and evaluate. What do you think, how long does it take? It's been going on for some time. But an evaluation component that, say, three years down the road we look at this again and you put a sunset clause on here, let's say, and three years down the road justify where it is. How long of a time period do you think that would need to be? You're probably going to tell me, well, I could justify it right now or you wouldn't be here.

[LB489]

MIKE SITORIUS: Yeah, I would like to tell you that. (Laughter) But I don't think you want that answer. [LB489]

SENATOR GAY: Yeah, but down the road. No, but down the road would...is that a long enough time? Because I see the fiscal note for three years. But this would probably, if we pass this, would go on. [LB489]

MIKE SITORIUS: You know, I think this is a program very similar to what you talked about before, Senator, in that it's a long-term commitment. It's a commitment now to develop those young people and the resources in the community to have output at the back end. I think you can measure interactions with young people. The young people that have presently been in the program, the previous seven years, are they matriculating into health professions and are they returning to some of those areas. So I think that this is an ongoing evaluation of what we have already been doing for the last seven years. So will three years give us the final answer? No. It's an ongoing problem and process. [LB489]

SENATOR GAY: So the...well, I'll save that for down the road. Maybe other people will add onto that, too, as we go. But any other questions? Senator Stuthman. [LB489]

SENATOR STUTHMAN: Thank you, Senator Gay. Doctor, how many dollars have you been getting in the past? Or have you ever been funded? [LB489]

MIKE SITORIUS: From the state? [LB489]

SENATOR STUTHMAN: From the state. [LB489]

MIKE SITORIUS: No, we have not received any state funding. [LB489]

SENATOR STUTHMAN: There has been an attempt to get state funding. [LB489]

MIKE SITORIUS: There has been an attempt. That is correct. [LB489]

SENATOR STUTHMAN: Yes. Okay, thank you. [LB489]

SENATOR GAY: Any other questions? I don't see any. Thank you, Doctor. [LB489]

MIKE SITORIUS: Thank you. [LB489]

RICHARD BROWN: Senators, thank you for the opportunity to testify before you today for this bill. We are very much strongly in support of it. My name is Richard Brown. I'm a

chairman of the Omaha Area Health Education Center and I'm also the chief executive officer of Charles Drew Health Center, a primary care, federally qualified health center in north Omaha that takes care of about 50,000 patients, people of that particular population in north Omaha. The AHEC center is very important because of its mission. Their mission is to partner with Douglas County and Sarpy County to recruit, educate, and inspire underrepresented students interested in careers in the health professions, as well as encourage healthcare professionals in providing equitable and quality services to disadvantaged and underserved populations. We continue to operate current initiatives and develop new programs designed to stimulate interest in the health professions. The infusion of the underrepresented minorities and disadvantaged individuals into the healthcare work force will contribute to eliminating the disparities in health status of the local Omaha area community specifically and in Nebraska in general. Since its inception in 2005, the Omaha Urban AHEC has developed significant presence in the community. There have been over 21,000 single and duplicate participants in the urban AHEC program, has been partners in programs and there's been community grants and programs given to us. During that time period, the AHEC has partnered with and supported over 81 distinct organizations ranging from Douglas and Sarpy County schools to hospitals and community agencies. In fiscal year 2007 we had over 9,600 program participants, with over 62 percent being minority. We provided over 700 hours of direct programming. We worked with 160 medical students, 150 college students, and over 1,300 high school students across Douglas and Sarpy County. In two weeks we will begin an innovative pilot program called Nurses Up. This program is designed to move individuals from government assistance into the front line of healthcare professions as certified nursing assistants. Omaha Urban AHEC designed this program in 2008, and we brought in two key partners--the Arbor Education and Training, which was the...which has the Employment First contract, and the state of Nebraska, and Metropolitan Community College which served as the training agent for the program. In the Nurses Up Program, Arbor will refer interested students and individuals currently engaged in one of the Employment First programs to AHEC. Metro will screen the applicants through a competency test and do a background check. The students then begin classes at the new CNA Lab and Training Center. And upon completion, the student will be a CNA, a certified medical (sic) assistant, and they will be trained in basic life support, and they will also acquire 16.5 credit hours from the metro junior college. In addition, they will be provided with an internship and direct access to employers demanding CNAs at an in-house job fair at the AHEC training center. It is the goal of AHEC, through the Nurses Up Program, to help over 70 individuals on government assistance in the next two years. And we'll help them transition to gainful employment in a high demand, front-line healthcare career as a CNA. Truly the AHEC center is making a difference in the lives of people in Douglas and Sarpy County. And we strongly appreciate your support of this bill and helping to develop the work force in Nebraska. [LB489]

SENATOR GAY: Thank you. Are there any questions? Senator Campbell. [LB489]

SENATOR CAMPBELL: Thank you, Senator Gay. Mr. Brown, the AHECs have really come under the auspices of UNMC as they started. Now will they have to become separate 501(c)(3), or will they still fit under that umbrella at the university? [LB489]

RICHARD BROWN: We'll still fit up under that umbrella. But we're a separate agency responsible for self-sustaining ourselves through programs and services that we can provide to serve the community, but also sustain the operations. [LB489]

SENATOR CAMPBELL: Thank you. [LB489]

SENATOR GAY: Any other questions? I don't see any. Thank you. [LB489]

RICHARD BROWN: Thank you. [LB489]

SENATOR GAY: (Exhibit 3) While other proponents are coming up to speak, we do have a letter of support from the Nebraska Hospital Association for the record. [LB489]

ROBYN HENDERSON: (Exhibit 2) Thank you, Senator Gay, members of the committee. My name is Robyn Henderson, that's R-o-b-y-n H-e-n-d-e-r-s-o-n. I'm executive director of Southeast Nebraska AHEC located in Beatrice. We serve 17 counties. Earlier today we had an opportunity to provide a folder to you that had some information about the AHEC program. One of the items in that was a map that showed our distribution of which...what committee, excuse me, which AHEC served which counties. And you'll notice that all 93 counties are covered. We...and we have actually...I'm sorry, I'm blanking here because everything I was going to say has already been said. So I'm winging this. (Laughter) All 93 counties are covered and we have had an opportunity and have done activities in all 93 counties. Some of them we've had an opportunity to be in multiple times doing multiple types of projects. We do the student awareness programs. We do the clinical rotation programs. We do continuing ed programs. And you'll see that those are noted on there. And I'm pleased to say that in our area we've done all three in all but three counties. So I'm very excited and will be working on getting those other two lined up where we've missed programming. Over the past eight years the AHEC program has put more than...over $10 million, as Dr. Sitorius mentioned. And our community partners have also invested an incredible amount of time and energy and support into this program too. And that's usually through their support of our activities and also their support of the clinical rotations program. In many cases the communities will provide the housing for the students that are there. They're usually there for at least a month and many times up to three months. They provide Internet access for the students. They make sure that there are meals provided, you know, and are truly welcoming, as I think Dr. Silverblatt mentioned. These students become a part of those communities for the month or three months that they are there. And they really do feel very warmly welcomed. We've had several students comment on

that. That's been a surprise to them, going into the communities, how widely and deeply accepted they have been in their short time there. Some of the AHECs have had, through another funding source, a federal funding source to be able to help those students who are doing their clinical rotations. And if the community does not provide funding, we can help them with...or does not provide housing, we can help them with the housing. We can help them with a weekly stipend. They're certainly not going to get rich from us because our weekly stipend is like $35 a week. But it helps take care of any meals that aren't provided. Maybe they can go to a movie or something that week. But we do feel that it's important to have students out in rural areas doing these community-based rotations. Again, it gets the students into the communities, it helps them become aware of what the role of the health professional is in the local community, and it helps them understand the challenges that they would face in a small community but also the incredible compensation that they would get, in many ways more than just financial. One of the issues that has been brought up repeatedly today has been behavioral health. And the AHECs have contributed substantially to helping develop the Telehealth Network. Central Nebraska AHEC, which is our first one that was opened, has invested, I believe, it's around $500,000 into the Telehealth Network. And we have used that extensively in our first several years to help do continuing education. One of the programs that we did, I believe it's been two years now, that was widely successful was a program for providers on returning...or for the local providers on returning veterans, helping them with their care, what to understand. We now have DVDs of that program that we'll be able to share with folks for additional continuing education programs. I see my time is done. And I didn't say probably half of what I wanted to say. But I'd be happy to answer any questions. [LB489]

SENATOR GAY: Thank you, Robyn. Sometimes those are the best testimonies anyway, so don't worry about it. Senator Wallman has a question. [LB489]

SENATOR WALLMAN: Thank you, Chairman Gay. Thanks for coming, Robyn. [LB489]

ROBYN HENDERSON: Thank you. [LB489]

SENATOR WALLMAN: You know, did BSDC management ever use this program much for training? [LB489]

ROBYN HENDERSON: Up to this point, we've not really worked with them. We have been in conversations with them and would like to use BSDC as a training site for behavioral health. It would be a fabulous opportunity. And I would hope that, however, whatever the decision that comes out on BSDC is that we would be able to work with them to develop a specific program geared to their needs, that we could help them not only with finding current employees, but also help with that pipeline of students that are interested in going into behavioral health. We have had some work...we've worked with some of the nurse practitioners and PAs that are in psychiatric specialty programs

within their training. It would be a perfect opportunity for those students to have a facility such as Beatrice to do training. [LB489]

SENATOR WALLMAN: Thank you, Robyn. [LB489]

SENATOR GAY: Senator Gloor. [LB489]

SENATOR GLOOR: Thank you, Chairman Gay. Thank you, Ms. Henderson. You gave us some examples of community partnerships, I think, was the term you used. Like the veterans, that strikes me as sort of an agency to agency relationship. Do you have any public and private relationships that you can talk about? [LB489]

ROBYN HENDERSON: We do. A couple of the AHECs were approached by their regional Kiwanis Clubs in their areas. And through that...through the partnership that developed they were able to help equip the rural rescue squads with pediatric rescue materials, so the mask, the face mask and some of those things that are needed on that front-line response. And they wouldn't have been able, those departments wouldn't have been able to purchase those for themselves. Again, the telehealth system was one that we worked extensively with. Let's see, I have some...excuse me here. We worked with the extension program. We also worked with the hospitals, local hospitals, they support us very strongly in what they do through volunteering their time and their staff's time to work with us. They will help replenish kits that we use to...in our training programs with the students. If we need tongue depressors or if we need cotton balls or things like that, they're more than happy to help replenish our supplies. We work with the local businesses in our community. They will help provide food and supplies again for our activities. I think we really have some unique models that have...that we have developed. We work with the Boy Scouts and the Medical Explorers Post in developing those programs. And in Gage County we started working...or have been working very extensively with the fire and rescue squads in Gage County and the Gage County Board of Supervisors to really refine and develop a program that uses the volunteer, because all of the fire and rescue squads there are volunteer, using them in a more efficient and effective manner. So I think we've developed partnerships really broadly across our communities. [LB489]

SENATOR GLOOR: Okay, thank you. [LB489]

SENATOR GAY: Any other questions? I don't see any. And then, Ms. Henderson, we did receive this Nebraska Rural Health Association letter of support. Thank you for bringing that. [LB489]

ROBYN HENDERSON: Yes. Thank you. [LB489]

SENATOR GAY: No other questions? No. [LB489]

ROBYN HENDERSON: Okay. I just had...I was going to respond quickly to Senator Campbell's comment. All of the centers were developed as 501(c)(3) programs. So we already have that status. And our relationship with the Med Center then is contractual. [LB489]

SENATOR GAY: All right, thank you. All right. Other proponents? [LB489]

GRETCHEN FORSELL: Good afternoon, Senator Gay and members of the Health and Human Services Committee. I am Gretchen Forsell, G-r-e-t-c-h-e-n F-o-r-s-e-l-l. I am the director of Northern Nebraska AHEC, located in Norfolk. And I have a unique perspective to provide you of not only being a center director in Nebraska but also previously working with an AHEC program in another state. Nebraska, as you've already heard today, is facing a severe work force shortage, but this work force shortage is not unique to you. This shortage is across the country. And seven years ago, when I was in the state of Georgia, we had the exact same work force shortage that continues there today. AHECs have helped decrease that shortage. They've made tremendous efforts in that state, just as we have seen in ours as we have brought more and more health professionals back to our communities and have them actually work. I am very pleased to say that our AHEC is seven years old and we know of 30 health professionals who are now working within the state of Nebraska who have directly been involved with our AHEC program. That's just one example. A similar thing is what I saw when I was in Georgia where we each and every year would look at hundreds of medical students, mental health professionals, allied health professionals who stayed in our state and stayed in our state because they had been in a pipeline with AHEC. They had worked with AHEC programs and saw the impact that they could have. Truly, AHEC can work. AHEC programs are not unique to Nebraska either. They are located in 48 states of our country and very soon our neighbor to the north, South Dakota, will probably be included. We worked with state and local and federal governments for over 37 years. So again, this program is nothing new. You've heard about how new the AHEC program is in Nebraska. But like I have told you, we have been very successful so far. And we have been successful because of that network that we have nationwide. We don't need to start anything new that probably hasn't been done. We've learned from other people's mistakes, people have learned from ours. We are not reinventing the wheel and we hope that you don't reinvent a wheel also. We are here on the ground and, as we've heard with our latest President, ready to go. Recently, the committee has heard testimony, for example, on the medical home model to be used with family practitioners. That is a system that the AHEC programs across the country are currently implementing because they are regionally based and ready to go. They know the practitioners. They know who is able to help out, who's interested in wanting to try innovative things. AHECs additionally have helped with behavioral health in other states, just as we are here. We know about the behavioral health work force shortage because we hear it in our communities. So what have we done but tried to work with

young people to get them to understand what it is. Remember back when you were young and you were in high school, the only health professional you may have known had been a doctor, nurse, someone...you know, very few. Unfortunately, our youth today don't know what a mental health professional is. If they do, it's from television. They don't know what a respiratory therapist is or a clinical laboratory specialist. We have the unique opportunity to provide those opportunities to students by things like a recent DVD that we have developed showcasing mental health careers, taking models of bringing people, like Robb Paulk, who you heard from before, is a presenter at my health careers camps and tells students what it's like to be a mental health professional, and more importantly of all what it's like to be a male nurse. We've also developed unique job-shadowing opportunities in all of the health professions, something that Senator Gloor is probably aware of and in many facilities was stopped by the fact of HIPAA and confidentiality regulations. AHECs have worked very closely to expand those opportunities. As I stated earlier, I have a unique experience of working in another state and seeing how things can happen. We have been very successful in Nebraska in the short time that we've been here. We've been able to show an increase in those health professionals and, more importantly of all, with our private and public partnerships. Robyn shared a variety of those with you. And we can even expand on more with hospitals who are working with different schools, schools that we are working with to expand and offer opportunities as we go. AHECs make a difference. AHECs programs can change the lives of not only young people but of our communities. One good example in the Norfolk area is a community health center which was now recently funded. Prior to its funding, that community health center had lost its nurse practitioner and five people lost their job. It was because of AHEC finding a nurse practitioner who wanted to come back to the area that that community health center now has a provider and seven more people are employed. We are a solution to your problem. It's a problem that you've heard in many different ways. You don't have to reinvent the wheel, we can make a difference. We've made a difference in the past and we hope to in the future. I thank you for your time. And if you have any questions, I'd be happy to answer them. [LB489]

SENATOR GAY: Thank you. Any questions? Don't see any. Thank you. [LB489]

GRETCHEN FORSELL: Okay, thanks. [LB489]

SENATOR GAY: Any other proponents who would like to speak? Any opponents? Anyone neutral? Senator Sullivan, you want to close? [LB489]

SENATOR SULLIVAN: Thank you, Senator. I'll be brief. I hope through my testimony and those that followed me that you can see how important AHECs are to this state and to the...what I would consider to be the infrastructure for healthcare. Once you start to chip away at that it weakens the whole system. And that's what we would be doing if we didn't continue funding. And I wanted to make just a couple comments with respect to

funding. You know we're going to be facing that concern across the board. We've been staring at a big economic crisis in this country. However, I want to caution us all that we shouldn't use as an excuse not to look at significant and important programs such as the AHEC in terms of considering what we're going to fund. Also, I think it's critical to consider AHECs, when they were first developed at the federal level, the whole vision of it was to be a partnership of federal funds, state funds, local participations in public-private partnerships. One of the features that's going on right now is that the AHECs here in Nebraska are operating on a basic funding mode. And there are...there is the opportunity for what's called federal model...federal funds coming down the pike. However, the restriction on that is that centers can only begin receiving model funding once all of the centers within this program have finished their basic funding. So some of the AHEC centers here in Nebraska have lost their basic funding. There's three more that have yet to lose it, and then...so it's critical, though, to keep that infrastructure in place so that we're able to access that model funding when it becomes available. So any questions? [LB489]

SENATOR GAY: I've got a question for you. On the funding, and I know when we get these fiscal notes a day prior, so you don't get a chance to look at them sometimes. But this one I was reading and it's kind of interesting. It just says, the area health education centers are estimating the cost for the state, and then it sounds like, okay you estimated, and it says 400...in '09-10 $500,000; in '10-11 at $900,000. How did they...do you know how they arrived at that and why it would jump from $400,000, $500,000 then to $900,000? [LB489]

SENATOR SULLIVAN: Probably because, as I just got done saying, they're losing that basic funding systematically. I mean, I think there are right now two of the... [LB489]

SENATOR GAY: So it's escalating? [LB489]

SENATOR SULLIVAN: Yes, uh-huh, right. But you have to also look at it from the standpoint then as they lose that basic funding and they...then they're anticipating more funding coming from the federal level. [LB489]

SENATOR GAY: Federal match. [LB489]

SENATOR SULLIVAN: On a reduced amount, I have to admit. So that's why they're asking for the $900,000. If you follow that. [LB489]

SENATOR GAY: Okay, so it's just an escalating...yeah. So, all right. And then did you work with them, give them information on the fiscal note then? Sometimes we do. [LB489]

SENATOR SULLIVAN: I hope I did. (Laugh) [LB489]

SENATOR GAY: You're shaking your head. They're saying no. Because sometimes, you know, you can give them information and then it may change it a little bit. [LB489]

SENATOR SULLIVAN: Sure, sure. [LB489]

SENATOR GAY: Okay. Then, I guess, the question is this, also there's some follow-up in here, which I like, on page...let me see, Section 3, it says what this bill does. And then you know what you're supposed to do, the method. The evaluation performance is...requires reports on the finance on an annual basis goes to the Governor and the Legislature. [LB489]

SENATOR SULLIVAN: Right. [LB489]

SENATOR GAY: At some point, I guess, when we talk about money and ongoing money, should we review these somehow? Because two, three years down the road, I mean, how do we...to me that seems kind of vague. But is there specific things we could put in here that says we're going to do this, this, and this, or that you could look at past history and say, here's the successes we had; here's what we hope to get and just for some measurement purposes? I mean should that be tightened up a little do you think or just... [LB489]

SENATOR SULLIVAN: We can certainly work on that. And I'd be happy to work with the...with Dr. Sitorius and the AHEC groups to finite that. But, I think, also I think it was Dr. Sitorius' comments that evaluation and accountability, I think, is a key point of all the AHECs. And so they would have the data as far as the performance of their respective programs. And so it wouldn't be something that would be impossible to round up. So I think we could do that. [LB489]

SENATOR GAY: So probably, I guess, what I'd say then before we Exec on this, maybe we should get some data of what's been out there. And I appreciate it, I got the information today as well. But we get busy and it would be good to have that information so we can make a good decision on this I would say. Senator Gloor, you have a question? [LB489]

SENATOR GLOOR: Thank you, Chairman Gay. And I was just going to say that's a great suggestion and I think especially if we can have an accountability piece that speaks specifically to the behavioral health concerns that we have for adolescents, if there are ways that that can make a difference I think it would help all of us and also help us if we get this to the floor. That's a great suggestion. [LB489]

SENATOR SULLIVAN: Thank you. We'll work on that. [LB489]

SENATOR GAY: Okay. Any other questions? I don't see any. Thank you, Senator Sullivan. [LB489]

SENATOR SULLIVAN: Thank you very much. [LB489]

SENATOR GAY: You bet. With that, we will close on LB489. I see Senator Nordquist is here on LB601. [LB489]

SENATOR NORDQUIST: Does the room always clear out when I get here? []

SENATOR GAY: Yeah, they're all clearing out for you. (Laugh) Whenever you're ready. []

SENATOR NORDQUIST: (Exhibit 1) All right. Thank you, Mr. Chairman, members of the committee. My name is Jeremy Nordquist, N-o-r-d-q-u-i-s-t. I represent District 7 in Omaha, here to introduce and open on LB601, which directs the Nebraska Department of Health and Human Services to submit an application to the U.S. Department of Health and Human Services for funding to allow Medicaid payments for various community-based mental health services. According to the bill, the application must be submitted by July 1, '09. Nebraska should be seeking federal funds to help finance our existing community-based mental health services. Other states take advantage of these funds which benefit both the state's finances and our citizens that are served. In fact, Nebraska has one of the lowest utilizations of Medicaid funding for behavioral health services in the country. We need to do a better job of accessing the funds that are available. Based on the input of behavioral health professionals across the state, I am offering an amendment to the committee for your consideration. I believe the page is distributing that. The intent of the amendment is to narrow the scope of the services to be covered by the bill, limiting it to just subacute, secure residential, and peer support services. Community support services and intensive residential services are eliminated in order to avoid confusion with current services and funding streams. This amendment will also significantly alter the fiscal note and it should allow Nebraska to gain much-needed additional funds that we are currently not accessing. Believe Nebraska should not continue to underutilize available Medicaid funds for services that we are currently...services that we are currently funding completely out of our state General Funds. I appreciate your full consideration of LB601. Thank you. [LB601]

SENATOR GAY: Thank you, Senator Nordquist. Any questions from the committee? [LB601]

SENATOR NORDQUIST: I guess I will also note, we distributed kind of a little spreadsheet that's basically a summary of the fiscal note on the original bill that the department provided the numbers. [LB601]

SENATOR GAY: Oh, here, he's going to hand it out right now. [LB601]

SENATOR CAMPBELL: They will be distributed. [LB601]

SENATOR NORDQUIST: Oh, sorry, will be getting it. Okay. Great. And it shows the savings, General Fund savings and then the federal funds that would be replacing it. [LB601]

SENATOR GAY: If the amendment were drafted? [LB601]

SENATOR NORDQUIST: The spreadsheet is as the bill is written because those are the numbers that were provided by the department in the fiscal note. I will note that two of the, as you'll see in the fiscal note and in the...and on our spreadsheet, two of the services listed in the original bill are new services that we don't currently provide. We do provide three of the five right now. Under the amendment, that would change it to, I believe we're providing secure residential and subacute, peer support services would be a new service. [LB601]

SENATOR GAY: Would be a new service, so. [LB601]

SENATOR NORDQUIST: Yeah. And that...on the fiscal note by the department you can see it would...the peer support services is new and it would have about $2.5 million General Funds and then we would draw about $4 million in federal funds. [LB601]

SENATOR GAY: Okay. So the fiscal note we're looking at then has... [LB601]

SENATOR NORDQUIST: Yeah, the fiscal note has five... [LB601]

SENATOR GAY: Tell me what the current fiscal note has. [LB601]

SENATOR NORDQUIST: Sure. Sure. Five...the five services that are in the bill right now that would be covered are secure residential; intensive community support, which is a new service; intensive residential rehabilitation, which we currently have; emergency community support, which we currently have; and peer support services which we currently have. With the fiscal note, if we went with the bill as is, it would require about $3.8 million in General Funds to draw down about $13 million in federal funds a year. The amendment takes us to just subacute, which is not included in the original bill and we don't have a number on that. There might be someone testifying after me that has some estimates, but we don't have numbers from the department. Secure residential would be in there and that's one where we would, on that program, we would be saving about $2 million a year in General Funds and that would be replaced with about the same amount of federal funds. [LB601]

SENATOR GAY: Okay. [LB601]

SENATOR NORDQUIST: And then the amendment has peer support services included. Ultimately, from the folks that know the numbers better than I do, not necessarily from the department but from the service providers, they're saying with the amendment the fiscal note would be pretty much be...pretty much a neutral impact on the General Fund and then we would be accessing federal funds. [LB601]

SENATOR GAY: Well, and the reason I asked you that, because we got to look at the fiscal note they gave us just yesterday. [LB601]

SENATOR NORDQUIST: Yeah. Yeah, that's right, and that's why I said we don't have those numbers from... [LB601]

SENATOR GAY: And then, yeah, so just in fairness to you,... [LB601]

SENATOR NORDQUIST: Absolutely. [LB601]

SENATOR GAY: ...there's a certain point where we won't get that new fiscal note until we pass an amendment. [LB601]

SENATOR NORDQUIST: Absolutely. Yeah. And I hope to work with the committee and the Fiscal Office and the department if you do decide to go with an amendment and pick certain services, that we get the right numbers from the department and everything. [LB601]

SENATOR GAY: Yeah, the reason I asked, I knew you were going to be handing that out. [LB601]

SENATOR NORDQUIST: Yeah. Yeah. [LB601]

SENATOR GAY: Okay. Thanks. Any questions? Senator Campbell. [LB601]

SENATOR NORDQUIST: Oh, go ahead. [LB601]

SENATOR CAMPBELL: Thank you, Senator Gay. Senator Nordquist, will you be staying to close in case we have any questions at the end? [LB601]

SENATOR NORDQUIST: I sure will. [LB601]

SENATOR CAMPBELL: Okay. [LB601]

SENATOR NORDQUIST: Yeah. Yep. [LB601]

SENATOR CAMPBELL: That would be fine. [LB601]

SENATOR NORDQUIST: Uh-huh. [LB601]

SENATOR GAY: All right. How many proponents want to speak on this? About five or six, say about seven or so. How many opponents? Anyone neutral? All right, we'll get started with the proponents. [LB601]

CAROLE BOYE: (Exhibit 2) Good afternoon. My name is Carole Boye, C-a-r-o-l-e B-o-y-e. I'm the CEO of Community Alliance in Omaha, Nebraska. As most of you know, Community Alliance is a nonprofit behavioral health organization serving adult men and women with major mental illness in the Region 6 area. We are the first freestanding, psychiatric rehabilitation agency in the state, starting in 1981, and we remain the largest in Nebraska today and provide a wide range of community-based services. We are strongly in support of LB601 and of the amendment language outlined by Senator Nordquist this afternoon. We need the Legislature's action, this committee's action, as called for in this bill because Health and Human Services Department is not acting. The services referenced in this bill, as amended, already exist and were developed specifically in response to the legislative mandate in the Behavioral Health Services Act to develop community-based services closer to home, family, friends, and supports. There are, however, other mandates within this statute, including the legislative requirement and expectation to maximize federal dollars and specifically to leverage Medicaid dollars for which state hospitals were not and still are not eligible. Yet we are utilizing primarily state funds for these services rather than leveraging and maximizing the federal funds, as the statute requires. The Legislature has had to act before. In fact, in my 27-year history with Community Alliance, every community-based rehabilitation service or substance abuse service added to the Medicaid plan that I know of has been added only after a legislative mandate to do so. We were the last of 50 states to include the rehabilitation option in our state's Medicaid plan. Nebraska Medicaid has historically always, always said no, and we have historically left millions of federal dollars on the table, and we are still leaving substantial federal dollars on the table today. We need your help and the Legislature's action, as called for in this bill, because HHS and the Nebraska Medicaid division has historically ignored emerging best practices and they still are. This was illustrated by the need for the Legislature to mandate a number of years ago the inclusion of assertive community treatment services within the Medicaid plan, after recognition of ACT services as an evidence-based best practice and long after SAMHSA, NAMI, and other national organizations recognized this service as an integral part of a comprehensive, effective, community-based system of care. Legislative action was still needed to mandate inclusion of ACT even after research studies consistently found these services to be both cost-effective and medically effective and even after virtually all other states included it within their Medicaid plans. Peer support services in many shapes and sizes is now emerging as a new best

practice in our field, backed by strong evidence including (sic) both effectiveness and cost-benefit. A number of other states have already included a range of peer support services within their Medicaid plans. Let's not have Nebraska be the last one again to add a service such as this. We need the Legislature's action, as called for in this bill, because of the additional barriers which continually seem to surface in the delivery of Medicaid funded behavioral health services to Nebraska citizens. We have learned that deadlines are essential. Going back to the ACT services, even after the Legislature mandated inclusion of ACT services in the Medicaid plan, it took HHS over five years to activate that service in our state. More recently, we've seen HHS decide, as a matter of administrative policy, that it will authorize Medicaid payment for subacute services only for those who are involuntarily committed. Translated, that means even if one meets clinical criteria and has a medical necessity for a subacute level of care, if he or she is not involuntarily committed, Medicaid will not authorize or pay for this level of care. This is the adult equivalent of forcing a child to become a ward of the state to receive services. One should not have to give up their rights to receive essential treatment. Finally, we need the Legislature's action, as called for in this bill, to end the cost shifting that is occurring with increasing frequency from Medicaid to the Division of Behavioral Health and local government. Cost shifting does not save money. Cost shifting does not maximize federal dollars. Cost shifting ultimately makes scarce resources all the more scarce for those who need them the most. This bill ends the cost shifting that is occurring in these three service areas, again in accordance with the amendment, and it will help to improve access to appropriate and effective levels of care. The stakeholders agree that this is something that we need to do. It's a benefit financially to the state; most importantly, it's a benefit to the people that we are all pledged to serve. Thank you. [LB601]

SENATOR GAY: Thank you, Carole. Senator Stuthman. [LB601]

SENATOR STUTHMAN: Thank you, Senator Gay. Carole, you said you're in agreement with the amendment? [LB601]

CAROLE BOYE: Yes, we are. [LB601]

SENATOR STUTHMAN: And are you in agreement with the fact of the fiscal note change, like Senator Nordquist said, you know, if we would utilize $2 million to $3 million, we could access $13 million? Is that true? [LB601]

CAROLE BOYE: It is, other than we, too, saw the numbers late last night so it's somewhat difficult to analyze them. But absolutely, we are leaving money on the table. There is no question about that. We can argue with the numbers. I would say particularly the peer support numbers are, I think, in terms of what the state portion of that would be, I think are very high and I think that it just points out that as, you know, if and hopefully when this bill moves forward that stakeholders, you know, perhaps need

to come to the table and let's talk about what a service definition looks like, let's talk about who might be covered, let's talk about a realistic dollar amount. When we did our analysis of that this morning what we found, if you just look at those three services, at worst...well, first of all, the fiscal note demonstrates that we're leaving $2 million on the table for secure residential alone. Two million dollars that we're spending right now, state dollars, on a service that's up and running right now we could recoup with federal dollars. That $2 million will serve a whole lot of people. Our own analysis, which I know someone is going to testify for, is that we're leaving at least, at Lasting Hope Recovery Center, probably at least a half a million dollars of federal dollars on the table right now today. So $2 million and a half million, that's $2.5 million. So even if we accepted the peer support number of $2.6 million, at worst, at worst, this bill is revenue neutral. And I would suggest it's positive for the state of Nebraska when we really get down to these numbers. [LB601]

SENATOR STUTHMAN: Okay. Thank you. [LB601]

CAROLE BOYE: Thank you. [LB601]

SENATOR GAY: Any other questions? Don't see any. Thank you. [LB601]

AIMEE FOLKER: (Exhibit 3) Hello. My name is Aimee Folker, A-i-m-e-e F-o-l-k-e-r. I sit as a member on the continuum of care committee, Lasting Hope Recovery Center, and represent NAMI Nebraska's consumer council. Good afternoon, my fellow Nebraskans. I am greatly honored to speak about something so close to my heart, so crucial to my own recovery from the completely devastating and debilitating effects of mental illness. I am proud to be here today to speak with you about peer support and peer-run services. Peer support, to me, was like the on-ramp to our great Nebraska highways, a road where the sky does not dome around you but spreads vast and wide into the horizon, an endless possibility with the support of roads and maps to get you wherever you dream of going. For most of my life I have suffered from acute and destructive anxiety. I sought out the best evidence-based treatments, the most respected therapists and doctors in the community where I lived. I tried psychotropic drugs, both new and old, and I worked consistently with all I had inside of me to get better. And I did get better, but only to a point. I learned to accept the limitations of my illness. I learned to live this life that lot had chosen for me. I accepted that with my medication and therapy, family, faith and friends, I would not just want to die anymore. I could exist. Some days maybe I wouldn't be able to leave the house, some days getting my mail would be all that I could do, and this was my life for many years. But something happened to break my world wide open to show me the road to living not just with my mental illness but beyond it. This was peer support. The actual interaction with others who had truly been where I had been, understood what I was going through, suddenly something inside of me clicked, something in me began to grow, something that no professional, no treatment plan, not even the unflinching love and support of my family and friends had been able

to provide. Like me, those who have experienced mental illnesses speak with a voice, authority, and reassurance of a lived experience. They show, not tell, how to take responsibility for recovery. Suddenly, I was driving myself around all the time, I was grocery shopping unaided. I began to attend meetings and became active supporting myself and others just like me. I organized voting drives, helped establish and became chair of Community Alliance peer support, an organization dedicated to recovery and community integration. For the first time, I believed that I could be a productive member of society. I began to garden. I joined a gym. I actually walked around my own block. My physical health improved, less doctor visits, less hospitalizations. My mental health became far better than it had been in ages, maybe even ever. All of this was possible because of peer-run and peer-driven services. The most amazing thing about peer support is that it works both ways. Those who work as peer support specialists stay well and grow, move into independent roles in their communities, and get paid. Being able to go back to work is a real empowering and motivating thing, and those receiving help from peer services not only get empathy and understanding but a tangible hope that they, too, can recover. My training as a peer support specialist has not only provided me with a purpose beyond my own symptom management but giving me drive and direction towards a life where my mental illness is just part of the job, a life where I no longer question why did this happen to me but expand my horizons and allow my experiences, my suffering, my unique understanding to help others, and in return I receive the greatest treatment--the ability to fuel my own maps and dreams. Peer services, peer support specialists, not only should they be a part of any mental health treatment; they should be a cornerstone. Thank you for your so important time. [LB601]

SENATOR GAY: Thank you. Any questions? I don't see any. Thank you for coming today. [LB601]

PATTI JURJEVICH: Good afternoon. My name is Patti, P-a-t-t-i, last name Jurjevich, J-u-r-j-e-v-i-c-h. I'm the administrator with Region 6 Behavioral Healthcare. This afternoon I am here to testify on behalf of the Nebraska Association of Regional Administrators. Chairman Gay and members of the Health and Human Services Committee, on behalf of the administrators of the six regional behavioral health authorities, I want to offer our support of LB601 and the amendment language offered by Senator Nordquist. As you may be aware, regional behavioral health authorities have a long history of advocating and planning for community needs, developing capacity, and identifying and promoting funding strategies that maximize available dollars for mental health and substance abuse services in our communities. LB601 provides a means by which services that are important to our citizens can be delivered and paid for in such a way that maximizes financial resources available. The notion of maximizing revenue and leveraging federal dollars is not new. Other states have established revenue maximization policy and developed techniques to access federal dollars available to them to support programs within their state. LB601 pushes our state Medicaid leadership to do just that--go after the federal dollars that are available to us to

help sustain services. If we as a state are not aggressive in accessing the federal funding, we are relying solely and unnecessarily on state behavioral health funds to support these services. That is not good business practice. Clearly, the concept of accessing additional federal dollars is one that we as administrators strongly support. I do want to offer two cautionary comments. First, as history has shown, the inclusion of behavioral health services in the state Medicaid plan diminishes the behavioral health system's control and oversight of the contents of the service definition. LB601...in LB601, our concern centers on the peer support service and we hope that you will encourage Medicaid to incorporate, to the extent that is possible, recovery and support theories, philosophies, and practices which are critical to the success of the peer support role. The second concern deals with the assumption identified in the fiscal note that current behavioral health funds will serve as match to leverage the federal funds. This practice has single-handedly reduced regional funding by $8 million annually. Over the last four years, a 22 percent increase in the amount of funds diverted from the regional budgets has occurred. These limited...these regional limited historically insufficient level of regional dollars are intended to support services for individuals without insurance, those with no means of payment for their behavioral health treatment and rehabilitation. As the regional dollars decrease, the ability to serve people without insurance is diminished. It is important to remember that not all individuals needing behavioral health services qualify for Medicaid. We have seen greater demand for public behavioral health services in recent years, as the eligibility for Medicaid and service authorizations appear to be declining. So while the regions have experienced increased demand and budget reductions to support Medicaid match, our state Medicaid has experienced cost savings in FY '08 of $25 million, as well as a requested $19 million budget reduction request for '09. Recent discussion with the Nebraska Hospital Association has created a new and collaborative opportunity to leverage federal dollars by using current payments to psych hospitals as a way to leverage federal dollars. This allows the behavioral health dollars to continue to pay for services for individuals without any form of insurance, while still accessing additional federal dollars to invest in our system. These are the kind of creative ways that we need to explore and expand to leverage these federal dollars rather than diverting regional funds from needed services. The amendment to LB601 clearly impacts the recently released fiscal note. Assumptions and projections in that note need to be scrutinized to ensure that accurate and timely data is incorporated in the methodology to allow for objective consideration of the bill. I encourage you, as members of the Health and Human Services Committee, to carefully question the fiscal piece of this bill and to seek alternatives to reducing the behavioral health funding currently available to the regions. Our thanks to Senator Nordquist for introducing this bill and for providing leadership in this area. We reiterate our support for LB601 and thank you for your time and attention to this important issue. Be happy to try to answer any questions that you may have. [LB601]

SENATOR GAY: Thank you. Any questions? Senator Stuthman. [LB601]

SENATOR STUTHMAN: Thank you, Senator Gay. Patti, you also feel the fiscal note is not correct on this bill. [LB601]

PATTI JURJEVICH: Well, obviously with the amendment it's going to change a bit, but I haven't had an opportunity to do much analysis on it yet so... [LB601]

SENATOR STUTHMAN: Okay. But... [LB601]

PATTI JURJEVICH: ...would like that opportunity. [LB601]

SENATOR STUTHMAN: But you feel we should pay attention to that. [LB601]

PATTI JURJEVICH: I do. [LB601]

SENATOR STUTHMAN: Okay. Thank you. [LB601]

PATTI JURJEVICH: Thank you. [LB601]

SENATOR GAY: Any other questions? I don't see any. Thank you. [LB601]

PATTI JURJEVICH: Thanks. [LB601]

RHONDA HAWKS: (Exhibit 4) Hello, again, Mr. Chairman, members of the Health and Human Services Committee. Again, my name is Rhonda Hawks, spelled R-h-o-n-d-a H-a-w-k-s. I'm here today as one of the founders of the Behavioral Health Support Foundation. Thank you, Senator Nordquist, for introducing this bill and thank you to the committee for allowing me the opportunity to testify. I will be very brief. I testified earlier that the Behavioral Health Support Foundation raised about $25 million from the private sector to support capital projects in community-based behavioral healthcare in Region 6, including creating Lasting Hope Recovery Center. Between Mr. and Mrs. Stinson, my husband I, we've made a personal commitment equal to about 20 percent of that total in cash gifts and countless hours in the past five years in an effort to assist agencies, hospitals and the region, consumers and their families wherever we can to help consumers stay connected to the behavioral health system, avoid hospitalization and concentrate on recovery and sustained wellness. These efforts were prompted by the passage of LB1083 and the commitment by communities to care for patients being discharged from the regional hospitals. One of the primary economic reasons to reduce the behavioral health population at regional hospitals was to take advantage of and leverage federal Medicaid dollars. This state is failing to do this, resulting in lost revenue that could be used to fund programs for the citizens of the state. At a time when many states are struggling with difficult economic challenges, we must maximize all the federal Medicaid dollars we can. In this way, the state can make state dollars available

to fund services that are otherwise missing from the behavioral health continuum of care. State Medicaid officials recently announced Medicaid funding will not be allowed for those patients who are subacute patients at a hospital that have not been committed. In other words, it will only cover patients that are committed. Do we want to force patients to have to be committed to get coverage to lose their civil liberties in order to be covered? The economic impact to Lasting Hope, we took a look at that and it looks like it will be something on the order of $500,000 in federal Medicaid that we would lose through the match, if that happens. Additionally, secure residential and peer services could and should be covered by state Medicaid in order to maximize funding in, again, an underfunded system. Estimates project that if secure residential services were included in the state Medicaid plan, as much as $1.2 million--and I know Carole referenced I think $2 million so it's something in the zone--could be ascertained from the federal Medicaid Program. Right now, we're using state dollars to fund those services. I urge you to take advantage of leveraging federal Medicaid dollars to help some of our most vulnerable citizens in the state of Nebraska. If you have any questions, I'd be glad to take them. Thank you for allowing me to testify. [LB601]

SENATOR GAY: Thank you. Senator Stuthman. [LB601]

SENATOR STUTHMAN: Thank you, Senator Gay. Rhonda, what year did the Behavioral Health Support Foundation start? I recall when we dealt with the issue but I don't know how many years ago it was. [LB601]

RHONDA HAWKS: Right. We started the Behavioral Health Support Foundation when we were going to purchase the old Richard Young building, which I believe was December of 2006, and the members of the board are Ken Stinson, me and Paul Jessen, our attorney. My husband was originally on and we had to remove him because we were related. (Laugh) [LB601]

SENATOR STUTHMAN: So you took care of that. [LB601]

RHONDA HAWKS: We took care of that. [LB601]

SENATOR STUTHMAN: Because I had remembered when we had this...creating that foundation and the private money and stuff like that, so... [LB601]

RHONDA HAWKS: Right, exactly. [LB601]

SENATOR STUTHMAN: ...but I didn't remember how long ago that was. [LB601]

RHONDA HAWKS: Right. And we got the state support also... [LB601]

SENATOR STUTHMAN: Yeah, uh-huh. [LB601]

RHONDA HAWKS: ...so that was very good. [LB601]

SENATOR STUTHMAN: Yeah. Thank you. [LB601]

RHONDA HAWKS: Yeah. Thank you. [LB601]

SENATOR GAY: Senator Gloor. [LB601]

SENATOR GLOOR: Thank you, Chairman Gay. Mrs. Hawks, just a thank you. You and your husband obviously are committed to this, have been committed to this, have devoted a lot of your time and money to behavioral health issues and a lot of Nebraskans have benefited as a result of it. So I don't know how all this will turn out but it, I think, bears saying once again thank you for the hard work that you and your husband have put into this. [LB601]

RHONDA HAWKS: Thank you. Thank you for saying that. That's very much appreciated. [LB601]

SENATOR GAY: Senator Wallman. [LB601]

SENATOR WALLMAN: Thank you, Chairman Gay. Yes, I, too, want to thank you. And... [LB601]

RHONDA HAWKS: Thank you. [LB601]

SENATOR WALLMAN: ...why is it that we haven't applied for these Medicaid dollars? You think it's too hard to evaluate/assess? [LB601]

RHONDA HAWKS: I don't know, but what concerns me is that when we were out selling our Lasting...selling the model for Lasting Hope to the private sector--and many of the people that donated to that, as you can well imagine, are business people, sophisticated philanthropists--... [LB601]

SENATOR WALLMAN: Uh-huh. [LB601]

RHONDA HAWKS: ...and we said one of the reasons we want to develop this and one of the reasons LB1083 is a good thing is because we can get folks out of the regional center, maximize federal Medicaid dollars. So I don't know the answer to why we've not been aggressive on that. Very disappointed that we haven't... [LB601]

SENATOR WALLMAN: Uh-huh. [LB601]

RHONDA HAWKS: ...and love to see us ramp it up. [LB601]

SENATOR WALLMAN: Okay. Thank you. [LB601]

RHONDA HAWKS: Thank you. [LB601]

SENATOR GAY: Any other questions? I don't see any. Thank you. [LB601]

RHONDA HAWKS: Thank you. [LB601]

SENATOR STUTHMAN: Thank you very much. [LB601]

RHONDA HAWKS: Uh-huh, thank you. [LB601]

SENATOR GAY: Other proponents. [LB601]

MARY ANGUS: It's going to be a real interesting one because I have laryngitis. My name is Mary Angus, A-n-g-u-s. This is kind of impromptu. I'd like to just address this as an individual. I'm a member of various organizations, agencies, and networks through which I have a lot of information and involvement with all of this. You just asked about the question about why HHS may not be maximizing Medicaid funds. As a person in a network who worked very, very hard and met with some of the members of this panel to encourage the department to apply for Money Follows the Person, a demonstration project which the proposal for which was written ten days before the grant deadline was made, I can tell you that the answers that I got at that point were it takes too much time and staff to administer these funds; we'd rather not have the $26 million that we've got for Money Follows the Person because it takes too much for our staff time. And Money Follows the Person has been an extremely helpful program and hopefully it will continue to work so...and to fulfill its promise to move 900 people out of institutions and get an enhanced match for the first year of that transfer to an 85 to 15 percent instead of 60/40. As a person with a mental illness, I have experienced some of the same things that Aimee spoke of. The strengths and the power of peer relationships, one of the things that I've come to fully understand and appreciate is the strength of that. The evidence bases are there. There is a lot of research that shows without peers and without peer inclusion we don't find the recovery that's possible otherwise. One other aspect of LB1083, the mental health reform or the Behavioral Health Reform Act, was the inclusion of consumers at every level of the development, programming, and evaluation of programs, and I think that could be a large part of this, especially if the department is being...I hate to say forced but if the department is asked to do this. I can't stress enough how much that all of us need to be involved in the programs that are developed to encourage our recovery, recovery philosophy, and my own recovery could not happen without my being included in all aspects as is mandated in LB1083. It's currently not happening and one of the points that is, it goes back to HHS being

unwilling and unable to believe in my value as a person and to believe in the experience and the expertise that I and others hold in the area of behavioral health. The reluctance of HHS to apply for Medicaid funding has continued over the period of time that I've been involved in advocacy. The first time I heard those words was in 2002, when I worked for the Real Choice Grant with the consumer (inaudible) task force. And rather than inflict upon you the continued laryngitis, I'd be very glad to answer any questions. Oh, I will add that I am a proud member of LD7 and Senator Nordquist is my senator. Thank you. [LB601]

SENATOR GAY: All right. Any questions? Don't see any. [LB601]

MARY ANGUS: Oh, I can speak. I don't feel bad. It just sounds bad. [LB601]

SENATOR GAY: I don't see any for you, Mary. [LB601]

MARY ANGUS: Thank you very much for your attention, Senators. [LB601]

SENATOR GAY: Thank you. [LB601]

STEPHEN SPELIC: (Exhibit 5) I may get the award for being brief today. Mr. Chairman, members of the committee, for the record, my name is Stephen Spelic, S-t-e-p-h-e-n, Spelic, S-p-e-l-i-c, and I'm here on behalf of Alegent Health in support of LB601. From Alegent's perspective, I wish to focus my comments on the issue of Medicaid payment for subacute services for both voluntary as well as involuntary patients. If you're not familiar with subacute services, subacute care is a step-down service from acute inpatient psychiatric care. Acute care is intended to be a three- to seven-day length of stay to stabilize and resolve a psychiatric crisis. Once the crisis is stabilized, the patient is stepped down to a subacute level of care, which is usually around a 25-day length of stay. The focus of subacute is to work with the patient and their families to develop a long-term recovery plan that includes community-based wraparound services that will help avoid the need for future hospitalizations. The Lasting Hope Recovery Center subacute unit in Omaha consists of 18 beds. Typically, about one-third of their patient population are of an involuntary status. So if the payment for voluntary patients is withheld, the economic impact would be the revenue loss of approximately $6,000 per day. Essentially, and this is key, essentially, if voluntary patients are excluded from payment, no organization could sustain this level of care which is critical to the community's continuum of services. I urge the committee to move LB601 forward for a vote by the Nebraska Legislature. It will increase both the cost-effectiveness and the success of community-based behavioral health in Nebraska. Thank you for your consideration and thank you to Senator Nordquist for bringing this bill forward. [LB601]

SENATOR GAY: Thank you. Any questions? Senator Stuthman. [LB601]

SENATOR STUTHMAN: Thank you, Senator Gay. Stephen, on the involuntary status of your patients, are those directed there by the court systems then? [LB601]

STEPHEN SPELIC: Most of them are there because of a Board of Mental Health petition or they're there under an EPC, emergency protective custody. [LB601]

SENATOR STUTHMAN: Okay. Thank you. [LB601]

STEPHEN SPELIC: Uh-huh. [LB601]

SENATOR GAY: Any other questions? I don't see any. Thank you. [LB601]

STEPHEN SPELIC: Thanks. [LB601]

CONSTANCE ZIMMER: (Exhibit 6) Senator Gay and other members of the Health and Human Services Committee, I am Constance Zimmer, C-o-n-s-t-a-n-c-e Z-i-m-m-e-r. I'm a consumer and a member of the Nebraska NAMI, National Alliance on Mental Illness. I am speaking on behalf of the board of NAMI in support of LB601. We urgently need quality mental healthcare in the community. Currently, the community services listed in this bill are provided with the state and counties of Nebraska paying the entire bill for those dependent on the public healthcare system for their care. Unfortunately, this is the majority of patients with chronic mental health issues, as few have health insurance benefits which cover those services. Federally, the Center for Medicaid Services has recognized the cost-effectiveness and the benefits of outpatient behavioral health services and is encouraging states to apply for waivers to include these services. The failure of officials in Health and Human Services to apply for these waivers makes no economic sense. With the passage of the stimulus bill, additional Medicaid monies will be available for the states, so this bill is particularly timely to help Nebraska qualify for this additional funding. It is estimated that an additional $310 million may be available for Nebraska. The LB1083 Behavioral Health Oversight Commission worked hard in the past few years with the regional behavioral health administrators and the Behavioral Health Division to begin to establish a network of community mental health services across the state. We are very pleased at the increasing numbers of peer specialists in the state. Peer specialists offer a unique face of recovery as they have been seriously ill and, through the support of family, friends, peer providers and professionals, have become stable and able to help others. Establishing the definition of peer specialists in a Medicaid waiver will also add the possibility of certification and credibility to this new profession, thereby helping more return to the work force and also helping to alleviate the shortage of behavioral health professionals in Nebraska. There are alternative peer-run models of care that Nebraska needs to establish as part of the service mix. We urge the committee to move LB601 forward for a vote by the Nebraska Legislature. It will increase both the cost-effectiveness and the success of community behavioral healthcare services in Nebraska. [LB601]

SENATOR GAY: All right. Thank you. Any questions? Don't see any. Thanks. [LB601]

CONSTANCE ZIMMER: Thank you. [LB601]

SENATOR GAY: Any other proponents? [LB601]

BRAD MEURRENS: (Exhibit 7) Good afternoon, Senator Gay, members of the committee. For the record, my name is Brad Meurrens, B-r-a-d M-e-u-r-r-e-n-s, and I am the public policy specialist and registered lobbyist for Nebraska Advocacy Services, the Center for Disability Rights, Law, and Advocacy. Rather than repeat what everyone has said before me more eloquently than I could, I would just want to say that Nebraska Advocacy Services is in support of LB601. You have my written testimony being handed out to you right now and a couple of handouts that we thought might be helpful in your deliberations around/including peer support services in the Medicaid waiver. For that, I will conclude my brief testimony and be happy to answer any questions you may have. [LB601]

SENATOR GAY: Thanks, Mr. Meurrens. Any questions from committee? Don't see any. Thank you for this. Any other proponents? Any opponents? [LB601]

VIVIANNE CHAUMONT: (Exhibit 8) Good afternoon, Senator Gay 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'm the director of the Division of Medicaid and Long-Term Care for the Department of Health and Human Services. I'm here to testify in opposition to LB601. Based on the amendment that I just found out when coming here, the rest of my printed comments aren't really applicable, so I'm just going to have to wing it service by service. First of all, I want to talk about LB1083, to start out with. The premise of LB1083, when that happened, and this was some...quite before my time, but it was to be able to provide more services, more behavioral health services in the state of Nebraska by leveraging the General Fund that was being spent in the regional centers. Medicaid does not reimburse for any care in the regional centers, so the idea was to take the General Fund that came out of the regional center, put it in services that Medicaid could in fact pay for and then you would more than double the funds because of the 60/40 split. We have, in fact, leveraged the federal money, which is the way that we're paying for a lot of the behavioral health Medicaid services. LB1083 did not provide for additional state funds to pay for Medicaid services or for any other services. It was supposed to be a leveraging of amounts already being spent in the budget for those services. So using behavioral health funds as a match is very consistent with the intent of LB1083. Now let me talk individually about the different services and please pardon if I don't sound very organized. Subacute services at Lasting Hope Recovery Center, the Medicaid Program pays for Medicaid clients at Lasting Hope Recovery Center at the present time. What we discovered after the Medicaid Program adopted, amended its

state plan to cover for the subacute services, and not just at Lasting Hope Recovery Center, by the way, but at other hospitals that offer the subacute service--Medicaid also pays for those and there are a couple of other hospitals as well--what was pointed out to the Medicaid Division was that previously the state funds that were being used were only for committed people. The Division of Behavioral Health only pays for people who have been committed. And so when Medicaid adopted its rules that we were paying for anyone at subacute services, we were, in fact had inadvertently expanded beyond what the state was already paying for by expanding this. So the letter that you all got on December 1 regarding our intent to move back to what we had been paying for and what we had state funds that we were levering for to pay for subacute, that's the reason for that. I do not know what the fiscal impact would be of paying for subacute services for any Medicaid client at subacute level, but I can get that information to you as soon as I get back to the office and ask for it. I can get it to you within the next couple of days. So that's what the change in subacute was. The secure residential, it is correct that currently behavioral health is paying for secure residential with state-only funds and that if we made that a Medicaid service there would be General Fund savings which would...could...you know, then you could use that for something else. The issue with that is, however, that when behavioral health pays for something with General Funds only there is a limit. You have General Funds. You run out of the General Funds, you stop providing that service. When Medicaid gets involved, Medicaid continues to pay whether or not you have an appropriation or not because it's an entitlement program. It's a totally different issue. So if there's a client and a service and a provider, Medicaid has to continue to pay unless there's limitations on the services. So that's the secure residential, so we can't guarantee. And then peer support, peer support is currently a service that we do not offer. Could you use the money that you save from doing the leveraging in the secure residential, could you use it over for peer support? Yes, but there's absolutely no guarantee that the expenditure will be limited to the amount that you're saving in General Fund because, again, it's a Medicaid service and, unless we limit it in some way that's acceptable to CMS, you may very well go beyond the amount that you saved, both in the secure residential, if there's any change in providers, if there's an increase in providers, if there's an increase in utilization. So you can't guarantee that pot and only that pot will then go to pay for the new service. As far as, you know, the cost shift, the cost shift is exactly what was contemplated by LB1083, just so you know. Medicaid didn't invent this. The idea was that we would take money that was already being spent by behavioral health and we would save some of that money by--Medicaid requires a state match, it's not free federal money--that we would take some of that money that would then be the Medicaid share for service and that would free up additional dollars for behavioral health. That has happened. If you have any questions, I'd be happy to answer them. [LB601]

SENATOR GAY: Any questions? Senator Campbell. [LB601]

SENATOR CAMPBELL: Thank you, Senator Gay. Ms. Chaumont, why am I not able to

say that today? I'm sorry. You talked about unless we put a limitation on services. Have we done that in any of the other areas where it would be a similar situation in terms of CMS? Have we limited others (inaudible)? [LB601]

VIVIANNE CHAUMONT: Dental, $1,000 limit; therapy, 60 visits; many services are prior authorized, chiropractors. Yeah, there are limits on services. [LB601]

SENATOR CAMPBELL: Have we looked into what other states have put on those limits to try to...and I understand what you're saying about the manageable amount on the General Fund... [LB601]

VIVIANNE CHAUMONT: Uh-huh. [LB601]

SENATOR CAMPBELL: ...but it would be interesting maybe to look at what those are to whether we could. [LB601]

VIVIANNE CHAUMONT: Well, you know, to be honest, a lot of states don't offer many of the services that Nebraska does offer. But if we're talking about the subacute services, I don't know what other states offer. We...that's actually an inpatient hospital service. It's, you know, a level of inpatient hospital care and different states, you know, could call that different things or not have that care, just you're either in the hospital or you're out in the community. We in Nebraska have this, you know, in between acute inpatient, you know, hospitalization and just out in the community. We have a level of care, other states may not have it. Peer support, other states have peer support services. I am not familiar with how they limit. I suppose you could, you know, limit a certain number of hours or a certain number of visits or a certain...you know, I'm not sure how that...how they would limit that. [LB601]

SENATOR CAMPBELL: Thank you. [LB601]

SENATOR GAY: Any other questions? Senator Wallman. [LB601]

SENATOR WALLMAN: Senator, thank you, Chairman Gay. Thank you for being here, keeper of the purse, huh? [LB601]

VIVIANNE CHAUMONT: Well,... [LB601]

SENATOR WALLMAN: I noticed here on peer support Medicaid there is waiver authority here on peer support. [LB601]

VIVIANNE CHAUMONT: I'm sorry? [LB601]

SENATOR WALLMAN: There's waiver authority here for peer support, so it must be...do

we have...it says this is new service. [LB601]

VIVIANNE CHAUMONT: It's a new service which Medicaid pays for services either through state plan or through a waiver. I think CMS has now said that you can pay for peer support through a state plan. [LB601]

SENATOR WALLMAN: Okay. [LB601]

VIVIANNE CHAUMONT: So the federal authority to do it, if we want to do it, is there. There's no doubt about that. Uh-huh. [LB601]

SENATOR WALLMAN: Yeah. Thank you. [LB601]

VIVIANNE CHAUMONT: Uh-huh. [LB601]

SENATOR GAY: Any other questions? I don't see any. Thanks. [LB601]

VIVIANNE CHAUMONT: Thank you. [LB601]

SENATOR GAY: Any other opponents? Anyone neutral? Senator Nordquist, you want to close? [LB601]

SENATOR NORDQUIST: (See also Exhibits 9 and 10.) Thank you, Mr. Chairman, members of the committee, for the thoughtful hearing today. You know, I see this kind of as just another piece in the puzzle to complete the full puzzle on what was LB1083 to make sure that we have the right services there for people with behavioral health and substance abuse issues. It's clear, you know, you can look at the fiscal note, depending on the service, we're certainly not maximizing federal funds and we owe it to the philanthropists in our community, like the Hawks and the Stinsons and others and other people who have stepped up to the table in the private sector and to the Nebraska taxpayers to maximize federal funds. And I really hope that we can get the department to the table to talk about maximizing federal funds. That's what this is about. So I appreciate your time and would be happy to answer any final questions. [LB601]

SENATOR GAY: Any questions? I don't see any. Thank you. [LB601]

SENATOR NORDQUIST: Thank you. [LB601]

SENATOR GAY: All right. With that, we'll wrap up LB601 and I'll turn this over to Senator Stuthman and we'll start on LB661. [LB601]

SENATOR STUTHMAN: Okay, we will have the hearing on LB661 by Senator Gay. Welcome again. [LB661]

SENATOR GAY: (Exhibit 1) Thank you, Senator Stuthman, members of the committee. I...Tim Gay, Legislative District 14, to introduce LB661. I have some prepared comments I was going to read and then I figured I'll just wing it a little bit because this is a...it's interesting how in politics, all of a sudden, how quickly you can be really popular and then probably an hour later be really unpopular. (Laughter) And I got a hunch that might happen today, so. [LB661]

SENATOR GLOOR: It's just like real life. [LB661]

SENATOR GAY: Yeah. [LB661]

SENATOR CAMPBELL: Senator Gay, we are watching your back here. [LB661]

SENATOR GAY: (Exhibit 1) Yeah. I know. I should turn around. But as I was listening today, of course I was one of the people asking for funds as well. And we had another person asking for funds, and then another person asking for funds, and I think so far just today, if we add it up, and you never know, in the fiscal notes we're talking $8 million, $10 million today. Throughout out the...so far up to date, just ball park, you all know, you hear this every day, we're probably up to $500 million, $600 million in new spending. We're halfway...and a little bit more than halfway through, so we're probably get up to $1 billion in new spending requests. So it's a tough job that we all have, and I don't say that to be, you know, to protect myself. I say that because the reason I brought this bill, to me, is really that I brought it on my own to look at opportunities where I think we could find some savings. When we look at...back when we started, we created LB830 was a bill introduced by Senator Lathrop, which I helped with the committee and some of you helped with that, to establish a preferred drug list and this is established to be implemented in July 2010. This preferred drug list was a result of recommendations by the Mercer government (sic) human services (sic) consulting commission to study the state's Medicaid pharmacy program as part of the Medicaid Reform Act. As passed, LB830 excluded from the PDL antidepressants, antipsychotics, and anticonvulsants. Although the PDL as it now stands will save money, save Medicaid dollars, the estimated savings by including these drugs on a list is very significant. According to estimates from Health and Human Services, maximum General Fund savings under the law as it now stands with just the PDL and supplemental rebates would be less than $700,000. If the state joins one of the three purchasing pools, that savings could increase to as much as $2 million--good savings. But compare this to including the three classes of drugs currently exempt and we could realize nearly $4 million in General Fund savings. I have a handout prepared by Health and Human Services that shows these potential savings. I'll hand this out to you. Given the current economic environment, the expected growth in Medicaid spending, and the shortage of behavioral health workers, as we just discussed earlier, it is imperative that we look at all the avenues available to deliver state services in the most effective yet efficient manner. I

know that there's people who would be testifying in opposition to this bill and their concerns are legitimate. Please be aware that this is not my intent to disrupt anybody's medical care and I, too, want to ensure that individuals, particularly those with mental health issues, are getting the medications they need. Current law does require that a 15- to 20-member committee recommend which drugs to place on this list. This committee is to include physicians, pharmacists, psychiatrists, and at least two members of the public. Other protections in place include allowing the prescribing of a drug not on the list with prior authorization, as well as allowing the prescribing of a nonlisted antidepressant, antipsychotic, or anticonvulsant without prior authorization if it can be certified that the individual is achieving therapeutic success or has experienced a therapeutic failure. So there are grandfather clauses already in place that if you're on there and it's working you get continued on. Again, my intention is not to bring harm to any individual. It also isn't my intention to paint a negative picture of the pharmaceutical industry. I believe they are a valuable contributor to providing excellent healthcare and are a very important piece of good health. My goal is to make sure that we utilize precious taxpayer resources wisely while still providing necessary medications to those in need. For those behind me, I would invite any of these groups following my testimony to work with me to address these concerns and to explore other possible avenues to maximum use of these resources. So in a nutshell, you know, I know many of you deal with budgets. You've been, prior to even coming here, you were dealing with budgets. You're running hospitals. We all have experience in dealing with budgets, but I'd be...I think it's incumbent on us that we look at all avenues available, and what I'm saying here today is we look at the avenue available, we discuss it like we would anything else, like we would the prior bill or the prior bill or the prior bill, and say is there good and bad, can we come together and find some opportunity to do the right thing? And I do believe in my heart that we need to explore this a little bit more. And I would tell you, and I would encourage any of you to help me, if we do find along the way that this would be detrimental, I of course would not pursue this bill. So with that, that was my intent of this bill. We're, I'm sure, you know, we're going to hear some things against it. And I apologize, quite honestly, I'll be honest with you, I wanted to talk to some people before and I talked to a few people before of my intentions and it was very difficult being the nature of new bill introductions and just the busyness that we've had that I wasn't able to convene any meeting. But my intent is, after today, to try to get some people together and see if there's some common ground we can find for a long-term solution. Thank you. [LB661]

SENATOR STUTHMAN: Okay. Thank you, Senator Gay. Are there any questions of Senator Gay? Senator Howard. [LB661]

SENATOR HOWARD: Thank you. Thank you, Senator Stuthman. Well, the first question that comes to my mind is why are we doing this now before the other bill has even gone into effect? And I'm sure you're ready...I mean, you expect this question. [LB661]

SENATOR GAY: Well, the other bill has gone into effect. We've passed it... [LB661]

SENATOR HOWARD: But they... [LB661]

SENATOR GAY: ...and it just takes time to set up the board. My understanding, talking to Director Chaumont, is the board is being set up and it will take place. We didn't want to rush into it. So it takes awhile to get the board together. You contract this out and then that's how it works, say. [LB661]

SENATOR HOWARD: Well, I can understand that, but the question goes back to why are we going to change this already? We don't even have the other up and running. [LB661]

SENATOR GAY: Well, we're in the process. The reason why, quite honestly, is because we're at a budget. There's opportunities that we're working together on and one was just two, three bills prior to find funding solutions because I don't think we have the funding solutions to...we've got a...you know, a lot has happened between when that passed and where we're at now. We had a complete meltdown of the financial system. We're all...we're in this budget crisis and we're getting all these federal stimulus dollars for two years. But I think this is a thing to look at now to implement policies while we're doing it and to say, hey, we can do this. But in order to wait and do it at some other time, maybe we will, I don't know, but I think now is the time to do it. This was specifically taken out, quite honestly,... [LB661]

SENATOR HOWARD: I remember that. [LB661]

SENATOR GAY: ...by myself and Senator Lathrop, because we didn't want to fight that fight. I knew exactly what I was doing when I took it out and I know exactly what I'm doing bringing this together. But I felt that it was the proper policy to start with and, now that we're doing that, I'd be remiss if I didn't come back and revisit this issue. And that's what I'm doing this year. [LB661]

SENATOR HOWARD: So it comes down to the one money...the one word. [LB661]

SENATOR GAY: It comes back to a lot of things, you know, dollars and...but it's not just the dollars, of course. Like I just said, if that were strictly the case, you know, that's not what I want to look at. I want to look at how we could maybe work together and get something done. But it's just, you know, it's a tough, tough deal. But saving money is not easy. It's easy to spend money; it's hard to save it, so. [LB661]

SENATOR HOWARD: Thank you. [LB661]

SENATOR STUTHMAN: Thank you. Senator Campbell. [LB661]

SENATOR CAMPBELL: Thank you, Senator Stuthman. That was part of my question because, as a new person, I didn't quite know that. The other thing is just really kind of a statement. Maybe as we take a look at this, we need to take a look at the other states that have developed formularies. And the only reason I say that is because my sense of psychotropic drugs and all the others that go with it, that's...it...oftentimes they work with a particular person but not the next person, and they aren't quite as interchangeable. So I just think we might want to look at that part of it when you do some more research on this. [LB661]

SENATOR GAY: Yeah. And if I could follow up a little bit, just in the time of when I've introduced the bill till now, I mean I think there are things that possibly could happen. Partly could be that psychiatrists would be able to issue...you know, there has to be flexibility. They could issue more because they're trained along the way much more than maybe a family physician would be. I'm looking for expertise from you all too. One thing, though, Senator Campbell, and this is my bill, of course, and I don't mean to...and of course I can't because we all have equal standing here in putting...but I'm looking for help. If we find out this is not the way to go, of course, I'm not going to continue to push it, but I think it's something we owe it to our colleagues when we go out to the floor and we're going to ask for opportunities in the future. This year, we're going to ask for opportunities in spending. And you know, if we don't get it from somewhere, we have a tougher fight ahead of ourselves. So maybe if we work together we get more done. [LB661]

SENATOR STUTHMAN: Senator Gloor. [LB661]

SENATOR GLOOR: Thank you, Senator Stuthman. And I think your preamble was well-spoken, Senator Gay. I mean, there are some difficult decisions in saying yes and no to a number of things. I also appreciate knowing, as a freshman to all this, that there's maybe opportunity to sit down and relook at this. I would say that the one unknown question for me is I'm not sure where we're at with making final decisions on purchasing pools, because I think we can come to some agreements but, depending upon who is operating the purchasing pool on our behalf and how they operate that purchasing pool, we can take and have a lot of handshakes and agreement on things but if they're incentivized...and I should say that in helping put together an HMO in central Nebraska, coming up with preferred drug lists was one of the most complicated and involved processes we went through. But we were able to do it, but we controlled it ourselves as a medical community. If we'd a had a third player in there, it would have been a lot more complicated. And so that piece may be the one that we have to spend some time talking about, is the purchasing pool that we utilize as part of this. They're incentivized just by way of dollar savings. That could be a complicating factor. [LB661]

SENATOR GAY: And, yeah, and you know that's a good point. But when I look at the way I do business, I guess, is I look at your expertise and you have that. And, Senator Campbell, you've been on the Medicaid Reform Council. You know, there's a reason why you're on the Medicaid and long-term care subcommittee, to look at the expertise we have and make that decision of where we go. Like I say, there's a part of this is...I'm no expert either, by any means. I rely on information we're getting and if we can pull people together. The prior bill we just heard was changed, you know, fairly quickly here and we need to get together and say, well, now where are we going, how does this all work--very complex stuff. I don't think this gets done without a lot of people sitting down at a table and saying...hammering it out and say, oh, that could work. But let's just don't say no before we even heard the whole story. [LB661]

SENATOR GLOOR: Point well made. And I'm not an expert either but I'll help, if I can be of help to you. [LB661]

SENATOR GAY: Thanks. [LB661]

SENATOR CAMPBELL: I think we're already enlisted. [LB661]

SENATOR STUTHMAN: Okay, thank you. Any other questions from the committee? Seeing none, thank you for your opening. [LB661]

SENATOR GAY: Thank you, Senator Stuthman. [LB661]

SENATOR STUTHMAN: We will now listen to the proponents. How many proponents do we have on this bill? One, two. How many in opposition? Two? No, more than two. [LB661]

SENATOR HOWARD: No, that's more than two. (Laugh) [LB661]

SENATOR STUTHMAN: Nine, ten, eleven maybe. So would the proponents come forward, please. We would like to take care of this bill within an hour so we will allow you to have your allotted amount of time, Director Chaumont. Welcome again. [LB661]

VIVIANNE CHAUMONT: (Exhibit 2) Thank you. Good afternoon, Senator Gay, Senator Stuthman, 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'm the director of the Division of Medicaid and Long-Term Care for the Department of Health and Human Services. I'm here to testify in support of LB601 (sic). This is actually a bill that maximizes funds. Last legislative session, LB830 required the department to establish a preferred drug list for the Medicaid Program, a PDL. A PDL provides a selection of therapeutically effective drugs for which Medicaid will allow payment without prior authorization. These drugs are considered preferred within a specific therapeutic class. Drugs that are nonpreferred are

available through prior authorization. The PDL process is intended to give preferred status to drugs which have safety, efficacy, or cost advantages over other similar drugs. It's important to recall how the process will work. A committee of physicians, many of them specialists and pharmacists, will be gathered. These professionals will extensively review the medical literature for each class of medication. Advantages and disadvantages of each medication within a class will be analyzed. If two products are found to be very similar, have equivalent efficacy and safety, then cost will be reviewed. Cost is not the only factor that will be used to determine if a drug will be preferred. Preferred simply means that it's preferred. It does not mean that nonpreferred drugs will be eliminated. They will still be available. Information regarding rebates available to the state is confidential and, therefore, not readily available. For this reason, although prescribers are aware of safety and efficacy issues, they do not know which drugs are most cost-effective for the Medicaid Program. By giving the more cost-effective drugs preferred status, a PDL assists prescribers in determining which products within a given class are the best value for the state. If there's a medical reason why a less cost-effective, nonpreferred product is necessary for a patient, there is a process available to prescribers to request exceptions. You should also remember that the original legislation, and that's not changed by this legislation, has a grandfathering-in clause for people who are stable and doing well on a certain drug regimen. The department is in the process of implementing the PDL required by last year's legislation. Currently, antipsychotics, antidepressants, and anticonvulsant drug products are excluded from the PDL. These three drug classes account for approximately one-third of Medicaid prescription drug expenditures, or about $46 million annually. Approximately 92 percent of dollars spent in these three categories are for brand-name products. Because these classes consist of mostly brand-name products, these classes account for nearly 40 percent of all brand-name drug expenditure. The savings generated from the supplemental rebates and market shift due to inclusion of these products on the PDL will be even greater on average than for other classes of drugs which a greater proportion of generic products. You don't get rebates on generics. A Mercer study of the Nebraska Medicaid Pharmacy Program estimated potential savings to Nebraska of $8.5 million to $9 million total funds, so that would be about $3.4 million General Funds, for implementation of a PDL containing all drug classes and collection of supplemental rebates through participation in a multistate purchasing pool. Excluding these drug classes reduces the potential savings by about $1.4 million in General Funds for one year. Passage of LB661, therefore, increases the savings associated with the creation of a preferred drug list by about $1.4 million in General Funds. These savings could be used to fund LB346, the bill which would establish a hot line and a program relating to children's behavioral health. Currently, there are 45 states with PDLs in place. Nebraska is one of the five currently without a PDL. A survey was done by department staff of all states, which resulted in responses from 35 states with PDLs in place. Of the 35 states responding, 21 have at least 1 of these drug classes on their PDL and none reported any serious issues resulting from their PDL processes. This past week, pharmacy staff reviewed the PDLs on the Web sites of 33 states.

Anticonvulsants were included on 24 of the 33 PDLs, antidepressants on 28 of the 33, and antipsychotics on 22 of the 33. The department believes that all these classes can be successfully added to the Nebraska PDL and expects that the Pharmacy and Therapeutics Committee, which is a committee that will establish the PDL, will be able to develop criteria and processes to assure appropriate use and adequate access to all three classes. You may hear today testimony in opposition about studies done which indicate that PDLs increase hospital and physician visits. This morning, I looked on-line and found studies of the PDL programs in three different state Medicaid Programs. The studies found no significant access barriers to medically necessary medications, no discernible difference in emergency room visits, medications, and no discernible difference in emergency...oh, sorry, the emergency room visits, hospital visits and physician visits. None showed an increase in medical costs as a result of implementation of a PDL. Of the three states referenced, one includes anticonvulsants, antidepressants, and antipsychotics. I did find one study indicating otherwise. That study was done by one of the major drug companies. LB661 would increase the collection of supplemental rebates and result in a significant savings to the department. The estimated savings of $1.4 million in General Fund would provide funding for LB346. Therefore, the department supports this bill. As to the question, Senator Gloor, about the purchase pool, you establish the PDL first. The purchase pool entity has nothing to do with establishment of the PDL. I'm happy to answer any questions. [LB661]

SENATOR STUTHMAN: Thank you, Director Chaumont. Are there any questions? Senator Howard. [LB661]

SENATOR HOWARD: Thank you, Senator Stuthman. Vivianne, could you explain to me what these...how does this rebate system work? I hear about this and I don't really know, but I...it seems to me like that's information we should know more about. [LB661]

VIVIANNE CHAUMONT: Sure, I'd be happy to, as much as I know. On federal laws, Medicaid federal law, does not allow the Medicaid Program to pay for any drug for which a rebate is not available, other than generics for which, I mean, for a brand-name drug for which rebates are not available. So states...there's, I guess, a list of, you know, what rebates each drug company has for its brand-name drugs. What...so we purchase a certain amount of drug A and then you send the invoice to the drug company and they say, okay, it's, you know, 10 percent of what you...and they refund it back to the state, which of course costs...cuts the cost of the state's, you know, use of drugs. What really happens in a PDL, preferred drug list, is that you say...you go through the process and you pick out the drugs that need to be on there, and if two are the same and one of them you get a, you know, let's say $100 bucks with a 15 percent rebate and another one is $100 bucks with a 5 percent rebate, you put the--and they're the same otherwise, you know, efficacy and all of that--you put the $100 bucks with the 15 percent rebate into the PDL. Well, soon as you do that, you know, usually what actually happens is that the drug company that offered the 5 percent says, we'll put you on 15 percent, too, if

you... [LB661]

SENATOR HOWARD: They'll match it. [LB661]

VIVIANNE CHAUMONT: ...if you'll put us on the PDL. And then you put them on the PDL and then the purchase pool. So that's kind of how that works. What the purchase pool does is it does...it does the Wal-Mart approach to purchasing. If you get a bunch of people together, you have better buying power, you've better negotiation over what rebates, what percentages are offered. So once you have established that PDL then...and you can't join a purchase pool unless you've established a PDL, then states join together and amass their purchasing power and then can negotiate higher rebates with the drug companies. [LB661]

SENATOR HOWARD: So based on that, you can change what you put on the listing, on the PDL list, from time to time based on... [LB661]

VIVIANNE CHAUMONT: Oh sure. We change it all the time. [LB661]

SENATOR HOWARD: ...based on...okay. [LB661]

VIVIANNE CHAUMONT: Uh-huh. [LB661]

SENATOR HOWARD: Well, that's...so it's just an ongoing process kind of... [LB661]

VIVIANNE CHAUMONT: Uh-huh, absolutely. [LB661]

SENATOR HOWARD: ...with that information. Thank you. [LB661]

VIVIANNE CHAUMONT: Absolutely. [LB661]

SENATOR STUTHMAN: Any other questions from the committee? Senator Campbell. [LB661]

SENATOR CAMPBELL: Thank you, Senator Stuthman. Ms. Chaumont, I just wanted to say thank you because you answered the question in terms of the statistics and that's helpful to know. And then it doesn't appear as if there's one that...one of the drugs that's just on everybody's list. It's just like they're all three kind of divided. [LB661]

VIVIANNE CHAUMONT: Uh-huh. Uh-huh. [LB661]

SENATOR CAMPBELL: Would you say that's an accurate observation? [LB661]

VIVIANNE CHAUMONT: It's an accurate. What also I think is happening as these PDLs,

I mean initially, another response to the PDL was, you know, it's going to be the most awful thing and, you know, people weren't going to get any drugs. I'm not talking about mental health drugs; I'm just talking about any drug. That was a bit of an overreaction. So now that things are going well, and with the budget crisis the way...going, more and more states are going with PDLs and more and more states are moving to add products that they had previously not included, like, you know, some products that they haven't included, are moving to add more. I've seen that, to add more products too. The list of exceptions is...I know California covers all drugs on their PDL, for instance, except HIV and cancer drugs. [LB661]

SENATOR STUTHMAN: Okay. Thank you. [LB661]

SENATOR CAMPBELL: Thank you. [LB661]

SENATOR STUTHMAN: Senator Gloor. [LB661]

SENATOR GLOOR: Thank you, Mr. Chairman. [LB661]

VIVIANNE CHAUMONT: I'm sorry, one more thing. And a lot of those states don't have grandfathering clauses, which we have. [LB661]

SENATOR CAMPBELL: Oh, okay. Thank you. [LB661]

VIVIANNE CHAUMONT: Sorry. Pardon me. [LB661]

SENATOR GLOOR: That's fine. Ms. Chaumont, I need a little further explanation. Have we made a decision yet about which purchasing pool we want to be part of? [LB661]

VIVIANNE CHAUMONT: No. You have to establish the PDL first. And, you know, I wish it was faster because I'm not the most patient person in the world, but first of all we had to... [LB661]

SENATOR GLOOR: But you are creative. [LB661]

VIVIANNE CHAUMONT: What? [LB661]

SENATOR GLOOR: But you are creative. (Laugh) [LB661]

VIVIANNE CHAUMONT: Yeah, right. (Laugh) We established that. First of all, we had to hire a pharmacist. We have a great pharmacist, I think, working with us now. We had to draft an RFP and we've awarded that RFP and are in the last stages of negotiating with that company. First Health was awarded the RFP and so they will be then, once they get the contract, then they'll start the work of getting the physicians and I think that

they're listed in the original, in LB830, you know, how many of these and that you have to have. So they'll start that work and then, I mean, that's what they do. They sit around a table or, you know, read all of this thing and decide from there, from the material, the professional material and their own experience, they pick the drugs then. [LB661]

SENATOR GLOOR: It's interesting you should have used the example of Wal-Mart when you talk about purchasing pools because there are, as it relates to purchasing pools, in my experience, Wal-Mart purchasing pools that are absolute and... [LB661]

VIVIANNE CHAUMONT: Uh-huh. [LB661]

SENATOR GLOOR: ...and rock bottom, if I can use that comment without being overly disparaging of the Wal-Mart Corporation, as opposed to some that are a little more lenient. [LB661]

VIVIANNE CHAUMONT: Uh-huh. [LB661]

SENATOR GLOOR: And to me, the decision that's made about a purchasing pool is going to go a long way towards assuring some quality concerns that people have. [LB661]

VIVIANNE CHAUMONT: Uh-huh. [LB661]

SENATOR GLOOR: You know, to be members of purchasing pools, you have to be compliant to a certain percent... [LB661]

VIVIANNE CHAUMONT: Uh-huh. [LB661]

SENATOR GLOOR: ...and some just don't have any wiggle room. No matter what the committee says, the purchasing pool can and often dictate whether you're going to get the level of discount you want if you're compliant, and sometimes it's close to 100 percent compliance, sometimes there's some wiggle room. So the decision about making that purchasing pool decision is a pretty important one. [LB661]

VIVIANNE CHAUMONT: Right. The members of...there's four...currently...I can't remember. I'm sorry, I just blanked if there's three or four purchasing pools currently. In the four...three or four that we're talking about, the members are only state Medicaid Programs, so. [LB661]

SENATOR GLOOR: Three, I think. [LB661]

VIVIANNE CHAUMONT: Three, yeah, I think you're right. I'm sorry. [LB661]

SENATOR GLOOR: On this sheet it's...and NMPI, TOP$, and SSDC, TOP$ with an S with a slash through it to look like a dollar sign. So I would imagine that could be the Wal-Mart. [LB661]

VIVIANNE CHAUMONT: That could be a typo. No. Oh, I'm sorry, it isn't. [LB661]

SENATOR GLOOR: It's not Wal-Mart? [LB661]

VIVIANNE CHAUMONT: Oh, no. No, Wal-Mart is not. I mean I... [LB661]

SENATOR GLOOR: No, no, no, no, I'm just using that as a... [LB661]

VIVIANNE CHAUMONT: Yeah, right. [LB661]

SENATOR GLOOR: ...allegorical. [LB661]

VIVIANNE CHAUMONT: Yeah. No, I think they're about the same. Some of the administrative costs and things, some of the...what's the right word, transparency of the different pools is why states choose to go to different places. But, you know, my understanding is that the purchase pool negotiates the rebate, and what actually is on the PDL is each state determines what's on its PDL. [LB661]

SENATOR GLOOR: Okay. [LB661]

SENATOR STUTHMAN: Okay. Senator Howard. [LB661]

SENATOR HOWARD: Thank you, Senator Stuthman. Senator Stuthman has urged me to make this quick. (Laugh) It's moving it along. So I'm not going to belabor this but since we're so diligently looking at the cost containment for drugs for adults, I again urge you to look at the psychotropic drug issue regarding the state wards. And you and I have talked about this. [LB661]

VIVIANNE CHAUMONT: Right. It's on the DUR agenda for the next meeting and it has been discussed on the DUR... [LB661]

SENATOR HOWARD: I appreciate that. [LB661]

VIVIANNE CHAUMONT: ...at the DUR. So I think it's a... [LB661]

SENATOR HOWARD: And specifically the psychotropic. [LB661]

VIVIANNE CHAUMONT: It's for the...yeah, the antipsychotic use in children. That's what's in the DUR board. It's a journey with them but I just saw the agenda before

coming over here. [LB661]

SENATOR HOWARD: Good. Thanks. If you can keep me informed, I'd appreciate it. [LB661]

VIVIANNE CHAUMONT: Uh-huh. Uh-huh. Sure. [LB661]

SENATOR STUTHMAN: Okay. Any other questions? Seeing none, thank you, Director Chaumont. [LB661]

VIVIANNE CHAUMONT: Thank you. [LB661]

SENATOR STUTHMAN: Any other proponents? I thought we had one more. [LB661]

SENATOR HOWARD: No, maybe she's not. I think she made a mistake. [LB661]

SENATOR STUTHMAN: I did? Okay. Okay, now we will listen to the opponents, the opponents. Good afternoon. [LB661]

CHERYL BUDA: (Exhibit 3) Good afternoon. I am Dr. Cheryl Buda, C-h-e-r-y-l, Buda, B-u-d-a. I am here on behalf of the Nebraska Psychiatric Society and the Nebraska Medical Association. We both are strongly opposed to LB661. I circulated a letter and I want to read some of it because I think this is a very crucial bill and a bill that needs to take a lot of consideration. There's a lot of details about this bill that need to be completely understood. Number one: Medical illness...mental illness is a medical illness and it is important that we do not "demedicalize" mental health. Treatment of mental illnesses most often require the use of medications. The core treatment is medications. And we cannot begin to develop an effective treatment plan for an individual with serious mental illness if all available medications are not considered as options. It is only through experience, training, and knowledge that the right medications are prescribed, and oftentimes, especially in the psychiatric population, multiple medical trials needs to be done. People that prescribe these medications take into consideration many things and it's just not cost. As a doctor, we look at the side effects, risks, benefits, alternatives, family history, comorbid medical conditions, and cost as well. Number two, this is a very important part: The Medicaid population with mental illness is a population that clinically seems to be the most ill of the ill. This is a very vulnerable population, a population that has multiple medical problems typically, multiple mental diagnosis typically, and often needs many social health needs. Again, cost can only be part of that decision. It cannot be the main part. It is very easy, I would think, to do a study to say if you use this med versus this med, because we know that there's very, you know, there's cheap meds and there's expensive meds, and unfortunately the expensive meds are what my population needs. And so you can do a study and say we're going to save this much money by, you know, using these cheaper meds, but I

think that you need to look at what are the downstream costs of this. If you do not allow medical providers to choose individual treatments for their patients, what are the possible consequences? There is a considerable spillover expenditure for other parts of the Medicaid system. How do you measure the cost of failed marriages; dysfunctional families; failed parenting; child and adolescent problems, as seen in the safe haven; academic problems; drug and alcohol abuse and treatment; the spillover on to the criminal justice system; homelessness; failed jobs leading to unemployment, Social Security disability? These are very expensive things. You also...and I mean I personally see this every single day because I treat mental illness every single day and I prescribe these medications every single day, that if you're not truly, fully, completely treating someone, they're in the hospital more. I mean I don't need to do a study of that; I know that. They're in the hospital more. They're having longer stays. They're repeat hospitalized patients. They're longer partial programs. They...if they're not in the hospital, they're seeing me every few days. They go to the ER a lot. They have psychotic breaks. They can become suicidal, homicidal. These are the things that we need to look at. And it is very difficult to do a kind of study to figure out that cost, but I would, you know, bet that if you figured the cost of all these things, it would far outweigh the cost of these medications. Number four: Access to quality mental health is important and I fear that if this bill passes there is going to be significant administrative things that a psychiatrist or doctor is going to have to do. And you know what? You know, medical or Medicaid reimbursement is already low and if you're going to force doctors to kind of figure out what meds they need and have to fill out prior authorizations or do any kind of step therapies or anything like this, I fear that, you know, some doctors are not going to continue to treat Medicaid patients. Our patients cannot afford to relapse and they cannot afford to have the cost shifted from the system to them. Maine Medicaid instituted a prior authorization and step therapy for atypical antipsychotics and that program was suspended because people were having acute psychotic episodes. They showed that they were in the hospital more. We should learn from these things. Nebraska's current policy to make all or substantially all of these medications available is based on the Medicare Part D language. These medications should be available to this vulnerable population and anything less than this is not quality care. I know this can be an overwhelming task to try to save money, but I think that the final thing of this all is if you do not stabilize a mentally ill patient, if you do not provide them with the medications that a doctor, who has gone to school for so long and has tried these different combinations, what they prescribe, if you do not allow them to do that and put stipulations on those things, then all the fancy programs and all the things that we're talking about today are not going to mean anything. We need to, you know, individualize the treatment and provide the medications that we need for our...this population. So that's it. [LB661]

SENATOR STUTHMAN: Thank you, Dr. Buda. [LB661]

CHERYL BUDA: Uh-huh. [LB661]

SENATOR STUTHMAN: Thank you for your testimony. [LB661]

CHERYL BUDA: Sure. [LB661]

SENATOR STUTHMAN: Are there any questions from the committee? Dr. Buda, it seems that, you know, with your experience and your practice, mental illness can be escalated by improper medication, correct? [LB661]

CHERYL BUDA: Yes. [LB661]

SENATOR STUTHMAN: And it could develop into a bigger problem of mental illness if... [LB661]

CHERYL BUDA: Absolutely. You know, when I see a patient in my office for the first time for an hour, by that end of that hour I have a very good understanding of what med I think they're going to need because I've tried these medications in patients. I've seen the actual results. I've tried different combinations. So by the end of that time I meet someone, I have a very good understanding of what med I would prefer, if that was my family member what med I'd want them to be on. So, you know, and it's important to understand that, like Senator Campbell said, one medication in one person does not work necessarily the same way in another person. And so psychiatrists and doctors and other professionals that prescribe these meds, they need to be able to individualize the treatment. Because if you're not able to do that, you're not providing the adequate care you need to do for this vulnerable population. And in my practice, my Medicaid patients, they're the sickest and they require the most time and they're the most complex and they're oftentimes on multiple medications, including antipsychotics augmented with mood stabilizers or antidepressants. It's, you know, it's just so important that, you know, you can individualize that. [LB661]

SENATOR STUTHMAN: And, Dr. Buda, do you feel that if you have a list of drugs that, you know, you have to utilize on that Medicaid individual and it's not the right one, it's going to create more problems? [LB661]

CHERYL BUDA: Absolutely. I would feel sorry for my patient in the fact that I know this med is not going to work for you, or you're going to have these side effects. I know that because I've seen it, but we've got to do it anyway and we got to have you fail it and we have to play the game so that we can try to get the meds that I eventually know that you're going to need. And I feel that putting that off and not doing the right med at the right time immediately is detrimental. You know, I've always been taught in...as a psychiatrist that you get that person with mental illness into remission ASAP, because the longer that you allow someone to be psychotic, the longer you allow someone to be depressed or anxious, their outcomes long term are much worse 100 percent of the

time. So I, you know, my goal is to get the right treatment for that patient immediately, which is going to save money down the road. Okay. [LB661]

SENATOR STUTHMAN: Thank you, Doctor. Any other questions? Seeing none, thank you for your testimony. [LB661]

CHERYL BUDA: Thanks so much. [LB661]

SENATOR STUTHMAN: Next testifier in opposition. [LB661]

TOPHER HANSEN: Senator Stuthman and members of the committee, I'm Topher Hansen and I am the president of the Nebraska Association of Behavioral Health Organizations and am executive director of CenterPointe. First name is T-o-p-h-e-r, Topher, last name Hansen, H-a-n-s-e-n. The NABHO has come out in strong opposition to this bill and I guess the place to start out is just where the doctor just delivered us information. The question is foundational: Do we have the experts? And if we're looking at the other states, in my mind, that's not the experts. The experts are the people that are delivering the service and we need to understand what the true issues of care are at the ground level as it impacts consumers and their care. Again, we come up against the cost versus care issue, and those things will always live in a dynamic tension but we have to err toward the side of care first and then cost. And if what we're doing is orienting ourself toward cost all the time, what we'll sacrifice is care and people get worse and ultimately you'll pay more. If what you do is err toward the side of care and then figure out creative ways to pay for essential care, then you will save money in the long run. And again, I would suggest and urge you to look at the true experts in telling how this impacts the world of consumer care and psychiatric medicine. Let me, too, because this says it far better than I can, just read a couple of paragraphs to you from a report in the American Journal of Managed Care from September 2005, and it's about atypical antipsychotics, considerations for Medicaid coverage. And they talk about all states follow one or more of the following restrictive policies: need for prior authorization, encouraging use of generic drugs, use of preferred drug list, fail-first policies, and defined limits on coverage. And they suggest that then that is the beginning of a friction, if you will, that slows people down and causes people to choose another avenue. What they say in conclusion is budgetary pressures in Medicaid Programs could result in restrictive drug coverage policies that ultimately cost the patient and society far more than the amount saved. The single most important consideration for patients with psychotic disorders is that costly hospitalization can be avoided by improved compliance with antipsychotic pharmacology, and compliance improves their tolerability. So if the drug being prescribed for them they tolerate well, they are more likely to comply with it and less likely to have higher cost hospitalizations. The risk of relapse in patients receiving antipsychotic pharmacotherapy is more a function of noncompliance than of the intrinsic limitations of the drugs prescribed. Financial pressures on private insurers, Medicaid, HMOs, and starting in 2006 Medicare

are driving new questions about the effectiveness and appropriate use of atypical antipsychotics. A strong case can be made that restricting physician and patient choice and proper access...and that doesn't mean that they're not available at all. It means just what the doctor said. You create that little bit of friction where they're going to say, not going that way, going to choose this one because it is easier, faster, I don't have to go through the red tape, whatever, whatever, whatever. So choice and proper access to these agents will not only reduce the quality of life for persons with severe mental illness but, in the long run, increase the cost to government and private insurance plans. This is from a Journal of Managed Care. These are people who are interested in managing cost as it relates to healthcare, and I would suggest that sources such as this--and in fact, I'll leave it with the clerk--sources such as this and others that really involve the people who are at the ground level, involved with patients and making these kinds of decisions work. Senator Campbell, your point is precisely the issue. In psychiatric medicine, there's not only the technical ability to prescribe. There's an artful ability to prescribe because every person is different, and the doctor noted that exactly; that what works for one doesn't necessarily work for another and they need the full panoply of options in order to find the right one for the right person. Otherwise, what we see is an increased cost in hospital care, crisis centers, and so on. So to invest our money wisely I think is a good idea but we've got to look at the care issue first. It is a philosophical difference that you're hearing the provider group come up with versus what the state's putting forward, which is let's think cost first and how it relates to care. These provider groups are saying, let's think of our care model first and then creative ways to fund. And I say, if you go look at that model of the care versus cost, you will find that it saves more money in the long run because people are not experiencing higher levels of care and quality of life is improved. [LB661]

SENATOR STUTHMAN: Okay. Thank you, Mr. Hansen. [LB661]

TOPHER HANSEN: You're welcome. [LB661]

SENATOR STUTHMAN: Any questions from the committee? Seeing none, thank you for your testimony. [LB661]

TOPHER HANSEN: Thank you. [LB661]

SENATOR STUTHMAN: Next testifier. [LB661]

BOB NEVE: Even though I see Senator Gay has apparently run away, I would like to thank him for his comments earlier. I very much prefer to like people rather than dislike them, and his comments very much helped me to like him a little better than before. My name is Bob Neve. I'm a mental health therapist and executive director of the Clearview Center in Omaha. I have a master's degree in mental health counseling and currently working on my second master's degree in clinical counseling. I was recently hired to

teach psychological assessment at Bellevue University this fall. I'm certified by the state of Nebraska as a LADAC and a PLMHP. I'm in private practice with counseling specialities in trauma, addictions, and depression, as well as career and relationship life coaching. I'm also a contract employee at Family Foundations, an agency whose primary scope of practice is working with individuals and families with developmental disabilities, severe mental illnesses, and severe behavioral problems. I'm past-president and...past-president of and currently advisor to the three Depression and Bipolar Support Alliance chapters in Bellevue and Omaha. And I'm currently secretary on the board of directors for the Bellevue Chapter. DBSA, formerly known as DMDA, is a nonprofit, self-help support organization with about 800 chapters in the United States and six other countries. These chapters run about 2,000 support groups for people who suffer from major depression and bipolar disorders. We know that a bill introduced in the committee by the Chair of that committee is very likely to stay alive. We know this bill will never have...would never have passed if it weren't for adding the exception that you now propose to eliminate. Why is that? Because smart people knew that spending more money would prevent bad things from happening; because conscientious people knew that the measure of greatness of a society is how well they take care of their orphans, widows and other vulnerable people, specifically people on Medicaid. Let me jump directly into the future to propose to you what the result will be based on what my clients have told me about their experiences and my and my colleagues' research. By my estimate, there will be about 5,000 to 10,000 people who will be directly affected by this bill and your considering not spending $1,000 or $2,000 a year on them, money that would very possibly prevent acute and subacute long-term hospitalization. New clients will be prevented by the bureaucracy from finding new medications to stop their mental and emotional pain. They'll be angry because they won't have the money to buy the new medication. They will start drinking more alcohol or they'll go to 17th and Nicholas in Omaha and buy meth and marijuana in an attempt to self-medicate. Some will find temporary relief there. Some won't use illegal drugs so they'll return to the state of mental and emotional anguish and confusion and horror that they were in before they found the new medication. The dark, uncontrollable voices remind them that they are stupid and shouldn't be alive. Their uncontrollable thoughts will repeat: Why is this happening to me? I'm so alone. Make it stop. God, why have you abandoned me? It's too late, just too, too late. There's nothing anyone can do. I wish I was dead. God, why are you doing this to me? How can this be happening? I can't do anything right. Why am I so weak? Why am I such a coward, hopeless, helpless, worthless, guilty? Imagine, Senators, if you were trying to put words together to persuade your fellow senators to vote for this bill but all that came out of your mouth was gibberish, and you knew it was gibberish but you couldn't seem to do anything about it. It's not uncommon for schizophrenia to stay dormant in your genetically predisposed brain for years and then emerge after one intensive stressful incident or after many years of average stress. Imagine if one day you are bright and eloquent and persuasive, and a few months later you realize you spent your entire retirement fund in a mania, in a few weeks on cars and clothes that you didn't need and now don't want, and now you don't see any reason to

live or to ask for help because you think there's nothing anyone can do. Imagine, Senators, if your children suddenly started showing signs of depression or bipolar disorder or schizophrenia and, rather than embarrass you, they ran away, never to be seen again. They'll end up in another state with an unknown identity being treated in a state hospital or badly regulated, poorly trained community centers. But we can always hope they'll end up at a state that has Medicaid that pays for the medication they need. To avoid these results you will create a fast-track approval system to get new meds on the PDL. We don't believe it will happen or, if it does, we believe it won't work efficiently. Finally, this attempt to save money in prevention will cost more in acute and long-term patient care. And I'll kind of skip because we've kind of covered that. But don't worry. The best doctors, therapists, and social workers out there are already preparing to cleanup the mess this bill would cause. My sincere hope is that you'll drop this bill in this committee and find other less painful, less horrific ways to save money in the Medicaid system. Thank you. [LB661]

SENATOR STUTHMAN: Okay. Thank you, Doctor. Is it Doctor? [LB661]

BOB NEVE: No. [LB661]

SENATOR STUTHMAN: No. Okay, Bob. Any questions from... [LB661]

BOB NEVE: Oh, I'm sorry, Bob N-e-v-e. Go ahead. [LB661]

SENATOR STUTHMAN: Yes. [LB661]

SENATOR GLOOR: Thank you, Mr. Chairman. Mr. Neve, there is a growing concern that I have, contrary to all the discussions people have had with me prior to this meeting, that there is some serious confusion about what we're talking about here and it became even more evident to me when I went out and talked to Ms. Chaumont afterwards. She didn't even understand part of what I was talking about. Would it bother you at all if every medication you and your association could possibly think of were on a list that got a discount? Other words, if you could order everything that you wanted to but it was on a list and the state got a discount, would that bother you for...? [LB661]

BOB NEVE: No, not at all. It'd be great. [LB661]

SENATOR GLOOR: That's what we're talking about, in part. We are talking, in part, about joining a purchasing organization and, as a result of joining a purchasing organization, you get discounts. I belong to Sam's Club. I go to Sam's Club sometimes not sure I'm really getting a discount, but that's the intent--this seems to be Wal-Mart day, by the way--because I'm part of... [LB661]

BOB NEVE: Right. Uh-huh. [LB661]

SENATOR GLOOR: ...that organization. And so when I talk about my concern about making sure that we pick the right purchasing organization to be part of, that's one of the reasons, because there is a possibility everybody in here will be happy because we've made the decision to join the right purchasing organization. Just because you joined a purchasing organization doesn't mean that you've automatically restricted people's access. That's where the PDL that's being put together comes into play. [LB661]

BOB NEVE: If what you put together doesn't restrict access to any medications that are out there, that would be great, of course. [LB661]

SENATOR GLOOR: Sure. [LB661]

BOB NEVE: It doesn't appear that that's the way that it's going to happen in reality. [LB661]

SENATOR GLOOR: Are some of your clients members of BlueCross BlueShield, United HealthCare, other insurance companies? [LB661]

BOB NEVE: I have clients on Medicaid, BlueCross, uh-huh. [LB661]

SENATOR GLOOR: If you don't have concerns about the way they operate their drug formularies and the purchasing organizations they're a part of,... [LB661]

BOB NEVE: Uh-huh. [LB661]

SENATOR GLOOR: ...they do. I mean we...that is commonplace in every part of a third-party payer that we have out there. [LB661]

BOB NEVE: Yeah. Absolutely. [LB661]

SENATOR GLOOR: And so I'm just cautioning people to understand there are a couple of different issues here that we need to keep straight so that we don't get concerned and throw the baby out with the bathwater. [LB661]

BOB NEVE: Oh, absolutely. [LB661]

SENATOR GLOOR: It can be a good thing for all of us if we're part of the purchasing organization. [LB661]

BOB NEVE: And it was very good to hear Senator Gay say in the beginning he'd be willing to talk about other possibilities for this. I'm very much open to that. But I'll also

say this. About 60, maybe 70 percent of my clients are private pay clients because of the payment practices Medicaid has in reimbursing therapists. BlueCross, I love BlueCross. If I have a BlueCross client, I know I'm going to get paid. If I have a Medicaid client, I don't know I'm going to get paid. So I have to restrict the number of Medicaid clients that I see. [LB661]

SENATOR GLOOR: I understand that. [LB661]

BOB NEVE: And again that's, you know, I'd hate to see all good psychiatrists, psychologists, therapists do the same thing that I'm doing. I feel a little guilty for doing that, but nonetheless it's a necessary thing to keep a business going, especially when I'm in business for myself primarily. And we know that the therapists who continue to get Medicaid clients, the best therapists get their own private practice and get their own private-pay clientele. I see my Medicaid clients more, I wouldn't say pro bono, but I kind of know that there are times that I'm not going to get paid for my Medicaid clients, and that's okay because I have my other clients that are paying cash. And so if this bill can get to a point where it's not giving better healthcare to those who can afford it better and very much neglecting people on Medicaid, that would be great. Let's make that a goal. But the way this bill is written, that's not what it says to me. [LB661]

SENATOR GLOOR: Well, and understand with insurance plans, you have people who I'm sure are covered under insurance who have different variations of what they have to pay for the drug pools that they are...or purchasing pools that their insurer is in. [LB661]

BOB NEVE: Uh-huh. [LB661]

SENATOR GLOOR: So you already have some of that stratification going on. [LB661]

BOB NEVE: Uh-huh. [LB661]

SENATOR GLOOR: I also understand and I think we all share a concern that that stratification not be dramatic when it comes to Medicaid patients, that they not be severely limited. [LB661]

BOB NEVE: Uh-huh. Right. [LB661]

SENATOR GLOOR: But being part of a purchasing pool, in and of itself, can be a very good thing for all of us and stretch those Medicaid dollars. [LB661]

BOB NEVE: Absolutely. And let's hope it's better than Sam's Club so we know we're getting a discount. (Laughter) [LB661]

SENATOR GLOOR: That's why I shouldn't have used that as a name. [LB661]

BOB NEVE: Okay. [LB661]

SENATOR GLOOR: Thank you. [LB661]

BOB NEVE: Thank you very much. [LB661]

SENATOR STUTHMAN: Okay. Thank you, Senator Gloor. Any other questions for Mr. Neve? Seeing none, thank you. Next testifier, please. I would also like to read into the record, we have letters of opposition from an individual, Linda Jensen, the Nebraska Hospital Association, Cheryl Crouse, Nebraska Psychological Association, and the Mental Health Association of Nebraska. We have received those letters; wanted to enter that in the record. (See Exhibits 11, 12, 9, 10, and 8.) And good afternoon. [LB661]

LAURA NEECE-BALTARO: (Exhibit 4) Good afternoon. I'm Laura Neece-Baltaro, L-a-u-r-a N-e-e-c-e-hyphen-Baltaro, B-a-l-t-a-r-o. I'm here today in two roles. First and foremost, I am the mother of Elizabeth who spent half of her teen years with uncontrolled seizures, many of them occurring at school and in front of her peers. Secondly, I'm here as an advocate for all Nebraskans with epilepsy. For the past 14 years, I have volunteered with the Epilepsy Foundation of America counseling epilepsy patients and teaching the public about seizures and seizure first aid. What I can tell you from my own experience with my daughter's epilepsy is that it took almost four years of experimenting with six different medications, which I might add were all that were on the market at that point in time, as well as her making lifestyle changes before we finally got her seizures controlled. Only by keeping a detailed diary and carefully charting treatments and circumstances were we able to finally recognize the several factors that were making it more likely that she would have seizures. The most important of those factors was using the proper medication at the proper level and taken with absolute consistency. Elizabeth's neurologist stressed to us that she needed to take brand name and I didn't know why, but he explained that many epilepsy medications are what he called narrow therapeutic index drugs. A narrow therapeutic index drug is one for which the blood level where it works for the patient is very close to the point at which it becomes toxic with uncomfortable and even dangerous side effects. If we were to look at a graph of the blood levels in a patient, the point at which it becomes effective and therapeutic would be here, and the point at which it's toxic would be here, and this narrow range, that's the narrow therapeutic index. The FDA allows generic medications to vary as much as 80 to 125 percent in bioavailability of the active ingredient. That's like saying that a cholesterol level of 160 is the same as a level of 250, and we know that that's not good. That much variability in a narrow therapeutic index drug means that using the generic product from one manufacturer and then switching to the same generic product but from a different manufacturer can lead to either breakthrough seizures or to toxicity. Additionally, generic drugs may also have different coatings and different inactive fillers, both of which may change the absorption rate and the potency

of the medication in a particular patient. I am not against generics. I take generic antibiotics and allergy medications myself and they work well for me. But in the case of epilepsy, the cost of using generic seizure medications is a very high one. Breakthrough seizures, at the very minimum, necessitate at least one and usually more additional visits to the doctor, and a lot of repeated and expensive laboratory blood testing to determine drug levels, to check for anemia, liver function. My daughter called herself the human pincushion during the years when we were trying to get her seizures controlled. Frequently, a breakthrough seizure will also lead to an ambulance trip to the ER and treatment of injuries. When my daughter had a complex partial seizure at a fast-food restaurant, even though we told them an ambulance was not needed, it was their company policy to call one. When it arrived, the EMTs on board, they were already known to us from previous trips to the ER. They were satisfied that her epilepsy was being treated and they didn't argue with us when we said that a trip to the ER wasn't necessary. That trip could have cost us well over $1,000 in ambulance and ER fees. A breakthrough seizure will also cause a person with epilepsy not only to lose their dignity but also to lose their driving privilege for several months, until they are able to regain control. If they have been controlled and have been driving, suddenly becoming uncontrolled means that they endanger the lives of those who ride with them and who share the road with them. The seizures themselves or their lack of transportation may lead to loss of income and even loss of job. Successful treatment of epilepsy requires absolutely consistent drug therapy. Because generics can vary from one manufacturer's product to that of another manufacturer, generics do not provide the necessary control and consistency, and any savings gained from their use will be negated by the cost of the additional medical care required and by the loss of the epilepsy patient's ability to function as a productive member of our society. In the work that I have done with support groups, I can tell you with great certainty that epilepsy patients want to be fully functioning partners in our society. They want to be working. They want to be contributing. They want to be paying taxes. [LB661]

SENATOR STUTHMAN: Thank you, Laura. Any questions from the committee? Seeing none, thank you for your testimony. Next testifier, please. [LB661]

MICHELE JOHANNES: Hi. [LB661]

SENATOR STUTHMAN: Good afternoon, almost good evening. [LB661]

MICHELE JOHANNES: I know I'm tired; you must be exhausted. (Laugh) I'll try to be quick. My name is Michele Johannes, M-i-c-h-e-l-e J-o-h-a-n-n-e-s, and ten years ago I had my first seizure. For the first four years after diagnosis, my seizures were very uncontrolled. I was given different medications in different doses over the four-year period but still averaged about 15 seizures a day. I have simple partial and complex partial seizures, and during my simple partial seizures I do not lose consciousness and I remember every unpleasant minute of them. Auras that accompany my seizures can

sometimes last for hours, making it difficult to concentrate on the tasks at hand. After those many years of uncontrolled seizures, I was finally prescribed a new drug that had recently become available in the U.S. called LAMICTAL. I started taking LAMICTAL as I weaned myself off of a previous medication and within months I was able to go a week with no seizures, and then gradually as my dose increased I could go months with no seizures. Over the years, my LAMICTAL dose has fluctuated. With epilepsy, any small change in lifestyle such as diet, stress or use of other medications, even something as simple as cold medication or antibiotics, can cause your seizure threshold to fluctuate and bring on seizures. I felt like LAMICTAL has given my life back to me. It's a precious thing to be able to be seizure free. I continue...I continue to struggle with lifestyle and medication fluctuations, but I have a drug that works well for me now. After or about four months ago I refilled my LAMICTAL prescription by calling my mail-order pharmacy. The type of insurance that I have requires three months of a prescription if it is mail ordered. I received my medication in the mail, but it was no longer the LAMICTAL I had taken before. Instead, a generic form of the medication had been sent to me. I called the mail-order pharmacy to request that the brand-name LAMICTAL be filled, but they said that my drug had just become available in generic and they were required by the insurance company to fill the prescription with the generic brand. I was not notified of this prior to the prescription being sent to me and, although I did not open the medication bottle, I was still unable to return the item. My insurance company said they would cover none of my costs for the brand name and I would have to pay full cost for it if I wanted to get the brand name from now on. The mail-order pharmacy would also not take the generic medication back or give me a refund, and I paid almost $700 for the generic version of my medication. Because I had recently been hospitalized for my seizures, I did not want to try switching to the generic version of my medication, and I was in a panic and called my doctor who then called in a prescription to a local pharmacy. I picked up the LAMICTAL and paid almost $400 for a one-month's supply. I did not want to have the hardship placed on my family with having such high costs for my brand-name drug, so I eventually tried the generic version. Within a day and a half of using the generic version, my auras had returned and I was not feeling confident in driving and, at times, I felt like I was on the verge of a seizure, kind of like now. (Laughter) Anyways, I am not against the use of generic medications. I think that people should have options for medications because of the cost-effectiveness. However, I do feel that many patients are uninformed, and I run a local support group here in Lincoln, with so many people who come to the group who do not understand what the consequences are with switching medications and manufacturers and the things that can cause the fine line that you walk with medication levels in your system. Any slight dip in blood levels can bring on breakthrough seizures and any increase in the blood level of the medication can cause side effects or toxicity. I have had both of these things happen to me and they're very unpleasant. I think that doctors and patients should have the option of deciding whether they should try a generic version or a brand-name version of their medication. My doctor explained to me that different manufacturers may cause inconsistency in my medication levels. Different formulations of the same drug

can vary from 80 to 120 percent in the therapeutic effectiveness. I believe all antiepilepsy drugs should be nonrestricted. This will ensure that epilepsy patients get the medication from the same manufacturer that they are used to. Their medication level in their system can remain consistent, which is vital for obtaining seizure control. Thank you very much. [LB661]

SENATOR STUTHMAN: Thank you, Ms. Johannes. Any questions from the committee? [LB661]

SENATOR CAMPBELL: Nice job. [LB661]

MICHELE JOHANNES: Thank you. [LB661]

SENATOR STUTHMAN: You might be one of my relatives. [LB661]

MICHELE JOHANNES: Pardon? [LB661]

SENATOR STUTHMAN: You might be my relative. [LB661]

MICHELE JOHANNES: I might be a relative? [LB661]

SENATOR STUTHMAN: Yeah. (Laughter) [LB661]

MICHELE JOHANNES: What are you going to do with the bill? (Laughter) [LB661]

SENATOR CAMPBELL: That just might be the best testimony today. [LB661]

SENATOR STUTHMAN: Thank you, Ms. Johannes, for your testimony. [LB661]

SENATOR HOWARD: That was good. [LB661]

SENATOR STUTHMAN: Any other testifiers in the opposition? How many more testifiers do we have? Any testifiers in the neutral? Okay. Good evening. [LB661]

CONSTANCE ZIMMER: (Exhibit 5) Good evening, Mr. Chairman and members of the committee. I am Constance Zimmer, C-o-n-s-t-a-n-c-e Z-i-m-m-e-r. I'm representing NAMI Nebraska. NAMI Nebraska appreciates the intent of the Nebraska Medicaid Program to lower the cost that Nebraska pays for prescription drugs. However, when LB830 was passed in 2008, the committee and the Legislature wisely included an exception for certain medications, including antipsychotics, antidepressants, and anticonvulsant medications. For those with serious medical...mental illness or co-occurring mental health and other medical conditions, the preclusion of mental health medications such as atypical antipsychotics and antidepressants might be detrimental

and not cost-effective. The European Journal "Encephale" in 2005 reported a three-year study comparing conventional antipsychotics to atypical antipsychotics for patients in France's socialized mental healthcare system. The cost-efficiency ratio per patient successfully treated over three years was $7,108 for long-acting Risperdal, $8,043 for Zyprexa, and $12,585 a year for the older conventional Haldol. The conventional antipsychotic Haldol costs were almost two times the costs for the same period of time when all related costs were factored in. The side effects of Haldol are awful: tardive dyskinesia, constant movements and shaking, drooling, along with confusion, delirium, and others. For persons with mental illness, finding the most effective medications and doses can take multiple trials because effectiveness and side effects vary significantly for every person. While several antipsychotic medications may have equivalent levels of overall effectiveness, they are not equally effective at the individual level. A medication that works well for one person with schizophrenia may not alleviate symptoms for another, or may have side effects that are intolerable, resulting in costly hospitalizations. NAMI members routinely share stories of how they finally came to find a medication or combination of medications that made a difference in living with mental illness. Day in and day out, our experience shows that one size does not fit all. Unfortunately, LB661 would take newer antipsychotics and antidepressants off the preferred drug list, creating barriers for accessing those that are not on the list. Due to both the nature of severe mental illnesses and the shortage of psychiatric prescribers, navigating bureaucratic procedures to obtain needed medications can become insurmountable barriers. This is critical because the unintended consequences and costs of lack of access to the most-effective mental health medications are extremely high: increased risk of emergency department visits, hospitalization, child custody relinquishment, homelessness, and incarceration. My own experience when I was...only had available to me the older antipsychotics and antidepressants were listening to a Harvard teaching hospital recommend to my husband that he put me in an institution and forget he ever knew me, whereas with today's newer atypical antipsychotics and antidepressants I am a nurse, the mother of three successful young adults, and an active and involved member of the community. Mental health medications play an important role in the lives of Nebraskans who live with mental illness. With the right treatment, success rates for mental illnesses are 60 to 80 percent, exceeding the success rate for heart disease. Yet for those who do not get the right care at the right time, the results can be devastating and costly. For the health and well-being of our state, NAMI Nebraska strongly urges the Health and Human Services Committee to oppose LB661's restrictions on mental health medications. Thank you for your service to the state. [LB661]

SENATOR STUTHMAN: Thank you, Constance. Are there any questions from the committee? Seeing none, thank you again. [LB661]

CONSTANCE ZIMMER: Thank you. [LB661]

SENATOR STUTHMAN: Any other testifiers in the opposition? And none in the neutral?

Senator Gay, would you like to close? [LB661]

SENATOR GAY: Yep, just a minute. [LB661]

SENATOR STUTHMAN: Do you want the lights on? [LB661]

SENATOR GAY: I don't need the lights. (Laughter) I'll keep it under 20 minutes. No, I'd like to take this opportunity to thank those who did testify in opposition, quite honestly, because now we all understand what we're talking about. It's very serious business here and I knew that. I mean I knew that coming into it. But as I was listening--and I was listening to one gentleman, he said I ran out but he didn't know I was watching him on TV (laughter) that...no, in fun--but I did hear a lot of opinions in what the bill is and I heard a lot of things that we could go on and on, but I'd say what could it be with a little bit of input and insight. We've got a lot of input here that we're taking notes; with insight, looking at what it could be. I mean that's the big version--where could we be? When the doctor was testifying, I mean, she's an expert. You know, maybe there's...and others are, too, but you know maybe there's different variations of who can prescribe, who gets other...who gets more options than others. What I'd say is how many...here's a question: How many primary care physicians prescribe psychotropic drugs? How do they arrive at these choices when they're prescribing them? I mean there are some things I think we need to investigate and say...and maybe when we do we'll find out this has no merit. But when I look at these, we really just cannot afford to add more money, more money, more money to every solution to our problems, and I'm afraid we can...I'm not saying you cannot spend new resources. I've never said that. But there's a certain point, I do believe, we owe it that we should investigate and explore all these options. I was reading a...currently in the process of reading a book, slowly, not much time, but this gentleman said we're running a schizophrenic tax-and-spending policy right now. We've got big government spending programs and a tax program which is reluctant to tax any constituents. This is a recipe for disaster and is unsustainable in the long run, which it is. I mean we cannot continue to say, well, we don't want to get new revenues, and then we look and say, well, we can get a match, we can do this, we can do that. So but at some point I think we need to make hard decisions. Maybe this isn't one of them; maybe it is. But I do appreciate everyone coming in. I think we've got some great input, things that we need to consider and we would, but I also would like to say let's be open-minded, let's roll up our sleeves and really look into this thing. And we'll contact some of these people who made some very sincere...you know, they spoke from their heart and everybody that's out here, we all know that, we know many of them and we work closely with them, they all have a great interest in mind, which I think we do, too, as a committee. I think we've got a great committee. I think we've got a lot of talent here that if we look into this I think maybe we can find a solution. Thank you. [LB661]

SENATOR STUTHMAN: Okay. Thank you, Senator Gay. First of all, I would like to read into the record that we have letters of opposition from the Nebraska Chapter of National

Association of Social Workers, and from...a letter from the Community Alliance. (See Exhibits 7 and 6.) Are there any questions for Senator Gay? [LB661]

SENATOR WALLMAN: Thank you, Senator Stuthman. [LB661]

SENATOR STUTHMAN: Senator Wallman. [LB661]

SENATOR WALLMAN: Yes, Senator Gay. [LB661]

SENATOR GAY: No, no problem. [LB661]

SENATOR WALLMAN: I didn't want to let you run off. (Laugh) [LB661]

SENATOR GAY: (Laugh) No, that's okay. [LB661]

SENATOR WALLMAN: Yeah, it bothers me, some of the testimonies, you know, that if...just say I'm prescribed on generic, if I wanted to pay the difference per brand name, you know, why shouldn't that person be able? It didn't sound like they had that option. So, you know, if that could be worked in there somehow. [LB661]

SENATOR GAY: Well, yeah. They were taking a generic, then got off the generic and some of these other things. I don't know what their individual circumstances were, even if they're on...you know, what their insurance policy is, whether they're on Medicaid, I don't know. But I think a lot of people, I don't know the numbers, but there's a lot of generics being used. They're prescribed a lot. And now some of these drugs, as we will find out, are super expensive and maybe some work, some don't. I just wanted to say how do we arrive at that decision of what they're going to use? But on some of those cases, though, I was hearing, you know, we talked about if you found something that's working, we don't take them off that. And if we find other options that will work, we could put them on that. The thing that kind of struck a chord with me is, well, maybe we don't need...we don't need more burdens on the...and then, if I have any burden, I'm just going to go and prescribe this, it's just easier; I don't want to go fight the battle. I don't think physicians work that way. And maybe they do, maybe we'll find out. I hope they don't. But I think the doctor spoke real quick. I'm in a business, too, I think where you come in, you listen to somebody and you kind of know what their problem is. Okay, well, this is probably what they need. Well, a trained psychiatrist probably is very, very good at that. That's all their years of training. Now maybe a family physician, they do a great job, but maybe they don't have that expertise and haven't seen near the patients as they...as someone else. So I think there's a lot of options to explore here. [LB661]

SENATOR STUTHMAN: Thank you. Any other questions? Seeing none, first of all, I want to thank all of the people in attendance here today. I want to especially thank those that testified. And I thank you for staying around as late of an hour it is, and that

will close the hearing. Thank you. [LB661]

Disposition of Bills:

LB489 - Placed on General File with amendments.
LB601 - Placed on General File with amendments.
LB603 - Placed on General File with amendments.
LB661 - Held in committee.

Chairperson

Committee Clerk