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Health and Human Services Committee
February 25, 2009

[LB136 LB291 LB342 LB390 LB590]

The Committee on Health and Human Services met at 1:30 p.m. on Wednesday, February 25, 2009, in Room 1510 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting public hearing on LB590, LB342, LB136, LB291, and LB390. Senators present: Tim Gay, Chairperson; Dave Pankonin, Vice Chairperson; Kathy Campbell; Mike Gloor; Gwen Howard; Arnie Stuthman; and Norm Wallman. Senators absent: None. []

SENATOR GAY: All right, we'll get started. Thank you for coming to the Health and Human Services Committee today. We've got a very long agenda today, five bills, and I know there will be a lot of people that want to speak on these bills. So what we're going to do, we do have a timing system here in the committee. We usually stick to five minutes. And I'm going to keep it at five minutes. But also to be honest with you, I'm going to reserve the right to kind of narrow that down later in the day, if the opportunity...if we need to do that. I'm going to see how it goes because it's not fair for somebody to be here at 6:30, Senator Coash to be testifying at 6:30 or 7:00 o'clock tonight, probably wouldn't be fair for those people that want to testify on LB390 or even for that matter LB291, which is Senator Lathrop's bill. So as we get later in the day it becomes a challenge for people. We're going to start with introductions. I'm Senator Tim Gay from Papillion-La Vista. And we'll start over to my right here. []

JEFF SANTEMA: My name is Jeff Santema and I serve as legal counsel to the committee. []

SENATOR GLOOR: I'm Senator Mike Gloor from District 35 which is Grand Island. []

SENATOR CAMPBELL: I'm Senator Kathy Campbell, District 25, which is Lincoln. []

SENATOR PANKONIN: I'm Dave Pankonin, District 2, I live in Louisville. []

SENATOR HOWARD: Senator Howard, my district is 9 and it's in Omaha. []

SENATOR WALLMAN: Senator Norm Wallman, District 30, which is Beatrice and parts of Lincoln. []

ERIN MACK: Erin Mack, committee clerk. []

SENATOR GAY: And Senator Arnie Stuthman is also a member of the committee. He's testifying on a bill in another committee. Throughout the day senators do have to come and go, throughout the process. We're still in hearings and they have other bills that they may be introducing in another committee. So they may have to be coming and going along the way. Our pages, Justin and Blair, are here to help you out. If you

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have...what we'd like, if you're going to come up and testify, there are testifier sheets. You need to print your name out and fill that out. Put those in the box for the clerk. If you could print. And then also when you come up if you can state your name and spell it out that helps because everything is being transcribed later. And it's certainly very helpful to understand who is testifying and that we get it right for the record. When we...if we're asking you any questions, wait after you're done testifying, we'll see if there are any questions for you from senators. If there are none then thank you. If there are questions, though, we do not limit the time on question and answer sessions, just testifying. Again, a lot of times if you've got something new to add or just want to come up and give your testimony, that's great. But to repeat what the person just in front of you said probably isn't the best use of anyone's time. So with that, I see Senator Dierks patiently waiting here. We'll get started on LB590. Welcome, Senator Dierks. [LB590]

SENATOR DIERKS: Thank you, Senator Gay. Last on Friday and first thing... [LB590]

SENATOR GAY: Yeah, (laugh) we moved you up. [LB590]

SENATOR DIERKS: What? I thought you said...I thought you asked me something. That comes later, huh? (Laugh) Well, thank you, Chairman Gay, members of the Health and Human Services Committee. My name is Senator Cap Dierks, spelled C-a-p D-i-e-r-k-s, and I represent District 40. I am here today to introduce LB590. I've introduced this bill on behalf of a woman that I met in 2007 when I returned to the Legislature, Mrs. Dee Shaffer, now of Ashland, Nebraska. She needed assistance to take care of her 29-year-old son, Brian. She's a single parent, Brian needs constant care. He's developmentally disabled, autistic, epileptic, has congestive heart failure and is allergic to all seven of the basic things in life that cause allergies. Dee has placed Brian in most of the facilities that the state provides to care for similar people. Yet because of his needs and level of care he received she has had to remove him and care for him on her own. She cannot hold a job on her own because Brian's needs are so great. There are a couple of people who can help Dee care for Brian, but the state pays for six hours of outside care per day for Brian if someone is available to come in and help Dee during that time. She obviously loves her son and has told me that it is her pleasure to take care of him. But his care takes money and that is why we are here today. The current system cannot care for Brian and other citizens who share his many disabilities. We need to help the family members who are willing to step in and care for their loved ones. I introduced the bill two years ago, LB635, that is similar to this bill. I withdrew the bill to work with the Department of Health and Human Services to see what could be done to assist Dee and Brian Shaffer. We all came to an agreement in my office, but Dee has encountered some problems in working with some of the department staff in receiving prompt payment and assistance when she needs respite time. My intent with this bill was to establish a law in Nebraska that would ensure family members can afford to stay home and assist their loved ones who cannot be cared for elsewhere. That means an adequate salary and funding to cover the special needs. In

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this case special needs include foods, health products, and medicines that will not trigger one of Brian's many allergies, and medical assistance such as chiropractic care and acupuncture. Currently, Dee is paid to be Brian's main caregiver but she receives no assistance in buying the specialized foods and services required to keep him healthy. My hat goes off to Mrs. Shaffer and others who lovingly sacrifice so much to care for their family members. We know we have problems in our state taking care of developmentally disabled people. If there are family members, such as Mrs. Shaffer, who will give up their careers and sacrifice to take care of family members, I would hope the state will step forward and properly assist in a system of meeting those needs. I believe this care would cost the state less than caring for residents at an institution. With that, Mr. Chairman, I'll try and answer any questions from the committee members. [LB590]

SENATOR GAY: Okay, thank you, Senator Dierks. [LB590]

SENATOR DIERKS: I should tell you Mrs. Shaffer is here. She'll be testifying right after me. [LB590]

SENATOR GAY: Okay, all right, sounds good. Thank you, Senator Dierks. Are there any questions right now? I don't see any right now. Thank you. You going to be staying around? [LB590]

SENATOR DIERKS: I think I will, yes. [LB590]

SENATOR GAY: Okay. [LB590]

SENATOR DIERKS: Thank you. [LB590]

SENATOR GAY: All right. Thank you. How many opponents or proponents would like to speak on this issue? All right, one, two, about three. All right. Let's get started. Come on up. [LB590]

DEE SHAFFER: (Exhibit 1) My name is Dee Shaffer, D-e-e, and Shaffer is S-h-a-f-f-e-r. I'd like to thank you senators and all present for the opportunity to speak to you on behalf of my son, Brian Shaffer, he could if he would. My name is...I'm the guardian and mother of Brian Shaffer. I'm a nurse of 36 years and I have a masters degree in nutrition and a published thesis on food allergies. I am a licensed medical nutrition therapist for the state of Nebraska, a registered dietician, and a certified lactation counselor. Brian, when he was little, professionals did not know how to safely feed him and this included the dietician in the area. I recognized that I needed to go back to school to learn how to feed him. When I got to the university I found out that I was a novelist in the food allergy. I could see that the food was not the only thing he began to react to. The drug allergies were many and chemicals in his environment were causing him harm.

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My...Brian has a well-established history of reactions, including anaphylaxis with dangerous seizures. Brian's unique needs make him one of a kind. Please refer to list number 1. As you can see, these are just some things that are taken for granted by most people. It's even an endangerment to him to go to the emergency room when he needs to go. This is only a partial list of known sources that have produced allergic reactions in Brian. We avoid large crowds of people and windy days. What most people take for granted are luxuries for Brian. We carry an emergency EpiPen wherever he goes. He is very limited to where he can go. What compounds his situation is that is autistic and limited in verbal communication. He cannot tell us when he is having symptoms of allergic reaction. He must be monitored very closely for any sudden behavior changes and any symptoms that may appear, many of which can be life-threatening. What I've learned over the past 29 years is that most of Brian's behaviors have a medical cause behind them. Please refer to list number 2. These are just some of the comments of the many doctors that have treated Brian, their reactions as well. The environment allergist said that he was allergic to the seven most basic things in life. And I looked at him and I said, okay. Much of what has been learned about Brian has been trial and error. Board certified allergists have tried treatments on Brian that did not work and caused him injury. Please refer to list number 3. These are...the only treatment of allergies for Brian that has worked has been the avoidance of the allergen with myself as the main caretaker and other things that are listed on here. Chiropractic and acupuncture have been very beneficial for Brian. And I do have documentation from charting that can prove that. He has to be watched constantly, which I can do, and make his home environment as safe as possible. Few visitors are allowed because of fragrances. Many doctors don't want to treat him for fear of liability issues. He cannot use most products or drugs because he's allergic to them. Please refer to lists 4 and 5 to see some of the major costs. Brian was diagnosed in 2001 with gluten intolerance and there is a prescription that's there in list number 6. This means that wheat, barley, rye, and oats had to be removed in addition to all the foods that he's allergic to. He's allergic to corn, which is in 98 percent of processed foods. Corn by-products are used...found in tooth paste, soaps, automatic dish washing soap, medications. Corn is found in almost about everything. He is also allergic to rice. Food costs are very high because we are limited to what he does not react to. We have to use a lot of organic foods. The list of what Brian can eat safely is shorter than the list of foods that cause him harm. Minute amounts of offending foods or minute residue, such as pesticides or preservatives make a big difference in Brian's life. The compounding pharmacist has been very beneficial, although just because it's compounded doesn't mean that it will work. Brian has been in school and several community-based programs but had to be removed because of health concerns and staff negligence. And I do have materials on that, if anybody is interested, but I can prove staff negligence. The problem I'm having right now with the HHS Department is their integrity at paying me on a timely basis. We started with a payment, it was going very fine until I mentioned some of the staff negligence that I was having with a nursing company. And when I did that Gay Jeffries had warned me that they would go ahead and they could hold my wages up to a

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year. And she pointed this out to me, and this was not mentioned when we had this agreement. And it came again that I had a staff that slept through a fire alarm in my home. I went and tried to wake him up, and I had to yell at him, and I finally had to kick their foot to wake them up to tell them that the fire alarm was on. And they didn't get up to check. I was in a different part of the house. And I reported this to Gay and she verbally gave me that notice again that she would hold my wages and that she would also go ahead and...she went ahead and put it in an e-mail, too, and you have that in your packet on there. When I go ahead and asked for the...why I'm not getting my authorization numbers on a timely basis, I am given all different kinds of excuses. There are several e-mails that are there. One time I'm told that it's 30 days, one time I'm told it's 15 days, and the one time I called in a staff said that everybody's was done. And when I found out, I said, no, I have not received mine, they went and checked on her desk and it was sitting on her desk and she was gone for three weeks. The most that they've kept back from me has been close to \$7,000. Now when I have these large amounts of cost that's very, very difficult. How can I go ahead and maintain what my son needs as well as take care of myself? So I want to thank you for listening. This bill is to protect Brian and others who are similar like him. [LB590]

SENATOR GAY: Okay. Thank you. Are there any questions? I don't see any. Thank you for this. This is good information. Thank you. Other proponents who would like to speak. [LB590]

TIM KOLB: (Exhibit 2) Mr. Chair, members of the committee, my name is Tim Kolb, T-i-m K-o-l-b. As CEO and executive director of the Kolb Foundation for Disability Education in Franklin, Nebraska, I'm here today to speak in support of LB590. In introducing this modification of the current Disabled Persons and Family Support Act, Senator Dierks demonstrates in LB590 his understanding of the necessity to provide resources for persons with severe disabilities that enable them to remain with their families in their own homes and communities and, if possible, to seek and maintain gainful employment. And that is not Mrs. Shaffer's situation but it can exist for many others. It's a tragedy and a waste when members of a family who experience a severe disability end up being placed in a facility in order to receive necessary and appropriate care that could have been provided by the family had the state provided the necessary resources for home and community-based services. Having a severe disability doesn't always mean a person needs a medical doctor or a nurse every day. It doesn't mean a person always needs a medical facility to live in, in order to receive even complex forms of care. Doctors and nurses have trained family members for years to do things very successfully for their loved ones at home that most people would associate with a hospital. But when families try to provide such care with only their own financial and personal resources, at least two bad things often happen. One, a two-income family will usually lose a wage-earner in order to gain a caregiver; and two, the former wage earner, now turned caregiver, begins to wear out and the quality of the care provided decreases to the detriment of the care recipient. If the family member with a disability is

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placed in a facility as a solution two more bad things happen. One, the family and the disabled family member lose the valued and loving day-to-day easy contact with each other; and two, the state potentially loses the productivity and tax dollars that could have come from the employment and earned income of the person with the disability who could have been employed if the state had provided the resources for home and community-based life. I might insert here I used to be employed. Had I been in a nursing home that would not have been possible. As I have said many times before, you can't acquire and hold a job if you're residing in a nursing home. Enabling people with disabilities to stay in their own homes at least gives them the chance to become a wage earner and a greater contributor to the state's economy. Now if you're thinking that the state already provides resources like this through straight Medicaid and Medicaid waiver programs you would be correct. However, LB590 doesn't duplicate services, it works to direct people to services that already exist, such as respite and personal assistance services, among others. It also provides resources other existing programs do not, such as, and now I am quoting from the bill language, "the purchase of special foods and medical needs not otherwise reimbursed," and "the caregiver shall receive financial compensation at a higher rate than a salaried state employee receives for similar work done at a state facility. The caregiver and his or her family shall be eligible for health insurance as if the caregiver is a full-time state employee." But the state's expenditures will not be without bound because the bill provides that, "the cost of care by the family at home will be less than the cost to the state for institutional care." LB590 is good for persons with disabilities, good for families, and good for the state's economy. Please move this bill to General File and pass it into law. Questions? [LB590]

SENATOR GAY: Thank you, Mr. Kolb. Any questions? I don't see any. Thank you. [LB590]

TIM KOLB: Thank you. [LB590]

JOHN O'NEAL: (Exhibit 3) My name is John O'Neal. It's J-o-h-n O-'-N-e-a-l. I am chair of the Government Relations Committee for the National Multiple Sclerosis Society, Nebraska Chapter. I've been working in the advocacy area for approximately the last ten years, when I was first diagnosed with multiple sclerosis. And every year our committee, which I'm a member, goes through all the one-liners for the bills in front of the Legislature to find bills that may apply, have special application to people with multiple sclerosis. And I came across this bill this year. And, frankly, it's been a real learning experience and that's the main reason I'm here today because I think this bill, this state law is one of the (laugh) best kept secrets in the state. Not that it probably applies to a lot of people but it doesn't specifically meet one particular kind of case, as you can see from the two people who have testified before you already. One has severe food allergies among other difficulties, and Tim Kolb's case has very different problems. I looked at this bill and I thought, we...our society wants people with multiple sclerosis to be able to live in the home, if at all possible, and if that's where they want to be. And

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we're searching for ways to make that possible. And I thought, well, this is something we're...this is a dream come true for us. Now my only comment on the bill as written and as originally enacted is that I wish it were mandatory, but it's not and there's no intent to make it so. But we...basically, we fully support this bill. And we will certainly let people who may need its assistance know of the bill's existence. We'll let other organizations who have similar goals to ours know as well because I don't think very many people know about this bill, quite frankly. This is the first I've come across it, quite frankly. And I've known Tim for five years and I've known that he's getting assistance from the state but we never really got to the nitty gritty as to why. So anyway, I support the bill. I think the changes they are wanting are very commonsensical. I just...I, frankly, think people being in the home should be really the standard. I mean people ought...that ought to be where you start rather than going to an institution. Just because you have a disability does not mean you need to be institutionalized. Anyway, I know you have a long schedule so I'll let it go at that. And I'd just leave some short talking points here that you may want to look at. But thank you very much. Any questions? [LB590]

SENATOR GAY: Thank you, Mr. O'Neal. Do you want those handed out then? Did you give them to the... [LB590]

JOHN O'NEAL: I just have one. [LB590]

SENATOR GAY: Well, they can make copies and get them to all of us then. [LB590]

JOHN O'NEAL: Yeah. [LB590]

SENATOR GAY: And then if you want that back, you'll get that. [LB590]

JOHN O'NEAL: Oh, fine. [LB590]

SENATOR GAY: Okay. We'll make copies and distribute them. Hold on a minute. Any questions? I don't see any. Thank you for coming. Any other proponents? Any opponents? [LB590]

VIVIANNE CHAUMONT: (Exhibit 4) 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. I am 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 LB590. LB590, as written, proposes to expand the Disabled Persons and Family Support Program. The department opposes LB590 because it significantly changes the nature of the program and will result in either a large increase in expenditures or a sharp reduction in the number of persons served. DPFS is a state program supported entirely with General Funds. The program is designed to provide limited financial support to people with low income and with disabilities for the purposes of maintaining

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or obtaining employment, maintaining independence, preventing institutionalization. Under current parameters, eligible individuals may receive funding up to \$300 a month or \$3,600 annually for services such as personal care, housekeeping, transportation, special equipment, and vehicle or home modifications. Services are intended to supplement but not replace or duplicate support available through other programs for which the family or disabled person is eligible. Funding earmarked for this program through the legislative appropriations process is limited to \$910,000 per year, which provided support to 639 persons in FY 2008. The number of individuals receiving caregiver compensation through personal care attendant services was 564. The department estimates that setting caregiver reimbursement at a rate higher than the rate paid to state employees performing comparable work will result in a payout of \$33,000 per caregiver annually, assuming coverage of eight hours of care per day. With the added extension of healthcare coverage to caregivers and their families, the state will incur costs of \$16,000 per family for those who elect to participate. Based on these combined costs of \$49,000 per year per caregiver family, the existing program appropriation of \$910,000 will be fully expended in providing services to only 19 individuals. If the appropriation is increased to cover the higher level of caregiver reimbursement proposed by this bill, the program will expend over \$22 million in FY '10 based on 10 months and over \$27 million in FY '11 based on 12 months. Additionally, coverage of special food or medical needs for the person with disabilities is broadly defined in the legislation, will increase claims for assistance, and will require additional administrative oversight to verify the appropriateness of the claims. This provision will add services not currently available and result in increased expenditures. LB590 also expands program eligibility to include individuals for whom the cost of care at home is less than the cost to the state for institutional care. This provision extends eligibility to a wider population and is expected to increase demand for program benefits. In summary, LB590 seeks to change the nature of the DPFS program by establishing compensation for a family caregiver at a level higher than the wage of a state facility worker, extending state employee health insurance coverage to caregivers and their families, removing current funding limits that apply to caregiver reimbursement, and expanding program services and eligibility criteria. These changes will result in a significant increase in program expenditures or a decline in the number of persons served. Therefore, the department opposes this bill. I'd be happy to answer any questions. [LB590]

SENATOR GAY: Thank you, Director Chaumont. Any questions from the committee? Senator Wallman. [LB590]

SENATOR WALLMAN: Thank you, Chairman Gay. Yes, Ms. Chaumont, thanks for coming. And, I guess, we figured you'd be against this bill. But that's okay. Do you think...do we have any money left over in this fund now? [LB590]

VIVIANNE CHAUMONT: We have...this is not a Medicaid fund, this is...\$910,000 is appropriated and that's pretty much what is spent. [LB590]

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SENATOR WALLMAN: It's all spent? [LB590]

VIVIANNE CHAUMONT: Um-hum. [LB590]

SENATOR WALLMAN: Okay, thank you. [LB590]

SENATOR GAY: Any other questions? I don't see any. Thank you. [LB590]

VIVIANNE CHAUMONT: Thank you. [LB590]

SENATOR GAY: Any other opponents? Anyone neutral that would like to speak?
Senator Dierks, you want to close? [LB590]

SENATOR DIERKS: Yes. Thank you, Chairman Gay and members of the committee. I came on this committee for the first time in 1989. And I spent 11 years here. In 1989, 20 years ago was when I first met Tim Kolb. And I keep thinking to myself, there but for the grace of God go I. And I just...my heart goes out to those people. And I know that there's difficulties out there. We tried, for those 11 years I was on the committee we tried to have a goal to have no waiting list for the developmentally disabled. We got pretty close one year, but it has never been...it's always...there's always been some. And it's something we really have to strive for in this state, I believe. Dee receives \$13.44 an hour for 18 hours every day for her care of her son. And if she works longer than that there's no pay. I don't think you can find an LPN that would work for that for that length of time. I'm appreciative of the time we've taken. I know you're a busy committee today. And if there's anything I can...any questions I can answer for you, I'll try to do that. [LB590]

SENATOR GAY: Any questions for Senator Dierks from the committee? I don't see any. [LB590]

SENATOR DIERKS: Thank you very much, folks. [LB590]

SENATOR GAY: Thank you, Senator. You bet. With that, we're going to close the hearing on LB590 and I'll turn this over to Vice Chairman, Senator Pankonin, and move on to LB342. [LB590 LB342]

SENATOR PANKONIN: Senator Gay, whenever you're ready. [LB342]

SENATOR GAY: Thank you. Thank you, Senator Pankonin, and members of the Health and Human Services Committee. For the record, my name is Tim Gay. I represent the 14th Legislative District, offering today LB342 for your consideration. LB342 provides a mechanism to allow the state of Nebraska's Medicaid program to utilize a less costly,

less invasive Pediatric Feeding Disorders Program at the University of Nebraska Medical Center's Munroe-Meyer Clinic for Children, who are already qualified for Medicaid and have been placed on a waiting list at the Munroe-Meyer Clinic. Last fall I had the opportunity to tour the program and spend some time with parents whose children are going through the program, as well as visit with the program's director, Dr. Cathleen Piazza. Children develop feeding problems when medical conditions cause eating to be painful or difficult. For example, reflux disease may cause some children to vomit during meals. The child then associates eating with the discomfort of this vomiting and refuses to eat. As a result, of course, children do not receive the nutrients necessary to grow and develop essential brain functions. One common initial treatment is the placement of an NG tube. An NG tube is a tube that is placed through the nose and is snaked into a child's stomach. If an NG tube does not achieve the desired results, the next procedure is to address feeding disorders in surgery for placement of a gastric tube or G-tube. I'll just leave it at that. A G-tube is a surgical intervention in which an opening is made in the child's stomach. The surgeon places a tube into the opening which then allows a caregiver to feed the child through the tube. This surgical treatment provides a child with important nourishment but does not result in improvements in the child's oral feeding. Some children may require even more invasive intravenous feedings called total parenteral nutrition or TPN is associated with significantly more negative side effects, like liver damages or even death in some of these children. Even though G-tubes may provide much needed nutrition for the child, the insertion of the G-tube does not promote oral feeding. In fact, research has shown that children with G-tubes are less likely to eat by mouth than children who do not have G-tubes. The need for a G-tube may persist over a lifetime if the child does not eat by mouth. Therefore, the cost of maintaining a child on a G-tube can be extraordinarily high in relation to the cost of childcare for...who eats by mouth. This is not to mention the fact that placement of a G-tube may result in delayed development of motor skills. The inability to eat is associated with poor language development, health and behavioral problems, caregivers stress and depression in the development of eating problems in adolescents. An alternative to this surgically invasive procedure is the intensive interdisciplinary treatment that is provided at the Pediatric Feeding Disorders Program at the Munroe-Meyer Institute. This intensive interdisciplinary treatment focus on the assessment of why the child does not eat, use of the assessment information to develop treatments to increase the child's oral intake, and caregiver training so that the treatment can be transferred to the home environment. This program has met with successes. The program currently boasts a 90 percent success rate with treatment programs. I believe this to be verified when insurance providers like United Health Care, Blue Cross Blue Shield of Nebraska and regions Blue Cross Blue Shield have paid in certain circumstances for the insureds to be treated in the Pediatric Feeding Disorders Program. By contrast though, Medicaid does not cover the Pediatric Feeding Disorders Program at the Munroe-Meyer Institute. Those children who have Medicaid do not have the option of pursuing this form of treatment that promotes proper nutrition. I agreed to introduce LB342 because I believe the policy of trying all possible feeding therapies

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before performing the G-tube surgery on a child is best policy. And I believe that this legislation based on projections we have seen during the interim could save money which could be reallocated to other important services. Indeed, as you will look at the fiscal note that the Fiscal Office has provided, we could realize an annual savings over three years after implementation of about \$2 million. I do encourage you to pay special attention to this fiscal note on the bill. It does demonstrate that we could realize real savings over the long term with this legislation. In summary, when I looked at this, and I said I agreed to introduce the bill, it made sense to me that we look at less invasive procedures. I know several of you have visited the center and you're familiar with it, but those of you that aren't, you can only imagine. I'm sure, you'll see what this would be like if this was your child and you had to do some of these procedures. We hear a lot, of course, things that aren't so good, but I do think early prevention if this could work. I know there are some...there will be opposition to this, I know that. But there is something I think we should look at and maybe think a little bit outside the box here instead of just saying it can't be done. Medicare won't pay for this, Medicaid. But maybe, you know, sometimes it's best to seek a waiver if we can long term. Because I'm not just talking about physical needs here. It's, you know, you talk about the development of these children. Who knows what's going to happen down the road. We don't even know with our own children what could happen. But I can only imagine getting started out on this track would be very difficult. You'll hear from parents I think behind me and they can explain more. And I'll, if you could, wait until their done and answer any questions you have. Or actually, save your questions for later for me because you know where to find me. But I would, Senator Pankonin, and I expressed interest, not to rush through things, but I don't know...I don't really know if we could have a show of hands how many people want to testify, but if we could even limit this to a half an hour or so, I bet we could get through this. So with that, I will close. [LB342]

SENATOR PANKONIN: Thank you, Senator Gay. Any questions for Senator Gay? How many proponent testifiers do we have today? Okay. About a half dozen, it looks like, six, seven, and Senator Gay has indicated we want to hear the stories. We do have a five minute limit. We've got a long hearing but we are very interested, so. First proponent testifier. Welcome, Mr. Fahey. [LB342]

BRIAN FAHEY: (Exhibit 1) Thank you. Good afternoon, Vice Chairman Pankonin, and members of the Health and Human Service Committee. My name is Brian Fahey, F-a-h-e-y, and it is my privilege to appear before you today in support of LB342. Let me also express my deep appreciation to Senator Gay for his introduction of this legislation that is important to many families across this state, some of who are here today, some who could not. In order to put this bill into some perspective, please allow me to tell you the story of my wife Amber and I and the birth of our twins. My wife gave birth to our twins, Michael and Gabrielle, 12 weeks premature. Their weights were 1 pound 5 ounces, and 2 pounds 1 ounce, respectively. When born, the twins suffered from a severe acid reflux and would vomit anything we would put into them. This condition

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persisted for a few months, which resulted in no weight gain, enormous stress on me, my wife, our families. With no other alternative, we placed an NG or nasogastronomy tube in my son. This did not help him very much. In fact, the tube acted like an accelerator for his vomiting. He was diagnosed with failure to thrive. The fear that his physicians, along with my wife and I was that if he were to get sick he would not have the ability to fight off an illness and survive. After extensive consultations, our GI doctor and pediatrician thought our next move would be a placement of a G-tube or gastronomy tube. My wife and I wanted to explore all possibilities, all possible options before we would allow my son, Michael, to undergo surgery. As a result, they suggested the Pediatric Feeding Disorders Clinic at Munroe-Meyer. Because of my son's emergency condition, we were immediately accepted and placed in an intensive outpatient treatment program. When my wife and I met Dr. Cathleen Piazza, our son was 9 months old and would not take a bottle or anything orally. He had an NG tube in place and a pump that would run continuous drip 24 hours a day in order to ensure that he received the proper nutrients. She asked that we set some goals with our son, which we did. The goals we set were twofold. First, to be able to remove the NG tube and second, for us to be able to feed our son orally during the day and not have to wake him up or ourselves in the middle of the night for night feedings. With my son's condition, and his NG tube, he qualified for Medicaid. Frankly, it was a blessing. Medicaid helped us with medical bills, night nurses that were needed to monitor the pump, give medicine, burp the child every few hours. When we initially met with Dr. Piazza, I informed her that my son was covered by Medicaid. At that time, she informed us that Medicaid does not cover the feeding clinic. Ultimately, that was fine for us because we have good health insurance through my wife's employer which did cover the feeding clinic. And I remember briefly thinking, why did my insurance carrier cover it and Medicaid did not. We obviously had a great experience with Munroe-Meyer feeding clinic. We met the goals we set out for my son. We were able to remove the NG tube and feed him orally during the day. My daughter also went through the program and we were able to avoid placing an NG tube with her. As we were leaving the program, I inquired about a number of children on Munroe-Meyer Institute's waiting list who were covered by Medicaid and did not have health insurance. At that time, I was informed that there were close to 50 children on the waiting list who were covered by Medicaid. I wanted to help and formed Nebraskans for a Healthy Future. There are roughly only ten of these types of feeding clinics throughout the country and we are blessed here in Nebraska to have a clinic operating at the Munroe-Meyer Institute. When I started researching this issue, I began to look at projections for costs because I believed, initially, that the state would probably be looking at spending additional dollars in this program. I was shocked to learn that we could actually project a savings to the state by utilizing this program in certain circumstances like we propose here, between an NG and G-tube placement. Trust me when I tell you, as an owner of a small title business in Omaha, I am very sensitive to taxes and their impact on my business. I would not have pursued the introduction of LB342 had I not believed that we could, in the end, save money for the taxpayers of Nebraska. My children, Michael and Gabrielle, will not benefit from this

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legislation. Rather, I pursue LB342 in an effort to help the unknown Nebraska family who may be going through a similar situation to ours who is not as blessed as my wife and I have been. As I close, I want to make this point clear. The University of Nebraska Medical Center did not ask me to do this. Rather, my family and I see a truly cutting-edge program here that is the envy of the Midwest. Thank you for your time and consideration of LB342. I will try to answer any questions you might have. [LB342]

SENATOR PANKONIN: Thank you, Mr. Fahey. Just hang tight there. We will see if there's any questions. I have a quick one. How are those twins doing now? [LB342]

BRIAN FAHEY: They're doing great right now. They need to sleep a little bit deeper. [LB342]

SENATOR PANKONIN: How old are they now? [LB342]

BRIAN FAHEY: They'll be two next Friday. [LB342]

SENATOR PANKONIN: Good. And so they've been able to take nourishment and... [LB342]

BRIAN FAHEY: They're taking nourishments. They're happy and besides getting stressed through mother and I, they're doing better. (Laughter) [LB342]

SENATOR CAMPBELL: It's just beginning. (Laughter) [LB342]

SENATOR PANKONIN: Well, we thank you for your testimony and coming down today and your interest in this issue from your personal situation and that's how, a lot of times, ideas get started, so. Thank you. [LB342]

BRIAN FAHEY: Thank you for your consideration. [LB342]

SENATOR PANKONIN: Okay. Next proponent testimony. [LB342]

CATHLEEN PIAZZA: (Exhibits 2) Hi, I'm Dr. Cathleen Piazza, it's P as in Paul, i-a-z-z-a. Good afternoon and thank you so much for taking the time to allow me to speak on behalf of children with pediatric feeding disorders and their families. I am currently the director of the Pediatric Feeding Disorders Program at the Munroe-Meyer Institute. Previously, I was at the Johns Hopkins University School of Medicine since 1986 where I ran the Pediatric Feeding Disorders Program at the Kennedy Krieger Institute and at the Marcus Institute in Atlanta. Both of those programs are run on a model that is identical to the one we run at the Munroe-Meyer Institute and both of those programs receive funding from Medicaid. Although I work for the University of Nebraska Medical Center, I am speaking, expressing my personal opinion, and my views are not those of

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the Medical Center. I have two letters here that I would like to present to you. They're from physicians, Dr. Thomas Attard, who is a noted pediatric gastroenterologist. He sees many children with pediatric feeding disorders. And even more notably, from Dr. Robert Cusick, who is a pediatric surgeon who does a large majority of the gastrostomy tubes in the state. [LB342]

SENATOR PANKONIN: Doctor, if you could just put those on the right side, and then our pages can get them. [LB342]

CATHLEEN PIAZZA: Thank you. Sorry about that. [LB342]

SENATOR PANKONIN: Thank you. And for future folks that have material, that's how that works. [LB342]

CATHLEEN PIAZZA: Thank you, sorry about that. Dr. Cusick says that all noninvasive, nonsurgical options should be explored first. His support for the program seems obvious to him and according to him requires no defense. I also want to say that I entered some scientific articles. I want to say that all of my testimony here today is based on scientific data that has been presented in peer review journals, some of those I have shared with you today. No human activity has greater biological significance than eating. Eating is a genetically programmed behavior that's necessary for our survival. But eating has a larger role in human behavior in that it forms the backdrop for many of the social interactions individuals have with each other. Feeding is the method by which parents nurture and bond with their children. And, in fact, most of our major life events, think birthdays, are marked in the context of food, and food often dominates our cultural and religious activities, think Christmas. But the emergence of feeding disorder can have a devastating impact on a child's physical and cognitive development and can cause significant stress for families. A feeding disorder is diagnosed when a child fails to eat a sufficient quantity or variety of food to maintain nutritional status. Most children with significant feeding problems will require some form of medical intervention and without this intervention, these children are likely to die from dehydration or malnutrition. These children are at long-term risk for behavioral and developmental problems. These feeding problems are not likely to resolve in the absence of intervention and may be related to lifelong struggles with eating. The most commonly used intervention for feeding disorders are tubes that are placed in the nose, stomach, or the small intestine. Less commonly used is called a total parenteral nutrition or TPN, which is essentially a form of intravenous feed. These interventions may rescue the child from his or her nutritional difficulties but they are associated with very significant side effects such as liver damage and extraordinarily high costs. In fact, in a study that was published by Crosby and Duerksen, they showed that "In patients receiving long-term home enteral nutrition, tube and tube-feeding complications are frequent and they result in significant healthcare use." Thus, these individuals become dependent on tube feedings indefinitely and the cost of this care and all of the attendant complications are paid for

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by Nebraska Medicaid. An alternative to tubes or TPN is the intensive, interdisciplinary treatment provided at the Munroe-Meyer Institute. The program has a 90 percent success rate in preventing tube placement. That is, we are able to increase oral intake for children who would otherwise need tube placements and we can prevent that tube placement in 90 percent of the children we see. This success rate is very high by any standards we have in medicine. The effectiveness of this treatment is supported in studies in peer review journals. In fact, a study by Keith Williams, who is at Penn State, he's a gentleman that I trained, he states, "The program, his program, was found to be cost-effective when compared to the cost of long-term supplemental feeding." Despite the scientific evidence of program effectiveness, children with Nebraska Medicaid do not have the option of benefiting from this service. And those costs were presented to you already so I won't belabor them. In the testimony above, I focus primarily on the costs and the efficacy of the various treatment options. What I did not mention is the quality of life issues that affect these children and their families. Imagine not being able to eat by mouth. Imagine a child going to her first birthday party and not eating cake. Think of all the activities that we do that are associated with eating and drinking. To me, this seems like a no-brainer. We have the opportunity to do great good and we can save money. Thank you very much. [LB342]

SENATOR PANKONIN: Thank you, Doctor. We'll see if there are any questions.
Senator Howard. [LB342]

SENATOR HOWARD: Thank you, Senator Pankonin. I was over at the Munroe-Meyer Clinic this summer too and toured that and I was very impressed. I saw the video tape of the little girl that initially was really resistant to eating anything. Didn't want anything in her mouth and really gradually came along and started eating like the average child. The G-tube that you referred to, when that's placed in a child, it's my understanding that that's for life, that's not removed or that's a permanent arrangement. [LB342]

CATHLEEN PIAZZA: It can be. Many children have G-tubes for very long periods of time. In fact, I did a workshop in Florida a couple of month ago and a woman, who is about my age, like 29, came up to me and she said, you know, I have a G-tube and everything you talked about in that seminar that sounded like me. In 1999, 20/20 did a program, a piece on our program at the Kennedy Krieger Institute and the most surprising piece or response that I got from that program were the adults, the number of adults writing to me stating that they had lifelong feeding problems and how significantly it impacted their lives. I was blown away by the number of e-mails I received. [LB342]

SENATOR HOWARD: Well, it seems like if we have a less invasive procedure that really is, what did you say, 90 percent effective? [LB342]

CATHLEEN PIAZZA: That's right. And you know, if you think about it, even for example with the gastrostomy tube placement, half of the children who have gastrostomy tube

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placements will have increases in their reflux disease which will then for many of them result in no weight gain or the need for an additional surgery a fundoplication which is even more invasive and more expensive. By contrast our program ends after two years because we teach these kids to be oral feeders. They don't need any other additional surgery. Even if you take those, let's say, out of 100 kids, the 9 kids that still need a gastrostomy tube after our program, and you subtract that cost, program plus gastrostomy tube from the overall savings for the other 90 children, it's still a cost savings. [LB342]

SENATOR HOWARD: Plus less worry for the parents, less for the little child to go through. [LB342]

CATHLEEN PIAZZA: Absolutely. The quality of life issues are, I think, self-evident. [LB342]

SENATOR HOWARD: Thank you. [LB342]

SENATOR PANKONIN: Hold on, Senator Gloor's got a question for you, Doctor. [LB342]

CATHLEEN PIAZZA: Certainly. Thank you. [LB342]

SENATOR GLOOR: Thank you, Senator Pankonin. Thank you for your testimony, Dr. Piazza. Do you accept every or almost every patient that presents to you for the clinic? [LB342]

CATHLEEN PIAZZA: No. We have very strict entrance criteria. The patient has to have a very severe feeding problem, which is usually that they eat less than 50 percent of their nutritional needs by mouth. They have to have tried other less intensive outpatient therapy first, for at least three months, or the problem has to be emergent. So for example in the case of Brian's son where he was in the hospital dehydrating, had an NG and was scheduled for G-tube placement, then we might take the child prior to outpatient therapy. But in most cases we ask the family to try a less intrusive, less intensive, less expensive form of therapy first. And if they fail, then they can come to us. [LB342]

SENATOR GLOOR: Are there screenings that are on the other end of the spectrum? In other words, patients who are so severe that they're not candidates for your program. [LB342]

CATHLEEN PIAZZA: That's absolutely correct. So if the patient is not a candidate for oral feeding, so there are some individuals who aspirate everything that's presented to them orally, and they would never be candidates for oral feeding and we would not take

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those children, where there's no chance of success. [LB342]

SENATOR GLOOR: Can I ask, what's your major source of funding for the program at this point? [LB342]

CATHLEEN PIAZZA: Private insurance, 100 percent private insurance. [LB342]

SENATOR GLOOR: Okay. Are there any grants, are there any research components to what you're involved in? [LB342]

CATHLEEN PIAZZA: Not right now. And I will say again, though, the programs that Marcus in Georgia and in Maryland were funded by Medicaid and Florida Medicaid has contracted with us also to pay for program services. So we've had examples, both here and in other states, where other states, not our resident state, were paying, other Medicais were paying for us. [LB342]

SENATOR GLOOR: Thank you. [LB342]

SENATOR PANKONIN: Doctor, I have a couple of quick questions. [LB342]

CATHLEEN PIAZZA: Sure. [LB342]

SENATOR PANKONIN: I visited your program, I think fairly...it was when I was first elected, either late '06 or early '07. I think you had just come to the program about that time. [LB342]

CATHLEEN PIAZZA: That's correct. I'm new to Nebraska three years. [LB342]

SENATOR PANKONIN: Right. And I was very impressed with the program and the type of care that was received and the problems that you had to try to confront. Since you've been there now that long, the last two and a half, three years, how do you like it here and how do you feel about UNMC? [LB342]

CATHLEEN PIAZZA: I love Nebraska, I really do. It's a great place to live. A great family orientation. I have two teenagers and it's wonderful to be in this sort of culture where I feel comfortable with them driving and running around, and so forth. (Laugh) [LB342]

SENATOR PANKONIN: Good. Well, it's obvious your passion for this work is obvious and we appreciate your coming down and taking the time to testify today. Thanks for coming. [LB342]

CATHLEEN PIAZZA: Thank you. For those of you that didn't come to see the program, we did submit a CD with some video tapes that Senator Howard mentioned so you

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could see the progression of treatment visually and just sort of get a better feel for it, so thank you so much. [LB342]

SENATOR PANKONIN: Thank you. Next proponent. [LB342]

JODEE LEACH: (Exhibit 3) Good afternoon, ladies and gentlemen, I'm Jodee Leach, J-o-d-e-e, Leach, L-e-a-c-h. I have a story to tell you about my son. Matthew Leach was born on August 18, 2003, with massive hydrocephalus and was diagnosed with Goldenhar Syndrome. This syndrome left our son with a malformed, recessed jaw and he was lacking a jaw joint on the left side of his face. After two months in the hospital, Matthew was ready to go home with a G-Button inserted in his stomach so he could eat. After many attempts and many therapists to get Matthew to take food and formula orally, we were unsuccessful. He was never able to eat food and drink anything for the first four years of his life. Early in 2006, the dietitian at Children's Hospital in Omaha told us about a new feeding program at Munroe-Meyer Institute. We wanted to sign up immediately. The program wasn't even up and running at the time we made phone calls and we were already on a waiting list. Believe me, the program was worth waiting for. In September, 2007, we received the phone call we had been waiting for. The feeding disorders program had an opening for us. The only hitch, was our insurance company going to pay the fees? After several phone calls to our nurse case manager at our insurance company, they finally agreed that it would be cost-effective. Matthew and his mom went through two months of inpatient treatment. Watching our son eat pudding and drink his formula for the first time left us speechless. We were in awe seeing the therapists work with him and being so successful. We would have never been able to accomplish this by ourselves. Without our insurance company paying for Matthew's treatment, he would never be able to learn how to taste, swallow, breathe, drink and enjoy the pleasures of eating without any misbehaviors. Matthew now drinks all of his formula from a cup. He eats all pureed foods you and I would eat. It is such a joy to watch our child eat macaroni and cheese, a peanut butter and jelly sandwich, barbecued chicken, and a number of other foods that other children without disabilities would eat. People take eating for granted. People can assume that everyone knows how to eat. My husband and I did until we had a child that couldn't eat. Our son and other children with certain behaviors and disabilities have enough struggles in their lives. Not having the ability to learn to eat should not be another one. And all children should be given this chance. Thank you. [LB342]

SENATOR PANKONIN: Thank you. Thank you for coming today. We'll see if there are any questions. Senator Gloor. [LB342]

SENATOR GLOOR: Thank you, Senator Pankonin. Just a little aside, with all you've been through, watch out for the PB on the PBJ sandwich. (Laughter) [LB342]

JODEE LEACH: I certainly will, sir, thank you. (Laughter) [LB342]

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SENATOR PANKONIN: Just wait, we may have another question. We'll have to see. (Laughter) I know everybody's nervous to get out of that chair but you're all doing so great. Any other questions? Seeing none, thank you. [LB342]

JODEE LEACH: Thank you, sir. Thank you for your time. [LB342]

SENATOR PANKONIN: Welcome. [LB342]

SALMA BIDASEE: (Exhibit 4) Thank you. Good afternoon, ladies and gentlemen, my name is Salma Bidasee, B as in boy, i-d-a-s-e-e, and my husband and I are parents of an adorable 4-year-old boy, whose name is Sean. Right from the very beginning when Sean was born we had to struggle with feeding issues with him. Many medical tests were done on Sean and medications for acid reflux were given to him but nothing improved Sean's very low caloric intake and his extreme pickiness with food. It would take about 45 to 60 minutes to feed Sean 4 ounces of yogurt and a banana for breakfast. During most of Sean's life, his growth curve has been about 4 to 10 percent. This is way below the average. When Sean was almost four, about August, 2008, the Munroe-Meyer Feeding Clinic contacted us and told us that Sean could start treatment in about a couple of weeks. He was on their waiting list for about 18 months. As you can see, the demand for their services is very high. Since starting his program at Munroe-Meyer Institute, he has come a long way. As of last week, Sean has been eating about 12 new foods. I could not have done this without their support nor their expertise. I am very thankful for their help and for having medical insurance to cover the majority of the cost. Not only is Sean eating much healthier, but also the enormous stress of worrying over his very strange resistance to eating has been greatly relieved. When I talk to other moms at the institute, I realize that there must be many more parents who need this very critical help that the feeding clinic offers. Kids with such an extreme feed behavior create a very hard family environment and their parents desperately need that extra help. I urgently appeal to the Nebraska state government to make the services of the Munroe-Meyer Institute available to all families. As a parent, it is very deeply heartfelt and troubling to know that I am fortunate to have health insurance to cover Sean's feeding and behavioral treatment and another parent does not have that insurance for such a program. The preciseness and expertise of this treatment significantly improves the very early growth and development of children like Sean. On a final note, Sean's teachers at the clinic are his friends. That's pretty cool to me. (Laughter) Thank you for listening to my testimony. [LB342]

SENATOR PANKONIN: Well, thank you for coming today. We'll see if there's any questions. Seeing none, thank you. [LB342]

SALMA BIDASEE: Okay. [LB342]

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SENATOR PANKONIN: Welcome. [LB342]

SONYA FERRIS: Good afternoon. My name is Sonya Ferris, S-o-n-y-a F-e-r-r-i-s. I'm very nervous to be in this seat. (Laughter) [LB342]

SENATOR PANKONIN: You'll be just fine. Just take your time. [LB342]

SONYA FERRIS: (Exhibit 5) I'm here today to speak on behalf of my youngest son, Jacob. Oh, boy. [LB342]

SENATOR PANKONIN: Just take your time. [LB342]

SONYA FERRIS: He has had to overcome several obstacles and endure immense pain in the short 20 months of his life. He was born with the deck stacked against him. He's had to endure five major surgeries and has a list of 20 specialists who have examined him time and time again. He has had to overcome so much and remains an inspiration to his family. From the first day of his life, eating was a struggle. I remember the first meal he had in the hospital consisted of 12 cc's of formula. From that day forward it was a battle for Jacob to eat. He was born with a small jaw that did not allow him to suck and swallow properly. He was constantly choking and turning blue with every meal. At one week of age he was eating only a quarter of an ounce of formula per meal. He was hospitalized for failure to thrive at three weeks of age. I began taking Jacob to Children's Rehabilitation in Grand Island to learn techniques to teach Jacob how to eat. Initially, we went once a week and then increased to twice a week. We also began fortifying Jacob's milk for additional calories. In August of 2007, after discovering that Jacob had a chromosomal abnormality, he was hospitalized at Children's Hospital in Omaha for an upper airway obstruction. During this four-day hospital stay a nasogastric feeding tube was placed for nutrition. This qualified Jacob to receive Medicaid benefits. We continued speech therapy twice a week in Grand Island. In September 2007, Jacob was diagnosed with pneumonia, possibly from aspirating milk during a meal. At this point it was uncertain if it was safe to feed Jacob orally. The first of three swallow studies was performed. Each study cleared Jacob to eat orally. Jacob underwent three surgeries between November 2007, and March 2008. He had a feeding evaluation, upper gastrointestinal study, as well as a gastric emptying study done in efforts to find out why Jacob was not eating. The tests came back normal. We took part in the Children's Developmental Clinic at Children's Hospital in August. We were referred to the Munroe-Meyer Institute at this time. While awaiting approval from Blue Cross Blue Shield, Jacob was back in the operating room again in September. This time to bring down a retained testicle and also have a G-peg placed. An incision was made through the abdominal wall directly into the stomach and a tube is placed into the stomach, thus allowing the removal of the nasogastric tube. In time the incision will heal around the G-peg, forming a stoma. This decision was made after realizing that Jacob was not going to be able to eat enough orally to sustain weight. The tube was placed on a

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temporary basis knowing that it would be changed out into a MINI Button and it would be inserted into the stoma eight weeks after the operation. However, when the eight weeks were up and it came time to change out the G-peg our world was turned upside down. The stoma had not healed properly and the button was inadvertently placed into the abdominal cavity instead of the stomach. Emergency surgery was performed to flush Jacob's abdomen and repair his stoma. The surgeon suggested that the reason for the stoma not healing properly was malnutrition. On December 24, we received our second letter from Blue Cross Blue Shield stating that they were denying coverage again. Individuals at Munroe-Meyer continue to discuss Jacob's situation with our insurance provider. In the meantime, we feel we have run out of options for our son to thrive without the use of the feeding tube. We are very thankful that Jacob receives benefits from Medicaid. Jacob qualifies for Medicaid through the waiver program because he relies on a feeding tube. It is because of the feeding tube that he qualifies. We are doing all that is necessary to help Jacob thrive without a feeding tube. If Medicaid could provide a means into the feeding program, Jacob would no longer need Medicaid, thus saving the state of Nebraska money. We believe the state has a responsibility to include children's day health services in assistance provided under the Medical Assistance Act and the social services program. Children such as Jacob must have services, as families cannot afford the cost of intense outpatient therapy. We are asking that the bill become law immediately instead of waiting for the July...or January 10, 2010, date, so Jacob and other kids not being accepted can receive treatment immediately. Children should be given an opportunity to reach their potential now and their opportunity to thrive should not be delayed. Thank you for your time. [LB342]

SENATOR PANKONIN: Thank you, Ms. Ferris. You did a fine job, so. [LB342]

SONYA FERRIS: I'm still alive. (Laugh) [LB342]

SENATOR PANKONIN: Yes, you did fine. Senator Stuthman has joined us and we're glad to have him. If you do see senators leave, they may have a bill introduction at another hearing, so don't be surprised at that. Senator Gloor. [LB342]

SENATOR GLOOR: Thank you. Nice job, Sonya. [LB342]

SONYA FERRIS: Thank you. [LB342]

SENATOR GLOOR: You've also utilized children's day health services, haven't you? Is that right, with Jacob? [LB342]

SONYA FERRIS: No. We have not been through the program because our insurance is denying us coverage. [LB342]

SENATOR GLOOR: Okay. You tried to get those services but were denied. [LB342]

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SONYA FERRIS: Yes, right. [LB342]

SENATOR GLOOR: Thank you. [LB342]

SENATOR PANKONIN: Other questions from the committee? Seeing none, thanks for being a great advocate for your family. Thanks for coming. [LB342]

SONYA FERRIS: Thank you. And the picture attached is Jacob. (Laugh) [LB342]

SENATOR PANKONIN: Yes, we figured that out. [LB342]

SENATOR CAMPBELL: And I assume that's Jacob in the picture. [LB342]

SONYA FERRIS: Yes, that is Jacob. [LB342]

SENATOR PANKONIN: Yep. Thanks for coming. [LB342]

SONYA FERRIS: Thank you. [LB342]

SENATOR PANKONIN: Next proponent in testimony. Seeing none, opponent testimony. Whenever you're ready. [LB342]

VIVIANNE CHAUMONT: (Exhibit 6) Okay. Good afternoon, Senator Pankonin, 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. 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 LB342. LB342 directs the Department of Health and Human Services to submit an application to the Centers for Medicare and Medicaid Services to either amend the Nebraska Medicaid state plan or to seek a waiver from the plan to provide funding for the treatment of pediatric feeding disorders through the behavioral health program. The bill further provides that pediatric feeding disorder treatments should occur prior to physician utilization of surgical techniques to address a pediatric feeding disorder. Coverage of feeding disorders by the mental health program would result in a Medicaid expansion. The Pediatric Feeding Disorder Program utilizes Applied Behavioral Analysis as the primary treatment intervention. Behavioral observations and positive reinforcement are used to teach new behaviors. Currently, Applied Behavioral Analysis providers are not an enrolled Medicaid provider type. Federal Medicaid rules require that nonphysician practitioners must be licensed by the state and practicing within their state practice act in order to be Medicaid reimbursable. While a licensed practitioner in the pediatric feeding program might supervise the Applied Behavioral Analyst actually providing the services, federal Medicaid requirements prohibit reimbursing anyone other than the person actually providing the service. Therefore,

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these services will not be Medicaid reimbursable. Medicaid currently provides coverage under the Mental Health Program for psychotherapy, rehabilitation, and medication management. Psychotherapy services are available to assist the child and the family in dealing with any mental health issues that arise as a result of the pediatric feeding disorder. These services would be provided by a licensed mental health Medicaid enrolled provider. Medicaid currently covers medically necessary physical health services to address feeding disorders. If a child has a physical health need related to a feeding disorder the necessary physical health service is covered. Treatment of pediatric feeding disorders through mental health services is not a Medicaid covered service. The department estimates that the fiscal impact of this bill would be approximately \$3 million. The fiscal note prepared by the Legislative Fiscal Office estimates a savings. We have concerns with that fiscal note. All the information provided regarding the success of the Munroe-Meyer program and, therefore, all analysis regarding the savings resulting from that program come from Munroe-Meyer. I have seen no independent evaluation of the program and its success. We do not know whether all the children evaluated and treated would, in fact, have had a G-tube without the intervention by Munroe-Meyer. We do not know whether any or all of the children in the program could have received services which could have resolved the disorder without services from Munroe-Meyer or with less expensive services than those provided by Munroe-Meyer. The assumption that Munroe-Meyer is the only provider who could do this service is not valid. The department has already received inquiries from other providers who want to do this program if authorized as a Medicaid benefit. The Medicaid program cannot limit providers to one without a waiver. It would be unlikely that the federal agency which oversees the Medicaid program would approve a waiver that limits the provision of a Medicaid service to one provider in the entire state. Therefore, assumptions about savings, using Munroe-Meyer data, even if accurate, does not necessarily equate with the savings that would in fact occur should the service be approved. We are not aware of how the costs of G-tubes were calculated and, therefore, how the savings were calculated. The costs of G-tubes can vary greatly depending on each child's condition. The fiscal note seems to assume that G-tubes are in place for many years. There are children whose needs will require a tube for extended periods of time or even life. These are not the children who would likely benefit from this program. On the other hand, there are children who only need it for a short period of time, even two or three months. While it is true that this program might be less costly for some children, it is equally true that it could be more costly for some children. This bill requires evaluation for the feeding disorder program before a physician can use a surgical technique to address the disorder. This means that every child needs to be evaluated. There are situations where the surgical procedure is required quickly to protect the life of the child. Requiring an evaluation may delay that surgery and increase the costs associated with it. There are currently 1,800 children with G-tubes in Nebraska. The fiscal note calculates the fiscal impact of evaluating 60. Additionally, the fiscal note does not calculate the costs of transportation, lodging, meals, escort services that the Medicaid program would be required to pay for the

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assessments and for the five times a week visits for the two-year length of the program. This bill results in a Medicaid expansion. Under Medicaid reform, the directive to the department is to contain, not increase Medicaid spending. I do not recommend relying on savings based on data by one provider. For these reasons, the department opposes LB342. I would be happy to respond to any questions. [LB342]

SENATOR PANKONIN: Thank you, Director Chaumont, and I think we do have some questions. Senator Campbell. [LB342]

SENATOR CAMPBELL: Thank you, Senator Pankonin. Ms. Chaumont, obviously from the testimony of Dr. Piazza, and I apologize if I didn't say that right, but she indicated that there were Medicaid approved, I think in the state of Florida, if I was hearing correctly, is that...did I hear her correctly? Did you hear that too? [LB342]

VIVIANNE CHAUMONT: That's an interesting question, Senator Campbell. That's what she said. I think she said Florida. I know she said Georgia. That's an interesting question. I sent out an e-mail to all 50 Medicaid providers describing this program and asking if any of the states paid for it and they all said, no, or I didn't get any responses that said yes. I didn't get a response from every...from every state. The state of...Nebraska actually paid for this program at Munroe-Meyer because of the way it was billed. It wasn't clear to us that this was what we were paying for and we, in fact, have recovered the money from MMI. So I would be happy to follow up with the states that they say cover this program and find out if in fact this is what they paid for and what they thought they were paying for. [LB342]

SENATOR CAMPBELL: Okay. That would be particularly helpful to the committee, I think. Thank you. [LB342]

VIVIANNE CHAUMONT: I'd be happy to do that. [LB342]

SENATOR PANKONIN: Senator Howard. [LB342]

SENATOR HOWARD: Thank you, Senator Pankonin. And my questions are along the same lines. When the Medicaid regs were drawn up, was this program available? I'm wondering if they addressed this, if the Medicaid regs addressed this program specifically in terms of an exclusion, or if it's addressed at all. It's a, you know, we recognize it as a less invasive than the surgery and the G-tube would be and it's just, it's troubling to me that if they don't recognize it. [LB342]

VIVIANNE CHAUMONT: The Medicaid program was started in 1965 as you know and they actually don't, they don't list every service. It would be impossible to keep up so they wouldn't list a service like this. The thing that I was talking about was that Medicaid pays for licensed professionals. The people that actually provide the service are not

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licensed professionals recognized in this state. They're ABA techs, Applied Behavior Analysts. Analysis technicians, I think, is what they're called. And this is not a service provided by a psychologist. This is not, and while Dr. Piazza might supervise those techs and then bill the services in her name, that is not an acceptable Medicaid practice. The person that is actually providing the service is the person that needs to bill for this service. So, you know, many things have changed in medicine and mental health over the last 40 something years that the Medicaid program has been in effect. It actually, I think, keeps out fairly well but there's some basic rules that are hard to get around. For instance, peer support now is obviously not a service in the mental health arena, not a service that we talked about in the previous bill. It is not a service by a professional that CMS has now added and said that that's a service that you can provide. So there isn't any guarantee that this service would be provided, would be eligible. And under the current rules, as I understand it, it's not. [LB342]

SENATOR HOWARD: Well, if the doctor performed this directly, if every doctor did the feeding with every one of these little children, that would be...that would come under the billing auspices? [LB342]

VIVIANNE CHAUMONT: If a physician did some kind of therapy to get a child to eat, yeah, we pay for physical occupational therapists to do this kind of service, physicians, nurses, we would pay for that. [LB342]

SENATOR HOWARD: So the difficulty comes in having someone that doesn't categorically fall into the billing? [LB342]

VIVIANNE CHAUMONT: Not a licensed medical practitioner, I think, is the term. [LB342]

SENATOR HOWARD: So if Munroe-Meyer used doctors to perform all the services, which obviously would cost more, we would pay, theoretically. [LB342]

VIVIANNE CHAUMONT: Theoretically. That would be one less problem to worry about. (Laugh) [LB342]

SENATOR HOWARD: Thank you. [LB342]

VIVIANNE CHAUMONT: Yes. [LB342]

SENATOR PANKONIN: Director Chaumont, I've got a couple of questions. One of them, you had mentioned that other providers had approached your office about providing similar services or these kinds of services, was that, was that, I think that was what you said. [LB342]

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VIVIANNE CHAUMONT: Yes. [LB342]

SENATOR PANKONIN: And I can understand where Medicaid may not really like it if there's just one provider because of cost issues and that sort of thing. Are these providers in the state of Nebraska, I assume, other ones... [LB342]

VIVIANNE CHAUMONT: Yes. [LB342]

SENATOR PANKONIN: ...and does that make it more attractive to, if you had to go for a waiver that there are other providers that provide like services, or do you think the level of service is so different between Munroe-Meyer? [LB342]

VIVIANNE CHAUMONT: I don't think that. I think other providers could provide the service. I don't think that's the issue. I think though...and having more than one provider would certainly make CMS feel better. They don't like to build the service around a provider, the autism waiver has been an example of that. So there's that issue. But we're basing all of these savings on Munroe-Meyer's data that says that they're 90 percent effective. You know, I don't know if they, you know, pick the people in order to maximize their effective...I don't know what they do. You know, I don't know that. But you could have another provider who isn't 90 percent effective, you're having to still provide the service and your cost savings are going down because sooner...you're providing this service and then you're going to have to provide a G-tube on top of that. That was part of my issue with that. [LB342]

SENATOR PANKONIN: Okay. And those are all valid but I think how do you then prove that when you have a provider that has this (inaudible) track record and I understand, you don't understand where, or you might not know with others, but so what happens in these sorts of situations? I mean, there's a...I mean, is there anyway to ever get out of this rut of not... [LB342]

VIVIANNE CHAUMONT: Of having just having the data of one provider? [LB342]

SENATOR PANKONIN: Yes. [LB342]

VIVIANNE CHAUMONT: Sure. There are other people, I assume there are other people who are doing it or at the very least you would hire an independent entity to study the program and see whether or not they are, you know, skewing it in anyway, or whether the people that they're treating are comparable to the people that you would be treating and you would have some kind of analysis. At the very least, I would expect that. [LB342]

SENATOR PANKONIN: Okay. Well, thank you and I think Senator Campbell's question is another good one of checking with the other states and maybe the people that

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Munroe-Meyer would, you know, that gave us the information might be consulted as well. Other questions? Seeing none, thank you for your testimony. [LB342]

VIVIANNE CHAUMONT: Thank you. [LB342]

SENATOR PANKONIN: We will now accept any neutral testimony, if there's anybody that would want to speak in the neutral capacity. The other thing I might mention. We probably have...it looked like we had a lot of material come in, committee clerk Mack, that you will read into...we'll have into the record. And so if there were any information that came, that will be part of the official record, so we appreciate that. Senator Gay. [LB342]

SENATOR GAY: Yeah, I'll close very quickly. Thank you, Senator Pankonin, and I appreciate the testimony. And I would say, I appreciate Director Chaumont as well. We have worked with her and that's a difficult task to come up, but she has been very good to work with up to this point. And we learned some things today, I did. And that is, maybe continue to move down that road. The other providers that were out there. I'll check. I was not familiar with those but I will check back with her and continue to work with both parties. But it's interesting on the fiscal note, though. Of course, we don't get those fiscal notes until yesterday. Fiscal notes showed some savings and when we find savings...when it costs a lot, you know, we rely on those. So I will also double-check that fiscal note and see, you know, what else I can...if there's flaws in that, I don't know. But I rely on a fiscal note like you would rely on a fiscal note. But I got some good ideas today from listening. You can see why, of course, we'd want to pursue this if, if indeed, there were savings. Part of the arrangement I had to introduce this bill was if there's savings I will continue to pursue it. I think there are savings. I will continue to pursue it and try to find out some more information so that you can make a good decision, but I did get five or six things and I'm encouraged to work with Director Chaumont, like I say, I know she has a difficult problem...difficult job, I wouldn't say it's a problem. But her job is...she's doing what she's supposed to do, and I will continue to work with her. And so we will be proponents of this program and I think it's common sense if we can stop something early in a person's life, we won't have continual problems ongoing, so. [LB342]

SENATOR PANKONIN: Thank you, Senator Gay. Any questions? Thank you. That concludes the hearing on LB342. (See also Exhibits 7-14) [LB342]

SENATOR GAY: I'd like to thank Senator Pankonin for taking over there. He did a very good job and thank those that testified on that. With that, Senator Avery is here to open up on LB136. Welcome, Senator Avery. [LB136]

SENATOR AVERY: (Exhibit 1) Thank you, Mr. Chair. My name is Bill Avery, A-v-e-r-y. I represent District 28. I am here to propose to you some changes in the SCHIP program,

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that is the State Children's Health Insurance Program. LB136 would expand eligibility and facilitate access to that program. As you know, SCHIP was created by the federal government in 1997. It was designed to reach those low-income families who are earning too much to qualify for Medicaid but whose jobs do not provide health insurance and they make too little to afford to buy health insurance for their children in the private market. This legislation passed in 1997, is aimed at the working poor. I want to emphasize this--these are not deadbeats. These are working people who simply don't have enough income to afford health insurance for their children. The program in Nebraska is called Kids Connection. It was created to implement the SCHIP program, and we created this in 1998. It was widely considered to be a model program at the time, both in the quality of coverage and in outreach and in enrollment efforts. Unfortunately, this is no longer the case. Our Kids Connection program has failed to keep up with the rising number of children who are unable to afford health insurance coverage in the private market. And Nebraska now ranks in the bottom seven states for providing healthcare for low-income children. That's not a place where we ought to be, and it certainly is not something you should be proud of. I am introducing LB136 to address the increasing medical needs of Nebraska's uninsured children. The bill does three things to strengthen our commitment to children and their health. The first thing it does is to raise eligibility of families from 185 percent to 200 percent of the federal poverty level. This will bring Nebraska into line with its neighboring states, with the exception of Missouri, which currently sets its eligibility standard at 300 percent. Currently, federal poverty guidelines for 2009 indicate that a family of four with an income of \$22,050 a year is considered poor. At 180 percent of the federal poverty level, a family of four with an income of \$40,793 is eligible to participate. LB136 would provide 12 months of...now let me go back a bit. If you raise that to 200 percent, of course, that would mean that the income would go up, eligible income would go up I believe to just over \$42,000. There will be people testifying after me that can give you an exact number on that. The second thing that this does is provide 12 months of continuous eligibility. The current law provides for an initial six-month continuous eligibility period followed by monthly eligibility determinations. This requires reapplication every...what I am proposing is that the reapplication would be every 12 months instead of every 6 months. And this, of course, would reduce administrative costs, but it would also take pressure off families who find themselves in constant bureaucratic red tape, constantly trying to keep up with eligibility requirements. And this would make it possible for them to benefit from this program over a longer period of time before reapplying. The bill does a third thing and that is it strengthens opportunities for enrollment and outreach and that is contained in an amendment that you have been passing around now. I would ask that the committee carefully consider this amendment because it's designed to take into account action that has occurred at the federal level this month, in fact. The U.S. Congress, on February 4, passed a new federal SCHIP bill. It was signed by the President on the 4th of February. So several new options became available for expanding Nebraska's Kid Connection under this new law. Under the federal legislation, Nebraska is eligible now to receive bonus payments of federal

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funding if we (1) increase enrollment of Medicaid eligible children by a certain percentage; and (2) if we implement five of eight administrative changes to improve enrollment. Nebraska currently practices three of these administrative changes, and LB136 as drafted would include a fourth administrative change, that is the 12 months of continuous eligibility. This amendment that you have before you would add two more changes that would add the fifth and sixth administrative change. And those include an express lane option. Under this option, a state may designate and utilize other agencies to do targeted outreach and enrollment for Kids Connection. And number two is something called presumptive eligibility. This adds a reference to Section 1920A of the federal Social Security Act to allow designated providers to determine if a child is eligible for Kids Connection based on a few questions. If deemed eligible, the child may be treated and the provider is reimbursed at a later time. The family has to complete the application process to remain in the program. That's the...the idea is you presume that the child is eligible at the time they come in for treatment. This amendment also includes requirements that the state engage in outreach activities such as public service announcements and the distribution of printed materials explaining the program. And this actually reinstates language that was previously in statute. The amendment also requires the state to apply for federal grants. The final portion of this amendment corrects inadvertent technical drafting changes. Three sections change eligibility for other programs that do not relate to children's healthcare. That's a very important part of the amendment. You'll see it on the first page where sections are eliminated. It was never my intent to, or at least it's not my intent to change additional sections at this time. This amendment returns those eligibility levels to those unrelated programs to 185 percent. And there is a significant reduction in the fiscal note as a result of this amendment. I believe the fiscal note now reads \$32 million. [LB136]

SENATOR GAY: Twenty-four million dollars and \$32 million. [LB136]

SENATOR AVERY: Yeah. That reduces down to \$5.5 million and that leverages \$14 million in federal funds. So I regret that the fiscal note cannot show that. They didn't know this at the time. So I wanted you to have that information. The U.S. Census Bureau indicates that there were more than 45,000 uninsured children in Nebraska in 2007, and there was no change in the number of uninsured in our state between 2006 and 2007, despite a decrease at the national level. So we're not improving while nationwide the nation is doing a bit better. The decrease nationally has been attributed to the fact that many states have improved their SCHIP programs to cover more uninsured children. I think now is the time for Nebraska to do this as well. The child poverty rate in Nebraska continues to rise. Nearly one third of Nebraska's children under 18 live in low-income working families. Poverty remains a complex issue. It affects housing, education, healthcare. As the cost of healthcare is growing at very great rates, Nebraska's employers are increasingly unable to provide affordable healthcare to our employees. We should not turn our backs on our children. We should not turn our backs on the working poor. So I ask you to advance this. I'm going to ask

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this--I know you've got a crowded schedule--I'm going to ask the people who are coming up behind me, some people who know a lot about this and a lot more than I do, to answer your questions. And I've asked them not to be repetitive and to try to keep their comments at least as brief as mine. (Laughter) [LB136]

SENATOR GAY: Or five minutes or less. All right, Senator Avery, appreciate it. Any questions for Senator Avery now? Senator Campbell. [LB136]

SENATOR CAMPBELL: I just want to be clear because I was asked this question today. But the extra money that is coming through the federal government is not tied to the stimulus bill. [LB136]

SENATOR AVERY: No. [LB136]

SENATOR CAMPBELL: It was a separate action. [LB136]

SENATOR AVERY: Separate bill. [LB136]

SENATOR CAMPBELL: And so it's not in that funding that will come to the state. [LB136]

SENATOR AVERY: And it was early this month so it was already passed and signed into law by the President before the stimulus package. [LB136]

SENATOR CAMPBELL: Okay. Thank you, Senator. [LB136]

SENATOR GAY: So I've got a follow-up question to Senator Campbell's. And so we're talking that was passed for a five-year time period, right? [LB136]

SENATOR AVERY: I think so. [LB136]

SENATOR GAY: SCHIP was passed for five years so by the end of five years it could change. So what you're saying then is it's not part of the stimulus. That the revised fiscal note, which we're going to have to go get, if the amendment is considered or we can go get one I guess, is a five-year, those numbers you gave us were for five years then the way you understand it. We'll check into that. [LB136]

SENATOR AVERY: If they're not, then I think that would be very bad calculations I mean because it is tied to the federal law. [LB136]

SENATOR GAY: Okay. [LB136]

SENATOR AVERY: I would point out, too, that under the federal law I think in the past

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most states were not getting the full 70 percent match from the federal government. Under this new law, that will be available in addition to the bonus program that I mentioned. [LB136]

SENATOR GAY: Okay, all right. Any other questions? Senator Avery, I would say I appreciate your comments on the proponents because I will just say I've got 9, 10, 12 letters of support, hundreds of e-mails. We get the drift here. [LB136]

SENATOR AVERY: Lucky you (laugh). [LB136]

SENATOR GAY: Yeah, but I guess on that, though, you know, we have a couple of things after so I'm saying, you said it, I'm going to repeat it a little bit--new information. We're all very familiar with this bill. And I think technical information is probably more helpful to your cause, quite honestly, than other things. But say what you need to say. I'm just throwing it out there again. [LB136]

SENATOR AVERY: In the interest of saving time, I will not close. [LB136]

SENATOR GAY: Okay. And we know where to find you. And just on that, though, too, I was thinking about going to three minutes. We're going to stay at five minutes and see how it goes because I know there's some technical things in this bill so. But if we get going too long, I may have to change that. So be prudent with our time. [LB136]

SENATOR AVERY: Well, I'm going to get back to my committee because we're about to wrap up there, and I'm going to come back here and listen, but I probably will not close. [LB136]

SENATOR GAY: Sure. Okay, thank you, Senator Avery. All right. [LB136]

SENATOR AVERY: No questions? [LB136]

SENATOR GAY: No more questions, no. [LB136]

SENATOR AVERY: Thank you. [LB136]

SENATOR GAY: All right. We'll hear from proponents. And how many are going to speak on this? I don't want to discourage anyone. Oh, that's not too bad actually. All right, great. Thank you. Hello, Jennifer. [LB136]

JENNIFER CARTER: (Exhibit 2) Hi. Good afternoon, Chairman Gay, members of the committee. My name is Jennifer Carter, J-e-n-n-i-f-e-r C-a-r-t-e-r. I'm the director of the healthcare access program and a registered lobbyist at Nebraska Appleseed. And I'm hoping that...I think my job today is to hopefully answer some of those technical

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questions. First, we would just like to thank Senator Avery for bringing this important bill again and for his continued leadership on children's healthcare issues. So I'm here to focus on the federal law and hopefully clarify Senator Campbell's question. I think everyone on the committee understands Kids Connection is funded through two different federal funding streams. One is the State Children's Health Insurance Program or SCHIP; one is Medicaid, with different matching rates. So the federal government currently pays 59.54, about 60 percent for our Medicaid eligible children, which generally speaking are children at the federal poverty level or below. When you're younger, you can be a little higher level. CHIP pays for children who are above Medicaid eligibility but still considered low-income enough that they couldn't afford coverage in the private market. SCHIP pays 71.68 or about 72 percent for our SCHIP eligible children. SCHIP is a block grant. It's a finite amount of money. There's just a pot of money we get to draw down at the 72 percent rate for the SCHIP-eligible children. Medicaid is obviously we continue to get matching rates for any child that's eligible for Medicaid. So there were several important changes that came about at the federal level about a month ago when SCHIP reauthorization passed. First, it significantly increased the funding under SCHIP so that our allotment is much bigger. It's going to go up about 86 percent in fiscal year '09 to \$41.8 million as opposed to I think it was \$22.5 million previously. This is really key because in the past we have run out of our SCHIP money. We were what was called a shortfall state. So what happened then was when we ran out of money to cover our SCHIP kids at 72 percent, we ended up getting a Medicaid matching rate for them--very smart way to run our program, still good but we ended up paying the 12 percent difference there through our General Funds. That won't happen any longer because our funding allotment should be big enough to begin with. They also have given us the opportunity. The state can go back in August and ask to recalculate their allotment if we made these improvements and this expansion in our programs. They could redo our allotment there. Separately, they created a contingency fund so that in the event that states do face a shortfall, which they sort of tried to write the whole law that that wouldn't happen, we would be able to get some funds to make up for that shortfall. So I think that's really important to recapture that 12 percent that we used to have to pay out of our General Funds. Also there's a change in the CHIP funding formula so that it's imperative that we do a better job with our program now because what they're going to do under the federal law is rebase us, is the term they use. They rebase our funding formula in fiscal year '11, and I think they're going to do that every two years, and they're going to look at states' actual spending. So we need to start making sure we are covering the kids that we want to cover now so that we can continue to get the allotment that we need to be able to pay for these kids at the 72 percent match, the children that are SCHIP eligible. Also, as Senator Avery mentioned, there are bonus incentive payments. These are actually...the purpose of these was to focus on our lowest income children and getting them the healthcare they need. So if you increase your Medicaid-eligible children by a certain target, and I apologize, I don't have the target yet. I was working with some federal folks, didn't have that yet. We will...and implement five of eight changes, we'll be eligible for bonus payments. We

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have three of those administrative changes in place and two, as Senator Avery described, there's two or three that we could then easily make changes in the current bill in the amendments, a couple of which are just restoring things that used to be part of our program. There is also separately...there is an increase in our Medicaid matching rate as part of the recovery package. Every state gets 6.2 percent added on to the Medicaid matching rate. So we would be at about 66 percent, but then you also get, I think we'd actually be higher in Nebraska because you'd get a little bit more for unemployment. They bump you up a little bit more. The GAO estimates that this will bring in as much as \$310 million additional Medicaid dollars to Nebraska through the nine quarters of the stimulus. I believe that's December '10. And if you look at our projected Medicaid spending, what our Medicaid match rate would have been, about 60 percent, and what it's predicted to be in '09 and '10, we get...it looks like we have nearly \$272 million in General Funds that will then be freed up and made available for us to reinvest in our Medicaid Program. [LB136]

SENATOR GAY: Can I...just ignore the light right now because I think you're doing a good job explaining this and you'll kind of set a baseline I think that we won't have to answer questions. So explain it thoroughly and I don't want you to... [LB136]

JENNIFER CARTER: Okay. [LB136]

SENATOR GAY: Sorry to interrupt, but go ahead. [LB136]

JENNIFER CARTER: No, no, I appreciate it because I obey the light. So we're estimating that we'd have that much Medicaid money freed up. I do think one thing that's extremely important is to reinvest that into healthcare and Medicaid. And so...or at least a portion of it and that would certainly free up some money to do that. And the point of the stimulus was to help the families that are struggling, of the Medicaid money anyway, is to help the families that are going to be struggling through this economic downturn and so that we can focus on those. A quick note about the fiscal note also that Senator Avery mentioned. I just wanted to clarify the three provisions which I believe is increasing eligibility for pregnant women, increasing eligibility for transitional healthcare and transitional childcare. Once those are removed, the expenditures for fiscal year '09 or fiscal year '10 I guess it would be, is reduced by \$2 million, a little over; and in fiscal year '11 by about \$2.8 million so that our General Fund totals in the fiscal note would be \$5.7 million in fiscal year '10 and \$7.4 million in fiscal year '11 so that would be the reduction under the fiscal note. So I'm happy to take any more questions. There's certainly a lot to talk about with all this. [LB136]

SENATOR GAY: Senator Gloor. [LB136]

SENATOR GLOOR: Thank you, Chairman Gay. I have to admit I've got a little confused about... [LB136]

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JENNIFER CARTER: Yeah, yeah. [LB136]

SENATOR GLOOR: ...of the dollars we're talking about. What do we impact as a result of approval of this bill? The \$310 million isn't impacted by decisions we make on this bill, is it? [LB136]

JENNIFER CARTER: No, no, that's true. We would be getting...well, yes and no. You would...we are getting the increase in our federal Medicaid matching rate. That's just going to happen automatically that we get 6.2 percent. But you don't draw that down unless you actually invest...do your state General Fund investing. So I do think this \$310 million is based on our projected spending. There could be more that we could draw down if we did... [LB136]

SENATOR GLOOR: If we spend more. [LB136]

JENNIFER CARTER: Sorry? [LB136]

SENATOR GLOOR: If we spend more. [LB136]

JENNIFER CARTER: If you do...if more kids that are currently eligible that we should have already figured out that we might have to spend money on get enrolled in a Medicaid Program... [LB136]

SENATOR GLOOR: Okay. [LB136]

JENNIFER CARTER: ...who are currently not enrolled. [LB136]

SENATOR GAY: Okay. Senator Wallman. [LB136]

SENATOR WALLMAN: Thank you, Chairman Gay. Thank you for showing up, Jennifer. You always do a good job. [LB136]

JENNIFER CARTER: Oh, thanks. [LB136]

SENATOR WALLMAN: I see some of these rural counties here. Do those kids always apply for this CHIP Program? [LB136]

JENNIFER CARTER: Well, I think that's an interesting question. I don't know why that is the case. And I don't know why it's the case that we have, I mean, about 60 percent of our uninsured kids are at 200 percent of the federal poverty level or less. And so I don't know why they're uninsured if the majority of those kids are income eligible for Kids Connection. I think that reflects some improvements we could make in our outreach and

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enrollment to make sure families understand that they might be eligible. And I think some of it is families that are working don't realize that they may actually be at a place even today, even before this bill, where they...their kids might be eligible for this program. [LB136]

SENATOR WALLMAN: Okay, thank you. [LB136]

SENATOR GAY: Senator Howard. [LB136]

SENATOR HOWARD: Thank you, Mr. Chairman. Just a follow-up to that, does a lack of providers enter into this? In some of these counties, the six Nebraska counties that rank so high, are there available providers that will accept this payment? [LB136]

JENNIFER CARTER: That's a really good question, and I don't know specifically for those counties. But I do think, I mean, we have certainly heard that there are...we could use more providers taking Medicaid for sure. So that's a good point. [LB136]

SENATOR GAY: Any other questions? I've got a question for you on the fiscal note. So you're saying the changes on this amendment, your estimate is it would save \$2 million off the \$24 million so you're still talking \$22 million? [LB136]

JENNIFER CARTER: I actually took it...I just calculated it would be the third, sorry, no, the fourth, fifth, and sixth paragraphs I just added up the General Fund expenditures predicted under those, and those amount to \$2 million. So I guess it would be still \$2 million off the total, but \$2 million off the General Fund expenditures. So if it was 7.7 in fiscal year '09 and '10, adding up what they predicted would be the increase in those once we don't increase eligibility for those, our General Fund dollars, as I understood this breakdown, would reduce by \$2 million. [LB136]

SENATOR GAY: Okay. Any other questions? Senator Pankonin. [LB136]

SENATOR PANKONIN: Ms. Carter, this sounds like the type of deal I'd say to Senator Wallman when I'm trying to sell him a tractor: You can't pass this deal up. Is that what you're trying to tell us? (Laughter) [LB136]

JENNIFER CARTER: I do think to some extent we can't pass this deal up. I mean I don't know how many other programs where we spend...when we spend our state dollars we get 72 cents covered, and that money has a stimulus effect in the state. So it goes beyond just helping us pay for the particular healthcare needs of those children. That helps stimulate things in the economy, people use healthcare, the nurse gets paid, the nurse goes shopping in the grocery store that, you know, all of that happens. And so the other thing I'm a little concerned about, too, is under the CHIP legislation if we don't at least make sure we're enrolling all the kids we want to enroll, and we would say going

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to 200 to make sure we're covering all the kids that we think we should be prioritizing, that money is going to other states. When they rebase in fiscal year '11 if they don't think we're doing a good job covering our kids, that money is going elsewhere. And I think that money should come to Nebraska. [LB136]

SENATOR PANKONIN: But it still costs...it would be a new... [LB136]

JENNIFER CARTER: There's still an investment for the state, absolutely. [LB136]

SENATOR PANKONIN: Okay. [LB136]

JENNIFER CARTER: Although some of that is offset in the next two years through the stimulus money over here because we'll get... [LB136]

SENATOR PANKONIN: So do we really know what it will cost? [LB136]

JENNIFER CARTER: I think the fiscal note, and I don't, you know, I don't know everything that's behind the fiscal note, estimates what it would cost for the kids that we're bringing onto the program. I think through the room that's going to be in our budget through the increase in our stimulus Medicaid match dollars we'll free up General Fund dollars that could help pay for this over the next two years. That's really where the room comes from. The room comes from the stimulus money and from recapturing that 12 percent in our CHIP Program that we used to have to cover because the federal government didn't give us enough of an allotment. And unfortunately, I don't know what that 12 percent total would be. I don't know how much we usually ended up paying over and above what our CHIP allotment was. [LB136]

SENATOR PANKONIN: So is this going to be the type of situation--one last question--that we do it for two years and then this money goes away and then... [LB136]

JENNIFER CARTER: The CHIP money won't go away, but the...and not having to pay that extra 12 percent doesn't go... [LB136]

SENATOR PANKONIN: Right, but the stimulus money could. [LB136]

JENNIFER CARTER: The stimulus money does go away, but I mean, the assumption is that revenues are back up at that point and so, I mean, that's what the, you know, the stimulus is for now when we're assuming state's revenues are down. So I think there is, yeah, the stimulus money presumably would go away. I would hope that we wouldn't need another stimulus two years from now so. [LB136]

SENATOR PANKONIN: Thank you. [LB136]

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SENATOR GAY: I've got a...actually it's a question for Jeff Santema. If we...to get a revised fiscal note instead of proponents giving us a fiscal note, can we just ask Fiscal for that or do we have to pass an amendment to go get the revised fiscal note? [LB136]

JEFF SANTEMA: Typically, I think the practice, Senator Gay, has been that once the amendment is adopted by the committee and the bill is advanced, then a new fiscal note is. [LB136]

SENATOR GAY: Well, if the amendment...the reason I say that, if an amendment were passed and the bill weren't necessarily passed out of committee, could we get a revised fiscal note without having to advance it to the floor? Because that would make a big decision, I mean that would...I think we'd need to understand that. You don't have to answer now, but we should check into that because I don't...you heard me arguing before about fiscal notes. We get them a day before and you never know what you're going to get. But we'll check into that. Another question I had, though, when you read, you read about people that were on private insurance, you raise these levels, and then all of a sudden they're dropping their private insurance to go on SCHIP. Explain how that works or does that work and is there anything in here that would prevent that from happening? [LB136]

JENNIFER CARTER: I think that technically somebody is free to do that. I think two things which is, and other people who are going to follow me are going to explain more about the federal budget...the federal budget, no, that's what I'm trying to do...about a family budget so you can get a realistic sense of what it would be like for families. But I think if somebody actually has affordable health insurance at this level I don't know how many...just because the other argument you hear all the time is nobody wants to change their private coverage when they like it and when they can afford it. And so I don't know how many families that can actually afford it would drop it if they like it in the first place and if it's serving, meeting their needs and they're able to take their kids for well child visits and all of that. And then otherwise, I think you're dealing with families, as you'll see, who by what we've been able to estimate in the private market, it's almost entirely unaffordable for these families. But this is trying to be focused on the uninsured kids, but there's nothing to prevent, there's no waiting period or anything included in this bill. [LB136]

SENATOR GAY: Well, I guess we'll check into that because that has been something that I know would be concern for a lot of other people not on this committee as well that I've heard. But affordability of healthcare is a pretty...my healthcare is very expensive, too, and I mean no one likes paying that. But I just wonder if you're a large employer, let's say, that you weren't making...you're right under that threshold, you're still paying a small portion. But I'd like to maybe go save that small portion, I still then dump my employer's insurance to come over. There's no...have you seen anything that could prevent that from happening? [LB136]

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JENNIFER CARTER: The only thing that I've seen is when you have...you actually essentially force a family to go without insurance for 12 months or something before they can come on. You have a waiting period. [LB136]

SENATOR GAY: Other than that, you haven't seen anything else. [LB136]

JENNIFER CARTER: I haven't actually. [LB136]

SENATOR GAY: Okay. [LB136]

JENNIFER CARTER: But I mean there may be other solutions out there. But I think, you know, we have less of a concern with that because of the income levels we're talking about that we tend to think you just...this is just something that we feel should be prioritized. [LB136]

SENATOR GAY: Yeah. [LB136]

JENNIFER CARTER: And so that might be something of a risk that you take, but the benefits to so many of our uninsured kids, particularly those that we get enrolled I think is worth it so. [LB136]

SENATOR GAY: I just know that's been a concern. [LB136]

JENNIFER CARTER: Sure, yeah. [LB136]

SENATOR GAY: Any other questions for Ms. Carter? [LB136]

JENNIFER CARTER: And I'm happy to talk more about it because I know I had to talk really fast about all the stuff that's taken me a long time to learn. [LB136]

SENATOR GAY: Well, we tried to help you being first. You always get all the hard questions, but we are going to reinstate the lights. Thank you very much. [LB136]

JENNIFER CARTER: Okay, sure. [LB136]

SENATOR GAY: All right. Other proponents. [LB136]

JOHN CAVANAUGH: (Exhibit 3) Good afternoon. John Cavanaugh, J-o-h-n C-a-v-a-n-a-u-g-h, and I'm appearing this afternoon on behalf of the Nebraska Child and Health Care Alliance in distributing a letter from the alliance over 50 statewide organizations throughout the state signed by my good friend Pat Connell of Boys Town. And to shorten time, I'm speaking on behalf of him and those other organizations, and

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hopefully I will stay well below the limit. I'm also the executive director of Building Bright Futures, a public/private partnership engaged in improving educational outcomes for students in our two-county area of Douglas-Sarpy County, approximately 40 percent of the state's student population. And I want to just quickly make several points. I know that the committee is very well versed on this legislation. First of all, I want to thank Senator Avery and the cosponsors, Senator Campbell and Senator Howard, for bringing this legislation before the Legislature and this committee and demonstrating leadership on this vital issue. My perspective on this has developed over the last several years in focusing on academic achievement and the academic achievement gap. We have extensively studied the causes for academic failure among our student population. And the number one individual cause for lack of academic achievement would be lack of access to healthcare. Now we have too many students, you already know that we have 45,000 student population in the state with no health insurance. This would add another 5,000, 5,400 to coverage and provide them access. It's absolutely critical and as you evaluate the economic impacts you do need to consider the educational impact. And the fact of the matter is, if a student has a vision impairment, undiagnosed and untreated, a hearing impairment, a dental condition or the whole range of healthcare conditions which we have, they are not going to perform well academically. They become the core of our failure population, our dropout population, our criminal population, and you know the whole rest of the story in terms of lack of economic success and economic drain. So you have to look at that side of the equation in addition to the basic fairness required for access to healthcare because each one of these children who don't have healthcare are also impacted in terms of their ability to perform and their ability to compete academically in our school systems and in our community. I do urge you to enact all elements of this. It's not simply increasing the eligibility to 200 percent. The other elements, in terms of extended eligibility to 12 months and presumptive access are critical. I do want to refer you to one part of our Bright Futures study, and we do document every impact on academic success, but I do have this recent chart by the Commonwealth Trust, a very respected research organization, that ranks Nebraska 6th in healthcare, child healthcare quality in the country, and 31st in terms of access. This is the critical element of access and we need to improve our standing throughout the country. So thank you for the opportunity to appear before you today and this is the most widely supported piece of legislation that I've seen in the state for a very long time and is critically needed for the success of our students. [LB136]

SENATOR GAY: Any questions? Don't see any. Thank you. [LB136]

JOHN CAVANAUGH: Thank you. [LB136]

TIFFANY SEIBERT: (Exhibit 4) Good afternoon, Chairman Gay, members of the committee. My name is Tiffany Seibert, T-i-f-f-a-n-y S-e-i-b-e-r-t, and I am the policy coordinator at Voices for Children in Nebraska. I'm testifying today in an effort to talk about the family budget, and I've provided some handouts here which I hope can get

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around before I start talking about it. We've done some significant research and you'll see in your packet I've provided a copy of each document based on county-specific data of all of the counties that you live in. So there will be seven different county breakdowns of a family budget. I'll briefly talk about what the budgets estimated...or what it's based on before you can take a look. There was a 2002 study conducted by a couple of Ph.D. researchers and in collaboration with Nebraska Appleseed. This study looked at county-specific data and estimated what it takes for a family to get by without public or private assistance. The family budget that I provided for you here is based on two parents and two children, an infant and a preschooler. So in the pie chart, that provides the breakdown of what a family needs to get by without public or private assistance, and we've provided...we've taken those percentages of the different costs in a family budget and applied that to 200 percent of the poverty level, so you can see the breakdown, at 200 percent of poverty, what sorts of costs would be needed to allocate to each expense for a family to get by without public or private assistance. What we found in the seven counties that the members of the HHS Committee represent is that in 2002 it was assumed that approximately 5.7 to 7.9 percent of the family budget would be required to obtain health insurance. This budget also assumes employer-sponsored health insurance and it assumes that the employee is only responsible for 27 percent of that healthcare plan. So then we, Voices, went ahead and called a couple of well-known health insurance providers in Nebraska and we received three estimates of plans and the costs, you can see at the bottom of your handout. These estimates of health insurance coverage are for a family of four as well. The estimates assume no maternity coverage for the family and they also assume completely clean health histories, which we know is not the case for many families. What you can see here is that the percent of the budget provided for healthcare above, between 5.7 and 7.9 percent, is not sufficient for the costs of the monthly premiums below for the three plans that we provided. The three plans that we provided respectively would require 13 percent of a family's annual income at 200 percent of poverty, 15 percent with a lower deductible, or 12 percent respectively of a family's budget at 200 percent. So what we believe that these data illustrate are that families are increasingly unable to access health insurance in the private market. I've also included with my testimony a letter from a mother who has been working with our organization. We've been trying to find her plans that are affordable, but she is exactly the type of family that we're looking to help with this bill. Both she and her husband work full-time. She is self-employed. Her husband's business offers private insurance but the premium is \$800 a month or \$200 a week, so they have struggled to find a health insurance plan that they can access. So I encourage you to read that letter, recognizing that these are the sorts of families we will reach with LB136 and by extending health insurance to 200 percent of poverty. And then secondly, I'd like to quickly address Senator Gay's question about crowd out. I think, as Jennifer Carter said, this might be an issue if we were talking about significantly higher levels of income, but I think what my budget does show is that at 200 percent of poverty families aren't skating by and they aren't easily able to afford private insurance. I think what it also assumes, that argument, is that employers are offering coverage at the rate they

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have in the past. We know that's not the case. And then I think it also fails to recognize that families do...would rather have private coverage in many cases and retain the choice that they're afforded with their private coverage. So with that, I'd be happy to take any questions. [LB136]

SENATOR GAY: Any questions? Don't see any. Thank you. [LB136]

TIFFANY SEIBERT: Sure. [LB136]

CHUCK BENTJEN: Senator Gay, members of the Health and Human Services Committee, I'm the Reverend Dr. Chuck Bentjen and I serve as director of Justice and Advocacy Ministries for the Evangelical Lutheran Church in America, or commonly referred to as the ELCA. And honestly, I have to say that I came here prepared with this great message about Christian values and how important it is to support this type of legislation, but I think I would be preaching to the choir here today so I will forgo that. I just simply want to say that from a faith perspective, and I think I speak not just from a Lutheran Church perspective but from the faith community in general, we see the provision of healthcare as a shared endeavor or a shared responsibility. Certainly individuals have responsibility to take care of their own health but also collectively as a society we have the responsibility to use our resources to benefit and promote the health of those who cannot afford it. And so we would strongly urge you to support this legislation and pass it on to the committee for...or pass it on to the full Legislature. It's been a long day. I would also like to just say that I am proud to be the constituent, a consistent, of Senator Wallman. [LB136]

SENATOR GAY: All right. All right. Were there any questions? I don't see any. Thank you. [LB136]

CHUCK BENTJEN: Thank you. [LB136]

SENATOR WALLMAN: Thank you for testifying. [LB136]

CHUCK BENTJEN: Thanks. [LB136]

BARBARA JOHNSON FRANK: (Exhibit 5) My name is Barbara Johnson Frank, B-a-r-b-a-r-a J-o-h-n-s-o-n, plain old Frank, F-r-a-n-k. Thank you, Senators, for the opportunity to speak with you for briefly today in support of LB136. I'm here representing the Social Ministry Committee of First Lutheran Church here in Lincoln. As our committee met on two separate occasions this week, we named advocacy for children's health as our priority. I also come to you as a retired teacher who was honored to spend 25 years working in schools in low-income areas in Lincoln. I've seen firsthand how access to healthcare, or lack of access of healthcare, affects children's learning. Children are no more able to deal with the fatigue and the pain that comes with throat

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infections and dental problems than the rest of us are. For the sake of children's learning, they must be healthy. And I come to you as a mother and as a grandmother. Our 25-year-old daughter, her husband and their 16-month-old daughter are living with us until this young family can get its feet off the ground financially. My daughter is a substitute teacher for two different school systems here. Our son-in-law helps with the childcare and patches together part-time jobs. My husband and I currently pay their family health insurance, which costs about \$3,000 a month and has a \$3,000 deductible. Recently, my granddaughter ran a high fever for several days, actually, it was closer to a week, off and on. I heard my daughter speak words that I never thought I would hear in my own family: I don't know if I should take her to the doctor; it costs \$100 for every visit. Well, they did take her to the doctor. Our granddaughter had a urinary tract infection caused by an E. coli bacteria that could have signaled a problem with her kidneys. Further hospital tests were required and again we thought are these tests necessary, knowing that all of the expenses would be out of pocket. A friend who was a doctor in Denver assured us that the tests were necessary and she told us that she has seen teenagers whose infections were not detected and who developed advanced kidney disease, some requiring dialysis or transplant. So, as in my own family, the questions for all Nebraskans becomes, now or later? Can you...should you detect an easily treatable condition now through increasing access to medical care or face a possibility of a child and the rest of us paying the price for kidney failure later? Today as I sit before you, my mind travels to the hundreds of working families I have known during my teaching career, to young families at my church, and to my own young relatives. I think about those young families who have no grandparents in the wings or whose grandparents, as much as they would like to help, have their own financial problems to solve. The people who need the services that LB136 would provide are not strangers. They are your neighbors' children and they are your grandchildren and your own family members and mine. The committee I represent believes that the honorable and compassionate thing to do is to help more working Nebraskans access the healthcare that is essential to their children's well-being. I thank you very much for considering our testimony. [LB136]

SENATOR GAY: Any questions? I don't see any. Thank you. [LB136]

BARBARA JOHNSON FRANK: Thank you. [LB136]

DAVID HOELTING: My name is David Hoelting. I'm a physician at Pender, Nebraska. That's spelled D-a-v-i-d H-o-e-l-t-i-n-g, and I'm speaking on behalf of the Nebraska Medical Association and also for myself. What I'd like to do real briefly, because I know it's getting late, but put a little bit of a kind of in-the-trenches picture on what's happening now and what's going to be happening as things get worse, as far as the economy is concerned. I live in...Pender is in Thurston County, which has the dubious distinction of being one of the poorer counties in the state of Nebraska. We have a lot of minorities in the county. We have a high Native American population, as well as

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Hispanic population, and a lot of individuals that fall right under this area, basically working poor. We have a lot of farmers in the area that really can't afford insurance policies that run sometimes several thousand dollars a month, if you have to buy it yourself, and may have marginal incomes. A lot of individuals, their spouses work in order to get insurance. More of them are being laid off. Right now in our area we have three major manufacturing firms that are cutting back dramatically. They're going back from, say, two or three shifts down to one or less than one or only part-time and are threatening to actually close up entirely, and this is having a huge impact on the area. We're seeing a lot more people in my clinic. And by the way, the clinic that we have is a rural health clinic which is set up to handle Medicare/Medicaid patients. We get a capitated fee on those individuals and basically anyone under this auspices is welcome in the clinic. But we're seeing more and more individuals that have no coverage whatsoever. When we see the sheets on the charts, they say none. When this happens, invariably what we see is that individuals are coming later on infections and they're coming sicker. We usually first see a drop in preventive med care: individuals that will tend to drop coming in for immunizations, they're going to come in...quit coming in for checks. The biggest population we're seeing trouble with is asthmatics. There are not a lot of chronic conditions that we see in kids, but asthmatics are ones that if you stay on top of the condition, if they are coming in regularly, making sure that they are using their inhalers, using preventive care, they can stay out of the emergency room, they can stay out of the hospitals. It's pretty easy, when you're having to pay for the meds yourself and you're looking at about \$130, \$140 for an inhaler, it's easy to say, you know what, I bet if we quit this Johnny is going to be fine. And they stop it and, lo and behold, he doesn't have any big asthma attacks then. He may go a week, month, two months, and all of a sudden about...usually about January or February they get respiratory infections and suddenly, instead of being able to shake off the infection like every other little kid does, you have a condition where the child is in the emergency room about midnight, because that's usually when these attacks come, or is being seen in the clinic sick enough that they have to be hospitalized. We also see conditions where infections that ordinarily can be taken care of pretty easily and cheaply wind up coming in late and wind up in the hospital. Two examples recently: I had a child two weeks ago that came in, six-year-old, had been under good control with asthma medication. Went off about six months ago because of loss of insurance coverage and didn't qualify for Medicaid at that time. Child came in, this time had an oxygen level of 80. It's supposed to be about 96. This is a level where you start thinking about whether you're going to have to tube them. And anyhow, we were able to get the child under control there. We also had a child recently that had gone two weeks on an infection, wound up with a periorbital cellulitis. This is an infection that threatens to go to meningitis if it isn't treated properly. I'll wrap up quickly. The thing of it is, there is a cost to us just simply saying the answer is always no when we talk about things that possibly expand it. There is some cost to the state, but not treating these conditions, not getting coverage costs us, too, in bankruptcies, in loss of businesses because of the bankruptcies, in loss of tax revenue the state is going to get, and just plain human suffering that's entailed with this. We're

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going to be getting a lot of money from the federal government that's going...we're going to be able to plow into the system to improve the livelihood and the health of the population of the state and I think it behooves us to take advantage of this and try to improve the lot of the citizens of the state here right now. Thank you very much. [LB136]

SENATOR GAY: Thank you. Any questions? Senator Gloor. [LB136]

SENATOR GLOOR: Thank you, Chairman Gay. Dr. Hoelting, have you...you've made reference several times to emergency room visits. Have you seen over the past couple of years a notable increase in the number and types of patients going to community hospital? [LB136]

DAVID HOELTING: Yes, we have seen a...in fact, actually the time period has been the last four months. We've seen a big uptake in people that are being seen in the emergency room because they don't want to come to the clinics because of the costs that are involved. They put off treating things till it gets to the point where they have no choice. And of course, these visits are extremely costly compared to going into the clinics and there's a much higher chance that they're going to wind up going from there to a hospitalization. Yeah, my partners, and I forgot to mention I've got three partners right now and then two PAs in our clinic, but we've all seen a big uptake, uptake basically in patients that are coming in for their care through the emergency room, which is the least cost-effective and the least effective means of taking care of problems. [LB136]

SENATOR GLOOR: Okay. Thank you. [LB136]

SENATOR GAY: Any other questions? I don't see any others. Thank you. [LB136]

DAVID HOELTING: You bet. [LB136]

SENATOR GAY: Other proponents? Any opponents? While Director Chaumont is coming up, Jeff spoke with me. He thinks he can get us an updated fiscal...we'll get that to you fairly quickly for your records, but we think we can get that done without an amendment. And then I'm not going to read all of these but we have many letters of support that were handed in. The clerk has them and those will be put into the record for sure. (See Exhibits 7-16.) So go ahead. [LB136]

VIVIANNE CHAUMONT: (Exhibit 6) Good afternoon, Senator Gay. I am Vivianne Chaumont, V-i-v-i-a-n-n-e C-h-a-u-m-o-n-t. I'm the director of the Division of Medicaid and Long-Term Care. My testimony is about the original bill, not the amendment, so I'm not going to bore you with reading my testimony. I just wanted to point out just some additional things that you should know while you're considering the amendment. The fiscal note for just the two items that the amendment says is \$5.9 million in General

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Fund for FY '10, and \$7.6 million in General Fund for FY '11. That doesn't include any increased costs from the increased enrollment that all the activities that people are talking about we should do to get more people in the door. When you get more people in the door, that obviously increases costs. So that \$5.9 million and \$7.6 million is the least amount. Somebody testified that the room for this comes from the stimulus dollars. You have to remember that the stimulus dollars are for a two-year period and the purpose of the stimulus dollars, as far as the Medicaid increase in FMAP was concerned, increasing the amount that they pay, was to give state budgets breathing room so that states did not cut their Medicaid eligible so that states would maintain their Medicaid Programs without making drastic cuts to eligibility, not to benefits and not to rates because those are still okay. They just didn't want you to make drastic cuts to eligibility. The purpose of the stimulus as far as the FMAP for Medicaid is concerned was not to expand programs. I wanted to respond to your question. Senator Gay, I believe you're the one that asked about crowd out to families. It is a huge issue in CHIP, and CHIP is a great program, no doubt about it. That's one of the downsides of the CHIP Program. People in fact do drop their health insurance, health insurance that they are...that they are, have been, and are able to continue to pay for. And the thought that people always prefer private insurance to Medicaid or to CHIP insurance is not necessarily true because private insurance tends to have copays, deductibles, things like that; CHIP doesn't have copays, deductibles for children. So that's another reason why people drop their health insurance to do that. And that was the only other information I had for your consideration. Oh, one other thing, I'm sorry. Excuse me. The \$310 million that the state of Nebraska is going to gain by this FMAP is an estimate by the congressional folks for the amount that Nebraska is eligible, and those are estimates for all the states. The estimates are based on a growth of the Medicaid Program of 10 percent per year. The Medicaid Program in Nebraska has not grown at 10 percent per year in a very long time, so the \$310 million is inflated. So want to get that out there as well. Uh-huh. [LB136]

SENATOR GAY: All right. Senator Pankonin. [LB136]

SENATOR PANKONIN: Thank you, Senator Gay. Director Chaumont, I just want to make sure I understand your statement about that in many states, because of their fiscal difficulties, this federal money is for folks to maintain the levels of...that they have. Is that...? [LB136]

VIVIANNE CHAUMONT: In all the conversations that I've heard with, you know, state Medicaid offices and all of the things, that's what...they were doing the FMAP because Medicaid is such a huge part of every state's budget that with the Medicaid increases, because of, you know, especially with the natural increases anyway and then the increases with the bad economy, that states were cutting eligibles, cutting benefits, cutting rates. I think there was a flat 10 percent rate decrease in California, for instance. I know Colorado has those same kind of things. Those are the ways you cut the

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Medicaid Program, by cutting eligibles. The stimulus is trying to just help states stabilize so that they get more money, more assistance from the federal government, so they can put less General Fund into their Medicaid budget. They're not tempted to cut their Medicaid eligibles in order to pay for roads and prisons and all the other expenses that states have. So that's all that I've heard. [LB136]

SENATOR PANKONIN: Is there a prohibition, though, of expanding in...from CMS or anything? Is it... [LB136]

VIVIANNE CHAUMONT: There is no prohibition for expanding... [LB136]

SENATOR PANKONIN: Okay. [LB136]

VIVIANNE CHAUMONT: ...about 300 percent, I think. Uh-huh. [LB136]

SENATOR PANKONIN: All right. Thank you. [LB136]

SENATOR GAY: Senator Campbell. [LB136]

SENATOR CAMPBELL: Thank you, Senator Gay. Oh, Ms. Chaumont, on the briefings that we've been having on the department, Mr. Landry talked about watching the trend line in terms of food stamps... [LB136]

VIVIANNE CHAUMONT: Uh-huh. [LB136]

SENATOR CAMPBELL: ...and being able to...that it would be important for us to watch that trend line because it is an indicator when families start having difficulty. Are there any trend lines that you're watching in terms of...I mean, I know you're watching them all. [LB136]

VIVIANNE CHAUMONT: Uh-huh. (Laugh) [LB136]

SENATOR CAMPBELL: I'm sorry. I'll reword that. [LB136]

VIVIANNE CHAUMONT: One or two. [LB136]

SENATOR CAMPBELL: Are there some of... [LB136]

VIVIANNE CHAUMONT: Yeah, uh-huh. [LB136]

SENATOR CAMPBELL: ...particular note when we think that we will begin to see this hit Nebraska, knowing that it's not going to have the staggering numbers other states may have? [LB136]

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VIVIANNE CHAUMONT: We don't know at this time if it's not going to have the staggering number that other states have. I mean, we're hopeful that it's not going to and we certainly haven't seen the increases that other states are seeing. We're seeing about a 1.5 percent increase in Medicaid eligibility over the last six months. You know, since I've been here, the Medicaid enrollment has kind of lingered right around 202,000, I remember that number, and right now it's lingering at about 205,000, so pretty insignificant, compared to the type of changes that other states are seeing. But we don't know that that's going to be what, you know, what happens. And to finance a program based on funding that will go away in two years is always a concern. Uh-huh. [LB136]

SENATOR CAMPBELL: Thank you. [LB136]

SENATOR GAY: Senator Wallman. [LB136]

SENATOR WALLMAN: Thank you, Chairman Gay. Thank you, Director Chaumont. In regards to...I heard you mention health insurance, people drop health, that's always a concern. But if I make \$50,000 a year and I don't have health insurance I'm not going to be qualified for this program, am I, my children? [LB136]

VIVIANNE CHAUMONT: You...it depends, actually, on how many kids you have and where you are. [LB136]

SENATOR WALLMAN: Well, yeah, if I have two kids. [LB136]

VIVIANNE CHAUMONT: And, you know, I don't have the list in front of me but I don't believe...I don't know because there are disregards. You know, there's disregards about how much of your income is counted. I have a list somewhere that has all that. I don't know that. [LB136]

SENATOR WALLMAN: I think it's around 42, but that's okay. Thank you. [LB136]

VIVIANNE CHAUMONT: Forty-four, something like that, without the disregards. [LB136]

SENATOR WALLMAN: Forty-four, yeah. [LB136]

VIVIANNE CHAUMONT: You know, the interesting thing about CHIP is that you cannot have health insurance and have CHIP eligibility. We encourage Medicaid, just, you know, the people that we get the 60 percent from to have health insurance and we have programs where we will actually pay for their health insurance premium in order to make Medicaid secondary and cut our costs, you know, where it's cost-effective to pay, you know, \$200 a month for a family because it will save us, you know, money in the long run. We do a cost-benefit analysis. But federally, the CHIP Program prohibits a child

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from being eligible for CHIP if that child has insurance. [LB136]

SENATOR GAY: Senator Gloor. [LB136]

SENATOR GLOOR: Thank you, Chairman Gay. And thanks for your testimony and I had forgotten that there are times the department pays for health insurance premiums, which I thought was wonderful, very creative, happen a lot. But one of the things that I hear a lot of is...and I have to say I heard this in my previous job when I was an employer, that people dropped company insurance plans to be part of the CHIP Program. And I remember asking my director of human resources, do we see this, and the answer I got back then was we don't know but we don't think so. I mean, we didn't see that kind of a bailout. How...where do we have the...I mean there's a rationale here. [LB136]

VIVIANNE CHAUMONT: Yeah. [LB136]

SENATOR GLOOR: Some of it makes sense intuitively, except I'm looking for hard data that somebody has some numbers that shows us that actually happens. [LB136]

VIVIANNE CHAUMONT: There have been all kinds of studies done on crowd out and I'll try to find some, not here in Nebraska but just generally, and I'll try to find some of those for you and forward them to you. You know, even if your health insurance is an amount that you can afford, if...and you know at some level you can't blame families for that. You know, if they're going to spend \$50 bucks on insurance when they can get this program, not spend the \$50 bucks, and spend \$50 bucks on another family need, you know, that's what happens. And then, you know, it's a better program in some ways because you don't have the deductibles and you don't have, you know, some of those things. So it's a huge concern. Uh-huh. [LB136]

SENATOR GLOOR: I'd appreciate anything that you've got that I can take a look at. Thank you. [LB136]

VIVIANNE CHAUMONT: Sure. Uh-huh. [LB136]

SENATOR GAY: Senator Howard. [LB136]

SENATOR HOWARD: Yeah, thank you, Mr. Chairman. Yeah, I have the same concern as Senator Gloor and I wondered if we collected data on that. Do we have any idea of the people that drop insurance? Do we have any hard data? Do we know the companies that these people... [LB136]

VIVIANNE CHAUMONT: Uh-huh. [LB136]

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SENATOR HOWARD: I'm wondering if there's some kind of a pattern,... [LB136]

VIVIANNE CHAUMONT: Uh-huh. [LB136]

SENATOR HOWARD: ...if there's some employers, you hear about this, that refer... [LB136]

VIVIANNE CHAUMONT: Uh-huh. [LB136]

SENATOR HOWARD: ...people to our system because they don't want to cover them. But I think all that would be very helpful in terms of actually having the information, having the facts. We all hear the stories but having the facts would be much more valuable. [LB136]

VIVIANNE CHAUMONT: Yeah. I don't know...I don't think we have...I'll check but I don't think we have any Nebraska data. [LB136]

SENATOR HOWARD: So it's just kind of a vague, we think it's going on. [LB136]

VIVIANNE CHAUMONT: I know that there have been studies done in other states because it's always a big topic in CHIP. [LB136]

SENATOR HOWARD: But there's not a checklist, there's not a checkoff, when you apply, did you previous have insurance? [LB136]

VIVIANNE CHAUMONT: No. [LB136]

SENATOR HOWARD: When did you discontinue it? [LB136]

VIVIANNE CHAUMONT: You know, I don't think so because we don't count that. There are states...there are states that have a six-month waiting period to try to discourage people from dropping their insurance, or a 12-month waiting period where then those states would collect the data that says, you know, I had health insurance, I dropped it, you know, December 1. And now you're not going to eligible until whatever. [LB136]

SENATOR HOWARD: Right. [LB136]

VIVIANNE CHAUMONT: But since we don't have a waiting period for that, we don't...you know, it's data that we don't collect. [LB136]

SENATOR HOWARD: It'd still be helpful to us to know if in fact this is true or what percentage. [LB136]

VIVIANNE CHAUMONT: Uh-huh. [LB136]

SENATOR HOWARD: And I want to agree with you on one point. I think you're absolutely right that if there was a program such as in Medicaid where we encourage you to carry insurance and we cover what it doesn't, and I think back to adoptions that I've done. And with adoptions, the family's insurance is first payee and the Medicaid covers what that doesn't, which I think we wise of us to do it that way. [LB136]

VIVIANNE CHAUMONT: Right. Uh-huh. Yeah, and that's...I mean that's a great program. That saves money and, you know, it's a program that we're working on to expand. The other interesting thing about CHIP is state employees can't be eligible for CHIP, so a state employee can't refuse to take the state health insurance and apply for CHIP. Basically, the federal government doesn't want to be subsidizing, you know, state employment benefits. They get sensitive about things like that, but...so it's an interesting program. [LB136]

SENATOR GAY: I've got a question for you. Have you seen this amendment? [LB136]

VIVIANNE CHAUMONT: No, I have not. [LB136]

SENATOR GAY: Well, part of this question is that the department shall develop and implement activities designed to increase public awareness and it says how you would go about doing that. Is that part of the...is that a mandatory thing, you have to go out and promote SCHIP to get the money? [LB136]

VIVIANNE CHAUMONT: Not in a Medicaid expansion. When the... [LB136]

SENATOR GAY: This would be Section 3. [LB136]

VIVIANNE CHAUMONT: When a state runs SCHIP as a separate program, as, you know, separate like Colorado runs it as a separate program as opposed to a Medicaid expansion, then there are all kinds of requirements for the state to go out and advertise and try to enroll people. What...I don't recall those kinds of requirements when it's a Medicaid expansion. And the interesting thing is that it's...that when you actively recruit or try to get more CHIP enrollment, what you end up doing is getting more Medicaid enrollment, you know, at the lower level just because people who aren't aware, you know, they'll, you know, you'll advertise and usually don't do that kind of recruiting for Medicaid enrollment, but that's part of the issue. So then you're talking about bringing people in. That's what I was talking about, that that's not reflected in these fiscal notes, bringing people in and you bring them in at the lower...at the lower...because in order to be eligible for CHIP you can't be eligible for what they call straight Medicaid, so... [LB136]

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SENATOR GAY: All right. Any other questions? I don't see any. Thank you. [LB136]

VIVIANNE CHAUMONT: Thank you. [LB136]

SENATOR GAY: Any other opponents who would like to speak? Anyone neutral? And then Senator Avery waived his closing, so we're going to close the public hearing. We're going to take a ten-minute break and be back at 4:15. Sorry, Senator Lathrop. They jumped the gun. [LB136]

BREAK []

SENATOR GAY: All right, Senator Lathrop, thanks for being patient. Sorry we got you here a little early and then... []

SENATOR LATHROP: That's all right. []

SENATOR GAY: Go ahead and open up on LB291. [LB291]

SENATOR LATHROP: Thank you, Chairman Gay and members of the Health committee. My name is Steve Lathrop, L-a-t-h-r-o-p. I am the state senator from District 12 in Omaha and I am here today to introduce LB291. LB291 is very simple. It basically provides that the Department of Health and Human Services need to develop regulations for the community-based programs. Let me tell you why I introduced LB291. As you know, three of you are members on that committee, the LR283 committee studied the issue of developmental disabilities all summer and fall. And in the course of our studies, and frankly, as observed by the Department of Justice, part of the problem with BSDC, which has been the focus of much attention, is that the community-based programs are not in a shape...they're not...and I need to say that I'm not critical of a number of the community-based programs, great people. You're going to hear from them probably in opposition to my bill. But a lot of really terrific community-based providers out there doing a great job. So this isn't a knock on them or a criticism but an observation we made in the course of doing this is that the Department of Justice contemplated, when they developed an agreement with the state of Nebraska for improvement of BSDC, that we would entice people out of BSDC. You can't force them out. You have to have their permission. No one is going to leave BSDC unless you reduce the license of BSDC, which was done, without the permission of the guardians. And so those guardians aren't going to give permission because, as we learned from listening to many of them testify, they have misgivings about the community-based programs. We heard a lot of individual horror stories about incidents that occurred in the community-based programs. And during one of our hearings, Helen Meeks was here, who is a great public servant and someone who's very intelligent and knowledgeable. Helen Meeks indicated that she thought in order to beef up and to improve the community-based programs we need some regulation. The ICF/MRs have CMS

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regulations. And they do, and you'll hear there are some regulations. But they've been in the process, they've been trying to develop regulations for ten years, and that process just gets derailed, it loses steam and it doesn't happen. My bill really calls upon the Department of Health and Human Services to develop regulations, not for the sake of regulating, but to provide for the safety and the habilitation of the people who are placed in community-based programs. Very simple. And I have received some e-mails in the last day or two or some communication from John Wyvill suggesting that they are working on that and doing it, and, boy, is this necessary or not necessary. I'd say I got halfway there with my bill. And we ought to move it just to make sure that that happens. And the people that have loved ones with developmental disabilities can have confidence that someone is paying attention to and doing surveys and keeping an eye on community-based providers. And that, I believe, will result in an increased comfort level and a greater willingness of families and guardians to consent to community-based care as opposed to residency at BSDC. [LB291]

SENATOR GAY: All right. Any questions from the committee? Senator Howard. [LB291]

SENATOR HOWARD: Thank you for doing this. I think this is very needed. Do you have any idea of how frequently their licensing inspections, onsite licensing inspection is done with these providers? [LB291]

SENATOR LATHROP: We did and we addressed it in the committees report. And I'm going to try to do this from memory, Senator Howard. But when they get...and you'll hear from them. I see Bob Brinker and company are here. When they are licensed they are inspected. If there is a complaint then somebody goes out. And in addition to that, the people have service coordinators, I believe. And the service coordinators come to the site from time to time so they serve in some respect as a little bit of over... [LB291]

SENATOR HOWARD: But they are with the individual, they service the individual that's there. They service the individual that's there? They're not... [LB291]

SENATOR LATHROP: That's true. [LB291]

SENATOR HOWARD: They are not there to provide oversight of the facility. [LB291]

SENATOR LATHROP: No, and... [LB291]

SENATOR HOWARD: I know those roles and that's very different. [LB291]

SENATOR LATHROP: It's different, but they'll tell you that one of the safeguards, though not regulation, is having that service provider and family come out to the facility. I think some regulation that covers, you know, some of the things, and maybe not in the same detail CMS would provide, but providing for the safety and habilitation of the folks.

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[LB291]

SENATOR HOWARD: Well, I think it's a big responsibility. And in working on regulations for the day care centers the best I could get was an inspection every five years, which I think is extraordinarily lax. [LB291]

SENATOR LATHROP: That's what's going on right now, as we heard I think, was that they...but I will say this, the Governor, after our committee report, did propose in his budget adding three more people to do inspections. [LB291]

SENATOR HOWARD: Good. [LB291]

SENATOR LATHROP: So I think that was a direct response to concerns we expressed about our...is the Department of Licensure getting out to these facilities frequently enough. [LB291]

SENATOR HOWARD: Good. Thank you. [LB291]

SENATOR GAY: Senator Gloor. [LB291]

SENATOR GLOOR: Thank you, Chairman Gay. And, Senator Lathrop, thank you for your efforts along these lines, working with the task force. I know you've been very committed to this and it gives me, coming into this fresh, a degree of comfort. But I'd like to ask you a specific question about a comment you made. And that was that you think that this will reassure family members when their family are sent out to community-based programs? Do you think that it really is that significant? That it will be important, that that's an important part of their comfort level of going from institution-based to community-based? [LB291]

SENATOR LATHROP: I think it's a piece of it. [LB291]

SENATOR GLOOR: Okay. [LB291]

SENATOR LATHROP: Right now the perception, and I can give you a place to look if you want to read it, and that's the second half of the Department of Justice's report. [LB291]

SENATOR GLOOR: Okay. [LB291]

SENATOR LATHROP: The first half, really, is a close look at BSDC. The second half is a look at community-based programs and their observation that people in Nebraska, people at BSDC perhaps is a better way to put it, those families don't have a degree of confidence in the community-based programs such that they're willing to say, yeah, go

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ahead and take my son or daughter from BSDC out to here. And it really is to the place where they won't even go look at them. And that's problematic if you're trying to get the census down or trying to have a...our provision of services evolve into a community-based, strictly community-based. Then we really need to entice them out of BSDC. And that won't happen until there's some...I think there's, you know, there's provider pay that's an issue. [LB291]

SENATOR GLOOR: Sure. [LB291]

SENATOR LATHROP: As far as I'm concerned, they need an increase in pay... [LB291]

SENATOR GLOOR: Competitive wage. [LB291]

SENATOR LATHROP: ...for those folks so that they can draw a good...the kind of people that they have at BSDC, good-hearted people that are willing to work hard and be trained and learn and that sort of thing. So there's a number of components to it. And I just think this is an important piece to reassure families (a) we do have rules and regulations not unlike CMS, and we do have people out doing the surveys. And I think the Governor has suggested adding three people to do that. And hopefully, how those two pieces, along with providing for a little more rate of pay for the workers will help. [LB291]

SENATOR GLOOR: Okay. Thank you. [LB291]

SENATOR GAY: Senator Campbell. [LB291]

SENATOR CAMPBELL: Thank you, Senator Gay. Senator Lathrop, are any of these accredited? Is there accreditation for some of... [LB291]

SENATOR LATHROP: I can't answer that. [LB291]

SENATOR CAMPBELL: I may ask that question this afternoon. [LB291]

SENATOR LATHROP: But I can tell you there's...a lot of the community-based providers are here today. Good people, they were very helpful to our committee and testified frequently. And I'm sure they'd be happy to answer that. [LB291]

SENATOR CAMPBELL: Thank you. [LB291]

SENATOR GAY: Senator Howard. [LB291]

SENATOR HOWARD: Thank you, Mr. Chairman. I'll make this quick. It sounds like what you're looking for is a standard of care, which goes right into the accreditation issue, so

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that families can...have a right to have an expectation. [LB291]

SENATOR LATHROP: Well, I think that takes me into a whole other realm. And rather than just agree with you, I'm not disagreeing with you, but I just don't know enough about accreditation other than to say, sure there would be standards and somebody would have to get recertified. But just knowing that active treatment is taking place and the folks are going to be safe... [LB291]

SENATOR HOWARD: Well, those are pretty minimal standards. But... [LB291]

SENATOR LATHROP: Right. [LB291]

SENATOR GAY: Senator Lathrop, just so you know, earlier we had a bill and we worked on it, and I thank Senator Stuthman, Howard, and Wallman who actually strengthened the reviews that are being done to put a little more teeth in them and get us a little more information. So that was done. And I think that will be helpful. You know, and we were on that committee with you and I was sitting next to you when Helen said how few people there were. I was surprised, too. I do think the recommendation was appropriate. And I do think that and possibly even more will be allocated, I'm hoping. So I think there's good things happening, not just so much for those people that are...may move from BSDC, whatever happens there. But there are many, many people out receiving community services now that, I think, it's very important for them and their families to know that we're paying attention and not just getting these reviewers. But when you talk about exactly what that would be, you know, the department shall adopt...how would they go about doing that? [LB291]

SENATOR LATHROP: You know I left my bill back in Judiciary Committee hearing. But this would be my...what I would contemplate would be to have people from the industry and people with some expertise in the subject matter working together so that it isn't just academic driven or we don't simply cut and paste the CMS regulations. I don't think that...I don't know that the community-based programs need that level of...because we listened to the conditions of participation and the countless standards that apply. But I do think some regulations that come...that involve the community-based providers working with experts in the field. And I think they've been doing it. That's the thing Helen Meeks told us, you'll recall, that this process has been going on for ten years. And they make a little ground and then it just loses steam and it doesn't get done. So... [LB291]

SENATOR GAY: So you feel...yeah. But a written policy that somebody could see, that's what you think we need? [LB291]

SENATOR LATHROP: A written policy that the people that we...the new folks that we hire to do surveys in Helen Meeks office, or in Dr. Shaffer's office, that those people have some standard to measure a community-based provider by. [LB291]

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SENATOR GAY: All right. One versus the other. Senator Stuthman. [LB291]

SENATOR STUTHMAN: Thank you, Senator Gay. And, Senator Lathrop, I think one of the concerns that I have, and I'm very supportive of community-based services, but in my mind the community-based services, let's take for example an individual that was in Beatrice and they...he gets out to a community-based service. It is my intent that that individual could get back to their community or close to their community, not get to a place that's 300 miles away so it's very...almost impossible for family members to communicate or visit the individual. But I think we need to put a lot of emphasis on, you know, on what you're trying to do in this bill and, you know, expand the community base. [LB291]

SENATOR LATHROP: I would say...yeah. I am a proponent of community-based care ultimately. If you were to...the regulations, I think, address safety and habilitation. I don't expect that the regulations would say you have to have a placement within 100 miles of your home. I think that's something that has to be worked out. When a person consents to a placement, they can say, I live in Omaha, I refuse to consent to a placement in Scottsbluff because we'll never get out there to see my son or daughter. That's different than the regulations. But I certainly agree that...and I think we have some things in the works where we might see more community-based programs that are intended to be placed where there's a concentration of families with a need. And I applaud that effort, which hopefully we'll hear about soon. [LB291]

SENATOR STUTHMAN: Thank you, Senator Lathrop [LB291]

SENATOR GAY: Senator Lathrop, do you think if on the community-based programs, I mean, just thinking though if you were closer to home and you had more opportunities for guardians and parents to visit their child, that would be, I think, very helpful as well because they're going to watch exactly what's going on in that home. [LB291]

SENATOR LATHROP: As long as the services are available...yeah. [LB291]

SENATOR GAY: Right, and they could be helping... [LB291]

SENATOR LATHROP: You and I have had that discussion. [LB291]

SENATOR GAY: ...in the...participating in this, too. And if we get more surveyors to say, hey, I got a problem here, take care of it. I think both of those things would be helpful long-term. I mean, just... [LB291]

SENATOR LATHROP: No question about it. [LB291]

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SENATOR GAY: ...you'd think common sense, that would make sense so... [LB291]

SENATOR LATHROP: No question about it. And the closer these folks can live to their home community, assuming the services are there, the better. [LB291]

SENATOR GAY: Yeah. [LB291]

SENATOR LATHROP: And I just think the chance for mom and dad and siblings and family to come visit... [LB291]

SENATOR GAY: Right. [LB291]

SENATOR LATHROP: ...for them to have an easier relationship after the placement is a win-win. [LB291]

SENATOR GAY: Senator Stuthman. [LB291]

SENATOR STUTHMAN: Thank you, Senator Gay. Senator Lathrop, you know, I feel that, you know, where the population is, you know, to me that's where the community-based services should be. And there should be a number of services there. But moving population out into the nonpopulated part of the state and the fact that there are...there's a bed available out there, you know, 300 miles away, you know, I think, you know, I wouldn't appreciate that. You know, those beds there would...should take care of that area. We should, you know, make sure that there is enough, you know, capacity here to respect the families and the individual that they're going to move to a community-base and... [LB291]

SENATOR LATHROP: I couldn't agree more. [LB291]

SENATOR STUTHMAN: Okay, thank you. [LB291]

SENATOR GAY: All right. Anything else? Thank you, Senator Lathrop. [LB291]

SENATOR LATHROP: Sure. [LB291]

SENATOR GAY: We'll hear other proponents who would like to speak. All right. How many opponents are we going to have talking? Oh, all right, come on up. [LB291]

CARLA SORENSEN: (Exhibit 1) Good afternoon. Carla Sorensen. My name is spelled C-a-r-l-a Sorensen, S-o-r-e-n-s-e-n. And I've worked in the field of developmental disabilities for about 22 years, including 13 with the state's Developmental Disabilities Division. I am currently the director of Research and Development at Collaborative Industries, Incorporated. The testimony I am providing today is on behalf of the

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Nebraska Association of Service Providers, which is an organization that's comprised of providers of services to people with developmental disabilities, community-based providers. I am testifying today to express opposition to the bill which would require Health and Human Services to promulgate a set of regulations to provide oversight to ensure the safety, care, and habilitation of people with developmental disabilities. Such regulations already exist, as does the structure for provision of oversight of services. There are existing regulations that provide a sufficient number of standards for the provision of services to address safety, care, and habilitation. These include regulations under Titles 205, 480, 175, and 172 of the Nebraska Administrative Code, as well as the contract to provide community-based development disability services, which this year is about 29 pages long, including the addenda and attachments. Oversight to determine compliance with these regulations and contract requirements is provided by many state employees from numerous departments of Health and Human Services, including the Division of Developmental Disabilities Central Office, Developmental Disabilities Service Coordination, Regulation and Licensure, and Protection and Safety, as well as other outside entities, such as those that enforce local fire and safety codes. Testimony during the LR283 BSDC Special Investigative Committee hearing included specific information about the needs of the community-based providers to ensure that people's needs are met, and that is that we need sufficient funding to attract, retain, and train staff capable of providing the services that are outlined in the regulations to a population of people with a wide array of needs and diagnoses. The current funding methodology dictates low wages, which in turn affects providers' ability to retain quality staff. What the committee needs to know about this bill is that the context in which it was introduced has changed. At a recent meeting with providers, the Division of Developmental Disabilities staff announced that a new set of regulations is near completion. And these regulations, Title 404, have been in the works for more than eight years. They were in the works when I worked for the department. But on Monday of this week, February 23, providers received a draft of the new regs and were notified that informal meetings will be held in March so that the division can receive comments from providers and other interested parties. A cursory review of the draft indicates that oversight responsibilities will change, and that the state's Division of Developmental Disabilities, which has long served as the state's DD authority, will no longer certify providers of developmental disabilities services. The regulations now make certification contingent upon compliance with hundreds of additional regulations that were not previously considered in certifying providers, and hold providers accountable for documentation and planning that was previously completed by the state's Service Coordination staff. Providers will have the opportunity to convey concerns about any changes to the regs at a meeting in March. In the meantime, LB291, which calls for the promulgation of another set of regulations, seems premature. Therefore, on behalf of the Nebraska Association of Service Providers, I encourage you to reconsider moving forward with the bill. [LB291]

SENATOR GAY: Thank you. Senator Gloor. [LB291]

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SENATOR GLOOR: Thank you, Chairman Gay. And thank you, Ms. Sorensen, for your testimony. I heard you talk a lot about regulations. And then I heard you talk a little bit about salaries. My question to you would be, where's my one-stop shop? If I want to know how compliant a specific facility is, everything from the Fire Marshal's report, to the local Health Department's food service inspectors report, to the departments evaluation based upon complaints, where is my one-stop shop? Where do I go to see all of those documents in one, nice file? [LB291]

CARLA SORENSEN: It probably doesn't exist now. I think that's the intent of the new regulations, the new set that was just recently introduced or drafted. [LB291]

SENATOR GLOOR: You think or you know? [LB291]

CARLA SORENSEN: Well, I've looked at it. There are many, many pages. I've had it for a couple of days. I'm not...there will not be...the department won't be looking at the fire safety code, those kinds of things, but may consider that in its review when it goes out to do reviews. So it may not be that you would be able to access that, but "assumedly" the department in its licensing and certification reviews would be looking at that. [LB291]

SENATOR GLOOR: If I can't go some place, given my current responsibilities as a state senator, I like the idea of somebody who has the time and who is paid to do it, who gathers up that information, takes a look at it to make sure everything is hitting on all cylinders. I think it...maybe it's not a question, maybe it's more of a comment, but... [LB291]

CARLA SORENSEN: And I don't think there's any opposition to that. It's just a matter of when the bill was introduced, there weren't regs and now there are. So going forth might make it so that there would be another set of regs, "assumedly." [LB291]

SENATOR GLOOR: Okay. Thank you. [LB291]

SENATOR GAY: Any other questions? Senator Campbell. [LB291]

SENATOR CAMPBELL: Thank you, Senator Gay. Ms. Sorensen, I'm going to ask the same question that I asked Senator Lathrop and he suggested that we ask the providers. Are any of them accredited? Is there accreditation for this? [LB291]

CARLA SORENSEN: There is CARF accreditation available, but many of the...and I'm not really sure which providers in the state would have that. The regulations that are currently in existence allow for a deemed status for providers that have an outside accreditation. But I don't know of any that have actually availed themselves of that. So... [LB291]

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SENATOR CAMPBELL: Thank you. [LB291]

CARLA SORENSEN: And I... [LB291]

SENATOR GAY: Senator Howard. Did you have more to... [LB291]

SENATOR HOWARD: Is that a lifeline? (Laughter) [LB291]

CARLA SORENSEN: I'm sorry. Yeah, that's what it was. (Laughter) [LB291]

SENATOR GAY: Did you have more to add to that or... [LB291]

SENATOR HOWARD: Well, and I'm also interested in this very same issue. Two questions, are any of these people, are any of these facilities, whatever they actually call themselves, are they JCAHO accredited? I know that's another accreditation body. And are they paid higher, are they paid at a higher rate if they are accredited? [LB291]

CARLA SORENSEN: No. There's no differential for accreditation. All providers are certified by the state and then particular facilities are licensed. And so that's...there's a distinction between certification and licensure. [LB291]

SENATOR HOWARD: But there's no I would say incentive for being licensed then or being accredited? [LB291]

CARLA SORENSEN: If there were a deemed status, that could be the case. I mean, if you didn't go through certification and licensure because you had a deemed status through accreditation, potentially, but I don't know that that's really been a big draw for most providers. And honestly, the accreditation standards are considerably different from the state standards. Many of them relate to outcomes, which frankly as providers we've been looking to try to get to that...where we measure outcomes instead of look so much as the process to get there. But in fact, you know, it's a completely different look than what the state looks at, which is in part, you know, some of the licensure is how big is the bedroom; how many...how bright is the light bulb, those kinds of things. And so accreditation standards are far outside of that. They would be looking more at outcomes for people, whether or not people have friendships, whether or not they're involved in their community, those kinds of outcomes. [LB291]

SENATOR HOWARD: So it's more like the quality of life than the quality of... [LB291]

CARLA SORENSEN: Well, it can be, yeah. [LB291]

SENATOR HOWARD: ...of their living environment. [LB291]

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CARLA SORENSEN: And, you know, whether or not there's proper medical care and whether they can access it. And so... [LB291]

SENATOR HOWARD: Legitimate. Thank you. [LB291]

CARLA SORENSEN: Sure. [LB291]

SENATOR GAY: Any other questions? I don't see...any other questions? I don't see any. Thank you. [LB291]

CARLA SORENSEN: Okay. [LB291]

SENATOR GAY: Any other opponents going to speak? I don't see any. I did see we got a letter from Brad on...do you want to talk, Brad. [LB291]

BRAD MEURRENS: No. [LB291]

SENATOR GAY: I kind of went through...you sure? [LB291]

BRAD MEURRENS: (Inaudible.) [LB291]

SENATOR GAY: (Exhibits 2 and 3) Okay, we did receive your letter then. Okay. Anyway, we did receive a letter from Nebraska Advocacy Services, a proponent. So...I'm going to do neutral right now, yes. Come on up. And then also while you're coming up, we'll listen to those who want to speak neutral. We received a letter from the Department of Health and Human Services in the neutral position as well. [LB291]

DAVE MERRILL: My name is Dave Merrill, M-e-r-r-i-l-l. And I'm the director of Region V Services. And we're a public service provider. And we've been providing support to people with developmental disabilities for over 35 years. As I was listening to the testimony, I had the impression that some committee members believe we have no regulations. When they're talking about the new draft of regulations it doesn't mean that there aren't lots of regulations that are in place. The last time I counted, there were over 2,600 that applied to us that didn't count State Fire Marshal standards and a variety of things that way. I think there's been some confusion because Helen Meeks was only talking for her division, Regulation and Licensure. And it sounded like community services were not being regulated when the focus is on Developmental Disabilities Division, that's where the regulations are, that's where our contracts are generated, that's where the fiscal accounting is. And I really would hate to see those split up. So that...have the same agency responsible for all those parts because state agencies don't always recognize what other agencies are doing. And I think Helen's testimony just really points that out. Our certifications happen every two years. She was saying it was four or five years for their visits, but it's every two years, unless you have problems.

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If you have problems then it's every year. And we have service coordinators and a lot of people with regulation. I just felt like there was some misunderstanding and so I wanted to testify from the neutral position. [LB291]

SENATOR GAY: Thank you. And maybe that misunderstanding, if that was occurring, if it occurs to us, you know, imagine what it would be to somebody in the public though. [LB291]

DAVE MERRILL: Oh, yeah. Yes. [LB291]

SENATOR GAY: You know what I mean. [LB291]

DAVE MERRILL: Yes. [LB291]

SENATOR GAY: So...all right. Any questions? I don't see any. Thank you. [LB291]

DAVE MERRILL: Thank you. [LB291]

SENATOR GAY: Others in a neutral position that would like to testify. All right. Well, Senator Lathrop, you want to close? [LB291]

SENATOR LATHROP: Just briefly. It does sound like the...whether it's coincidence or by design, we now have some regulations that are...that have just been published. I haven't had a chance to look at them. And I don't know if they are the regulations that they've been working on for ten years and now with this bill coming up they finally kicked them out of Health. If that's what they are, then there's no harm in making sure that they go from this stage to implemented. But while I was sitting, listening to people talk about this, something occurred to me which was I've always wondered, not to take up a lot of your time, but I've always...you probably wondered the same thing. How can people say the families say such nice things about BSDC, and then when the feds come in they say, oh my God, the place is terrible. And what occurred to me, the way I've reconciled that is there's a lot of really good people down at BSDC. There's good people from Beatrice, loving, caring, rural, good Nebraska people taking care of these people the best way they know how to, intuitively. The difference is, is that the intuitive part, the caring part doesn't get you to the standard. We're not meeting the standard by being loving, caring, intuitive people. So there is a need for regulation. There is a need for bringing people not just you're good people and you love these folks and you care for them, but to...in order for them to do that at the standard of care, they need training. We need to make sure that those standards are in place so that they're not just there doing what comes natural, but they're doing what people are trained to do. So that's why I think regulation and...and that's my explanation for that whole contradiction down in Beatrice. [LB291]

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SENATOR GAY: Senator Howard. [LB291]

SENATOR HOWARD: Well, thank you, Mr. Chairman. I just have to say this. We have to be very careful not to lose or discount or disregard the piece that you're describing. But it goes a little further, it's called a relationship. These people developed a relationship. [LB291]

SENATOR LATHROP: No question about it. And I can tell you the people at BSDC have them, those employees are loving, caring... [LB291]

SENATOR HOWARD: And the parents have them. And I think that's a big part of what's been lost in the movement. And I think that's the scary...the really scary part is that relationship which leads to trust, which has just been eliminated. [LB291]

SENATOR LATHROP: Yeah. And they're certainly doing that in the community. I don't mean to make it sound like that's a unique situation. These people, you don't just take this job because you want the money. It is...they love and care and have relationships with these people and it's obvious. It's happening at Beatrice, and it's happening in the community-based programs. [LB291]

SENATOR GAY: Senator Pankonin. [LB291]

SENATOR PANKONIN: Thank you, Senator Gay. And those that have served on your committee, Senator Lathrop, and I appreciate all the time that's been spent by you especially. But as I understand it, there's really kind of two dimensions. It's active treatment and integration into the community as much as possible. Is that kind of a nutshell of where we need to get to? [LB291]

SENATOR LATHROP: I think everyone would agree, and if you even brought the parents from BSDC in, the long-timers, the folks who have had somebody there for 40 years have a different perspective. But if you had somebody that had been there a year, they'd say, yeah, you find a community-based program integrating them so that they go to the barbershop to get their haircut and they go to the doctor's office to get their care. Those things, that's a goal I agree with. Just as an aside, the long-timers from BSDC, the people who have had their son or daughter there for 23 years, they have a different situation because that's home. [LB291]

SENATOR PANKONIN: Yeah, it is. [LB291]

SENATOR LATHROP: These people are developmentally disabled... [LB291]

SENATOR PANKONIN: You get your haircut there and... [LB291]

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SENATOR LATHROP: Yeah, and that isn't really about whether being integrated is a better idea or a good idea. They have a whole different concern, which is my developmentally disabled daughter who calls that place home. It's the only thing that she's known and, you know, she's 36 and she's been there 30 years. So...but integrating into a community, I agree with that as a goal for as many people as we can get there. [LB291]

SENATOR GAY: Senator Lathrop, this bill deals with regulations on community-based providers, correct? [LB291]

SENATOR LATHROP: Yes. [LB291]

SENATOR GAY: I mean, I would agree with you on the BSDC employees. I think that was a management issue. We all agree on that. That needs to be improved. And we're trying to improve that. But, you know, Mr. Merrill that just talked at the end was saying, well, we have all these regulations. And did you receive this letter from John Wyvill? I see you got "cced" today. [LB291]

SENATOR LATHROP: I did, like this morning,... [LB291]

SENATOR GAY: Yeah, we just received it. [LB291]

SENATOR LATHROP: ...saying that they had just come up with the regulations. [LB291]

SENATOR GAY: But I wonder if we need to do a better job, as Senator Gloor said, to maybe look into people understanding this. [LB291]

SENATOR LATHROP: I don't have a problem with that. I don't have a problem with that. And I'll be the first to admit that I didn't look at all those regulations and say, boy, they're missing one. You know. But Helen Meeks, who you listened to testify, very, very intelligent state employee and a sharp person as far as I'm concerned in my take, suggested that they'd been working on this. They've been working on it for a reason and that it just wasn't getting done. And she thought it was a good idea. [LB291]

SENATOR GAY: All right. [LB291]

SENATOR LATHROP: That's the bill. [LB291]

SENATOR GAY: Yeah. And we will definitely look into this and give it consideration and move on. Any other questions for Senator Lathrop? [LB291]

SENATOR LATHROP: And did you say move it? (Laughter) [LB291]

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SENATOR GAY: There you go. (Laughter) [LB291]

SENATOR LATHROP: This afternoon? [LB291]

SENATOR GAY: Yeah, there you go. We're getting...we're "Execing" right after this. [LB291]

SENATOR LATHROP: All right. Okay, thanks. [LB291]

SENATOR GAY: Thank you, Senator Lathrop. All right. We'll close the hearing on LB291, and move onto LB390. Senator Coash. [LB291 LB390]

SENATOR COASH: (Exhibit 1) Well, thank you, Senator Gay, members of the HHS Committee. It's nice to be in the HHS Committee hearing room. I am Colby Coash, C-o-l-b-y C-o-a-s-h, and I represent the 27th District here in Lincoln. I'm passing out the written portion of my testimony here. This bill is going to seem real technical in nature, but it's really quite simple. This bill is more about math than technicalities. It's about math and a better way of doing business. The intent of this bill is to change the current reimbursement unit for assisted services funded through the Division of Developmental Disabilities for community-based services from an hourly rate, which it currently is, to a daily unit. I brought this bill forward because the current system of reimbursement units for assisted services funded through DDD for community-based services is not working. This is a bill as a result of community-based providers requests and the department's unwillingness to move on the changes proposed in this bill. So I give you a little bit of background here and we'll have some following testimony that will hopefully answer any questions. The current objective assessment process, which we call the OAP, an intervention unit allocation method, does not work for service auditing purposes. And I think we saw this recently with some audits by our state auditor. Paying by units and auditing by hours is a problem. Allocating funds based upon intervention units takes advantage of a one to many staff supervision ratio, auditing by hours does not. DDD defines community-based developmental disability habilitation services in two broad categories: We've got assisted services and supported services. Department rules and service contracts require that people receiving assisted services have on-site and immediately available the entire time a person receiving services in the service environment. So assisted, there's always somebody there. People who receive supported services have staff available on an intermittent basis--could be a few hours during the day, could be half a day on the weekends, with many periods of time on their own. This bill only addresses the type of services that are 24 hours when someone is there all the time and accessible the people in services. As I mentioned, the OAP begins in dollars. And when a person is served, they have a team that determines what type of service that they're going to get. And then they use the dollars that are converted to intervention units by dividing those dollars by the hourly intervention unit rate. This is

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the math. Right? This bill aims to change the reimbursing methodology to a daily rate, not hourly, and does not change the rate. The rate stays the same. The change would work in the following way: So you would arrive in an assisted residential daily rate. The dollars generated by the OAP would be divided by 365 days. There's your daily rate. We also have assisted vocational services, and those are going to be divided by 260 to reflect a five-day workweek, 52 weeks out of the year. So why go to this system? I'm going to give you a little story to illustrate the problems that providers have with an hourly reimbursement method as an example. Imagine a staff person driving two individuals to the grocery store to assist them in shopping. Which person in services is getting the service of the one staff? Under the current method to provide the services as authorized, the staff person would have to clone himself or cut himself in half and neither of those is going to be possible. That was the problem that we found through recent audits by the state auditor. He brought to light difficulties in tracking hourly rates for the purposes of an audit. I followed that pretty closely. For example, in a one-to-many supervision ratio whose intervention units are provided when all together at the same time. This bill eliminates this challenge and has the support of our State Auditor. I have a letter here from the Auditor for the record. Thus far the department has not been willing to change from an hourly to a daily reimbursement rate. And I've outlined in the testimony here seven reasons why we ought to change to a daily rate, and I will just hit a couple of highlights. There's problems with our overnight hours, how those are allocated. The biggest thing that I'd like to point out to the committee is that this takes the focus on quality and off of ratios. Establishing and verifying staff to client ratios is not necessary with a daily rate. A provider would accept a person and meet their needs the same as anybody else as defined by the department and their team. The current contract requires providers to meet all the needs in the assisted setting without regard to current hourly intervention unit authorization. If a provider delivers all the units and the need is not met, then the outcome is not met without regard to how many staff was on-site. And there's some other reasons. I'd like to point out, we did a little bit of research. A daily reimbursement is not uncommon the department, it's not uncommon to our state. Child welfare services use it pretty much across the board. Our own BSDC is reimbursed on a daily rate--inpatient behavioral services, nursing homes, hospitals, and assisted living. So this is a model that works for many services. In closing, I'd like the committee to understand this bill. It will provide to be cost-neutral, which as the fiscal note that came out today illustrates. And a way for providers to focus more on doing their jobs of providing services to the most vulnerable of our citizens. This a time in our state when we need to focus on quality and not auditing. Taxpayers want assurances that their money is being spent appropriately. Providers and families want quality service outcomes. I believe this bill provides for both. Before I close, I'll pass these to enter into the record. We've got some letters of support from various individuals for the record. And Roger Stortenbecker who is a community-based provider administrator and a former disability director will follow this testimony, should be able to answer any questions about how providers might go about implementing this bill from a provider perspective. And we'll leave it at that. [LB390]

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SENATOR GAY: All right. Thank you. Any questions? Senator Howard. [LB390]

SENATOR HOWARD: Thank you, Mr. Chairman. Just a quick question. You're example of the individual taking the two people to the grocery store, on an hourly rate could he only charge for one? Was that the difficulty? [LB390]

SENATOR COASH: Well, what we found through watching the audit process is that the department would want to know who is being billed for that, who's providing that service. And the... [LB390]

SENATOR HOWARD: Under who's name or who's number. [LB390]

SENATOR COASH: Right. And the provider is going to say, well, I was helping or support both of them. And they say, well, that doesn't work with our process. [LB390]

SENATOR HOWARD: So tried to bill under both of them. [LB390]

SENATOR COASH: Well, the system is set up to do it that way, but when the auditors come through they say, well, you have authorization for this person and you have authorization for this person, but you only have one person, who are you going to bill for. But we were actually...you know, you're actually... [LB390]

SENATOR HOWARD: So it has to be individual. [LB390]

SENATOR COASH: That's right. [LB390]

SENATOR HOWARD: Well, what about the daily rate then? How would that be different? [LB390]

SENATOR COASH: Daily rate says that we're going to focus on outcomes. And you're going to take the conversion and say you have to provide services as outlined by the department and their team, which is already in place, and say you have to provide services to both of these people. And it doesn't matter...you have to provide those services regardless of how many staff it takes. [LB390]

SENATOR HOWARD: But they could bill for both of those. [LB390]

SENATOR COASH: Yeah. [LB390]

SENATOR HOWARD: Okay. Well, that's what I wanted to know. [LB390]

SENATOR GAY: Senator Gloor. [LB390]

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SENATOR GLOOR: Thank you, Chairman Gay. The term I would use is per diem. [LB390]

SENATOR COASH: Sure. [LB390]

SENATOR GLOOR: Is that an appropriate term to use as far as you're concerned? [LB390]

SENATOR COASH: Sure. Per diem. In the DD community we use a reimbursement rate and a methodology, that a per diem is accurate I would say. [LB390]

SENATOR GLOOR: Okay. Thank you. [LB390]

SENATOR GAY: Senator Pankonin. [LB390]

SENATOR PANKONIN: Thank you, Senator Gay. Senator Coash, appreciate you bringing this concept to us. I'm just curious about...I know you have background in this field, but does this come from your personal experience or did people approach you or just the background behind the bill or why you...or the Auditor's Office or how did this come about? [LB390]

SENATOR COASH: All of the above. We watched several...I watched as both a person who works in the industry and as a taxpayer, I watched several audits happening with community-based providers. And of course we have to watch that because we have...as community-based providers, and I say "we" because I work for them, we have a responsibility to give the taxpayers what they're paying for. And the methodology doesn't allow us to do that in a way that satisfies the need of the families, satisfies the need of the Auditor which was a new thing, and then the department as well. So this bill was a result of watching that and saying, well, if I could ever get in here I think we could address this. And, again, it's a cost neutral thing. It's really a math thing that really simplifies things. And when I talked to the State Auditor, his indication to me was, yeah, this may have saved a lot of problems that we've seen with auditing community-based provider services. [LB390]

SENATOR PANKONIN: Thank you. [LB390]

SENATOR GAY: Any other questions? Don't see any, thank you. [LB390]

ROGER STORTENBECKER: (Exhibit 2) Mr. Chairman, members of the committee, good afternoon. Thanks for the opportunity and thanks for paying attention to this bill. My name is Roger Stortenbecker. I'm the chief operating officer for Developmental Services of Nebraska, that is a nonprofit community-based developmental disability

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service provider that provides services in Omaha, Lincoln, and Kearney. We support approximately 174 people total across those three communities. Developmental Services of Nebraska supports moving to a daily reimbursement rate, or a per diem as Senator Gloor pointed out, for assisted services. Currently, there is a confusing mix in the use of monthly, daily, and hourly units and staff ratios are thrown in there in the mix sometimes too. I promise to be brief and merciful. There's lots of details here and I'm the guy that when somebody asks me the time, I start by telling you how to build a watch. So this has been painful for me to take this down to a few minor points. First of all, with monthly, there is an annual service authorization for each person that's determined by the department and is set at an annual dollar amount. The dollar amount is divided by 12 to come to three or to 12 equal monthly amounts that's available to each individual person. The DD service contract requires us then to meet all that person's needs. No matter what they are, we have to meet their needs within that service authorization amount that's available for the month. Now, there's no adjustments made. If it's a 28-day month, a 30-day month or a 31-day month on the authorization end of things, it's 12 equal installments. So one would be led to believe that it's either an annual that's divided to a 12 month or at least a monthly service authorization. However, when a person receives less than a full month of service and that monthly amount is prorated down to a per diem, so we've begun to depart from the monthly amount. I understand why that happens. If somebody uses half of a month, they change from one provider to another or they're gone days, the department doesn't like to pay for those all those days to one provider and then have to pay the next provider the entire monthly amount. Per diem makes sense to me. When a person leaves services, they'll take their authorization with them. That was really the original design of the intervention unit system. Colby...Senator Coash mentioned that I was at the department as the administrator, and I was there at the time that this intervention unit authorization process was designed. Sole purpose for that process was to decide how to allocate the available resources. So its design was only to say a person, based upon their need level, gets this much money. It was never designed to be used by the State Auditor for an audit, which is I think really what contributed to kind of their headaches because it does take advantage of the one to many ratio. It enjoys those economies for one staff person with three people, if that's all they need. So when you try to figure out which one of those three people is getting their hours, it can't be done. Then we've got an hourly look at authorizations. The unit authorizations once we take that annual amount, divide it by 12, break it down to a day, and then turn it into units, the number of units are based upon an hour of staff time. Then there's a lot of rate buildup on top of that. So the number of intervention units that are authorized in a month are generally less than the number of clock hours that we have to staff it. Senator Coash mentioned, and he is correct, that when someone is in an assisted service, we have to staff it the entire time that person is present. So if they're in a house for 24 hours a day, 30 days, we would have to staff that without regard to what the service authorization is, even if it were 100 units or 150 units. So we have to staff it no matter what. In addition, in the intervention units there is a little bit of a bugaboo there with an eight-hour overnight problem. When

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the State Auditor was doing his work, he tagged eight hours per location, per night that could not be claimed in staff hours because the department said those eight hours are included in the rate buildup. So we were already getting paid in our intervention units, we couldn't claim it in hours of overnight. Now, that's unless you've got somebody who's got one-to-one or they've got to wake overnight authorization. So what happens is this gets real big and real confusing because we're trying to have one foot in three different kinds of funding. Is it annual, monthly, per diem, hourly? What is it? So it's caused a lot of confusion and a lot of our attention has been focused off of delivering those high-quality services that our new regs will help us get to. And we've had to focus on making sure we document staff timecards in a way that will keep us from getting sideways with the department. One quick example, if I can anticipate a question here, so what would we do different under a per diem? One very real example for us at our company is if we have to deliver based upon timecards to match intervention units, what I will have to do is have, for example, three staff people filling those hours at the hourly rate that I pay them. What I might be able to do instead under a per diem is find two people more credentialed to meet all the needs, but I wouldn't have the staff hours to fulfill all of the timecard demonstration that every hour of intervention was delivered, but I would have a higher quality result. Two more qualified people might be able to do better work than three lesser qualified people. Okay. As was said before, it's a common practice already, widely used per diem. Be happy to answer any questions. [LB390]

SENATOR GAY: All right. Thank you. Any questions? Senator Pankonin. [LB390]

SENATOR PANKONIN: Thank you, Chairman Gay. Mr. Stortenbecker, thanks for your testimony. I've got two questions based on the fiscal note. The first one is, fiscal note as has been stated earlier today, we get those a day ahead, so we don't have a lot of time. But, you know, it says basically that it's revenue neutral and you agree with that assertion on the statewide? [LB390]

ROGER STORTENBECKER: Yes, yes. [LB390]

SENATOR PANKONIN: But there's a following comment, "However, the Department of Health and Human Services is unsure whether the Centers for Medicare and Medicaid Services, CMS, will allow the department to reimburse providers on a daily rather than an hourly basis. If this is not allowed, then the department could be in jeopardy of losing about \$94 million of federal funds received annually from CMS." That's kind of a big gamble, I think. [LB390]

ROGER STORTENBECKER: Um-hum. I'm ecstatic that you asked me that question. (Laughter) [LB390]

SENATOR PANKONIN: Okay. Good. [LB390]

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ROGER STORTENBECKER: Every state has the opportunity to craft their home and community-based waiver application. It is quite literally a template that the feds put out and you fill in the blank how you're going to do certain things. One of those selections the state gets to make is how you're going to reimburse your providers and how you're going to claim back to CMS to get paid for the services you provide. Nebraska elected to go to the intervention unit method. And back when, if I can say "we" because I was there at the time, back when we did that, CMS was pretty critical about going that direction because they could see the possible problems. But we were just hardheaded enough we pushed it and we got what we wanted and here we are. The state could also go back in now and request that to be changed. Now, they will have to explain why it's necessary and it will have to make sense to CMS. If they don't ask for the change, CMS will clamp down and say, we're not paying for all those services you delivered that were inconsistent with your waiver application. So, yes, they have to make the application. Yes it's extremely possible the department will have to get behind it, they'll have to support it because if it's one of those places where, you know, we don't really want to do this, but we're being told we have to. So if you said, no, it's not going to be any skin off our nose. We can't have that. It's going to have to be everybody is going to have to have buy in, CMS will go with it. State of Iowa does it. The states all around us do it. Our own case management services, services coordination is what we call the position, it's known as case management under CMS services, that's a monthly rate. The state's own service, case management, service coordination is a monthly rate. [LB390]

SENATOR PANKONIN: So the follow up question on my part would be, so even if we pass this bill, we have to get permission from CMS before we proceed. I mean, we make an application for the waiver and we have to...or the change and we have to wait on that so we don't risk a lot of money in the meantime. Is that a fair... [LB390]

ROGER STORTENBECKER: That's correct. That is correct. We have to have their agreement because they're throwing 60 percent at the bill. [LB390]

SENATOR PANKONIN: Okay. Thank you. [LB390]

ROGER STORTENBECKER: You bet. [LB390]

SENATOR GAY: Any other questions? Senator Wallman. [LB390]

SENATOR WALLMAN: Thank you, Chairman Gay. Thank you for being here. I learned a lot here. I learned here that rates five and six, you know, now say are them yearly contracts or just day by day also or yearly do you think? [LB390]

ROGER STORTENBECKER: Well, there's a couple of different levels. We have an annual contract that we sign with the department to deliver services. The department sets the rate. We don't have any say in that. We can't negotiate. The department

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determines how much each person is going to get for authorization. We don't have any say in that. And then we have to agree person by person can we meet their needs and will we do it for the amount that the department will pay. And if we say yes to that, that's from that point forward then we'll provide continuous services until either we lose our certification, our contract or the person moves or lose our services some way. [LB390]

SENATOR WALLMAN: Thank you. [LB390]

ROGER STORTENBECKER: You bet. [LB390]

SENATOR GAY: Any other questions? I don't see any. Thank you. [LB390]

ROGER STORTENBECKER: You're welcome. [LB390]

SENATOR GAY: Other proponents? [LB390]

BOB BRINKER: (Exhibit 3) Good afternoon, Mr. Chairman, members of the Health and Human Services Committee. My name is Bob Brinker. I'm the director of ENCOR. I had four points. I'm down to three based on previous questions asked and answered, so operate in that vein. Today I'm here to speak in favor of LB390. As you know, the specific issue with LB390 is to switch the reimbursement for DD providers from an hourly basis to a daily basis for assisted services. Residential assisted services include group homes, extended family homes, and day services include workshops and other special day programs. In either case, staff is present when the people are receiving services. With this change, we would be paid on a per diem for services rendered. My first point I'd like to talk about is what's happening in other states, and I'll keep it quick. The current method of payment in Nebraska for these services is unique as compared to neighboring states. All other neighboring states pay on a per diem rate, which I'll describe. Colorado uses a seven-tier per diem rate. Kansas uses a five-tier per diem rate. Iowa uses a per diem rate based on historical costs which is negotiated through the county. South Dakota uses a 13-tier per diem rate. For Kansas and Colorado, I obtained this information off the Internet. For Iowa and South Dakota, I talked to other providers working in those states. In addition, somebody forwarded me coincidentally the state of Arizona's payment, and that's a per diem rate as well. It's a 12-tier method. Based on this information, it's clear that the predominate method of payment for assisted services within our region is a per diem. In addition, our agency does emergency residential placements for adult protective services which is also part of the Nebraska Health and Human Services System. In return for these services, we are paid on a per diem as well. Also, our agency has done a few private pay placements and a few placements from school districts into our day services, and these were all done on a per diem basis as well. My point is, the per diem is the standard and the one that makes the most sense given these types of services, especially with what was previously testified. A couple of quick comments on the practical side. Payment using the hourly

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method is difficult to track and monitor. For example, all of the authorized hours for the individuals residing in a group home become the maximum staffing which can be reimbursed for that month. In theory, this sounds okay, but in practice there are too many variables which make it difficult to manage. Specifically, meeting the needs of people is not a static proposition. If everyone came home from their day program at 4:00, went to bed at 10:00, got up at 6:00, and leave the next morning at 8:00 this might work, but it does not happen that way. The people we serve get sick and need to stay home, get up during the night, want to stay up past 10:00, want to attend activities with another staff, possibly with others they live with, and they need to go to doctor and dental appointments. All this goes into what it takes to run a group home and serve people in residential. All these variables plus many others have to be managed within these hours. Needs and circumstances change each month. With a per diem, we would be reimbursed for the service and have the flexibility to manage staff needs. My final comment deals with flexibility. There was some talk that this would cut down with flexibility, and I frankly find that not to be the case. Currently, funding is determined on an individual basis and this could continue on a per diem basis. This would allow money to follow the person. This is a strength of our current system and allows the person, their family choices in provider and changing providers, if needed. And this is what we've been doing and we've been doing this for many years and it's worked out well, and we've been complemented on this and this can continue under a per diem basis as well, so. With that, I close my testimony and answer any questions you may have. [LB390]

SENATOR GAY: Thank you, Bob. Senator Wallman. [LB390]

SENATOR WALLMAN: Thank you, Chairman Gay. Yeah, thanks for testifying. Now, do you have a waiting list for services or... [LB390]

BOB BRINKER: Individually since 1992 ENCOR does not have a waiting list for services. July 1 of that year the state became the caretaker of the waiting list. [LB390]

SENATOR WALLMAN: Thank you. [LB390]

SENATOR GAY: Senator Pankonin. [LB390]

SENATOR PANKONIN: Thank you, Chairman Gay. Director Brinker, thanks for coming and helping us on this issue and I've learned a lot today as well. First of all, I appreciate all the great efforts you make in my area and having visited your facilities and group homes and I just appreciate your whole organization's efforts. Does this make it easier for them from an accounting standpoint? Obviously, we heard about the auditing area. [LB390]

BOB BRINKER: Most definitely. [LB390]

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SENATOR PANKONIN: So it could even be maybe a potential savings, but it just makes it easier, it's more understandable, it's just... [LB390]

BOB BRINKER: It's easier, it's understandable, it's easier to administer, and it's easier for us to make...deal with needs that change month in and month out. As I indicated in my testimony, it's not a static proposition where they're dealing with people and lives. Different things happen just for you and I. And within this hour system it's very difficult for us to track, maintain that. And this would allow us, per diem, get paid to do the service, then you move on. [LB390]

SENATOR PANKONIN: Thank you. [LB390]

SENATOR GAY: Any other questions? I don't see any. [LB390]

BOB BRINKER: Thank you very much. [LB390]

SENATOR GAY: Thanks, Bob. Other proponents who want to speak on this. Any opponents? Anyone neutral on this? All right. Senator Coash, you want to close. [LB390]

SENATOR COASH: Thank you, again, Senator Gay and members of the committee. I'll just briefly close here. It's been a long day for me as well over at Judiciary, so. These issues seem fairly complicated. I know you've got a lot to read over. Let me just offer my support to help you work through these complications, you know, make sure you understand exactly what this bill is trying to do. I'd be more than happy to do that, you know, explain what a unit is. And Roger mentioned the rate buildup and how that intervention rate is determined. I'd be more than happy to work with you, the units and all that. Now, my grandma used to say, keep it simple, stupid. And that's really what this was about for me. Let's make it simple. Senator Pankonin, you said let's make it easier. Absolutely. And in the community-based provider side when we're spending less time on auditing and looking at timecards and things like that, that means we're spending more time and more resources at the bottom line which is providing the service. And that's really what this bill is about for me. It's about freeing up time so that we can concentrate as a community-based provider community on the services. So what's going to happen to the service expectations under this bill? Absolutely nothing. Service expectations are exactly the same that they were. What's going to happen to the outcomes expected by providers, by the department? Absolutely nothing. I saw the fiscal note and I said, that is a big gamble, I agree. And I'm going to...as you heard though, lots of other states do this, they found it. I will work diligently to make sure this is not a gamble because it shouldn't be. This should be absolute. This is not a problem because if it is, it'd be irresponsible. I'd have to, you know, pull the bill, so. With that, I will leave it at that in case anybody has anymore questions. [LB390]

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SENATOR GAY: Hold on. Senator Gloor. [LB390]

SENATOR GLOOR: Thank you, Chairman Gay. I'll be very brief. I think this is very commonsensical and I would probably paraphrase what you're grandmother said of keep it simple, Senator. (Laughter) [LB390]

SENATOR COASH: Yeah. She would said...thank you. [LB390]

SENATOR GAY: Any other questions? Senator Pankonin. [LB390]

SENATOR PANKONIN: Thank you, Senator Gay. Senator Coash, just one last question. The department is not here. Have you worked with them or do they have a position on this issue? You know, we didn't get a letter that we know of. [LB390]

SENATOR COASH: I talked with John Wyvill prior to even submitting this bill, told him I was thinking about it. Asked him what he thought. He said, well, we do what is outlined in statute. He knew the bill was coming and you can read into his absence here. [LB390]

SENATOR PANKONIN: That's probably neutral then. [LB390]

SENATOR COASH: As neutral as I would. Again, I think it comes down to math on the provider side. I think it just comes down to math on the department side as well. And so I'm hoping that's the way they see it, but they are aware I brought the bill. My hope was maybe they...you know, there was some question as to whether the department could just change this on their own. And I would have preferred that to be honest. I don't like to force the department's hand. But when I called them in I said, would you consider doing this? And they said, well, we're not...that's not really where they were, so hence the bill. [LB390]

SENATOR PANKONIN: Okay. Well, we appreciate your work on this issue. It's been an interesting hearing. Thank you. [LB390]

SENATOR COASH: Thank you. [LB390]

SENATOR GAY: Other questions? Kathy, did you... [LB390]

SENATOR CAMPBELL: No, that was my question. [LB390]

SENATOR GAY: Okay. Thank you. I don't see any other questions. Thank you for your patience today and all those that waited around this afternoon. So with that, we'll close the day. Thank you. [LB390]

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Disposition of Bills:

LB136 - Placed on General File with amendments.

LB291 - Held in committee.

LB342 - Placed on General File with amendments.

LB390 - Placed on General File with amendments.

LB590 - Held in committee.

Chairperson

Committee Clerk