[LR513]

The Committee on Health and Human Services met at 1:30 p.m. on Tuesday, December 14, 2010, in the Omaha Douglas Civic Center, 1819 Farnam Street, Omaha, Nebraska, for the purpose of conducting a public hearing on LR513. Senators present: Tim Gay, Chairperson; Kathy Campbell; Gwen Howard; and Norm Wallman. Senators absent: Dave Pankonin, Vice Chairperson; Mike Gloor; and Arnie Stuthman.

SENATOR GAY: All right. Thank you all for coming. We're going to get started. We're going to get started here. I need members to quiet down. All right. Thank you all for coming. We're going to get started. This is a public hearing on LR513. We have an agenda. At the end of the day, we have it open for public testimony. I was asked and I don't think it would be a problem at all if you want to put in some written testimony, we can keep it open for a couple of days. Feel free to put in any written testimony that you want to on something you hear. I don't think anyone would mind that at all, so we'd encourage that. If you do want to visit and talk and testify right now, that's fine, too, at the end. We'll get started. On my agenda, I have Director Dr. Scot Adams is going to start out. Thanks for coming today, Scot. Scot, before you get started, I would say this is a just a regular hearing like we have. We're being recorded. It's not on the Internet, obviously, but it is being recorded and will be put in, we will have a report that we'll submit to the Legislature, oh, probably in a week or so. But with that, if you have any phones, if you could silence the phones, we'd appreciate it. We appreciate the city... [LR513]

SENATOR CAMPBELL: Silence the window. [LR513]

SENATOR GAY: ...for the window, I guess we can't do anything about that. (Laugh) I would hate to hear that on a windy day. But we will get started. With us today, I'll introduce my colleagues. We have the clerk down here helping us today, Lisa Johns; Senator Norm Wallman; Senator Kathy Campbell; Senator Gwen Howard; and our legal

counsel, Michelle Chaffee is here; and I'm Senator Tim Gay from the Papillion area. So with that, we'll get started. And, Scot, go ahead and have at it. That's your draft here I think. [LR513]

SCOT ADAMS: (Exhibit 1) Oh good. Thank you so very much. Good afternoon. My name is Scot Adams, S-c-o-t A-d-a-m-s. I serve as the director of the Division of Behavioral Health within the Department of Health and Human Services. And thank you for the opportunity to provide an overview on the two topics that LR513 touches upon. First, with regard to the Chapter 206 regulations, I would note that this is a process allowed by LB1083 back in 2004, and its purpose was to implement the Nebraska Behavioral Health Services Act. The work began on the revision to the current regulations back in 2005. And at that time, decisions were made that while the Behavioral Health Services Act required many things to occur, priority had to be given to some things. And so priority was given to transitioning people from regional centers to community-based services while bringing up those community-based services so that folks could move from the regional centers into the community, and this was no insignificant task. In June of 2010, the last of the mental health patients at the Norfolk Regional Center were moved from that facility. Services to adults at the Hastings Regional Center had concluded in April of 2007. The focus on changes to regulations began in earnest, then, really about two years ago. More than eight public meetings with various constituents were held to discuss, propose, negotiate, and clarify the direction and intent of proposed regulations. Our original intentions were to draft regulations for the Division of Behavioral Health and the Division of Medicaid and Long-Term Care, in synchronicity, so at least three meetings were held, public meetings, were held with the Division of Medicaid and Long-Term Care in addition to numerous meetings composed of Behavioral Health and Medicaid staff by themselves. However, as the result of encouragement by the Legislative Performance Audit Committee earlier this year to get this task completed, the Division of Behavioral Health moved on in its development of its regulations. The Division of Behavioral Health has been in close contact with the regions, providers, and others to ensure the necessary regulatory and monitoring

activities to implement LB1083 were going on at all times. On October 18, 2010, this year, the regulations were forwarded to the Attorney General's Office for their review, and that's where they are now. Once that review is complete, they'll be forwarded for the Governor to sign and then to the Secretary of State to be filed and become effective, unless there are changes at those levels, of course. With regard to the strategic planning process, which is the second focus of today's interim study, strategic planning for the implementation of behavioral health reform has been ongoing for several years. One can go to the Division of Behavioral Health Web site to find a series of documents--literally scores of them--that can easily be considered strategic planning documents. About ten work groups were formed back in 2004 to plan for the implementation of LB1083, and much of that thinking remains cogent today. Additionally, each of the behavioral health authorities has a current strategic plan approved by the division, and has had one since at least 2004. Notwithstanding the presence of many strategic planning documents, the division began planning for a singular statewide strategic plan about two years ago. Various constituent groups provided a variety of input and opinions on what such a plan should be, what it should include. And the input came from consumers; advisory committees; providers, both individually and through their associations; and our closest partners, the regional behavioral health authorities. Today, I've distributed a copy of the draft strategic plan for your review. This plan has been in this form for about eight weeks now, receiving comment and review by various persons, including the general public through news releases and through a Web site developed to receive comments, as well as a survey that was developed. This draft will continue to draw public comment today through the comment in the public hearing here, and I look forward to listening to people's reactions to the strategic plan and to making final adjustments as a result of the comments today. And for this opportunity I want to thank the committee and the timing that you have. I would like to speak to the process by which the draft was developed. We formed a joint strategic planning group comprised of nine members from the mental health, gambling, and substance abuse committees at the state level, as well as regional behavioral health authorities and two staff from the Division of Behavioral Health. And I think this is

an interesting note: Without encouragement or a demand from me or from anyone else, seven of the nine members on this joint strategic planning group are persons who are themselves consumers of behavioral health services or family members thereof, and it occurred naturally and ordinarily, if you will. I think that's quite a statement that the best people from each of those committees and groups were seen to be folks who were in recovery themselves, and I think that that's a neat statement about Nebraska. In addition, three national experts provided input and review of this draft: Sheryl Mead, is an international voice for consumers; Dr. Tom Kirk held my position in Connecticut; and Monica Oss is the principle of Open Minds, a behavioral health consulting group to payers and providers in behavioral health systems across the country. Given these unusual times, great flexibility in planning is a necessary element, and I think that the plan reflects the exigencies of insurance parity, the potential for healthcare reform--who knows where that's going to lead these days, changes to regional center utilization, and work force deployment, as well as electronic health records, the broad distances of Nebraska, and the need to begin to consider the development of community-based sex offender treatment services also. Given the variety and the number of prior planning and relevant documents, the ongoing nature of strategic planning if done well, and the involvement of many partners now and in the future, we chose not to start with a blank piece of paper, but rather to build on the strengths of our experience and that of Nebraska's consumers as well as that of our other partners in the behavioral health reform to consider the national landscape and what other states have done, and to retain the ability to be agile as a changing, turbulent environment continues to evolve. The structure of the plan identified three major domains. We called them baskets. Domain sounds a little more formal here, but we ended up with baskets. The first are those things that the Division of Behavioral Health ought to lead given its statutory responsibility and authority. The second are those things that the division will need to work in partnership with others to attain. And finally are those ideas that are good ideas but which the division or other partners probably will not get to in the near term, but they ought to have the light of day shown on them so that others might pick them up and run with them. There are five strategies to implement further LB1083: accessibility, quality,

effectiveness, cost efficiency, and accountability. And through these broad highways of activity, the division hopes to improve behavioral health services across the state in ways envisioned by LB1083 and its supporters. Within each of the five strategies are several more specific activities and objectives, and I think this plan offers solid ideas to give a general sense of the direction that allows others to have confidence in the government's position. We anticipate and we will rely upon others' work in the implementation of this plan, some of which may be provided to you today, as a matter of fact. Further, this plan expects annual action plans to make real its sort of broad goals and directions. But together we will be able to move forward more fully to implement the vision of LB1083. I would be happy to respond to any questions you might have and will remain here throughout the day in case you would like to call upon me further. Happy to respond to questions. [LR513]

SENATOR GAY: Thank you. Any questions? Senator Campbell. [LR513]

SENATOR CAMPBELL: Director Adams, have we had much response off your Web site yet? [LR513]

SCOT ADAMS: Originally, we had a survey, Senator, in which there were questions raised with regard to, what do you think of the direction of this and that, and there were about 393 responses from different people across the state to that. With regard to the current draft, it's been a much smaller number but a couple score have responded to the draft plan. In addition to the Web site, I've also personally gone out to, at this point, to about a dozen people to talk about the plan and hear their perspective individually. [LR513]

SENATOR CAMPBELL: Okay. Thank you. [LR513]

SCOT ADAMS: Um-hum. [LR513]

SENATOR GAY: Any other questions? I've got a question for you, Scot. You talked about the strategies of the implementation. [LR513]

SCOT ADAMS: Yeah. [LR513]

SENATOR GAY: So you have an annual action plan to implement those strategies then? [LR513]

SCOT ADAMS: Yeah. And let me give you a couple of examples of those to give you a flavor of that. One of the things that we have done that we'll continue to do is that each region is required to develop a regional budget guideline or regional budget process. We issue guidelines at the beginning of that, identify priorities, statewide priorities, and then each region is expected to sort of develop its own plan of implementation in addressing those particular priorities so that there is an annual implementation plan within the particular regions. And so in this case, we would begin to identify the particular areas of this plan, depending on timing and negotiation and conversation with our partners, the regions, we'd identify priority areas, and then each region will probably have variable implementation of that. What they do will be different, but that will happen. A concrete example is, a couple of years ago we thought that transition-age youth were a very important priority to pay attention to, so each of the six regions began paying attention to that specific population. In other years, it has been the emergency system and so on. So we'll be drawing from this document for that kind of work. A second area of annual implementation planning will be perhaps the creation of work groups in some areas to develop and think further with regard to some of the topics that may be new. A couple of examples in there rest with, I think, the role and function in the Lincoln Regional Center in particular, what's its proper role, what's the right size, those kinds of things. Secondly are the possibility of development of community-based sex offender treatment services is another area that the state needs to begin consideration of, and so particular work groups may be formed around those topics. [LR513]

SENATOR GAY: So on this report, this is...you're ending public input or testimony on Friday, and then would that plan then be like at the beginning of the year out or March, first quarter? [LR513]

SCOT ADAMS: What I'd like to do is work through the particular changes we hear from today and from the Web site and the other comments from the other input that we've received on this draft and run it by that joint strategic planning group one more time, as well as the national experts for one last touch and make sure that it's consistent and comfortable with Kerry, of course, my boss, and we'll go from there. [LR513]

SENATOR GAY: Um-hum. Okay. Thanks. Any other questions? [LR513]

SCOT ADAMS: So I hope by end of year is my target. [LR513]

SENATOR GAY: Yeah. Any other questions for Scot? All right. Thank you. [LR513]

SCOT ADAMS: Thank you. [LR513]

SENATOR GAY: Appreciate it. Rhonda, Rhonda Hawks with the Behavioral Health Support Foundation, and then I have Monica Oss, CEO of Open Minds, after Rhonda. [LR513]

RHONDA HAWKS: (Exhibit 2) Mr. Chairman, members of the committee, my name is Rhonda Hawks, spelled R-h-o-n-d-a H-a-w-k-s. I'm the vice president, treasurer, and secretary for the Behavioral Health Support Foundation and former chairman of the Behavioral Health Oversight Commission and a trustee for the Hawks Foundation, testifying today in a supportive capacity of LR513. Thank you for allowing me to testify. Before I share my formal remarks, I'd like to take a moment to thank each of you for your service to the state. Today's hearing also brings us sadness in that this is the last time we'll have an opportunity to present to and thank Chairman Gay. And I truly do

thank you. You have been an incredible leader. Your willingness to listen and work through difficult issues has been greatly appreciated. You've been a tremendous support and all of you on the HHS Committee has been a tremendous support, so thank you very much. [LR513]

SENATOR GAY: Thanks. I appreciate it. Thanks. We waited until December to (laughter) (inaudible). [LR513]

RHONDA HAWKS: That's right. [LR513]

SENATOR GAY: Thank you. [LR513]

RHONDA HAWKS: We're very sad that you're going out. [LR513]

SENATOR GAY: Yeah. [LR513]

RHONDA HAWKS: So, again, thank you. One in four families in Nebraska experience mental illness. You likely know someone who is affected. We often talk of behavioral health, mental health, and substance abuse on a system level, and we don't really focus on real life experience of a person suffering a psychiatric crisis. I recently received a phone call from a friend of mine who was desperately seeking services for his daughter, an age 19 college student, for the first time ever. He had no idea how to get services, where to go, and at first, he confided it was a friend and later tearfully admitted it was his daughter. His daughter was subsequently admitted to an acute care facility. He later called me and said, my daughter is safe and getting needed treatment because of Lasting Hope. He could barely speak because he was sobbing. This speaks to the stigma of admitting a loved one who has a mental illness and the initial feeling of, how do I really get help. My personal experience with this disease is one I've spoken of many times and affects families very broadly. My father was diagnosed with schizophrenia in his early twenties, having three young children and a wife who helped

him navigate the myriad of doctor appointments, varying doses and trials on psychotropic drugs, emergency protective custody, frequent and extended hospital stays, and self medication with alcohol. This lasted 20 years before dying prematurely at 49. This is not an unusual story, and I remain convinced that my father would have been homeless during his times of extreme psychosis without an advocate or a strong family network to keep him connected to the system. Because of his connectedness, however, he also enjoyed periods of recovery and wellness. LB1083, passed in 2004, was a great start at moving away from institutionalization and toward community-based care. We've come a long way in instituting LB1083. Moving individuals out of regional centers and back to their home base is very important. Ideally, we'd love to see a huge drop in services for high-end services like acute and subacute hospitalization, those provided at Lasting Hope, for example. Realistically, we will always have some level of individuals experiencing a psychiatric crisis, however, we're working hard to concentrate on services that are community based and can reduce our need for acute beds. Lasting Hope, like all behavioral health institutions, is not a money-maker. During my one-year tenure as chair on the Behavioral Health Oversight Commission, we issued a strategic vision in our final report. The next step was to come up with a strategic plan. The state of Nebraska has been lacking in a plan of how to move forward effectively in a way that doesn't hurt consumers. The Behavioral Health Support Foundation, concurrent with the Division of Behavioral Health's work on a vision and objectives for behavioral health that Scot Adams described today, hired a consulting group with multistate experience on the behavioral health side. This group is called Open Minds, and I'm delighted to have Monica Oss from Open Minds with us today to offer testimony on the consensus panel work on a strategic plan. Again, as Scot outlined, the Division of Behavioral Health has recently come up with a very good strategic vision and objectives. We believe that when combined with the work set forth by a consensus panel which Open Minds conducted and that Monica, again, will describe today, we're on the right track. The Behavioral Health Support Foundation, founded by the Stinson family and the Hawks family, convened a 28-member consensus panel from across Nebraska with the aim of determining areas of strategic focus. The 28 members included consumers, Division of

Medicaid, Division of Behavioral Health, regions, providers from community-based agencies, private psychiatrists, educators, and private sector involvement. Two major areas of focus were determined during the process: performance measurement initiatives and regulatory reform initiative. Performance measurement was targeted to understand the performance of the behavioral health system in total and by component; provide information needed to make system budgeting decisions; identify areas for system performance; identify best practices with good outcomes for future system investment; and improve the return on investment of public dollars by improving the performance of the system for consumers. A regulatory reform initiative was chosen to reduce unnecessary administrative costs throughout the state of Nebraska's behavioral health system. Monica Oss, CEO of Open Minds, is here today to describe these two initiatives in more detail. I would be remiss if I did not acknowledge that we know you have some very difficult budget decisions before you. Our plea today is to share that great progress is being made in the behavioral health system. Together, working as partners, we've advocated through very difficult waters. We'll continue to be a strong partner but we must have stability in funding and agreement to move forward on a system that provides measurements and better accountability to taxpayers. Bottom line: We ask that you do not cut funding for behavioral health. As you can see from our work at Lasting Hope, great things are happening. We also know that in order for this to succeed, we need to continue our plans to address the critical work force shortage that exists in this arena and again ask you to protect the funding that was allocated to LB603. Thank you for the opportunity to testify. I'd be happy to answer any questions before I turn it over to Monica. [LR513]

SENATOR GAY: Any questions? Senator Wallman. [LR513]

SENATOR WALLMAN: Thank you, Senator. Yeah, thank you for coming here. [LR513]

RHONDA HAWKS: Oh, you're welcome. [LR513]

SENATOR WALLMAN: And I appreciate what you do. And when we turn more over to regions, are you concerned that regions won't distribute the money to the people that are doing good jobs? [LR513]

RHONDA HAWKS: From Lasting Hope? [LR513]

SENATOR WALLMAN: Right, yeah. [LR513]

RHONDA HAWKS: We have a wonderful relationship with Region VI. We're fully confident that we'll receive the funding. I know it's a difficult balance for a region because they see all the needs. But this is a unique partnership at Lasting Hope. The private sector put in $25 million. We believe that that's a unique thing that doesn't happen everywhere in the state of Nebraska, and the reason that the philanthropists invest that money is because they were counting on support from the state. And we cannot make the economics of Lasting Hope work without the $6.55 million. [LR513]

SENATOR WALLMAN: Thanks. [LR513]

RONDA HAWKS: You're welcome [LR513]

SENATOR GAY: Ronda, I've got a question. You talked about the regulatory element of your study, and maybe Monica is going to cover this. If she is, just say so. [LR513]

RHONDA HAWKS: Um-hum. [LR513]

SENATOR GAY: But on the regulatory, with the budget being what it is, there's going to be cuts, I mean. So that regulatory piece, did you add up what you could save on efficiencies or actual costs if those were to be implemented? And I don't know what they are yet, but. [LR513]

RHONDA HAWKS: We did not come up with a financial total because we do not have a specific list of exactly what they are, but there's things like credentialing between the feds and the state, like if you're credentialed by the feds, why do you have to go through all that again? Why do you have to do two audits? It's things that kind of are commonsense based, and I think there is a way to get to the bottom of how much money that can amount to. What we did kind of, on the first pass, Senator Gay, was say: Okay, here are the things where we believe that is, on the regulatory reform side, kind of a low-hanging fruit, the stuff that ought to be like a no-brainer to change. So we have done that and said, okay, every little bit of money that we can save can be ploughed back into a system that in my view has never been overfunded based on all the agencies that I work with across arts, education, ministry, and social services. This is a group that knows how to squeeze all they can out of a buck. [LR513]

SENATOR GAY: So, well, I guess on that. And I don't mean, you know, some things seem so easy, just get rid of this or that. And then there's different kinds of savings, I guess, just the direct monetary. But then there's the efficiency where a nonprofit or a provider doesn't have to hire somebody or...because everyone is probably trying to make people do more with less, obviously. [LR513]

RHONDA HAWKS: Exactly. [LR513]

SENATOR GAY: And that's going to happen again in the coming years or the next biennium I'm sure. [LR513]

RHONDA HAWKS: Um-hum. [LR513]

SENATOR GAY: So, but I guess on some of those things...and, Monica, when you come up maybe you can talk about that, too, if you...but I think that's important to get a number on those things, so. [LR513]

RHONDA HAWKS: It is. I think that's a great point because there's some things that can be done where you don't have to have an extra staff person, like if you...if there's something that's done on a federal level to sign off on a plan, and on a state level you need an extra person to sign off on the plan, there's a personnel or a staff person that perhaps would not need to be in the staffing plan, reduce costs on the state side so you'd save those monies, and you could invest it in, you know, whatever it be, more program dollars, many different things. So I think that's a great point. [LR513]

SENATOR GAY: Or maybe not so much, and I know people hate to hear about staff reductions, but what I've seen so much is not so much a reduction even, it's just not having to hire someone... [LR513]

RHONDA HAWKS: Attrition. Exactly. [LR513]

SENATOR GAY: Yeah, through attrition or however they want to manage their business. [LR513]

RHONDA HAWKS: Um-hum. Right. [LR513]

SENATOR GAY: But a lot of times I don't need to hire five more people for this new regulation or... [LR513]

RHONDA HAWKS: Exactly. [LR513]

SENATOR GAY: ...and then they can find other productive things for them to do. It's just a productivity savings. [LR513]

RHONDA HAWKS: Exactly, right. [LR513]

SENATOR GAY: So, but we can cross that, I guess, later. [LR513]

RHONDA HAWKS: That's a great question. [LR513]

SENATOR GAY: Anyway, is there any other questions? [LR513]

SENATOR CAMPBELL: Maybe we come back after. [LR513]

SENATOR GAY: Yeah. Would you be willing to...after... [LR513]

RHONDA HAWKS: Absolutely, sure. You bet. Okay. [LR513]

SENATOR GAY: Yeah. Okay. All right. Thank you very much. [LR513]

RHONDA HAWKS: You are welcome. [LR513]

SENATOR GAY: Monica. Go ahead. [LR513]

MONICA OSS: Ready? [LR513]

SENATOR GAY: Yup. Go ahead. [LR513]

MONICA OSS: (Exhibit 3) Good afternoon. My name is Monica Oss, M-o-n-i-c-a O-s-s. I'm the CEO of Open Minds, which is a national firm specializing in the financing of behavioral health and social services. In our work, we work with a number of states on the very behavioral health policy issues that are the subject of LR513. And I'm just pleased to have the opportunity today both to provide...I hope there will be some context for the resolution and give you an update on the work that I've had the privilege to kind of facilitate with the Nebraska behavioral health consensus panel. You know, I think right now, and I'm sure you're well aware of this, the states are facing some, you know, incredible budget issues. In our work with states, we see three sort of big factors

that are really creating, I think, kind of new and difficult policy decisions in the behavioral health area. One of them is certainly the development of neuroscience, and you see this in the pressure on pharmaceutical budgets as we get new and more expensive pharmaceutical agents in the budget. One is the whole evolution of information technology. And as Rhonda referred to earlier, this has made things like telehealth and electronic health records kind of now become the state of practice. The third and I think the area everyone is greatly focused on is certainly the recent financial, and I would say national, financial picture and some of the legislation that followed. You know, it's interesting to me. I've been in financing of healthcare for 25 years, and I would say the last 24 months have been the most chaotic. I mean, we've had the recession, the stimulus bill, the passage of parity legislation, which is very, you know, specific to behavioral health, the stimulus package itself, and now healthcare reform legislation. And so one of the interesting parts of working both with the consensus panel is both been an eye on what's here in Nebraska now and what can we expect to see in just three short years as a result of some of these changes. And I think two of the big pieces that we did discuss frequently in the consensus panel process, and I want to make sure the panel is well aware of, is that with the changes that we expect to see from healthcare reform and parity, we really do expect to see more funding for behavioral health coming from what we call the insurance side, which would be Medicaid, Medicare, private insurance, where in the past we've had a large...close to 40 percent of Americans either uninsured or underinsured for mental health. So that's a, kind of, big and current change that we see happening across the country. The second is the, kind of, changes in technology. We're seeing more integration of behavioral healthcare with primary care, which presents, you know, a set of issues and challenges which we have addressed in the consensus panel process for how do you essentially facilitate that communication and collocation of service there. In our work at the state level, given all the current financial pressure, we see state governments do it, you know, reacting to the change in financing in five kind of key cross containment ways. One of them is certainly to reduce eligibility for service. There has certainly been the reduced coverage of service at the state level. We see a lot of pressure on provider fees with, you know, the

rate decreases and rate cuts. A big interest in moving more to performance-based contracting, how do you pay for outcomes and monitor outcomes. And then a big portion, many states, for privatization and outsourcing of a lot of previously government-run functions. All of those things I think are in play here in Nebraska. They were certainly things the consensus panel talked about as part of how do these things fit in the mix of the future for behavioral health services here. There are a few things about behavioral health that are a little bit different. And for the folks here who have a greater knowledge of the general healthcare system, I always like to point out that behavioral health is about 8 percent of the budget but, unlike the rest of healthcare, Medicaid and state and local funds pay for 50 percent of all national mental health expenditures. If you look in other areas of healthcare, that's closer to 90 percent is paid for essentially by private health insurance and Medicaid and Medicare, so there's this huge, I would say, difference when we look at behavioral health and this integration of state and local funding with Medicaid and Medicare funding that makes the planning and I would say the prospects of budget cuts much more problematic in behavioral health because one cut affects other pieces of the system. Like the rest of healthcare, we see most behavioral health funding goes to acute care. That's no surprise in terms of inpatient and crisis response. But I do like to point out that particularly in the mental health and addictions area, our estimate right now--and this is based on economic studies done by, you know, not myself but by academic researchers--is that for every dollar that's spent in mental health and addictions, there are about two and half dollars that are spent in other social service areas--law enforcement, corrections, homeless shelters, disability payments. And I always like to point out, and you'll see when we get to the work of the consensus panel, that when you start changing mental health and addiction funding streams, it's critically important to measure and monitor what's the effect of spending in other service areas at the same time. So we want to look for unintended consequences as part of that. We've done a lot of work with state systems around, you know, what are the elements for state systems that really will bring best value for taxpayer dollars. And we look at things like ending fragmentation of treatment, and here we're talking about not only coordination of service between Medicaid and the state system itself,

integration of those dollars, how do you link with primary care, how do you link with inpatient and community-based providers. So fragmentation is one big spending area. The second, which I referred to earlier, is trying to monitor what are the effects of, kind of, cross containment initiatives on corrections, child welfare, and other social support systems. And the third is kind of the lack of really focused disease management. I think one of the issues that Nebraska as a state with the Medicaid plan and the Department of Behavioral Health will see in the future is most of the new data shows that it's 10 percent of the consumers in the system who actually spend 85 percent of total dollars, and that's not just mental health. That includes kind of all chronic health conditions. I think coming up with those integrated effective strategies to manage the costs of that small group are really the way to get big savings for the state in a cost-effective and outcome-driven manner. You heard Dr. Adams testify earlier about the overarching strategic plan for DBH, and I was actually honored to participate in that process as a subject matter expert. Since he described that, I won't go into any detail. But I do want to talk a little bit here about the work of the Nebraska consensus panel and how that really dovetails in that overarching vision that Dr. Adams talked about for DBH. The consensus panel itself was created after the Behavioral Health Oversight Commission process. And largely, you know, my initial involvement was through the Behavioral Health Support Foundation who underwrote the creation of the consensus panel and really had, I think, a very specific charge, which was the Oversight Commission process had just ended, and that is: How do you bring together a group of expert stakeholders, kind of those thought leaders in Nebraska in behavioral health, look at the behavioral health system, and identify what are the possibilities for great success and the impediments to success in that system? We focused in the initial meetings, which started a little over a year ago, largely focused on the adult system, mental health and addictions. We brought together 25 members from across the state, kind of all portions of the system, everyone from the state Medicaid office and Dr. Adams' office at DBH, the regional administrators from all parts of the state, the providers, stakeholders, and set about on a process to identify what are the...I would say, moving from strategy to tactics. What are the tactical, tangible things that we could put in place here in Nebraska

that would really change the system, and I like to say for the two pieces, both for better service for consumers and better use of taxpayer dollars as part of that process. It was an interesting process in two ways. I would say that overall we had a great deal of consensus about the problems and, as you can well imagine, a font of many ideas about the solutions. And in the end, through I thought a pretty interesting process, there were really three things--and I think we have several of the consensus panel members here today that can speak to this--I think there were three things that became very apparent in that initial discussion with those thought leaders. One of them was it's very difficult to make recommendations to the Legislature about cutting budgets because we don't have a robust set of performance data. I mean, we spend a lot of time talking about if we were to recommend cuts or additional funding, where would we even start. And really one of the big impediments was a lack of, I would say, unified, standardized performance data across the DBH and Medicaid funding that makes up the system here. So that was kind of an initial, I would say, major finding. The second--and this, to me, was interesting--is the whole issue of access. I'm sure as legislators you hear a lot about having trouble to get access to certain kinds of services in certain areas. What we discovered again is that the access issues varied whether you were in Omaha or Lincoln or Kearney, and that what we needed again was better data to really look at what is time to access, who can access those services, again, coming back to the, you know, real data to make real decisions about work force and improve systems. And the other, which as Rhonda alluded to, was not an initial focus of the consensus panel meetings but ended up being a consistent theme among the thought leaders there, which is we know these are tough budget times. But we think there are things that are just regulatory and administrative requirements that we would recommend be changed so we could actually not get more money but make better use of the money we're currently getting. So that really...the consensus panel process had two pieces. That was really the conclusion of the first piece which was here was the three key, I would say, strategic and tactical recommendations of the thought leaders here in Nebraska. And then we embarked on a phase two which has much more...I would say a much more tangible work product, which was to tackle the two big issues that came up in that

meeting. Could we get a group of Nebraskans to agree on one set of performance measures, which is no small feat among a group of professionals? And did...across the state, did we have concurrence about what those regulatory reform issues are that would bring savings to the system and to the stakeholders in the system? We had a five-month process, and I do want to thank not only the foundation for underwriting this but the 25 consensus panel meetings who I'm sure per person spent 80 to 90 hours of their personal and professional time kind of devoted to review, meeting, and recordkeeping as part of the process. On the regulatory reform issue--and, Senator Gay, you had kind of asked the quantification question--there were really five big...I would say five big domains for regulatory reform. One of them involves you all, which is the whole issue of asking for cost analysis before there are regulatory and legislative changes to oversight. Do we really know when we change rules what their cost effect is on the provider system and the regions themselves? And then several of them had to do with, I would call it, management process. One was the whole issue of multiple licensure and accreditation requirements for providers that you could in fact be one program, have an accreditation audit, a state audit, a licensure audit, a CMS review, all for the same program, all gathering the same information. And it is possible, by the way, to quantify that. We've done that in other states. I've just finished a project in Florida where the average provider said they spend...they have 11 FTEs doing essentially accreditation and licensure compliance in a fairly medium-sized provider organization. And that is something we have not done that level of quantification here but something that certainly can work with the foundation and the consensus panel members on. One of the other pieces that was in the recommendations for regulatory reform was a more transparent process in terms of the budgeting of behavioral health services between DBH and Medicaid, and I think that transparency is a theme of the regulatory recommendations. And the last, and one I think as someone who grew up in a rural area and now lives in a rural area, I would emphasize the fifth of the five initiatives is...and this is not unique to Nebraska, but there are many regulatory requirements that make it difficult to use technology in delivering service, something that is key to improving rural access and reducing provider costs. And so the fifth of the

recommendations was around removing barriers to e-health or telehealth as part of an overall cost containment and work force access strategy. The regulatory reform white paper will be provided along with my testimony. There's detail on all of this, and I did make a note about your request for quantifying the effects of some of these things as a kind of useful next step. So the regulatory reform piece was one of the key pieces of the second convening of the consensus panel. The other was this whole issue of performance measures. And I will say that measuring performance in healthcare, if we had...there is no magic wand and neither the feds nor many state governments have kind of figured out what is it that you would measure that would give taxpayers and consumers comfort that their money was being well spent in the public system. But there are good templates for this. There are about seven or eight states that have a fairly robust performance measurement for behavioral health. As a kickoff to the consensus panel process--and just to give you a little background on process, we went through what does that look like in other states, what do other states measure, how are those things reported. And, from there, used a typical consensus panel facilitation process to actually lead the group through a process of which of these things are relevant here in Nebraska; which aren't. What are the issues that would make it most useful for us to know what our performance as providers, you know, consumers outcomes, you know, public investment of dollars, what that looks like. We, I think, did a couple things in design that I think are important just for reference. One of them is, the initial start in measuring anything in my professional experience is no one likes to have their performance measured. So what we did was start with, I think, a good baseline for moving that process along, and in the interest of not adding a lot of expense either at the state level or at the provider level, tried to use current data that was available but may need to be corrected in other formats. So I would like to point out, we were very cognizant of budget issues for all of the stakeholders and tried to put together a scorecard that would fit with that. The second is that we designed this in a way that HHS could expand this to children or developmental disabilities or other parts of healthcare, that we tried to keep an eye for not only is this useful for adult behavioral health but the concept of having a transparent public performance report card is

something that could be used across the healthcare system. The long and the short, we ended up, and this was a tough process, we started with about 185 measures and we ended up with 18. In large part to try to narrow the focus and the scope, they fall in four areas: consumer outcomes; consumer perception of service and recovery; kind of continuity and access to care, because that was a very big issue at the start of the process; and then the last piece was the cost effectiveness and, if you will, efficient use of system resources. I won't read through all of these. I just want to do a little bit of a highlight in each. And you'll find in my handout I actually have some examples of what these things look like. I'd like to point out before anyone looks at the actual numbers that these are all fake numbers. These are design-only templates. So as you're looking at those graphs, please don't jump to any conclusions about the data itself. But I think there were I think three really important pieces about the performance measures that we're recommending. The first was that these were--and this is very consistent with what Dr. Adams said before me--very focused on in the end the system exists to get consumers back to work and back to home and back in the community. And there's a very large focus in the outcome measures about, you know, are consumers, you know, essentially...do they have housing, are they satisfied with the system, are they having continued interaction with law enforcement, are they employed, all the things that really matter to us when any of us use the healthcare system is kind of an integral part of that scorecard. The second area in terms of continuity of care and access to care looked at, I think, what was one of the continual issues that I heard throughout the consensus panel process, which is, do Nebraskans have adequate access to mental health and addiction treatment services? So there's a focus at looking at access by level of care in region to really help plan, where do we invest public dollars; you know, where do we have access issues, how do we create cost-effective solutions, and use that for the basis of that. The last domain, the cost-effectiveness area is where everyone tends to gravitate in times of budget issues. But really looking at things like what is the administrative overhead cost of running the system, what do we spend per person in providing service, you know, do we have...what do consumer average length of stay look like, are our readmissions to crisis services on the decrease or the increase, things

that I'm happy to get into in any amount of detail but are really selected by the consensus panel members as indicators of these are things that will tell us, is the system working well, do our policy decisions (inaudible) good and would guide essentially future budget discussions as part of the process. There are a few things on the agenda, and I want to leave some time for questions if there are any. We've been talking with the consensus panel and the foundation about a couple of the next steps. One of them is certainly moving the performance measurement system from a design concept to an actual data test of gathering actual data and starting to do initial benchmarking across the state on a selected number of issues. The second, and this gets to I think the quantification request, Senator Gay, is to develop a plan for how do you implement those regulatory reform pieces, and that would involve, you know, kind of the cost effectiveness of each of them and the challenges of implementation. And the last is generally, and getting to my opening, kind of, remarks, how do we facilitate better integration from the consumer perspective between the various systems in Nebraska, Medicaid, behavioral health, DD, primary care, and looking at that initiative. But I'm hoping that this is kind of an overview of the work of the consensus panel and, again, I'm happy to answer any questions that any of you might have. [LR513]

SENATOR GAY: All right. Thanks. Any questions? I've got a few. [LR513]

MONICA OSS: Um-hum. [LR513]

SENATOR GAY: You talked about...and then you just kind of touched on it in the end, on the about two. Let's go with the first of the regulation changes or whatever. [LR513]

MONICA OSS: Um-hum. [LR513]

SENATOR GAY: And when that's done, there's several things you had mentioned, the cost of these new regulations. How do you monitor the cost of the new regulation that someone might dream up and say, wow, that's a...okay, that's been talked about before

and a lot of other things and I'm probably correct, but...and then new technology barriers, all those things. And then I think there was one more. What was the other one? Cost of the new regulations? [LR513]

MONICA OSS: Yeah. One was cost of the regulations. One is coming up with what they call deemed status, they're trying to streamline licensure and audits because that's a huge issue. [LR513]

SENATOR GAY: Licensure. Okay, so you have public health involved in that, and we have the six different divisions. [LR513]

MONICA OSS: Yup. Um-hum. [LR513]

SENATOR GAY: And they all...and it probably drives Bryson crazy but his job is to try to pull everyone together, the way I understand it, and say, listen, you need to do this, this, and this. They're all integrated. [LR513]

MONICA OSS: Um-hum. [LR513]

SENATOR GAY: So what seems easy just to change something is not so easy to do. So when you look at that on the regulations, do you have a...when they looked at that, the different people that are stakeholders said, well, I don't like this one, I don't like that one, whatever. You have those spelled out somewhat? [LR513]

MONICA OSS: We do. And I would say the key theme...and, again, you'll have the kind of written detail, one of the things that came up frequently is that many times when...if you're a provider of service that when the different state licensure bureaus are there and your accrediting bodies which you have to maintain, the joint commission or this CARF, and then the CMS audits, they repeatedly ask for the same information. And some of it wasn't so much, we don't want to have oversight, what we'd like to do is have the

oversight bodies kind of collaborate or streamline the amount of time we need to spend pulling data so we could do it once and provide it to the group. The other issue which we do find in other states is many other states have adopted a policy that if you're accredited by a national accrediting body, you then have a less frequent state licensure review, which is...you know, it's called deemed status. You essentially give credit, if you will, to the provider for participating in some national review process so they have fewer state reviews. So it's those kinds of specifics that are in the formal white paper. [LR513]

SENATOR GAY: So there's different tiers if somebody is accredited they're a large organization because we've talked about accreditation... [LR513]

MONICA OSS: Yup. [LR513]

SENATOR GAY: ...and the state is not accredited on certain things, and we haven't wanted to pursue that. But what about the small providers that are out there? There's many small providers, I understand, I think, I mean, that are out there providing services to the state. Would there be two tiers, like one for a larger accredited agency and another tier for somebody that's smaller? [LR513]

MONICA OSS: Well, you actually could...I mean, one of the recommendations is that you would separate the provider organizations, regardless of size, kind of into those that have national accreditation and those that don't, and then be able to use essentially the information that they would submit as part of the national accreditation process in lieu of regathering that information in a state licensure process. So some of it is almost doing a gap analysis of what's the difference, if you will, between a typical state licensure review and an accreditation review, and then limiting the scope of the state licensure review to the things that were not gathered by the national accrediting organization. [LR513]

SENATOR GAY: If you wanted to pursue that, yeah. [LR513]

MONICA OSS: If you wanted to pursue that. [LR513]

SENATOR GAY: And then on this performance measurement, you said...I guess when somebody says to me in my business or whether it's federal government or my boss or whatever, oh, by the way, we want to start tracking eight new things for a report I got to do next. [LR513]

MONICA OSS: Um-hum. [LR513]

SENATOR GAY: And to me we kind of like, oh, really, and we've got to start tracking all this stuff. [LR513]

MONICA OSS: Yup. [LR513]

SENATOR GAY: But in one hand we're saying all these regulations that are costing us money that the state is requiring, what did your members say or your stakeholder group about that, though? Because that's a cost. Now we got to go and say, well, if we're going...or are you already tracking those? Or I guess on the new regulations or performance measurements... [LR513]

MONICA OSS: Um-hum. [LR513]

SENATOR GAY: ...I'm going to track, you went from 185 down to 18... [LR513]

MONICA OSS: Um-hum. [LR513]

SENATOR GAY: ...which is thank God. [LR513]

MONICA OSS: Yeah, here at 18 key measures. [LR513]

SENATOR GAY: Okay. On those 18 key measures, are those things that are already kind of doing... [LR513]

MONICA OSS: I would say, you know--and I'm just looking at my list here--of that group, probably half of them, the various stakeholders, and it would vary slightly if you're talking to regional administrators or a provider organization, are already reporting these measures to the state, either to DBH or to Medicaid, and it's really a matter of organizing the data in a slightly different way, making it comparable, and then making it transparent so you can compare the performance at a regional level. So some of it's collating similar data and making that available. The other pieces, especially on the cost effectiveness and efficient use of systems data, much of those seven measures we would actually get from actual DBH databases or from the Medicaid data set. Things like length of stay, number of readmissions, those are actually not things that providers would report. Those would be things that we would extract from existing Nebraska state databases and just report them by region and by provider. [LR513]

SENATOR GAY: And you visited with Scot and his group on those things? [LR513]

MONICA OSS: Actually, Scot's group participated in that process and the Medicaid office had the head of behavioral health and long-term care participated in the consensus panel as well. [LR513]

SENATOR GAY: All right. Thanks. [LR513]

SENATOR CAMPBELL: Did anybody discuss with you how poor the MMIS system is with Medicaid? [LR513]

MONICA OSS: Well, you know, I think...like all states, I haven't been in a state where someone isn't critical of the state's data-gathering capabilities, so there were discussions about as this moves forward, certainly some of the capabilities of the

central state system would need to improve. But I would say, in my expert opinion, the things that we're looking at here would be capacity increases that the state would need to make anyway to be in compliance for Medicaid expansion and other things. I don't think there's anything here out of the ordinary in terms of data that we would hope to get from Medicaid and DBH that they wouldn't already be planning in some IS expansion. [LR513]

SENATOR CAMPBELL: In the federal healthcare discussion when they discussed behavioral health, did they look at any performance measures that would dovetail with these? [LR513]

MONICA OSS: Well, in fact, many of the measures of these 18 measures are in fact from the federal NOMs database, so we made sure that these were not running contrary to the initiative that DBH already has in place to do that federal reporting. I think the big change and one of the...you know, when you get to implementing any performance measurement system, there are all the...I would call it the logistical and blocking and tackling of where do you get things and how do you display them. I think one of the challenges will be--and this is a broader policy challenge: How do you extend that work that DBH is doing across the Medicaid population to have I would say a better picture of the system as a whole? And that's an issue that we'll need to...as we move to phase two in the beta test we'll need to iron out. But, yeah, all those national outcome measures if at the federal level have been incorporated in this. [LR513]

SENATOR GAY: All right. Any other questions? I've got one. When you...so you took a statewide stakeholder group and how did they then...if I'm out in Scottsbluff versus Omaha, I'm familiar with the metro area, but it's a diverse state as you found out I'm sure, like other states. [LR513]

MONICA OSS: Um-hum. Yup. [LR513]

SENATOR GAY: It's not that unique. But so when they came together and said, you know what, we don't have that here, we don't have that, how did the stakeholders come together then and say...how did you go about voting and deciding who's...that everyone was fair... [LR513]

MONICA OSS: Well, it's sort of if you're familiar kind of with the nominal voting process. You know, you engage people in discussion, you allow people the opportunity to kind of rule out things that were particularly problematic for some folks. I mean, like many things, a consensus panel is ultimately the big compromise. So you work through the process of what things are most important to most of the folks and do that. I think there was less disagreement about the measures themselves than I think...and this is what I found in putting performance measurement systems in place in other areas: I think there is great trepidation about the results. I mean, because no one likes to be measured, and every region and every provider I think has...you know, in the back of our head none of us like to be measured in how will I stack up and will...you know, when you enter into a performance measurement. I will say the consensus panel members were very brave because they're measuring a lot of things that frankly could make any of them look fairly negative if the data wasn't good. But what you do is you enter into these things with a perspective on...our goal with performance measurement isn't to penalize people but to identify problems and solve them. And I think that's kind of the key to making people, you know, give up data and participate in a process like this, is that kind of openness to that. But I would say there was less concern among the regions and the various types of delivery systems here about the actual members. But I think there's a fair amount of concern about how will one region look compared to another, how will one provider look compared to another. And so everyone is kind of moving forward with this, I would say, with their fingers crossed in a collegial fashion. [LR513]

SENATOR GAY: I've got one more question (laughter). So if they're doing that and I say now I'm going to put myself on the line because there's a lot of great providers sitting out here in the audience behind you... [LR513]

MONICA OSS: Um-hum. [LR513]

SENATOR GAY: ...and others who couldn't make it here today. And then now I say, oh, by the way, I'm going to start tracking myself on 18 measures. [LR513]

MONICA OSS: Eighteen new metrics, yup. [LR513]

SENATOR GAY: I'm now going out there on a limb a little bit. [LR513]

MONICA OSS: Um-hum, very much. [LR513]

SENATOR GAY: So now what's the next step after you...? You track measurements for a reason. [LR513]

MONICA OSS: Um-hum. [LR513]

SENATOR GAY: Did that group discuss about now what is after this? As on this end of the table I think when you see measurements and you see somebody who's not meeting them... [LR513]

MONICA OSS: Um-hum. [LR513]

SENATOR GAY: ...we all of a sudden assume and don't give them the benefit of the doubt; say, oh, by the way, they're not doing what they should be doing, instead of here's a tool to go correct yourself. Was the group a little bit nervous about, oh, by the way, you didn't hit nine measurements and...? [LR513]

MONICA OSS: Um-hum. Well, we had that discussion in great detail. I mean, there's a lot of concern among all the stakeholders about now that I'm going to be measured and

benchmarked...I mean, everyone has some trepidation. You know, I think the key is...you know, in its best form, performance measurement does two things I think are really critical. As a finance person, they help you guide your finance: Where do you make investments? From the provider and consumer perspective, hopefully what you identify is who's doing the best job, and can I replicate what they're doing? If they're the most cost-effective, if they have the fewer readmissions, if they have great consumer satisfaction and I don't, then I want to find out what they're doing and try to promulgate best practice. So it's my hope that really the purpose of this is those two things, which is, how do we guide investment in the system since we have a limited amount of dollars; and the other is, how do we use the data to actually improve what we're doing? But your caution is something that was discussed a lot by individual providers about, what will this mean for me if I don't do well? [LR513]

SENATOR CAMPBELL: In the national healthcare there will be a lot of emphasis on readmission to hospitals... [LR513]

MONICA OSS: Yup. [LR513]

SENATOR CAMPBELL: ...and the hospitals are beginning to look at the benchmarks and dashboards that they can put into place... [LR513]

MONICA OSS: Um-hum. [LR513]

SENATOR CAMPBELL: ...to start monitoring this and do something about it. Will we see the same thing in behavioral health? [LR513]

MONICA OSS: Um-hum. And in two ways. I mean, in looking specifically to readmission, on the consensus panel we had a number of the inpatient facilities represented. They're already reporting the readmission data as part of HEDIS, which is doing exactly that readmission monitoring. The interesting part for us is we'll be able to

then not only have a national behavioral health readmission number, but a Nebraska number. And I think that will...as a consultant to the field, that will tell us a lot about how well this continuity of care works in the system. [LR513]

SENATOR CAMPBELL: And the reason for some of that question, and some of my colleagues that are sitting here are also on the LB603 oversight committee, which is a response to the safe haven, a collection of bills. But in talking to Magellan and one of their reports several months ago, they were beginning to look at the readmission rate. And we had just a little...we touched on that a little bit, but from listening to you most likely we're going to be touching on that a lot more. [LR513]

MONICA OSS: It's one of the integral measures here. And you're absolutely correct that the focus at the federal level I think there's going to be tremendous pressure on inpatient facilities who accept either Medicare or Medicaid to not only reduce their readmission rates, but the MedPAC commission has proposed basically if there's a readmission within 30 days that the inpatient facility actually not get any money for the readmission. I mean, there's....this has not been enacted but there's a big push by the advisory committee to penalize hospitals for readmissions, and I think you'll see that. Given the current state of the federal budget, I would expect to see that happen in the next year or two. [LR513]

SENATOR GAY: That will be interesting. [LR513]

SENATOR CAMPBELL: Or if the patient, at least from a hospital's standpoint, suffers something... [LR513]

MONICA OSS: Um-hum. [LR513]

SENATOR CAMPBELL: ...that the hospital caused which was not in the immediate presenting disease or whatever one the person came to the hospital. It's just really

fascinating to see all the dashboards come out on the quality, and what you might have just askance looked at a couple of years ago, you're really going to look at more thoroughly. [LR513]

MONICA OSS: Um-hum. [LR513]

SENATOR CAMPBELL: Very helpful. [LR513]

SENATOR GAY: Yeah. Very helpful. [LR513]

SENATOR HOWARD: You know, in listening to all of this, it really sounds like this is all going to be data driven rather than needs of the human being, and I think there's a big risk in that. Coming from the perspective of the social worker, there's a lot that contributes to an individual's situation. It's not in an isolated, you know, this is just a one-time occurrence. There are things that take a long time to be addressed. I remember when I did child protection work, often it wasn't what the family was identified or what they came into the system with a particular problem; the filing by the county attorney was all the things that contributed or revolved around that. And I hope that isn't lost in this analysis. [LR513]

MONICA OSS: Well, I...just to address that, I do think that when you look at the measures themselves that there is I think not only the first two domains are completely focused on kind of the consumer experience in the system, but I would say by measuring access and what they call penetration rates, how easy is it for me to get service, that you're going to go a long way to making the system a lot more consumer-friendly. The other piece--and this is just in my life as a finance person--is it's very difficult to ask for budget increases or investments in work force or other things without data to support that. So I like to view this, at least, as this is the quantification of the consumer experience in the system in a way that we can take this forward to policy people around resources. [LR513]

SENATOR HOWARD: Well, I won't disagree with you that the data is important and I think looking at child welfare we've never done the job we could do in collecting the data that's available, but I hope we don't lose the balance. [LR513]

SENATOR GAY: So if you're measuring access or whatever, entry into a system, it's going to be different on that. I'd be concerned a little bit if you're out in a region and looking at the regional director part of it,... [LR513]

MONICA OSS: Um-hum. [LR513]

SENATOR GAY: So in the Omaha region or Lincoln you probably have more psychiatrists or just people to deliver the services. [LR513]

MONICA OSS: Um-hum. [LR513]

SENATOR GAY: As they go further west, my colleagues would say, listen, you know what, they've got to come 200 miles to access the nearest LMHP or whatever it is or there may not even be a psychiatrist around, and may not be a lot of the services that are here. [LR513]

MONICA OSS: Um-hum. [LR513]

SENATOR GAY: Should they be...how would they not be penalized, though, on that measurement? Is there a fairness thing at a certain point? Because I can't deliver the same service there as I could here. [LR513]

MONICA OSS: Well, there's a difference...and actually as someone who has done a lot of work in rural health, that difference, being able to quantify that, I think is very important for rural providers to be able to ask for additional resources. [LR513]

SENATOR GAY: Like telehealth or something like that? [LR513]

MONICA OSS: Well, it can be telehealth. It actually could be...in northern Michigan, working with their system, we actually put in a differential rate for rural outpatient providers to make it more cost effective for providers to actually open up a rural practice. But, again, I keep coming back to it, it's very difficult to go to the legislator or the executive branch and say, I'd like more money for a rural practice without quantifying what is the access issue. So I'm tending and I think the consensus panel discussion was less around...because, yes, I think the rural regions will have far higher time to access care just because it's like rural America everywhere. I hope what it does is enables us to say, well, look, here are places where the access rate is unacceptable and kind of what are the solutions, and then what does it take to actually fix that. [LR513]

SENATOR GAY: All right. Anything else for Monica? [LR513]

SENATOR CAMPBELL: I must say that the charts in the back of the report are very interesting. [LR513]

MONICA OSS: Oh, good. Well, like I said, the data is all fake. (Laugh) [LR513]

SENATOR CAMPBELL: I know, but how you're tracking and what measures you're using. [LR513]

MONICA OSS: Um-hum. Well, it was really I would say the collective genius of the consensus panel, because a lot...and, again, if you think about the number of man-hours contributed by the consensus panel members, a lot of time and thought went into thinking about what would be a good representation of how well the system works. [LR513]

SENATOR CAMPBELL: Interesting. [LR513]

SENATOR GAY: All right. Thanks. I don't see anymore questions. Thank you very much. [LR513]

MONICA OSS: Good. Thank you so much for the opportunity. [LR513]

SENATOR GAY: Did you have question for Rhonda? [LR513]

SENATOR CAMPBELL: I do not. She had some questions. [LR513]

SENATOR GAY: Okay. All right. Topher Hansen is here. Thanks for coming. [LR513]

TOPHER HANSEN: Thanks for having me. [LR513]

SENATOR GAY: No problem. [LR513]

TOPHER HANSEN: Topher Hansen. I come here representing NABHO. The president was not able to make it today and so I've been tapped. And I have to start out by saying that I have not had a chance to review, nor has NABHO as an entire group, the Open Minds report. We have had the strategic plan that was drafted by the division, we have had that in our possession and are making comments on it and reviewing that. With that, I guess I would mix in some of our own conversations as well as some of the ideas presented here today in reflecting what we think the system is facing and what's happened since LB1083. It's been six years since LB1083 was passed. I sat on the first oversight commission and spent a year listening and reading and hearing, and developed with the group a large report that is sitting on a shelf and is not recognized. It's not part of any report here--is not being used in any way, shape, or form. And my concern in our system is the time that's passed and the utilization of the people that are

in a position to know and to help us move forward. And I think just now we are gaining traction in starting to move on some of the ideas and some of the principles that have to happen in order to run an effective behavioral health system in Nebraska. Right on the verge of major change. My motto has been: We are only a million eight; we can do this. A million eight gives us great advantage in that we don't have so many people that we can't begin to wrap our arms around this. We do have a broad geography that presents some challenges, but the world of electronics has presented options to us that we're not fully taking advantage of, and that was raised earlier--and I speak of telehealth--that we are not utilizing what we've had. In fact, we may be wearing out the system we have available to us without even using it in that it's becoming antiquated. We have a backbone structure that's available and not fully utilized. And again it's because there are barriers in place that aren't allowing us to fully access that. So some things that I think about when I see all this and have had the conversations in our statewide organization that consists of regions and consumers and providers and Magellan sits as a member. And I guess the first thing that comes to mind is one state, one set of policies. Just like with the person, it ought to be one person, one system to address their needs. So it ought to be mental health, substance, primary care, all moving forward at the same time. That's the way the person is going to get better sooner for longer. And as a state, the way that we can line this up is to form one set of policies that applies from birth to death and that has to do with behavioral health. That should be transparent. We have to quit finding $10 million and $27 million, that we should know where the money is and we should be able to account for it and not keep finding it. We have to be accountable, so the budget has to go on the table in full presentation so all the pots are known and all the expenditures are known and we shine the light of day on the whole thing. That's accountability. Holistic, I kind of touched before, that to the extent we have a narrow toolbox in our approach, then that tells us how many times we'll come back to do business, and the readmission rate applies to that. But if what we do is broaden our scope so our system is able to care for people in all the facets that they need because it is never...at least in my line of work, it's never one. In fact the cooccurring case is changing its language and is now being looked at as complex

cases. So better capturing that it's not just two things, it's 12, and that we have to do it all at the same time. So the holistic nature of what we ought to do ought to be there. We need to figure out how to cross these boundaries and have the right people in charge for the right kind of work. And on that note I would then comment, one of the frustrations that we have experienced as providers and have conversation at meetings is about the policies of Medicaid really leading the charge. We have even gone so far at NABHO as to hire the Appleseed Center to monitor the regulation changes because they come so fast and have so many implications that we have no time to sit and discern all the different regulation changes and what their impact might be, and have hired legal counsel to help us do that. So this is driving and impacting all areas of the state and essentially has taken the driver's seat, which is wrong. The financing should not take the driver's seat. It should be a support mechanism for the mission and values of the state of Nebraska. And I think what the division and what the consensus panel have helped give us is some values and some principles and then some details about how we can begin to go about this. But I have not heard how Medicaid is involved in this in terms of being a support mechanism. Is it a payor? Medicaid is just a payor, and we have to know the rules there and then use those rules to deliver the system that we value. The integration of all of this is key. To the extent we don't do this and be holistic, then, again, we will waste money the first time, the second time, the third time. Can't tell you how many people have come in to our programs and say, I've been through treatment ten times. Ten times. That's wrong. Two, three times is not necessarily unusual for people who have more than one chronic condition, but ten times is because they're not getting the holistic care they need. We have to broaden this out and do good assessments up front and then do good delivery of services to follow up. I analogize that to going in to your mechanic with a car that has four flat tires, and they welcome you in the door and say, glad you're here, good to see you, and by the way, we only do left sides. So they pump up your two left tires and send you out the door and say, see you later. And, of course, everything fails within the first couple of blocks. So there again it kind of goes to the readmission rate. If people are going through ten times, we have to go, wait, something is wrong here. We're not doing something we need to be doing. The

effectiveness of a program if we are not...and this is a critical piece of what has been presented today, that the effectiveness of programs has to be measured, otherwise we don't know if we're harming people. If all you're doing is treating and not measuring your effectiveness, then you may be harming more than you're helping and that doesn't work. Now the performance issues are tricky because they do involve finance and they do involve qualities. And what we do with our performance is look at how we perform in different program to know, did we hit the goals that we think, and if we didn't, what interventions do we need to employ that could help change that? Let me give you an example. We...in our residential programs what we call elopements, or people leaving before they're finished with treatment, happen at a very high rate. The national average is 45, 50 percent, and we are no exception to that. And we fight with that all the time. And so we measure what time of day, what day, and reasons, background reasons, why people elope. So then we try and employ different interventions to help thwart that so they aren't leaving at those times of day, so we're addressing the issues that seem to be the big issue in all the people that are eloping and so on. So outcomes and performance measures are gigantic. We have to do that as a system so we can know we have a quality system and are helping people, not hurting people. Efficiency, of course, is mandatory. If you're not efficient, you're going to go out of business if you haven't already. You have to be able to stretch every dollar as much as possible, but it's not just dollars. It also has to do with access. So are you efficient in your process, in your workflow, so that you can move people through the door sooner? We measure how many people stand in line and how long do they wait. And last year, as one of the years, we were able to move more people through the door sooner because of workflow, but that doesn't stop us. We're now revamping our workflow because we think we know a better way. It's a constant quality improvement process that has to be employed by everybody. Of course, the good consumer perceptions. We can think we're doing great all day long but we really need to ask the consumers: Did this work for you? How was your session today? Did you meet the goals that you were here to meet today? Did you feel like you were treated with dignity and respect? Did you meet your treatment goals? Do you feel like you'd recommend somebody here? Things like that to measure the

quality. Some of the concerns that we have relate to the statute itself. LB1083 does a couple of things. One, it requires integration of the funds, that all the funds that go to behavioral health be integrated to then work together. Instead, what we've seen is Medicaid and the division have had a very difficult time putting that piece together, and the division has kind of gone off now just to develop this without that agreement or that collocation of funds. We think that's important that, again, Medicaid be a funder, be a tool, be something that the division understands and utilizes to maximize the amount of care that we can provide and the quality of care that we can provide in Nebraska. The other piece that's set out there and that was discussed a little bit here is rate methodology. We have come to this committee to talk about rate methodology, and frankly it was not understood I think. Why are we doing this? It's not involving money. Should we even do this? Well, the whole notion is, we need to be precise about what it costs to deliver services, and then we need to know are we keeping pace with the providers in giving them the resources they need to provide these services. So the data we generate out of the system and the cost analysis that we can do for providing services gives us an ability to then do the rate methodology set out in statute. I mean, it's not just our idea and something that we fancy. We think that not only it went in here because of this, but we think it's still a good idea that you all ought to have the best information possible when trying to make these tough decisions. And if you don't know if we're getting a million dollars more to run this business and what it costs us or a million dollars less, then you don't have the right information. And what we need to do is set up a system that allows you to have accurate information with which to make critical budget decisions, which can make or break organizations, frankly, which then translates down into hundreds, probably, of consumers that are receiving care. Just so you know how all these things play together, the Medicaid window of medical necessity has narrowed, and so fewer people are getting through those doors than once did. And we have seen frustrating situations, for instance, in our community support program where people have functional social deficits and also are severely and persistently mentally ill. That's the criteria to get in the door, and we've called up to get authorization. This is a low-level, fairly low-cost service, and have called and had them denied because they

were too smart to be that way, they were too high-functioning to be severely and persistently mentally ill and were denied that, and then have to turn around and think of 13 other things in order to do this. If we integrate our system and get wise about how to make a portal and put the right people through it, then we're going to be more efficient and more effective. Other things are happening in community support on the Medicaid side. The billing system is going to be different and cause providers to...I don't know a provider that thinks they're going to be able to make money on this now. We've all agreed to it. We're all continuing to try and revamp our operations, rethink the way we do business in order to meet this. But I can tell you right now, this is one of the lowest level costs of service. And CMS has said, get a better payment system under way. This will impact the behavioral health system. And what we're all trying to do is figure out the right ways to do business that can meet the economies or we're going to go broke and have to stop doing the business on the Medicaid side. The behavioral health division is still continuing in the ways that we've all agreed sometime back, so now we've got two systems to grapple with in our administration of services. And then the other piece on the funding side that you should know about is that Medicaid and child welfare and behavioral health are all colliding. And what we're seeing, for instance, in providers where moms are coming in that may have Medicaid into services and the child is in the child welfare system...or I'm sorry, a child in child welfare system who is not on Medicaid and then coming into the behavioral health setting. The behavioral health divisions and so on are saying, that's a child welfare case, not a behavioral health case. And then...and so there's that war where we can't get funding approved. And it's causing a lot of problems for providers across the state in terms of just...it's not that the people aren't there, it's not that we're not ready to serve, it is that we don't have payor and it gets put not on our back because there are other clients standing in line, but the back of that consumer who can't get in the door and get the services they need. The questions I have I guess, again, that is one of our giant frustrations is access. And one of the principles in the state's strategic plan is insist on access. I don't know how to insist on access (laugh). I mean, we've been trying to insist on access. It's really difficult. We have...in our long-term dual diagnosis program, we have a six-month wait to get in.

And people who are...when you have the priority system that the block grant dollars create, if you don't have super serious problems, you may be in the tail end of that wait list for a long, long time and it becomes very difficult. One of the ways that we can get our access better, besides being efficient, and that's always something every business ought to be doing is increasing efficiencies, but the other things we can do is adjust our capacity to meet the demand for those services. And it will be...I think of it as a bell curve. The high acute ought to be at the low end. There ought not to be monstrous highly acute services. It ought to be at the low end of the system. And then the middle is some residential on this end and then a lot of outpatient and then a lot of support services to help people in that safety net kind of situation to stay well. So we need to develop our system so we have an appropriate level and develop that capacity to meet that, otherwise we're going to stand in line and we're going to be talking about these problems forevermore--just the way it is. And I guess the other pieces that we need to think about that are right on our front door is healthcare reform. This is...again, I've not had a chance to look at the consensus panel report. But healthcare reform is at our front door. We need to not react to that in two years or three. We need to really be planning for that right now and how that's going to happen. And, to date, that conversation has not really taken place at the state level with providers and regions and so on. We haven't had that conversation about what's our future look like in relation to healthcare reform. The integration of primary care, this is a tsunami moving across the country in the public system. Everybody understands that these two worlds affect each other, live together all the time, play together all the time, we cannot keep them separate. And we need to be thinking in the behavioral health division how are we going to link primary care services into what we're doing and really be more holistic. Technology to enhance our systems, electronic health records is on the way and we...that's a huge efficiency in services. It costs a little bit to get in but the efficiency is what could take a supervisor a half to a full day to do can be done in two to five minutes just because the data is gathered and screens come up that can show them how current everybody's files are and what reports aren't done and so on, just by viewing (snapping fingers) screens like that. So that and the telehealth system, because if you're out in Cherry County and you

have a mental illness and addiction and primary care problems you are in big trouble because services cost...well, take time to get to and are scarce. And yet if what we did was used our technology available, the telehealth system, to use that backbone and look at what options are available to us to put the technology together, then we can have doctors' offices become sources of behavioral health. We can integrate that doctor's office. So to the extent that the doctor has a behavioral health issue come in his or her door, then they are able to consult. And where are the vast majority of psychotropics written, the prescriptions? In those doctors' offices. And we need to link this system together and use this technology to do it. And the technology is fantastic today in terms of what it does in putting somebody in clear view so you feel like you're sitting across the table from them. So we have the availability, we just need to take advantage of it. The other issues, one other issue that I'll mention that you ought to know about, as well, is the Medicaid IMD, Institute of Mental Disease rule that is and will be affecting capacity across the state. Any program that has more than 16 beds is considered an IMD and will have to reduce. So the programs that are 24 or 20 or anything over 16 either have or will need to reduce in order to be compliant with Medicaid. Currently, we're working on the...there is discussion about the language that the division has with the regions on if you're going to provide behavioral health services then you shall also provide Medicaid services. And we have a program, for instance, that we do in collaboration with Houses of Hope and we get 3 to 5 percent Medicaid a year. That's the majority, that's the numbers. And yet if we reduce down to 16 and we will serve fewer people, we're at 20 now, our capacity. And what we want to do is not serve Medicaid people and have them go to other Medicaid services and we serve more people so we can get the people in line in the door. And that's a problem right now. It's not being allowed right now because of this language. But we're talking about how to get that done and creating some diversity in our state so we have different abilities in different places. So it is a huge system, it is complicated but it is something that we can still wrap our arms around. We can still get it done. We just have to put the minds of the state together like the consensus panel did to start solving some of the problems and creating some of this direction. If it happens top down it's not going to go as well. But in

groups like the consensus panel, where stakeholders and representatives of stakeholders come together, that's the way an effective system will be developed and NABHO is fully supportive of that. [LR513]

SENATOR GAY: All right. Thank you, Topher. Any questions from the...don't see any. Thank you. [LR513]

TOPHER HANSEN: It was thorough. (Laugh) [LR513]

SENATOR GAY: Thanks. Jonah Deppe. [LR513]

JONAH DEPPE: (Exhibit 4) Good afternoon. My name is Jonah Deppe. I'm the executive director for NAMI Nebraska. That's spelled J-o-n-a-h D-e-p-p-e. I'm often asked if I'm related to Johnny Depp. But, no, he doesn't have that extra E in there. (Laugh) My comments are probably going to be a little different because I probably am focusing more on the more recent draft strategic plan and some issues that we feel around that. NAMI is a statewide organization that represents consumers and family members. I am a family member. And during the past several years and at least in the past six years I know that we've sat on several strategic planning task forces or committees related to behavioral health. And I've had other consumers and family members on there. In fact, people served on the LB1083 Advisory Committee and commission. And to date, with all these planning activities we haven't really seen the expected participation of consumers and family members that we felt was going to come out of some of the guidance that was in LB1083. And more recently I did have a group of consumers and family members look at the new strategic plan guidelines and I did put their comments with my packet for you. And we did send those on to the Division of Behavioral Health. I think their, you know, their comments are...kind of hit the nail on the head in several places. You know, it seems like the strategic planning goals, when you look at the goals, are focused on some special populations instead of an overall priority for all the persons who are experiencing behavioral health episodes in their

lives, whether it's mental illness, substance abuse, or gambling. And NAMI and its members certainly support effective prevention and treatment for cooccurring disorders and appropriate services for sex offenders which are goals 1, 3 and 4. But the outcomes seem to be focused on the development of supports and documents. And NAMI members would like to see outcomes related more to the services provided through the Division of Behavioral Health. And so hopefully that will come out of that. But we hope we're not going to spend four years getting there. We've already spent time discussing these issues and never seem to see something that you can really measure and see are there being some results. It does look like in the Initiatives for Strategy 2 of that plan, that to improve the quality of behavioral health services for children and adults that we would see some of this happening, some of these hopes being brought to the forefront. We, you know, and again as I said we hope that it wouldn't take four years to develop all of this, that we started to see some action and have plans come out of this and some action taking place. And I did happen to serve on the consensus plan piece and I fully endorse some of the things that are coming out of that. But access to services in the community is important to both children and adults. And home- and community-based services need to be not only accessible but they need to be available. Moving from residential care to home- and community-based services is not going to be successful unless those services are available in the community. And developing standards and publications for standards for access to care will not be successful if the services are not available. The lack of availability and access is what consumers and families are presently experiencing as service providers are closing services due to lack of authorization for payment of these services. Partnership initiatives with the state agencies, including those outside the Department of Health and Human Services, are important to a recovery-oriented system of care. Persons receiving services should be involved in monitoring the quality and availability of services. This isn't a new concept. I worked with Head Start for years and Head Start has families and other people helping monitor what's going on and the quality of what's happening in their program, and there are other programs that do that. And this concept of having consumers and family members help monitor the quality of care and how it's happening should be something

that would be very helpful to the division and the Department of Health and Human Services. Yesterday, there was a Children's Health Summit in Omaha. And I know some of us were there. And it was sponsored by the Omaha Bright Futures Program where the importance of education and health working together to improve the lives of children and their families were discussed. A medical home, including behavioral health services along with physical health services, was part of the discussion by persons working in both the health field and education fields. Especially for children--the Department of Education and school districts working with health resources available can often obtain services for children earlier and therefore prevent the need for higher levels of care when they become adults. NAMI would encourage the Division of Behavioral Health to develop a closer relationship with the Department of Education, especially as they are developing their action part of their strategic plan. NAMI is particularly pleased to see that children are mentioned in the strategic plan and would like to see that monitoring includes services for children and youth. Children were mentioned in LB1083 and, sadly, that was all they received was a mention. There wasn't anything that really happened to provide services. The Medicaid division received a SIG grant for developing an infrastructure for children and adolescent services. The results of that planning process, led by the Division of Behavioral Health, was disappointing to say the least. The state received $750,000 a year for several years to develop an infrastructure for services for children. And I don't think we have that in place or anything close to it. Other efforts by the division have still not identified a system of care for children and youth. The infrastructure so that they can get appropriate timely services and also the one population that's really in need of these services are the kids that are in transition, the 19-year-olds, and you need to start before they hit 19. Because where they're now getting services or the lack of services are most likely in our jails. I get a lot of calls from parents that ask me, you know, what can I do and what are the services? And these are the kids that are in the 19-25 age range. NAMI certainly supports the concept of person-centered care and a recovery-oriented system of care and would very much like to see these concepts implemented by the Division of Behavioral Health, the regional behavioral health programs, and service providers. We believe effective services

include the implementation of these practices in evidence-based programs. Monitoring should include fidelity to these evidence-based practices as they are implemented. Person-centered care including self-directed care could impact the cost-effectiveness of providing behavioral health services. The reason I say that is because oftentimes the services that people are directed to get, they don't have any input into it, so do they really participate? Do they participate the way that they might benefit more from it if they have their own concerns addressed as we're building these plans of treatment for them? We recognize the funding issues being faced by the state and also the nation support the movement towards home- and community-based care as potentially being cost-effective. But that won't be cost-effective unless the services are in place. And also I think if there is enough out there that shows that you're really not going to be looking at saving dollars, it's just a way of handling the payments for services. NAMI fully supports the Division of Behavioral Health's vision that Nebraska's public behavioral health system promotes wellness, recovery, resilience, and self-determination in a coordinated, accessible consumer- and family-driven system. NAMI supports the inclusion of children in services...children and youth in planning as more recent efforts to develop plans have not included children and youth or their families. NAMI members are concerned that while these planning efforts are being implemented, services will be reduced more than they presently are. And we recommend that persons affected by behavioral health and their families from across the state participate in all the planning involved with the division's strategic plan. Thank you. [LR513]

SENATOR GAY: Thank you. Any questions? I don't see any. Thank you very much. All right. We do have any public testimony, if someone wants to share anything with us on your plan that the department did or the Open Mind study. I know some of you haven't seen that. Well, what I think we'll do is Director Adams has his open until Friday. We'll leave any comments open until Friday as well, Friday at 5:00, I assume is when you're going to shut yours down. So if you want to put any comments written to the committee, just address them to the Health and Human Services Committee. And we'll get them in here and then create a report. That's what we're going to do with the legislative

resolutions, there will be a report. And I don't know, on those, are those mainly on-line? Are we public? Do we have to print anything? Do we print anything? [LR513]

MICHELLE CHAFFEE: I have to put five copies and they go to (inaudible). [LR513]

SENATOR GAY: Okay. We will do the report as we should. But also, do we put them on-line too? Hopefully, we do. But we should. But anyway, I think this is great information today. Thank you all for coming and sharing with us. Come on up here. And...but I think a lot of this, you know, I've always found...I think it's good education. And I know senators cover a lot of things but appreciate the committee members being here. And it's good information that we need to keep hearing and get your input. So keep giving us your input because it does certainly help when you're trying to make decisions. And I know sometimes those decisions not everyone is happy with. But it certainly helps I would think for all of us. So thank you all for your time here today. Go ahead. [LR513]

MARY ANGUS: All right. My name is Mary Angus, A-n-g-u-s, regular spelling M-a-r-y. I wanted to add a couple of things. I wasn't going to testify but I did want to add one thing. In the past couple of years, the various committees have been talking about the budget and what kinds of cuts to services or eligibility, etcetera, might improve our budgetary situation. And there have been decisions not to cut the number of sessions for mental health or substance abuse or put an annual cap on the amount of money that would be spent partly in response to concerns about whether the parity bill will be involving our Medicaid division. And I hear several people talking about the problem with Medicaid driving behavioral health. And I think that's been very true. While those cuts have not been made, there's been a concurrent move by Magellan Behavioral Health to alter the authorization process--I think Topher made mention of this at one point--authorization process, number of sessions they will authorize in a given time period. One of the biggest features that I see is that in 2009 their medical necessity, the criteria for medical necessity in 2010 were changed to include "motivated to treatment." Now if I have a

broken leg, I have a broken leg, it needs to be treated. If I have a mental health disorder then it needs to be treated, at least by my initial. However, one of the ways that they determine that I'm motivated to treatment is if I show up for sessions and take my medications as prescribed. To me that amounts to forced treatment in terms of prescriptions. So they could look at my prescription usage and decide that I'm noncompliant and refuse to treat me. The other issue has been that if not in fact, in practice there has been a 75-session cap placed on authorizations for an individual receiving sessions. And in practice that has generally been lifetime. I have been...I have experienced mental illness for, jeez, 30-some years. I have had more than 75 sessions in my lifetime. I have been discharged because I...the treatment, for whatever they decided is...it's called maintenance treatment. Despite the fact that I may have particular issues, particular goals and deadlines for me to meet those, it's been decided that that's maintenance treatment. I'm not so much complaining for myself. But the fact of the matter is while on one hand we're claiming we're not putting caps on issues and we're not putting treatment caps on services, we are in effect placing those by virtue of a "I'm not Medicaid, I'm Magellan, I'm not behavioral health, I'm Magellan," that's their decision to make. And I think that has been very detrimental. One of the things that was mentioned earlier is readmission rates. Well, when you start changing and narrowing the focus of medical need, your readmission rates will go down because they won't readmit. That's one way of making those figures look good. So I just wanted to add that there have been these side issues going on that you may not be aware of. And so if we're talking about improvement in the division and the way mental health services or behavioral health services are delivered that's a piece you might not hear about when we go directly. So I thank you for the opportunity. And if you have any questions, I'm more than willing to stay, but I suspect everybody is kind of going, "What time is it?" Anybody? [LR513]

SENATOR GAY: Any questions for Mary? No. That is good because it is an issue that we're looking at. So... [LR513]

MARY ANGUS: Thank you very much. [LR513]

SENATOR GAY: (Exhibits 5-7) All right. Anyone else? All right, with that, I'll wrap it up. And thank you all for coming, appreciate it. And if you have any comments, you have until Friday at 5:00 to submit those to the department or to our Health Committee. [LR513]