[LB925 LB949 LB1158 LB1160]

The Committee on Health and Human Services met at 1:30 p.m. on Wednesday, February 8, 2012, in Room 1510 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public hearing on LB949, LB925, LB1158, and LB1160. Senators present: Kathy Campbell, Chairperson; Mike Gloor, Vice Chairperson; Dave Bloomfield; Tanya Cook; Gwen Howard; Bob Krist; and R. Paul Lambert. Senators absent: None.

SENATOR CAMPBELL: Good afternoon and welcome to the hearings of the Health and Human Services Committee. And I apologize for being late. Senator Gloor and I were trying quickly to eat lunch. And I don't know about Senator Gloor, but we did get finished I think. And so we do apologize for being late. I'm Kathy Campbell and I serve as the senator from the 25th Legislative District, which is Lincoln and northern Lancaster County. And with that, we'll start to my far right.

SENATOR LAMBERT: I'm Senator Paul Lambert, from District 2. I serve part of Otoe County, part of Sarpy County and the entire Cass County region.

SENATOR BLOOMFIELD: Dave Bloomfield, District 17, made up of Wayne, Thurston and Dakota Counties in the northeast corner of the state.

SENATOR COOK: I'm Tanya Cook. I represent the 13th Legislative District which is in northeast Omaha and Douglas County.

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

SENATOR HOWARD: Senator Gwen Howard, Omaha, District 9.

SENATOR KRIST: Bob Krist, District 10 in Omaha, Omaha, Bennington, and some parts of unincorporated Douglas County.

DIANE JOHNSON: And I'm Diane Johnson, committee clerk.

SENATOR CAMPBELL: And serving as pages today, Phoebe is from Lexington and Michael is from Columbus. So if you need some assistance, they'd be glad to help you. A few housekeeping announcements. First of all, please turn off your cell phones or silence them. It's so disturbing if you're trying to testify and you hear a ringing phone. Handouts are not required in this committee. However, if you have handouts we would like 12 copies. And if you need assistance with that, one of the pages will help you. If you are testifying today, please complete one of the fluorescent orange sheets and print legibly your name. And when you come up to testify, you can give that to the clerk and your handouts and the pages will distribute them. The reason that we ask for that sheet

is so that the clerk of the committee will type in your name correctly as she is working with the minutes from the hearing. As you come forward to testify, you'll sit down and we'll ask you to state your name for the record and spell it. And a lot of people have said, why do I have to do that if I've already given you the orange form? The reason you have to do that is because that's how the transcribers for the hearing know that your name is correct and is correct in their records. So that's why the duplication. We do have a light system in the committee. Each testifier is allotted five minutes. So you'll have green until one minute left, and then you will have a yellow and then at the end of your five it will go to red and you'll probably look up and I'll be going time, time, time. So please try to be respectful of all the people who testify by keeping your testimony to five minutes. And I think those are the announcements and reminders. So we will open the hearing on LB949. It is from the Legislative Performance Audit Committee, which would require reports and a strategic plan by the Division of Children and Family Services of the Department of Health and Human Services. And the Chair of that committee is Senator John Harms. So we are particularly pleased to welcome you, Senator Harms.

SENATOR HARMS: (Exhibit 1) Thank you, Senator Campbell and colleagues. My name is John N. Harms, H-a-r-m-s. I represent the 48th Legislative District. I presently serve as Chair of the Legislative Performance Audit Committee. And today I'm here to introduce to you LB949 on behalf of the committee. LB949 would provide additional fiscal accountability and transparency for child welfare spending, which we believe are essential in light of the problems we and others have identified related to privatization of the child welfare services. As you know, we conducted a performance audit of child welfare privatization at your request as part of the LR37 study. LB949 addresses two concerns raised in that audit. One, the absence of key goals privatization was expected to accomplish or meaningful benchmarks and time frames for achieving those goals. And number two, the difficulty the Legislature had in getting accurate, timely fiscal information from the Department of Health and Human Services about funding the child welfare services contracts. Specifically, LB949 requires that for the next two budget cycles the Department of Health and Human Services include a strategic plan of the child family services in its budget request of the Legislature; that the plan must identify the main purposes of each program in the division; the goals for measuring progress in meeting that purpose, as well as benchmarks and time frames for meeting those goals. The bill also requires that in the alternative or the alternate years, 2013 and 2015, the Department of Health and Human Services give your committee and the Appropriations Committee an update on its progress towards meeting those goals in the preceding 12 months. LB949 would also require Child Family Services to provide your committee, and again the Appropriations Committee, with quarterly updates, starting October 2012, on any movement of funds over $250,000 into the child welfare subprogram from other budget subprograms within the budget Program 347. This requirement addresses a concern raised during the LR37 study that the Department of Health and Human Services move funds in a manner, excuse me, have moved funds in the past in this manner. And it was very difficult for the Legislature to actually follow and to track where

that money was coming from. Finally, LB949 states that the Legislature's intention that the child welfare subprogram within budget Program 347 be separated out and established as an individual program for the purposes of being able to monitor it. And that would be in the next biennium. This is another transparency measure which would allow the Legislature to better oversee spending in the child welfare. I don't believe that a statutory change is necessary to create a new budget program. But including this intent language will signal to the state budget office that we would like to see this done. That completes my testimony, Senator Campbell. I did pass out a sheet that lays this out by section for you. So when you have a little bit of time and you want to really go back and take a look at this bill, this lays it out nicely. It's much easier for you to follow and it will be much convenient for you. I'd be happy to try to answer any questions if I might. [LB949]

SENATOR CAMPBELL: Are there any questions for Senator? Senator Krist. [LB949]

SENATOR KRIST: Not a question as much as a comment. Having...being on both this committee and the Performance Audit Committee, I want to thank you for your leadership in this effort. [LB949]

SENATOR HARMS: You're welcome. [LB949]

SENATOR KRIST: And I know we've talked about the importance of the oversight and maintaining the oversight, just not with management, but the funds themselves. Thank you. [LB949]

SENATOR HARMS: You know, if you track the money you know where the issue is and that's pretty important for us. And right now that's difficult for us. Any other questions? [LB949]

SENATOR CAMPBELL: Go ahead. Other questions? [LB949]

SENATOR HARMS: Senator Campbell, oh, go ahead, I'm sorry. [LB949]

SENATOR CAMPBELL: Go right ahead. [LB949]

SENATOR HARMS: No, I'm not going to be able to close today. I have to go next door for another bill that I have coming up just right after this. Martha Carter is here. So if there is some questions, if other people want to testify on this and you have some questions, I would allow Martha to close for me because she understands it well. [LB949]

SENATOR CAMPBELL: You know, Senator Harms, we had a lot of excellent hearings as we went through LR37. But certainly the hearing that we had with your committee

and the work of the Legislative Audit Committee was just sterling. And I can't thank you enough because I think it really helps us to understand how the Performance Audit Committee works and with the topic, and particularly Martha Carter and her staff were just exemplary in terms of working through some issues and helping provide some documents that we might have needed. So I do want that compliment in the record. [LB949]

SENATOR HARMS: Well, thank you. Well, I would tell you that Martha Carter and her staff do an excellent job. And, you know, that...the findings in their proposal and what they submitted to you, they did that shorthanded. So they had to spend lots of hours trying to filter through all this information. And I think it raised our level of people understanding how the Performance Audit Committee can really help you. [LB949]

SENATOR CAMPBELL: Exactly. [LB949]

SENATOR HARMS: I mean, it's really here, it's for you. If it's an issue you want to take on, you just have to identify it and if the committee decides they want to do it, I think they'll do a fine job for you. [LB949]

SENATOR CAMPBELL: But I do hope people have taken the time to take a look at it. We've certainly put the audit in the LR37 report, but it helps to understand the issues that... [LB949]

SENATOR HARMS: It does. [LB949]

SENATOR CAMPBELL: ...we looked at in child welfare. [LB949]

SENATOR HARMS: It does. Thank you very much. [LB949]

SENATOR CAMPBELL: Thank you, Senator Harms. With that opening of LB949, we will take testifiers. How many people wish to testify in favor of LB949? Anyone on LB949? Oh, that's...you come forward. Those who wish to testify in opposition? Okay. Those who wish to testify in a neutral position? Ms. Helvey, you might be the (laughter) whole star of LB949 here, you and Senator Harms. [LB949]

SARAH HELVEY: (Exhibit 2) All right. Well, I'm happy to be here. When no one raised their hand, I just wanted to run up to get it started. Good afternoon. My name is Sarah Helvey, that's S-a-r-a-h, last name H-e-l-v-e-y. I'm a staff attorney and director of the Child Welfare Program at Nebraska Appleseed. We support LB949 because we believe ongoing problems with fiscal oversight are critical and must be addressed. The committee is well aware of the State Auditor's report which found, among other things, that the department overpaid one contractor by millions of dollars, provided no documentation for various contract amendments totaling, at the time of the report, over

$25 million, and expended thousands of dollars on duplicate claims and payments to the wrong contractor. The committee is also well aware of the Legislative Fiscal audit report...Fiscal Office's report, rather. And as Senator Harms noted, the Performance Audit Committee's report as well, noting concerns about shifts in expenditures between subprograms in Program 347, and specifically noting the transfers by the department of reappropriated funds and underexpenditures of other vital subprograms in Program 347 to private child welfare agencies. And so we support LB949 because we think creating a separate budget program, requiring regular financial reporting by the department to the HHS Committee and the Appropriations Committee, and requiring appropriations requests process include a strategic plan that identifies benchmarks and goals would help prevent these kinds of issues in the future. The financial impact of the privatization over the course of the last two years has been, you know, unacceptable at best, and devastating at worst. And so we really support this effort to put into place fiscal oversight which we think is importantly needed. So happy to answer any questions. [LB949]

SENATOR CAMPBELL: (Exhibits 3 and 4) Are there any questions for Ms. Helvey? Thank you for your testimony this afternoon. Other testifiers on LB949? Okay. Seeing no one who wishes to testify, we will close the hearing. Just a minute, I'm sorry. Do the senators have any questions of Ms. Carter? Okay. Thank you very much. Okay, we will close the public hearing on LB949. And we should note just for the record that we also received support letters from Mr. Terry Werner from the National Association of Social Workers, Nebraska Chapter; and a letter of support from Sarah Forrest on Voices for Children. So we will proceed to the next hearing. Senator Fischer is here. Welcome, Senator Fischer. This may be the very first time this year that you've been here? [LB949]

SENATOR FISCHER: This year, this year. [LB949]

SENATOR CAMPBELL: This year? Oh, no, you've been here before. [LB949]

SENATOR FISCHER: Thank you, Senator Campbell. I've been before your committee before, not often, but a few times. [LB949]

SENATOR CAMPBELL: We will go ahead and open the hearing on LB925 brought to us by Senator Fischer. And it would provide duties for the Department of Health and Human Services relating to contracts with providers under budget Program Number 514, Health Aid. Senator Fischer, go right ahead. [LB949]

SENATOR FISCHER: Thank you, Senator Campbell. Good afternoon and thank you to the members of the Health and Human Services Committee. For the record, my name is Deb Fischer, F-i-s-c-h-e-r. And I am the senator representing the 43rd District here in the Nebraska Unicameral. I appear before you today to introduce LB925. The purpose

of this bill is to create a preference system for aid distributed under Program 514, Health Aid. The bill directs the Department of Health and Human Services to prioritize those applications for funds from the following: public health departments, as defined in 71-1626; federally qualified health centers, as defined in section 1905(l)(2)(B) of the federal Social Security Act, 42 U.S.C. 1396d(l)(2)(B) as such act and section existed on January 1, 2012, or public or private healthcare facilities that provide comprehensive, primary care in addition to preventative care services. I would like to provide you some background on how I decided to introduce this bill. I have long been supportive of public health, particularly coming from a rural part of the state. On Friday, December 30, 2011, the Omaha World-Herald printed an editorial entitled "Funding Issue Very Critical." The editorial explained that the state's tobacco settlement fund, which is used to fund public health, is likely not sustainable. This article got me thinking on how we as a state could make an additional commitment to our public health programs. I spoke with several people about my concerns and realized that often our state and federal dollars through this program go to private organizations that don't provide comprehensive health, but rather small, targeted programs. These discussions led me to Program 514 and the belief that our tax dollars should be going to established public health programs and federally qualified health centers. Finally, if the dollars need to go to private organizations, then the money should go to those organizations that provide comprehensive, primary care. I don't want this bill to limit services for any segment of our population or region of our state. For that reason, the bill clearly states that DHHS may contract with a public or private healthcare facility which does not provide comprehensive, primary care, to prevent the severe limitation or elimination of access to the services in any region of the state. I would like to take a moment to address the fiscal note. I was surprised that DHHS determined that they would need two full-time employees to administer the changes proposed in the bill. The department is already administering the RFPs and other processes to determine the grant recipients. And I would think that those same individuals could probably handle the changes in this bill. I know there are many organizations here today to testify, including several representatives from public health. And I appreciate your time. And I'd be happy to answer any questions. [LB925]

SENATOR CAMPBELL: Any questions for Senator Fischer on the bill? Senator Fischer, at this point there are no priorities set in 514, other than what the department may set. Would that be accurate? [LB925]

SENATOR FISCHER: Correct. Correct, that's my understanding, Senator. You and your committee are the experts on this. [LB925]

SENATOR CAMPBELL: (Laughter) Boy, we learn something every day, that's for sure. [LB925]

SENATOR FISCHER: But it's...truly, when I saw that article and realized the shortages

that we already face and that I am familiar with in rural areas and the, I believe, severe limits that we have in offering comprehensive healthcare to the people in my area it caught my eye. And I tried to address that. As Senator Howard can tell you, I've always believed that public funds should go to public institutions with regards to education or with regards to health. [LB925]

SENATOR CAMPBELL: Okay. Senator Fischer, will you be closing on the bill? [LB925]

SENATOR FISCHER: I plan to stay, yes. [LB925]

SENATOR CAMPBELL: Okay, excellent. Thank you very much. [LB925]

SENATOR FISCHER: Thank you very much. [LB925]

SENATOR CAMPBELL: With the opening of LB925, how many people wish to testify in favor? How many wish to oppose LB925? Two. How many in a neutral position? No neutral, okay. We will start with the proponents. So the first proponent, please. Good afternoon. [LB925]

KAY OESTMANN: (Exhibit 5) Good afternoon, Senator Campbell and members of the Health and Human Services Committee. My name is Kay Oestmann, K-a-y O-e-s-t-m-a-n-n. I married it, I didn't spell it. (Laughter) I'm president of the Friends of Public Health. And I'm also a health director in the Southeast District Health Department. We're here today to support LB925. LB925 will provide an opportunity for a state division of public health within the Nebraska Department of Health and Human Services to support local public health departments capacity building. Local public health infrastructure is critical for responding to the needs of the community. To understand the importance of continuing to build public health capacity at the local level, it is best explained by their role in addressing public health needs in their communities. We provide scientifically based programs dependent on local health needs and priorities determined through a regular, comprehensive community health planning process. The departments have assumed the key leadership role in the coordination and planning of health services and have been successful in bringing together local organizations to address the public health needs the communities have identified. The health departments have formed partnerships, task forces and coalitions to leverage funds to address the unique public health needs in communities. Whether it's high rates of cancer, smoking, diabetes or heart disease, low birth rates, fluoridation of water, lack of adequate dental, medical or child care, need for bilingual interpretation, injury prevention, automobile crashes, seat belt usage, underage tobacco and alcohol use, addressing meth in the community, domestic violence, disease outbreaks or environmental hazards, public health has a presence in Nebraska. The local health departments are leaders in developing healthy communities across the entire state. We have made tremendous progress in the development of a seamless public health

system in Nebraska that reduces fragmentation and provides accountability. The local health departments have developed a statewide assessment that enables them not only to identify potential barriers to good health, but also to compare this data throughout the state. The local health departments have incorporated local health data with that captured by DHHS to better enable health planning in our districts. With this process we are able to gather and adjust in-time data so that it is representative of the population of the state, district or the county. We then are able to assure that the health needs are addressed and services appropriately developed in our district. Through this process we identify qualified partners and recognize their value in providing needed services in our communities. This information is used in planning health and prevention-related activities at the local level so that available resources are directed effectively. It is also important to note that each department is governed by a board of health, as directed in statute. Members of the boards include local physicians, dentists, county commissioners, and community members. The local health departments provide an annual report to the Health and Human Services Committee of this Legislature, that's you, on the use of funds and the activities accomplished in their communities. By statute, the departments also publish an annual report for their communities. LB925 provides an opportunity to increase this capacity development for local public health. It is our understanding that the bill would not impact current grant funds allocated and does not intend that the local health departments would be automatically awarded grant funding from the Department of Health and Human Services available to the local level for 514 programs. The health departments would only apply for funding that will meet an identified community need that they have the expertise to meet. Based on the prevention funding changes proposed through the healthcare reform, this bill will ensure the local public health has the opportunity to effect change that produces improved health outcomes in our communities. Thank you for letting me testify. I would entertain any questions anybody has, try to answer. [LB925]

SENATOR CAMPBELL: Questions? Ms. Oestmann, this really did help to establish health clinics all across the state, did it not? I mean, that's really kind of the network that had been established with these funds? [LB925]

KAY OESTMANN: Health districts throughout the state, yeah. [LB925]

SENATOR CAMPBELL: Right. [LB925]

KAY OESTMANN: Every county in the state is covered by a local health department now. [LB925]

SENATOR CAMPBELL: And I think there's only two or three counties that actually put money into the health departments, at least I know of one of them, let's put it that way. [LB925]

KAY OESTMANN: I don't know exactly how many. I know that there are several that contribute and, you know, if they aren't contributing monetarily, why, there's a lot of them that contribute in other ways,... [LB925]

SENATOR CAMPBELL: Yes, that's true. [LB925]

KAY OESTMANN: ...you know, in-kind things that are done. You know, and things are rough out there in the rural area, you know, with the decreased funding that the counties got last year and with the talk of the inheritance. A lot of the counties that do get funding, get it from the inheritance tax monies. So that's a real concern right now. So, you know, we're out looking for partners so that we don't replicate things that are being done well. We assure that the programs are being done in our communities if it's part of our health needs assessment, and if there's somebody that's got a program going that's doing well, why, we support that or we help them to make it better. You know, we don't replicate things that are already out there and doing well that we identify as a need. [LB925]

SENATOR CAMPBELL: Excellent. Any other questions or comments? Thank you for coming this afternoon... [LB925]

KAY OESTMANN: Thank you. [LB925]

SENATOR CAMPBELL: ...and your testimony. Our next proponent. Welcome. [LB925]

CHARLES NEUMANN: (Exhibit 6) Thank you and good afternoon to all of you senators. My name is Charles Neumann, I go by Chuck. Neumann is spelled N-e-u-m-a-n-n. I'm vice chairman of the Adams County Board of Supervisors and also the vice president of the South Heartland Health District Department in Hastings, covers a four county area. I'm also engaged in animal agriculture, helping feed the world one mouth at a time. And I'm here in regards to Senator Fischer's bill, LB925, which, as I understand it, would provide consideration of our governmental public health infrastructure in administering funds that are distributed from Health and Human Service Program 514, Health and Medical Assistance Aid. In the ten years since the passage of LB692, allowed for creation of district health departments, our local health infrastructure in south central Nebraska has grown by leaps and bounds and has developed increasing capacity to carry out and evaluate programs that impact the population's health. South Heartland Health Department serves over 46,000 people, of which 31,000 will reside in Adams County where I serve as a county supervisor. Our district health department leverages funding for our communities through both competitive and noncompetitive avenues. I'd like to give you one example of how funding leveraged by our local health department is impacting Adams County. South Heartland District Health Department competed for funds from DHHS maternal and child health block grant. From these funds, our health department was awarded a three year grant, plus a one year extension, to support

wellness initiatives in worksites in all four counties. As one of the nine participating workshops...worksites, Adams County, the Adams County employees, which we have 140 employees, we were able to establish an active worksite wellness community...committee, administer health risk assessments and health screenings, and begin implementing environmental and policy changes at the county level. Since initiating the wellness program, we have 22 percent fewer employees with high blood pressure, and employee coronary risk improved by 11 percent. In addition to the educational programs and wellness activities for our employees, we have succeeded in implementing a tobacco-free campus, not just a tobacco-free building, but a campus, and a vehicle policy, and installed healthy vending machines in the Adams County Courthouse. And one of the touching things, after the first couple of years, when we did this assessment of our employees, it was kind of like a health fair type thing. I had one employee come up to me and said how much they appreciated that we took...that we did this, because through the blood screening they were able...they found a life-threatening disease. And I thought that made it all worthwhile right there to save one person. And so just wanted to give you that one example that wasn't in the prepared statement. Our local health department is instrumental in programs such as these because it has a well-trained staff who have assessed the health needs of the district and identified priority needs within our communities; use evidence-based approaches to address our community health issues; collaborate closely and/or subcontract with other important partners in the community. As an example in this case, our health department partnered with expert staff at our hospital, reimbursing the hospital in order to offer lower cost health screening lab work, health risk assessment surveys, and health coaching to our employees. This is just one example of how public health funding to the local health department is improving the health of people living in our local communities, especially out, like Senator Fischer, out in rural Nebraska. I would entertain any questions if you have any. [LB925]

SENATOR CAMPBELL: Supervisor Neumann, thank you very much for your public service and for coming today. [LB925]

CHARLES NEUMANN: And thank you for yours, and everybody here too. [LB925]

SENATOR CAMPBELL: Are there questions for the supervisor? We always appreciate seeing the supervisors. [LB925]

CHARLES NEUMANN: Thank you, have a great day. [LB925]

SENATOR CAMPBELL: You, too, sir. Our next proponent. Good afternoon. [LB925]

DEBORAH SCHOLTEN: (Exhibit 7) Good afternoon. My name is Deb Scholten, D-e-b-o-r-a-h is my formal name, S-c-h-o-l-t-e-n. And I'm the health director at Northeast Nebraska Public Health Department. Our office is in Wayne, and we serve Cedar,

Dixon, Thurston and Wayne Counties. Senator Bloomfield's area is our...(laugh) Good afternoon. In 2005, a large conference was held in central Nebraska for statewide trade association. After the participants departed for their homes, several of them became very ill with severe gastrointentestinal problems; in laymen's terms, vomiting and diarrhea. Some of you might have experienced that in your lifetime. The physicians' offices and hospital laboratories around the state began reporting widespread salmonella poisoning from undercooked pork. The State Epidemiologist's Office contacted each of the local health departments with a list of the convention registrants from their respective health districts who needed interviews as part of the infectious disease investigations. The local health department staff members then contacted the local residents who were in attendance at the convention. The first person I contacted, after introducing myself, said, I know exactly why you are calling; I have never been so sick in my life. Prior to the statewide system of local health departments in Nebraska, which began in 2002, there was one person at the state level in the Epidemiologist's Office doing infectious disease investigations for the entire state. That person was only able to cover maybe a third of the infectious disease cases through to completion. Now local health departments routinely do them in each district. With the advent of electronic health records, which includes laboratory tests, there are more and more infectious disease investigations needed because of the better reporting. This is an example of governmental infrastructure that works. Local public health departments are in a position to know about local needs because we do local needs assessments and write local health improvement plans. We are a natural conduit to the people who are our neighbors, our friends and our families. In most states, this is a logical process of delivering public health programs and services that address local needs. Senator Fischer's bill addresses situations like this--local public health departments implementing public health programs for our local citizens. In our Northeast Nebraska Public Health District, the infant and child death rates were higher than the state average. We sought and obtained a maternal child health grant award that funds a child-fetal-infant mortality review process to begin to address this very important issue. We organized a Child Death Review Team made up of county attorneys, medical providers, child advocacy center staff, and law enforcement to review each child, infant and fetal death case. In each case, we looked for factors that might have played a role in preventing the death if it had been in place. We do not look to find blame or fault with anyone. We also have another group that is part of that project, the Community Action Team. We named this group Caring Connections. It is made up of various service providers from schools, the ESUs, the community action home visitation program, and others. Our health department learned that the home visitors employed by another agency were in need of additional training, so we used a portion of our funds to provide training to those home visitors. We believe that sharing and partnership strengthen our local public health system. In 2009-10, when the national H1N1 public health emergency was declared, the local public health departments took our responsibility very seriously and put in hours to vaccinate as many citizens as possible. Most local health departments didn't have existing immunization programs, so the efforts were

enormous to acquire equipment, mobilize supplies and train staff. Fortunately, due to those strong partnerships, the local healthcare community health departments were able to effectively coordinate vaccine distribution, as well as to staff public vaccine clinics, often with assistance from our partners. The state of Minnesota is ranked number ten in investing state resources into local public health departments. I'd like to go down to their philosophy. Protecting the public's health is so basic and the consequences of not protecting the public's health are so serious that both the state and federal constitutions contain provisions to ensure this protection. And I will go down to the bottom. For the good of our citizens, we want to strengthen the state and local public health partnership in Nebraska. And we ask that you support LB925 to help us accomplish this goal. [LB925]

SENATOR CAMPBELL: You did a great job there. I do want to note from the paragraph that you had to delete, because you were very gracious about watching the time, as you're one the smallest of the 21 local health departments. [LB925]

DEBORAH SCHOLTEN: Um-hum, we definitely are. And our infrastructure has never been very large. And so that's a real limitation. And we're very concerned about our future, so. [LB925]

SENATOR CAMPBELL: Yeah, I can understand that. [LB925]

DEBORAH SCHOLTEN: So please read that paragraph. (Laugh) [LB925]

SENATOR CAMPBELL: Senator Bloomfield should have a question, shouldn't he. Yes. [LB925]

SENATOR BLOOMFIELD: I do not have a question, I just want to thank you for coming down. And I'll tell you I will get there to visit (inaudible). I will make it one of these days. [LB925]

DEBORAH SCHOLTEN: He already had a pointed question for me. (Laughter) He wondered where we got this big, fancy sign. I said, it was from categorical funding from the CDC because we had no way to get our messages out before, so. (Laugh) [LB925]

SENATOR CAMPBELL: Other questions from the senators? Yes, Senator Gloor. [LB925]

SENATOR GLOOR: Thank you, Senator Campbell. Thanks for the testimony. Let me ask you this question since you've had higher infant and child death rates. Have you noticed an increase in infant death rates (inaudible). [LB925]

DEBORAH SCHOLTEN: I wish I could say we did. This program is about two or three

years...that is something that we won't see the benefits from for a very long time. And every year is different. I mean, we don't average a certain number. Part of the numbers come from both reservations that are in Thurston County. They have...they are part of our fetal...or it's called a FIMR process. But they also have their own within the Aberdeen area, tribal chairman's health board, etcetera. But that is something I think is so important to address that we've spent a lot of time in that area. [LB925]

SENATOR GLOOR: Okay, thank you. [LB925]

SENATOR CAMPBELL: Any other questions? Thank you for coming today and your testimony. [LB925]

DEBORAH SCHOLTEN: You're very welcome. [LB925]

SENATOR CAMPBELL: Our next proponent. Welcome. [LB925]

REBECCA RAYMAN: Good morning. My name is Rebecca Rayman, R-e-b-e-c-c-a R-a-y-m-a-n. And I am the vice chair of the Health Center Association of Nebraska. I'm also the executive director of the Good Neighbor Community Health Center in Columbus, and also the East Central District Health Department. Nebraska's federally qualified health centers are community-based organizations that provide comprehensive primary care and preventative care, including medical, dental and behavioral health, pharmacy and support services. We provide our care to persons of all ages and all backgrounds according to their ability to pay. Our mission is to provide access to quality, affordable, integrated primary care and preventative services in our communities. In 2010, the six health centers in Nebraska were the healthcare home for 63,330 patients; 93 percent of our patients have incomes under 200 percent of poverty; 57 percent of them are uninsured. We save valuable tax and private dollars by keeping people out of emergency rooms, helping the working poor and their families to be healthy and employed, and preventing costly services that occur when people do not get the primary healthcare services that they need. We drive down costs in the healthcare system. We welcome Medicaid and Medicare patients and those who are uninsured. We welcome those who have difficulty finding providers and whose practices have no room to serve them. Our centers have clinics in Gering, Columbus, Norfolk, Madison, Lincoln, Omaha, and Plattsmouth. But we really serve patients from about 42 Nebraska counties. The Omaha centers also run school-based clinics in high need areas. Other communities across the state are also interested in having federally qualified community health centers, but they await funding to move forward. We would also like to point out that the community health center in Gering is under the umbrella of the Community Action Partnership of western Nebraska, a CAP agency. My own center is under the umbrella of the East Central District Health Department, a public health agency. The Legislature's investment of General Funds and healthcare cash fund revenues has been core to our ability to serve people throughout the state. We have

been good stewards of state dollars. We run efficient and effective clinics. We are your experts in providing primary healthcare for underserved patients with complex issues and needs. Our centers currently have multiple partners in the community and in the health sector. We also work closely with other community organizations. We play an essential role in our ability as a state to serve people who would otherwise have no healthcare home. We appreciate being listed in this bill as a vital part of the healthcare system in the state. And we stand ready to contract for additional services if the bill should be enacted. Thank you all. [LB925]

SENATOR CAMPBELL: Any questions for Ms. Rayman? Ms. Rayman, as always we appreciate your testimony. And I know that you have provided a lot of data to us in the past and we appreciate it. [LB925]

REBECCA RAYMAN: Thank you so much. [LB925]

SENATOR CAMPBELL: Thanks for coming. [LB925]

REBECCA RAYMAN: Thank you for what you do. [LB925]

SENATOR CAMPBELL: Next proponent. Okay. We will move to those who are opposed to LB925 who wish to testify. [LB925]

KORBY GILBERTSON: (Exhibit 8) Good afternoon, Madam Chair, members of the committee. For the record, my name is Korby Gilbertson, it's spelled K-o-r-b-y G-i-l-b-e-r-t-s-o-n. I'm appearing today as a registered lobbyist on behalf of the Nebraskans for Public Health Funding. I have a handout for the committee. Nebraskans for Public Health Funding are made up of the family planning clinics across the state. I want to make sure to note that once you get your handout, if you look at the sheet I'm handing out, number 5, Columbus, and also number 10, Gering are on there and were just mentioned by the last proponent. So I kind of feel like I use everything she said, but in my opinion it's in opposition of this legislation. And I'm going to give you a little editorial comment to begin why it worries me a little bit. In 2006, there was a similar bill to this; and I think Senator Howard was around when this happened. And my honor and name were drug through the mud by a certain member of the Legislature who was trying to take money away from the family planning clinics and couched it in terms that they were just trying to give this money to the local health clinics. And then it was revealed through an e-mail that this person sent out that in fact I had been perhaps telling the truth. And that bill was pulled from the budget and the funding was restored. So I got a little pause when I first saw this legislation introduced because my fear is that, although 514 funds have a great number of other issues, there is a little part of 514 that some of you might not be familiar with, because it's not listed in LB925. But these are funds that are used specifically for reimbursement for pap smears, colonoscopies, cervical biopsy, cryotherapy, and a number of other procedures done by family planning

clinics across the state that used to be held just so that the funds could go to Title X family planning clinics across the state. In 2006 or in 2007, we agreed to open those funding...that funding stream up to any provider that could then apply for those. And the money also got shifted over to Every Woman Matters. Since that time, the funding questions have gotten very interesting. And we've met numerous times with HHS trying to figure out how the funding stream should go through the state. My argument was always I don't care when the money runs out, I think we should run through this money every year and give every person services that we can and make sure that we're providing services as the Legislature directed in the statute. But right now we're receiving reimbursement for one or two things off of this list, and money is being held, hundreds of thousands of dollars are being held in anticipation of spending those funds on other issues that aren't specifically enumerated in this. Those are our concerns. And if we further take away the ability for these family planning clinics to get money, we are afraid that more of them will have to close. I think it will be interesting to note 5 of these 27 facilities are already in Senator Fischer's district. There has been one that has already closed in her district because of funding cuts that have happened. I don't want to sit up here and have you think that I'm trying to bash the local health departments. That's not the case at all. Family planning clinics already work hand in hand with local health departments every day. And as you can see, a number of them are on this list are already current providers. Our concern is that anytime there is a hierarchy for how these funds are going to be spent, there will be people on the lower end of the totem pole, and this obviously puts a number of these clinics who provide very valuable services to people across the state at the bottom of that totem pole. I'd be happy to try to answer any questions. [LB925]

SENATOR CAMPBELL: Are there any questions for Ms. Gilbertson? Seeing none, thank you for coming today. [LB925]

KORBY GILBERTSON: Thank you. [LB925]

SENATOR CAMPBELL: Our next opponent. Good afternoon. [LB925]

RICHARD NATION: (Exhibit 9) My name is Richard Nation. And that's R-i-c-h-a-r-d N-a-t-i-o-n. I'm the CEO of Blue Valley Community Action. And I have some prepared comments that are going around at the moment. But I'd like to say a couple of things before I get into those. Several of the people who have testified in favor of this bill are partners of our organization. We work with them and we have worked with them for many years. Some public health departments we have worked with before they were a statewide coverage. And we certainly do not want to be misunderstood here by testifying in opposition to this that we in any way don't support them, because I have...and probably of all the community action agencies in the state, Blue Valley has been the most supportive of public health and the expansion of public health. And I really believe what needs to happen is that this Legislature needs to spend more money

on public health. But having said that, this bill I believe does a disservice to those of us who are private, nonprofit organizations, who are providing very good service. But we do not show up on the priority list at all. So we will probably lose our services. And now I'd like to go into my testimony if I may. Blue Valley is a private, nonprofit charitable organization serving southeast Nebraska. We are designated by the IRS as a 501(c)(3) organization under the federal tax code. I have been in the position of CEO for 35 years and have seen a lot of ups and downs both in programming, funding and, of course, legislation. I am here to speak in opposition to LB925, which would impact many organizations, including our own. However, my main opposition stems from the impact this proposed change would have on those we serve. Those most in need will see programs they depend upon uprooted. Staff with whom they have developed relationships and trusting relationships will be let go, arrangements for the various services moved to unfamiliar locations. The transition alone will be wrenching for many. As we have witnessed recently with other programs suddenly transitioned from past practices, this transition may be going in the opposite direction, moving from the private sector to the public sector versus the opposite. However, it still will be very disruptive. Furthermore, the changes may cost well beyond the Fiscal Analyst's estimate, particularly if you consider the costs beyond HHS that various organizations and public bodies will have to endure. The bill creates a massive transfer of funds now going to private entities to government entities, a major expansion of government. It will cost hundreds of Nebraskans their private jobs before it begins to add public jobs. It will cost more public dollars than are currently being spent because organizations like my own subsidize the operation of many of the programs within this bill every year to the tune of several...tens of thousands of dollars. Local public entities do not have access to these private funds. So they will either be back to the Legislature asking for more revenues or they will be at local governments asking for property tax increases to pay for the additional costs. I would like to remind the committee that elderly, poor and other disadvantaged Nebraskans already have a great deal of stress due to the national economy, the challenges made from the state and staffing the programs that the state operates. Before the Unicameral proceeds with the concept of LB925, I believe the issue should be thoroughly studied and a complete listing of what Program 514 included so that people in the state know when their lives may be impacted. The bill does not list the programs in budget Program 514. I had to contact the senator to find out what was in there. And those who didn't go to the trouble of doing the research may be surprised to find that their lives were impacted by what I call a stealth bill that was passed...that could have been passed in the Legislature in a state that normally has transparency in its processes. So I thank you for this opportunity and I'd be glad to answer any questions. And I hope you have some. [LB925]

SENATOR CAMPBELL: Questions? Mr. Nation, you refer to a number of agencies, like yourself. Do you have a list with you? [LB925]

RICHARD NATION: I do not, but, I mean, a lot of community action agencies, for

example, do operate some of the programs in this bill, the WIC program, for example. [LB925]

SENATOR CAMPBELL: Okay. So... [LB925]

RICHARD NATION: And that would be hundreds of thousands of dollars. And, you know, we cooperate now with the public health departments. And I think most of us are doing a pretty good job, otherwise we wouldn't be re-funded. So I do hope that by not being a priority, and the bill says, must prioritize public health departments; and while I wish the public health departments were adequately funded, you know, this is a threat to both our organization as well. And we use the various programs that we operate; and we share the costs, you know. We might have one person being paid out of part of one program and part of another program to make sure both are done. If we were to lose one, we might have to close the other program down as well, even though that's still funded, because we wouldn't have the staff time. [LB925]

SENATOR CAMPBELL: Are most of the agencies community action agencies? [LB925]

RICHARD NATION: The ones that I'm familiar with, the one program that I'm most concerned about is the WIC program. But I know that a lot of community action agencies do WIC not all of them but a lot of them do. Other organizations besides community action agencies do that as well. And I don't have a list I'm afraid. [LB925]

SENATOR CAMPBELL: Okay. Other questions by senators? Yes, Senator Cook. [LB925]

SENATOR COOK: Thank you, Madam Chair. You made mention of this, your opinion being that this might be a stealth bill based on your research of the services under 514. [LB925]

RICHARD NATION: Well, the fact that the programs aren't listed, people don't know what is being impacted. [LB925]

SENATOR COOK: Okay. And you've read that listing yourself? [LB925]

RICHARD NATION: No, I have not. I mean, I had to... [LB925]

SENATOR COOK: Okay. [LB925]

RICHARD NATION: ...contact a senator to ask what was in that thing. And they know the, apparently they have...you folks must have a budget process that you have these things in. But that is not general knowledge to the public is all I'm saying. [LB925]

SENATOR COOK: I see. Thank you very much for... [LB925]

SENATOR CAMPBELL: Okay. All right. Thank you, Mr. Nation, for coming today. [LB925]

RICHARD NATION: Thank you. [LB925]

SENATOR CAMPBELL: The next opponent. Anyone else in the hearing room who wishes to be in opposition to LB925? Anyone in a neutral position? Okay. Senator Fischer, would you like to close on your bill? [LB925]

SENATOR FISCHER: Thank you, Senator Campbell. And thank you, members of the committee. I would also like to thank all of those who came to testify today. As I said, I'm not usually before this committee. So it's always interesting for me to learn more about the issues of health and how we organize it here in the state. I've learned about Program 514 now and that is listed in our budget bill every year. But as the gentleman just testified, the programs are not. But that information...I do have a copy of all the programs that are listed. There's a variety of them, and that is available to any of you from the Fiscal Office. So that is there. The Legislature has charged our public healthcare districts to provide our citizens services to meet their needs. And I believe we need to ensure proper funding for that to allow them to meet that charge. It's not an expansion of government. Rather, it's a proper funding of government. Last year and for the last eight years now you've heard me talk about government needs to set priorities and decide what we're going to fund and how it's going to be funded. And you especially heard me talk about that last year with regards to a highway funding bill, that we need to set priorities. But we have infrastructure in place across this state. They are called public health districts, but yet we do not fund them. And my concern is, after reading an editorial in the Omaha World-Herald, in December, that we're going to see a continued loss of funding, and all of you here know that we are short on dollars. But we have an infrastructure here in Nebraska, and I believe we need to fund it. And I believe this bill recognizes that by setting those three distinct priorities on how the funding needs to be distributed and, of course, recognizing that public health should be at the top of that list because it is something that's been created by the state of Nebraska, by this Legislature. And we have a responsibility to fund it. Thank you. [LB925]

SENATOR CAMPBELL: Any questions? Senator Gloor. [LB925]

SENATOR GLOOR: Thank you, Senator Campbell. Thank you, Senator Fischer. I have another answer for the tobacco settlement money, but that's another bill for another committee. (Laughter) [LB925]

SENATOR FISCHER: Will I see you in Revenue again this year? (Laugh) [LB925]

SENATOR GLOOR: I don't think so. Conundrum. We in this committee have been listening an awful lot in the past months to the Department of Health and Human Services say why they think private, not-for-profits can do a better job spending taxpayer money than they can when it comes to child welfare. And yet you have a bill that says you think the department can do a better job spending taxpayer money than private, not-for-profits. And so explain to me why you have more faith in the department than they seem to have in themselves when it comes to how they're going to control and make adequate appropriate use spending those dollars? [LB925]

SENATOR FISCHER: As I said earlier, you folks are definitely the experts in dealing with the Department of Health and Human Services. I have sporadically, throughout my eight years, mostly on constituent issues...the department would handle how this money is distributed. And I believe under this program, if you look in the budget it's like $62 million, the majority of it does come from the feds. And on that list, which I can have my LA provide to you, it shows which money comes from the General Fund, which from cash funds, and which from the feds for each of those programs. We don't, on the information I have, we don't have the amount; but for each program that's listed there. So I believe they can make those decisions because they're making them now, they're making them now. And this just puts into place a priority. I believe you folks on this committee are going to be having some bills which may address some of those other issues with HHS and how it's handled. But this, in my opinion, doesn't change the mechanism in place with the department; it just changes the priority system that is in place. [LB925]

SENATOR GLOOR: Okay, thank you. [LB925]

SENATOR CAMPBELL: Any other questions? Thank you, Senator Fischer. [LB925]

SENATOR FISCHER: Thank you very much, appreciate your attention. [LB925]

SENATOR CAMPBELL: And, yes, we would appreciate that list, that would be great. [LB925]

SENATOR FISCHER: Okay, we will get that to you. [LB925]

SENATOR CAMPBELL: Thank you. With that, we will close the hearing on LB925. If you are departing us, please do so quietly, and any conversations please have in the hall. All right, as we have people exit, a great number of people exit, Senator Krist will make his way to open on the next bill. We will open the hearing on LB1158. Senator Krist has brought this bill forward to provide requirements for medical assistance behavioral health managed care contracts. Good afternoon. [LB925]

SENATOR KRIST: (Exhibits 10 and 11) Senator Campbell, fellow members of the

Health and Human Services Committee, I have two amendments that the page will hand out to you. The first amendment strikes the entire Section 1 and replaces it. There's some relatively significant changes. The second amendment simply changes a one-liner. The two of those I would hope, after consideration in Exec, we would be able to put into a committee amendment with any additional changes that we would want to put in as a committee. LB1158 provides a reasonable framework for contracts signed by the Department of Health and Human Services as they move toward a new system to deliver behavioral health systems to low-income Nebraskans, adults and children, who are eligible for medical assistance. And I apologize, I'm Bob Krist, K-r-i-s-t. The language in LB1158 would be part of the Behavioral Health Services Act, originally passed in 2002, reforming the delivery of mental health and substance abuse services paid for by the state of Nebraska. It is a reasonable evolution of future service delivery if we put a framework in the state statute that holds all parties accountable. I'm going to pause there and just remind most of you of the conversations that we have had many times. In 25 years connected with the federal level in contracting, I have found that if a contract is established in a fair, reasonable manner and there is an understanding of what services are asked for, provided for, and paid for at the beginning of a contract, there continues to be a great deal of trust between the state and service provider as a contractor. When a strong contract is not in place, well, we've seen what happens. This committee has grappled with child welfare from many viewpoints attempting to fix a system that had no plan or benchmarks. This bill establishes a framework the department must follow as they contract with a managed care company to implement a system of care for low-income Nebraska families. It sets, in my opinion, reasonable, accountable guidelines capping administrative costs and performance incentives tied to the quality outcomes. It requires reinvestment in the system while also providing the opportunity for incentives tied to development of quality services. What we've been dealing with in this session when it comes to child welfare system must be completely recognized and directed to ensure the health and safety of our children. LB1158 attempts to protect those same children, as well as adults who need healthcare services, from future offenses designed to reduce and restrict access in the name of saving dollars. Efficiency and cost savings can be realized if we set the parameters. LB1158 takes a reasonable and fair approach that has been proven in other states much further down the road in their implementation of managed care in the behavioral health systems. I know that there are experts behind me. I've made that statement in other committees, and it didn't pan out to be true (laughter); but I know...they're laughing because I had a little situation the other day. Anyway, I know there are experts behind me; and I would suggest to you without standing on my soapbox one more time, if a contractor knows what the state requires of them, if the services are funded in a fair and reasonable manner, if the benefit of actually projecting a fair and reasonable profit is involved that is sustaining an administrative overhead function and providing those services in a logical, fair manner, there will continue to be trust between a service provider and the state. I will be here for closing. [LB1158]

SENATOR CAMPBELL: All right. Are there any questions for Senator Krist on LB1158? We're going to hold off all our questions. [LB1158]

SENATOR KRIST: Oh, goody. (Laughter) [LB1158]

SENATOR CAMPBELL: How many people in the hearing room wish to testify on LB1158? Okay, we will start with the first proponent then. Good afternoon. [LB1158]

CAROLE BOYE: Good afternoon. Could I start with a disavowal of any expertise? (Laughter) [LB1158]

SENATOR CAMPBELL: No, I'm sorry. You can't do that. (Laughter) [LB1158]

CAROLE BOYE: (Exhibits 12 and 13) Senator Campbell, members of the committee, my name is Carole Boye, C-a-r-o-l-e B-o-y-e. I serve as executive director of Community Alliance in Omaha, Nebraska, and today I'm testifying on behalf of the Nebraska Association of Behavioral Health Organizations, or NABHO, in support of this bill. Our health and human services system seems to have faced some extraordinary challenges and opportunities over the recent past. Currently, children's services are the rightful focus of your significant and thoughtful attention. Not that long ago, developmental disability services were in the forefront of legislative leadership and action; and before that, we looked to all of you to focus on our state psychiatric hospitals and reforming a behavioral health system that was overly reliant on institutional care. Each of these experiences has reinforced something we already know: that challenge, opportunity, and change is a double-edged sword. If we do it right, the state and all of our citizens will benefit. But if we don't, if we do it wrong, everyone, especially those most in need, are going to be hurt. Now we see a new challenge and a new opportunity on the horizon: moving Medicaid-financed behavioral health services to an at-risk system under a managed care contract. NABHO has worked diligently on efforts to help positively shape this change, and we, too, have looked to the experts. This includes having contracted with TriWest Group and Dr. Andy Keller, who is with us today, who has researched successful models in other states, and also us consulting with the industry, other healthcare colleagues, consumers, and advocacy groups. Based on our understanding of where HHS is in, where they're at in this process, NABHO anticipates that this significant change will go into effect by July of 2013. There is currently a request for public input process underway, and an RFP and contract negotiations with the successful managed care bidder will most probably take place prior to the next legislative session, prior to our next session. At-risk managed care is clearly another double-edge sword. It does hold the promise for better coordination of services, for innovation, for increased use of best practices and of course, for cost controls for the state; but there are significant land mines as well if we don't do it right. Our current experience with children's services and our historic experience with first and second-generation managed care starkly illustrate these land mines. Poorly constructed

and unmanaged contracts resulting in a lot of money getting lost in the system and a whole lot of people getting hurt. We want this to work. NABHO wants this to work for our state, for our communities, for the organizations we work for, and most of all, for the people we serve. And we believe that one meaningful way to tilt the scale in favor of success is to have basic contractual parameters and safeguards in place. This bill, made stronger and more clear with the refinements and amendments Senator Krist has outlined, would assert legislative leadership by proactively establishing guidelines by which Medicaid would negotiate an at-risk contract. It incorporates best practices and results found in other states, and it addresses key areas of accountability and protection such as the percentage of dollars that has to be spent on services rather than administrative care, profit margins, provisions for incentivizing system improvements, and accountability based on actual performance. At-risk managed care is coming to Nebraska for Medicaid-funded behavioral health services. Rather than just hoping for the best, let's learn from our past mistakes and work together to give it the best possible chance for success. NABHO believes that adoption of LB1158 this session, before a contract is negotiated, is a very important step in that process. Frankly, we feel a real sense of urgency; and we ask that this committee and the Legislature please put these basic practices, guidelines, and parameters into place. Thank you. [LB1158]

SENATOR CAMPBELL: Thank you, Ms. Boye. Questions? I'll take Senator Gloor. [LB1158]

SENATOR GLOOR: Thank you, Senator Campbell. Thanks for your testimony. Are substance abuse programs included under the definition of behavior health services? [LB1158]

CAROLE BOYE: Yes. [LB1158]

SENATOR GLOOR: Okay. Does NABHO have members that are operators in substance abuse programs? [LB1158]

CAROLE BOYE: Yes, yes. [LB1158]

SENATOR GLOOR: Okay, thank you. [LB1158]

CAROLE BOYE: And this support and this contract would incorporate both mental health, substance abuse, children and adult. [LB1158]

SENATOR GLOOR: Good. I wanted to make sure we weren't looking at a gap somewhere. Thank you. [LB1158]

SENATOR CAMPBELL: Other questions? [LB1158]

CAROLE BOYE: I also handed out a letter from Nebraska Medical Association in support of the bill. [LB1158]

SENATOR CAMPBELL: Thank you. And I do think you qualify as an expert. [LB1158]

CAROLE BOYE: Thank you, Senator. [LB1158]

SENATOR CAMPBELL: Our next proponent. Welcome. [LB1158]

ANDREW KELLER: (Exhibit 14) Good afternoon, Senator Campbell, Senators. Thank you for the opportunity to be here today. My name is Andrew Keller, A-n-d-r-e-w K-e-l-l-e-r, and I am a partner and senior consultant with TriWest Group, we're a human and health services consulting firm. We are under contract to NABHO, and I'm here on behalf of NABHO as a proponent of this legislation that Senator Krist has introduced. I want to just mention my background. TriWest works with a lot of states, primarily states, but other funders as well, counties, federal government-funded projects as well. And we've worked in over a dozen states that have implemented these types of programs, so I'm drawing on that experience as well as experience of folks that we have consulted as part of our consultation to NABHO. I want to, I have some slides just kind of summarizing what I'm going to say today. The first one at the bottom of the first page you have summarizes some things I got to share with you all back in December when I had the privilege of testifying in relation to children's services, and the main gist of that was that the contract is key. That managed care companies are, I consider them sort of neutral players. They're going to deliver what they're required to deliver under the contract. The better the contract is written, the better those services are going to be, and I think Senator Krist really summarized it well when he mentioned the word trust. They really want to have a trusting relationship, and that's one thing, you know, I think of it in terms of a performance improvement partnership. This is very difficult work that the department is trying to have folks undertake on their behalf, that the managed care organizations will undertake. And if they don't have a framework that really shares financial risk and pulls people into a relationship where they need to trust each other and work together, then you're not going to have the types of complex changes and difficult things done that need to be done. And the other piece that I think is really critical, too, that I mentioned back then is that our systems are underfunded. We do not have enough money. That's not ever going to happen probably in the near future that we will, so we need to make sure that we don't lose resources in the process of taking on these new opportunities. The next slide, slide three, talks about the framework we're doing around three critical contracting issues, which I wanted to talk about and which this legislation underscores. NABHO has been working with a broad coalition of stakeholders and national experts including providers, substance abuse providers, mental health providers, hospitals, stakeholders such as consumers and family members. And we are working to respond to the state's request for information and giving them lots of input that, actually about 120-130 pages of input that we've pulled

together, that's technical input that we're going to put in terms of helping this be a very good and effective contract. But the one page or so of terms that are in this legislation we felt were so important, and we support others who feel that they're so important, because they are necessary for establishing trust between the branches of government, between the Legislature and the department as you go forward in this. And I think we've seen and we've heard through the difficulties of the child welfare system over the last year what happens when that sort of planning and consensus is not built. So this is in no way meant, we expected the department will probably want to do these things; but we think it's important that there be alignment going into this between the Legislature and the funders and the department around three areas: accountability provisions, financial incentives, and the reinvestment of savings. Those three areas we think are paramount for there to be agreement on and clear parameters for contractors. The first one is accountability to build systems. Complex, people with complex needs need to have a performance partnership pulled together and need to have complex things done; and those things don't just happen on accident. If you don't structure the system with certain safeguards in place, there's the risk of having unintended adverse consequences. Two basic things that need to happen is you have to have a set amount on administration and not exceed that, because you don't want to have too much spent on administration. You also don't want to have too little spent on services. But contemporary contracting, the most recent contracts that have gone into place, what we see as sort of the best practice states such as Louisiana, Arizona, Massachusetts, have put in place additional requirements around enhanced administration using the administrative capacity of the managed care organization to do care management and coordination; and to do that, you need to spend a little bit more. You need to spend more than like a seven percent floor; but if you don't spend it with clear accountability and transparency from the department giving oversight, then you're not going to be able to be sure that goes to the things you need as opposed to going towards profit, and that's why the amendment Senator Krist offered is so important, and it affects section one as well as two and four. The second area is align financial incentives. This one's pretty clear. We basically don't think there should be too much going to just unbridled profit. We think that there should be a reasonable profit built in of 2-3 percent as well as risk sharing for downside risk. But along with that, performance incentives so that the things we want to have happen are ensured to happen, both negative incentives for a failure to perform as well as positive incentives for things that we want to have happen. And finally, a reinvestment pool that has community input, stakeholder input so we can fill gaps with the money that is left over through the effective services and the reduction in the use of unnecessary restrictive care and other adverse consequences. So if you put all that together and there's agreement on that, we think that's the best recipe for going forward, and we think it's the type of critical future that should be built into statute and not just left up to whether or not that may or may not happen. [LB1158]

SENATOR CAMPBELL: Okay, thank you, Mr. Keller. Questions any of the senators have? I must say I'm always amazed how you get a lot in that five minutes. (Laughter).

That's a compliment, Mr. Keller. Our next proponent. Good afternoon. [LB1158]

C.J. JOHNSON: Good afternoon, Senator Campbell. In fact, I'm going to talk real slow after Andy got done, because I don't have that much to say. Actually, my name is C.J. Johnson, C.-J. J-o-h-n-s-o-n. Again, Senator Campbell and members of the Health and Human Services Committee, I am the regional administrator at the Region V Behavioral Health. I'm here representing the Nebraska Association of Regional Administrators. We are here to offer our support of LB1158. To be brief, we want to thank Senator Krist for working with us in relation to the amendments that he also introduced in relation to this bill. We think that it clarified the intent of the bill, and simply to say that what Mr. Keller previously said, we also support in relation to having good clarity with contracts, parameters, and support any ability when necessary to reinvest funds into the ongoing support of behavioral health services within the state of Nebraska for children, adults, and their families. [LB1158]

SENATOR CAMPBELL: Mr. Johnson, that may be the shortest (laughter), I don't know, that I've heard you. [LB1158]

C.J. JOHNSON: I know. Thank you. [LB1158]

SENATOR CAMPBELL: Questions for Mr. Johnson? Thanks for coming today and representing the regional administrators. Our next proponent. Good afternoon. [LB1158]

BRUCE RIEKER: Good afternoon. [LB1158]

SENATOR CAMPBELL: Whenever you're ready. [LB1158]

BRUCE RIEKER: (Exhibits 15 and 16) Chairman Campbell, members of the committee, my name is Bruce Rieker, it's R-i-e-k-e-r. I'm here testifying on behalf of the Nebraska Hospital Association in support of LB1158, and I also have a, am submitting a letter of support from Alegent Health Systems for your review as well. And if I could try to even be shorter than C.J., I do have a few things to say, but I would say that representing Medicaid providers, they would jump at the chance of having a guaranteed profit margin in the services that they would provide. So, we'd like to point that out that some of these restrictions or the provisions that Senator Krist boldly put into his legislation, I applaud him for doing this, and our members do as well. It was introduced, as probably many of you know, this legislation was introduced in response to a situation that occurred with institutes of mental disease and how the state needed to come in compliance. And therefore, the state is moving to a statewide behavior health managed care system. Our hospitals are very concerned that any time you inject another entity into the delivery of the healthcare system, it takes more of the limited resources we have out of the system that could be used for providing care, making access and quality available to those who desperately need it. Usually what happens in a managed care situation is undoubtedly

the state saves money. However, Medicaid providers will incur greater amounts of uncompensated care as well as undercompensated care; and you can see in my testimony that right now Nebraska's hospitals on average, and we have many hospitals that when I say on average, obviously are going to be above this, but on average lose 28 cents on every dollar of care that they provide to Medicaid recipients already, and our concern is that that negative margin will go even higher as a health, or excuse me, as a managed-care organization and a statewide behavioral health managed care program is put in place. We think that these are very good provisions to put into a managed care contract with any managed care provider. In fact, we think they're so good that the next time the state negotiates for the physical health or the primary care side of healthcare, that provisions similar to this should be incorporated in those contracts as well. And with that, we would urge you to advance LB1158. [LB1158]

SENATOR CAMPBELL: Questions from the senators? Thank you, Mr. Rieker. [LB1158]

BRUCE RIEKER: You're welcome. [LB1158]

SENATOR CAMPBELL: (Exhibit 18) Any other proponents in the hearing room? Those who wish to testify in opposition to LB1158? Those who wish to testify in a neutral position? I knew I would get to the director in one of those categories. While the director is making her way up, we also want to note for the record that we received a letter from the Children and Family Coalition of Nebraska in support. Good afternoon. [LB1158]

VIVIANNE CHAUMONT: Good afternoon. [LB1158]

SENATOR CAMPBELL: Are you walking legally now? [LB1158]

VIVIANNE CHAUMONT: No. (Laughter) [LB1158]

SENATOR CAMPBELL: Okay, we'll keep asking. [LB1158]

VIVIANNE CHAUMONT: (Exhibit 17) Thank you. Friday, I hope. Good afternoon, Senator Campbell and members of the Health and Human Services Committee. My name is Vivianne Chaumont, V-i-v-i-a-n-n-e C-h-a-u-m-o-n-t, and I'm the director of the Division of Medicaid and Long-Term Care for the Department of Health and Human Services. I'm here to testify in a neutral capacity on LB1158. I've previously briefed the committee on the issues regarding Institutes for Mental Disease, the IMD issue that the Nebraska Medicaid program is facing. And just briefly, federal statutes and regulations prohibit Medicaid from paying for any services provided to an individual 21 and over and under 65 who lives in an IMD, and an IMD is basically an institution of more than 16 beds that is primarily engaged in providing treatment or care to persons with mental diseases including medical attention, nursing care, and related services. Generally speaking, an institution where more than 50 percent of the residents have a behavioral

health diagnosis may be considered an IMD. You're all aware of this, but in the summer of 2011, CMS requested assurances from Nebraska Medicaid that Nebraska was not paying for services to individuals who live in an IMD. Nebraska was unable to provide that assurance. So in order to come into compliance, we submitted a corrective action plan to CMS stating that we would issue a request for proposal to move the Medicaid behavioral health program to at-risk managed care by July 1, 2012, and that we would implement at-risk managed care statewide by July 1, 2013. The benefits of at-risk managed care are that the company manages utilization and provides access while the state gets control of its costs. The at-risk managed care company can manage care by providing services that the Medicaid program itself cannot provide. A prime example is paying for clients who live in an IMD. Fee-for-service Medicaid cannot pay for such clients, but at-risk managed care can pay for such clients because it's providing the services in what is known as "in lieu of" the more expensive inpatient psychiatric hospitalizations. So Medicaid staff currently is gathering input through town meetings, through a request for information, in order to post a request for proposal by July 1, 2012. There are components in LB1158 that the department would like to incorporate in the development and implementation of managed care contracts. For instance, CMS requirements already cap the administrative portion of the rate at 15 percent. Federal regulations require that CMS grant approval of the actuarial soundness of the managed care rates and grant approval of the actual terms of the contract. We plan to establish limits on profits, requirements for community reinvestment and performance measures. These are best practices used by many states in these contracts, and they've been around a long time. There's nothing new there. What concerns me about the bill is the cementing of these requirements at specific numbers in a statute. The statute could hamper the flexibility of the department to adjust specifics based on the bids that it receives. The restrictions in LB1158 could result in fewer or no companies bidding on the behavioral health managed care contract now or in the future. It's in Nebraska's interest to have several companies bid this contract so we have good choices in making this step. Failure to have a contract in place on July 1, 2013, has severe consequences in the current environment. If we do not have a contract in place on July 1, 2013, we are out of compliance with federal requirements, and we will need to stop paying for services provided to Medicaid clients who live in IMDs. This includes all Medicaid services, not just those related to living in an IMD. The loss of federal financial participation could be as much as $20 million a year. The department is in favor of contractor accountability through performance measures and the ideas behind the bill. However, setting these in concrete may have consequences which are unintended and put the behavioral health system at greater risk. I appreciate the opportunity to voice these concerns, and I would be happy to answer any questions. [LB1158]

SENATOR CAMPBELL: Questions? Any questions? Senator Howard. [LB1158]

SENATOR HOWARD: Thank you, Senator Campbell. Just so we're all on the same page, who are we contracting with right now to provide the services? [LB1158]

VIVIANNE CHAUMONT: We don't have at-risk managed care currently in the state for behavioral health. [LB1158]

SENATOR HOWARD: What would you call Magellan? Is this an entirely... [LB1158]

VIVIANNE CHAUMONT: It's an administrative services organization. It's not an at-risk managed care organization. [LB1158]

SENATOR HOWARD: So it's providing this...I just want to understand. [LB1158]

VIVIANNE CHAUMONT: Yeah, yeah. [LB1158]

SENATOR HOWARD: So it's providing the services, and how would that change under this? [LB1158]

VIVIANNE CHAUMONT: Okay. No, that's okay. I'll just kind of... [LB1158]

SENATOR HOWARD: Is it too complicated? I don't want to... [LB1158]

VIVIANNE CHAUMONT: No, no, no, but I'll just do a little managed care 101. [LB1158]

SENATOR HOWARD: Good. I think that would help everybody. [LB1158]

VIVIANNE CHAUMONT: If that's okay. Okay, let's start with fee-for-service. Providers provide services, they bill Medicaid, we pay. An administrative services organization...well, let's go to the other side then. At-risk managed care, the department calculates a rate based on what it has been paying for the services that are going to be managed by the at-risk managed care company. Then we go through actuarial, all these steps that CMS has. We come up with an actuarially sound rate which we will then offer to the managed care companies to bid on. That rate is what's known as PMPM, per-member, per-month, so we will pay a per-member, per-month to the company that wins, and they will be at-risk for anything that the client needs for that month. So there obviously are clients who won't have very many, none, zero or very little services, and then there will be clients who will have much higher needs than the per-member, per-month, and the company switches around. It is very common to have, in behavioral health contracts, risk quarters, like the bill suggests, it is very common to have community reinvestments. We're planning on having all of those things. I've seen that at work. It works very well, and some of the other types of things. Okay, so that's at-risk managed care over here where they're totally at risk for the services that are provided, and then there's fee-for-service. Kind of in the middle is an administrative service organization where we pay, we have Magellan, as the ASO contractor, do network certification, prior authorization, utilization review, those types of things for us,

administrative services, but the bills actually come to us. Magellan is not at-risk. So we calculate something that, you know, a rate that we pay Magellan; but they are not at-risk for the services. We are paying them for an administrative service. This is very different than paying at-risk where they will be at-risk, they will be paying the, you know, for the services. And we will, our exposure is for the rate that we've set up. [LB1158]

SENATOR HOWARD: Is that where the 15, the currently 15 percent comes in? [LB1158]

VIVIANNE CHAUMONT: CMS regulations...CMS has a lot of regulations regarding the rates for at-risk managed care companies, and they have a 15 percent cap on administrative expenses. [LB1158]

SENATOR HOWARD: Administrative. Okay, well, that's very helpful. [LB1158]

VIVIANNE CHAUMONT: And don't forget that, you know, administrative...you know, there's the administrative expenses are bad expenses. They're not bad expenses. Customer service is an administrative expense. But there is that, there is...what you want to have profit quarters is so that company isn't taking, you know, a lot of money profit out. You want to put some kind of cap on that. We totally agree with that. [LB1158]

SENATOR HOWARD: Okay, so the 15 percent right now is what we pay or what we feel is reasonable for administrative services? [LB1158]

VIVIANNE CHAUMONT: A maximum of 15 percent. [LB1158]

SENATOR HOWARD: A maximum, okay. And this bill calls for 7 percent, or is that an equivalent? [LB1158]

SENATOR KRIST: It's 7, 7 percent. [LB1158]

VIVIANNE CHAUMONT: It's 7.5? It's 7? Seven. Okay, sorry. Yes. [LB1158]

SENATOR HOWARD: Is that an equivalent figure? Is that fair to... [LB1158]

VIVIANNE CHAUMONT: No, that's...yes, the CMS outside limit is 15 percent. What I've seen contracts is between 7 and 10 percent being reasonable. [LB1158]

SENATOR HOWARD: Okay, thank you. [LB1158]

SENATOR CAMPBELL: Senator Krist. [LB1158]

SENATOR KRIST: I was going to get to this in closing, but we can have this discussion

better this way. When the federal regulation allows a cap on administrative overhead of 15 percent, very often that administrative cap applies to contract, subcontract, down the line. So when you have a federal cap on administrative overhead, for example in the child care, child welfare system right now, you have a prime contractor. If we establish this same kind of cap at 15, there would be, all the way down to the service provider, there would be no more than 15 percent overhead or administrative fee allowed within that contract. That's currently the way the federal regulation is written. In other...I'm not familiar with the Medicaid or CMS contract caps the way it's written, but it doesn't allow you to go over that in the administration of any of the services that are required in that particular area. So what we've been missing is a state in terms of our other contracts, quite bluntly, is we've been allowing...we've thrown money at a situation. We've been allowing the contractor to spend money as they see fit, and by the time it gets down to fund Andy Campbell's adventure, he doesn't get more than $10 or $15 at any particular area, when in fact the fees on top of it for Andy Campbell may have been in the $30 to $35 range. And in terms of letting a contract, because you've represented these solid principles in terms of contracting, I'm assuming that the cap is the cap. In reality, as you said, it's someplace between 7 and 10 percent across the country right now. [LB1158]

VIVIANNE CHAUMONT: I think best practices that I've seen are between 7 and 10 percent. Yeah, there's a 15 percent cap that CMS won't approve it, but I think 7 to 10 percent is reasonable. I, can I just... [LB1158]

SENATOR KRIST: Yep. [LB1158]

VIVIANNE CHAUMONT: I'm sorry. I think there are very big differences between the contracts in child welfare, and I think we need to make sure that we see those differences between the contracts that are currently in child welfare and at-risk managed contracts that Medicaid programs enter into. There is a whole slew of regulations on the Medicaid side that have to be, the rates have to be approved. You have to have an actuary certify rates based on current data, and it is a very complicated and expensive process to have that done. And then all of that has to be...there's all kinds of guidelines from CMS, and it all has to be approved by CMS. The 15 percent is what that managed-care company can have as admin. I don't, I've never heard in a Medicaid contract the concept that you were talking about, you know, the down the line to 15 percent. Because don't forget that the providers, well, you're talking about physicians, drugs, all of that kind of thing. So I can't say that I'm familiar with that. I just know that administrative cap is to the contractor that the Medicaid program will contract with. What they do with their providers, they are within certain limits, like they have to provide the services that we would have provided fee-for-service, but they can provide services that we wouldn't have been able to provide fee-for-service, because they're not covered under, you know, under federal Medicaid or under our own statute. They can, you know, they can pay higher rates than what we pay. They can pay lower rates. If they want to incentivize, they have all kinds of things that they can do that our hands are

more tied for, so. [LB1158]

SENATOR KRIST: Okay, thank you. [LB1158]

SENATOR CAMPBELL: Any other questions for the director? Thank you, Director Chaumont. [LB1158]

VIVIANNE CHAUMONT: Thank you. [LB1158]

SENATOR CAMPBELL: Anyone else in the hearing room who wishes to testify in a neutral position? [LB1158]

TOPHER HANSEN: Good afternoon, Senator Campbell. My name's Topher Hansen, T-o-p-h-e-r H-a-n-s-e-n. Members of the committee, I am the executive director of CenterPointe, also a member of NABHO. I come here as an individual having been involved in this process and want to say that the points that the director has raised about an administrative cap being between 7 and 10 percent, we have found through researching, this is, in fact, a range that is common in practice. A point in fact is the Louisiana plan, that I think you all are somewhat familiar with, had similar provisions as the ones in this bill and had multiple providers responding to it. The kinds of, certainly the thing we don't want to do is set up in statute limits that would hurt the process instead of helping the process, and so we have tried to put forward the best knowledge about how to set the guidelines. And again, I know that in Louisiana, the comparable terms produced multiple bidders, and we don't believe would be a situation that would restrict our interest, if you will. [LB1158]

SENATOR CAMPBELL: Okay. Any questions or comments on that? Thank you, Mr. Hansen. [LB1158]

TOPHER HANSEN: You're welcome. [LB1158]

SENATOR CAMPBELL: And we can get one of the pages to collect that from you. Okay, when you're ready. Anyone else in the hearing room on the testimony? Would you like to close, Senator Krist? [LB1158]

SENATOR KRIST: I would, very briefly. As vocal as I have been about contract processes throughout our LR37 process and the time that I've been involved with this, many of these kinds of concerns have come to me. I have totaled four of these contract bills in different committees, and my intent is to again establish a point where when the state is bound, that there is a solid trust factor that goes involved with the state itself and with the contractor that provides a service. And I'd like to say something for the record that I think is very important to this discussion. We may not agree with the 7 or 10 or 15 percent. It may have to evolve into some other solid percentage, or it may be a floating

percentage based upon the Dow, I don't know. But the point of this discussion is simply this. The United States government at the federal level and the contracting that I am used to seeing does not expect anyone to do something for nothing. They expect that there is going to be fair and honest pay. That's that administrative overhead fee we talked about. In the contracts I'm familiar with now, the GNA, as it's called, is 7.5 percent. We need to look at the opportunity to, as a state, as a Legislature in terms of our oversight, to be able to project ourself into the discussion so that we look at sound contracting principles that bind the state being good stewards of taxpayers' dollars in a fair and honest way that provides service providers out there with an honest living. And there has been a tendency across the board, I think, in our discussions, to see where the state might have expected somebody to do something for nothing, and that can't go on any further. I thank you for your time. [LB1158]

SENATOR CAMPBELL: Did you have a question, Senator Gloor? [LB1158]

SENATOR GLOOR: If I could, and I wasn't going to, but you made a comment that finally has me thinking maybe for the record, I ought to ask this question. I can't argue at all with the intent behind the bill. Yeah, we need good, solid contracting provisions, measures in place; but as Director Chaumont pointed out, we are locking in some numbers here. And by locking in those numbers, we could put ourselves in a position of having contract, somebody who agrees to that contract who is, as they say, the lowest bidder, which may not mean the best quality provider. Or worse yet, what if nobody does submit a bid and we find ourselves trapped with something in statute that we're not in a position to be able to rectify short of a special session? The trust here from us to you is that these numbers are numbers that you think won't put us in a position where we've painted ourselves into a corner with numbers that hamstring us when it comes to making sure that we have quality providers or a provider at all, or a contractor at all, I'm sorry. [LB1158]

SENATOR KRIST: I think you've heard from at least one of the testifiers that they would love to have a guaranteed profit when they entered into contracts. If seven is too low or too high, that's a discussion I think we need to have. But there are contracting principles that would allow the state to go out for a request for proposal that would be nonbinding to say, are there, are there interested vendors that want to participate in this RFP? And the federal government does it all the time to see if there's enough veteran small businesses, all those kind, to see if there is, and then they get very restrictive when they go out. That's how they...so there would be nothing that would prevent us from testing the waters to see if those vendors are out there, and I certainly don't want to do that. I am more of a fan of a good cost-benefit analysis being done up-front and of a best-value contract being sought in almost every case. And if you can find the lowest bidder and the best value, that's the ideal contract. [LB1158]

SENATOR GLOOR: Great, thank you. [LB1158]

SENATOR KRIST: Thank you, Senator Gloor. [LB1158]

SENATOR CAMPBELL: With that, we'll close the public hearing. If you are leaving us today, just leave quietly. [LB1158]

SENATOR GLOOR: We'll now move to LB1160. Welcome, Senator Campbell. And you're welcome to start any time you'd like.

SENATOR CAMPBELL: Thank you, Senator Gloor and colleagues on the committee. It is again my privilege to represent you in the introduction of LB1160. This bill...oh, I'm sorry. It's Kathy Campbell, K-a-t-h-y C-a-m-p-b-e-l-l. [LB1160]

SENATOR GLOOR: That could have been embarrassing. (Laugh) [LB1160]

SENATOR CAMPBELL: We need to make sure we've got that on the record. LB1160 provides for, one, legislative oversight of the Nebraska Child Welfare System through an improved data collection system that integrates child welfare information into one system to move effectively to manage, track, and share information, especially in the case management area. Number two, the bill increases child welfare outcome measurement through increased reporting by lead agencies and the department. And, three, an independent evaluation of the child welfare system. Under the data system, the department shall develop and implement a web-based, statewide automated child welfare information system to integrate child welfare information into one system. Objectives for the system shall include but not be limited to improving efficiency and effectiveness, access to real-time information including prior case histories and tools that support consistent policy and practice standards, improved reporting capabilities, accountability and case review requirements, track services, payment processes, and progress through use of dashboards. The capacity of the system shall include integration across related social services programs through automated interfaces including, but not limited to, the courts, Medicaid eligibility, financial processes, and child support. On or before December 1 of 2012, the department, with the assistance from other agencies, shall as necessary report in writing to the Legislature on a plan for the data collection systems describing the design, development, implementation, and cost of the system. And, colleagues, I would add that this may be one of the most important things that we could put into place because policymakers' decisions are only as good as the data that can come before them. The second part of the bill deals with reporting. On or before September 15, 2012, and each September 15 thereafter, the department shall report to the Health and Human Services Committee of the Legislature the information regarding child welfare as outlined in the bill, including children served by lead agencies and children served by the department, sibling placement, children's behavioral health data, case management, noncourt involved children, residential placements, out-of-state placement, thank you, Senator Howard, lead agency finances,

client satisfaction surveys, and advocacy center interactions. On or before September 15 of 2012, and on or before each September 15 thereafter, the department shall provide a report to this committee of the Legislature on the process for monitoring lead agencies, including the actions taken for contract management, financial management by the lead agency, cost-benefit analysis, quality assurance and oversight, children's legal services, performance measures and effectiveness of lead agency communication. And the last portion of the bill deals with evaluation. Requires the department to engage a nationally recognized evaluator to provide an evaluation of the Nebraska child welfare system and services. The evaluator shall be a national entity that can demonstrate direct involvement with child welfare, have broad interaction with national entities, experience with child welfare research, and be independent of the department and lead agencies with no contractual relationship or consultant relationship with the department or a lead agency within the preceding three years. The evaluation shall include a review of child welfare services regarding improving outcomes, whether the cost is reasonable, and a review of the last three years of placements of children in residential treatment settings. The evaluation shall be completed and a report issued on or before December 1 of 2012 to the Health and Human Services Committee of the Legislature and the Governor. As a closing comment, I think today we have seen part of what we realized in LR37, and that is that we need to have oversight of the departments and the systems that deal with children. And certainly Senator Harms's effort in his bill in terms of the financial oversight, this then places in this committee the other parts of the oversight that we've certainly felt in LR37 need to be in place. And with that, I will conclude my comments, if there are any questions. [LB1160]

SENATOR GLOOR: Are there questions of Senator Campbell? Seeing none, I'm assuming you will migrate back... [LB1160]

SENATOR CAMPBELL: I will, thank you. But you can go ahead and call the... [LB1160]

SENATOR GLOOR: Can we see a showing of those who would be in support. And those who would be in opposition. We'd ask those of you in support to step forward and provide your testimony. Thank you. [LB1160]

SENATOR CAMPBELL: Good afternoon. [LB1160]

LISA SNELL: (Exhibit 19) Good afternoon. My name is Lisa Snell, L-i-s-a S-n-e-l-l, and I am a child welfare researcher from the Reason Foundation, based in Los Angeles. And for the last five years, I've been working with the Children's Bureau and the federal government on a national quality improvement center for child welfare privatization. And we have done seven different pilot projects on performance-based contracting in child welfare. And we also have done several comprehensive surveys on the extent of child welfare privatization and concerns around child welfare privatization. And one of our surveys surveyed stakeholders for child welfare in all 50 states, and that included

judges and child welfare administrators at the state and county level, and nonprofits, and child advocates, and the whole realm of different stakeholders around child welfare. And one of their top three concerns was quality data management and quality data reporting. And they felt that nationwide one of the missing links in child welfare is good data systems that can be used to make evidence-based decisions about practice and best practice in child welfare. Having said that, there are good examples out there of states that have reformed their data systems. And I'd just like to start with Florida for one example. They use a...through their now more successful privatization than in the past, they have come up with a quality improvement system where I would describe it as a try, try again kind of system, where all the stakeholders, nonprofit, private, judicial, legislative, have regular meetings where they make evidence-based decisions about what will happen next based on data. And in order to do that, they have come up with a state-of-the-art web-based data system. And even more than that, and this is what I think is critical to include in this kind of a system as you're thinking about this going forward, is that it incorporates the needs of the line workers or the social workers in terms of making their jobs much easier. So it's a very user-friendly system, and it includes GPS, so that every visit to families is recorded through GPS. And also they have handheld devices so that they can immediately take pictures as evidence that they are actually making these visits and put data and notes into the state's case management system immediately, so that it has greatly improved in Florida compliance with several measures, including the frequency of visits to families, the condition of the case files, and the evidence that goes into each child's plan. So I would encourage you to look at, or whoever ends up eventually implementing this, look at best practices for data management and try to have the most real-time data, the most state-of-the-art system, and the most comprehensive in terms of indicators that you can find out there, because it makes a huge difference in terms of quality indicators. And it also helps with several of the other kinds of initiatives that you might consider. For instance, if you're going to go down the path of getting a IV-E waiver that the Obama administration is now making available to states, that has several data requirements in order to qualify for the waiver. So having a good data system makes it much easier to get a waiver to start with. It also will help whatever form the eventual commission or committee or quality improvement stakeholder group that meets moving forward for best practices in child welfare. It will help them to make data-driven...the thing is that child welfare is filled with anecdotal evidence that is very compelling. But we also need to fall back on not only anecdotal evidence, but what the trends actually are. And I'm going to wrap up right now. Nationwide, we've seen a reduction of 150,000 kids in foster care, and almost 50,000 of those kids in the last three years. And I would argue that the states that have the best data systems are the ones that are leading the way in terms of changing the culture for being one of child removal automatically to one of front-end services that serve family on a much broader continuum of service. And I think that's really what Nebraska is also interested in doing. And data management makes a huge difference to that. So it's a very good idea to support this bill. [LB1160]

SENATOR CAMPBELL: Thank you, Ms. Snell. Questions or comments? Senator Gloor. [LB1160]

SENATOR GLOOR: Thank you, Senator Campbell. And thanks for giving us an example. But have you been using the terms evidence-based practice and best practice interchangeably? [LB1160]

LISA SNELL: Well, I would...I'm using it very vaguely. So... [LB1160]

SENATOR GLOOR: Yeah. [LB1160]

LISA SNELL: ...without a very...I mean, I'm using it as data-driven practice is what I mean. [LB1160]

SENATOR GLOOR: Okay. [LB1160]

LISA SNELL: Data-driven practice, that's essentially what I mean. [LB1160]

SENATOR GLOOR: Okay. And your example that used GPS tracking and immediate on-line entry to the record,... [LB1160]

LISA SNELL: Right. [LB1160]

SENATOR GLOOR: ...all that is data-driven... [LB1160]

LISA SNELL: Yes. [LB1160]

SENATOR GLOOR: Okay. All right. Thank you. [LB1160]

SENATOR CAMPBELL: I think that is just...when we looked at that this summer, Ms. Snell, reading some of the things from Florida, it was just amazing at how much information they're doing in that handheld device. And for the supervisors to know at any one point where people are, I just thought it was really fascinating. I appreciate you bringing that example. Have you had a chance to look at LR37? [LB1160]

LISA SNELL: Yes, I've read all the reports. [LB1160]

SENATOR CAMPBELL: Was there any particular...did you notice that you were quoted in the report? (Laugh) I didn't want to miss mentioning that to you because we used your quote I think from a previous report. [LB1160]

LISA SNELL: Right, so I think it was on another...obviously, I tried to stick to the topic of the bill. [LB1160]

SENATOR CAMPBELL: Yeah, I know, I appreciate that. [LB1160]

LISA SNELL: But obviously bringing the judiciary in as important stakeholders is such a critical part of this reform. And, you know, I know that you guys already have a program here, the voices of children or...I'm missing the name of it, but where it is working in some localities, right, to help the judiciary to be on board as far as... [LB1160]

SENATOR KRIST: Eyes of Children. [LB1160]

SENATOR CAMPBELL: Oh, Eyes of the Child? [LB1160]

LISA SNELL: Eyes of the Children, Voices For Children, Eyes of the Children. And so, you know, that's one area for all of these states that are going through child reform, regardless if privatization is involved or not, is...obviously the judges decision is what impacts whether a child is removed or not in the end. And so if there is a culture shift, it's important to get the judiciary's input. [LB1160]

SENATOR CAMPBELL: Well, I mention it... [LB1160]

LISA SNELL: So you asked about the report more generally. I mean, my take on it is that you have a lot of very specific recommendations that could immediately impact children; like, for instance, getting a better data system, establishing a minimum rate for foster care families. And I just would encourage you to move as quickly as possible to those action items. And I would also say that a lot of the stakeholders that are currently working have already been addressing a lot of those issues, even though their outcome data may be questionable and there may be other financial issues, that it would be important to not lose the work that they've already been doing around all of your recommendations on the ground, even though there have been accountability issues for different stakeholders. [LB1160]

SENATOR CAMPBELL: Thank you for coming today. [LB1160]

LISA SNELL: Thank you. [LB1160]

SENATOR CAMPBELL: Oh, I'm sorry, Senator Howard. [LB1160]

SENATOR HOWARD: Thank you. And, yes, there have been accountability issues. (Laugh) One of the major things that we deal with. I just, for clarification now, do you work for the Platte Institute? [LB1160]

LISA SNELL: No, I don't. They just contracted with me to write the study. So as an outside author, they just asked me if I would do a study for them on child welfare.

[LB1160]

SENATOR HOWARD: This is a general study. I just got this over noon and then another copy just right now. So... [LB1160]

LISA SNELL: Yeah, so it's a study...so it looked at...it basically has looked at the situation in Nebraska. And I looked at your recommendations and I talked about what happened in other states, like Florida and Kansas. And I made some general recommendations, which basically the recommendation is to move on all the action oriented items and that I would not recommend a complete restructuring. That other states have been through similar kinds of very stressful financial issues around child welfare. But one of the things that privatization or restructuring does is it shines a light on a lot of inherent things that have been there all along. And the other thing is when you make a culture shift to right sizing child welfare away from child removal, that in itself has many financial unintended consequences, no matter who is implementing it, that makes it very difficult, because financing at the federal and state level everywhere in the United States does not support reducing child removal. It's oriented toward funding foster care and other kinds of services. And so there's not a lot of mechanisms in terms of finance available to reducing child removal. So there's no money, for instance, if the electricity is turned off, to fund getting the electricity turned on versus child removal. I mean, obviously, there are specific pots now that do that. But the major funding for child welfare is a different kind of structure. So that's why one of the recommendations in the study is I would really encourage you to get the IV-E waiver, because in states like Ohio, Illinois, Florida, that has made the huge difference in them being able to reduce their foster care population, because they get their financing aligned with the goal. And they are able then...and then as soon as they start...so like, Florida has reduced their population by 45 percent. As soon as the first 5 percent of the population falls off, it frees up a lot of money for these other kinds of things, like data systems and quality improvement, where you can make front-end investments because now you have money for that without actually having to add additional money to the system. And that's really what happened in Florida. If you look at the data on how their continuum of service, where they have so many more services to families than they did ten years ago, the only reason they've been able to do that is because they freed up resources through the waiver. [LB1160]

SENATOR HOWARD: Well, I want to bring you back to something that you said,... [LB1160]

LISA SNELL: Okay. [LB1160]

SENATOR HOWARD: ...which is regarding services, more preventive services. [LB1160]

LISA SNELL: Okay. [LB1160]

SENATOR HOWARD: And are many of the states that you've looked at, and you mentioned Kansas and Florida, and are there other states too? [LB1160]

LISA SNELL: So Illinois would be another huge state. [LB1160]

SENATOR HOWARD: Are they utilizing an early intervention, a preventative program? [LB1160]

LISA SNELL: Yes, so some of the resources are freed up for early intervention with those community-based members, where they're able to go into the community and they're referred from other agencies, like schools or as their continuum services. So they're not just families that have been involved with the state. [LB1160]

SENATOR HOWARD: Right, right. [LB1160]

LISA SNELL: So they have front-end service. And the other thing is, of course, they use structured decision making at the investigative level on the front end very effectively. So I don't know if you've done this, but one of the things that Kansas did that really helped them is they did a very serious audit of the children in care at the current moment. And they tried to identify how many kids were there because of truancy, electricity bills, kind of the low end of the neglect spectrum. And right away they targeted those families for intervention by just being so specific about the reasons. And that would be an important part of any data system that you build. [LB1160]

SENATOR HOWARD: Is there, on the states that you've looked at, is there a specific focus toward targeting families that haven't come into the system but have infants, young children who need supportive services because there are some definite clues that there could be harm,... [LB1160]

LISA SNELL: Right. [LB1160]

SENATOR HOWARD: ...there could be neglect. [LB1160]

LISA SNELL: Yes, to as much as they...so like in Arizona they have a program called Family Builders that does a certain amount of that. I mean, there's good best practice examples of that kind of service. The most difficult part is just identifying those families. Who is it that's referring them, the hospital, the school? It's capturing them on the front end that is the most difficult part. [LB1160]

SENATOR HOWARD: Okay. Did you reflect our early intervention program in here in the work that you looked at? [LB1160]

LISA SNELL: It's much more general than that. I didn't go into... [LB1160]

SENATOR HOWARD: Okay, all right. [LB1160]

LISA SNELL: ...specific programming that you offer. [LB1160]

SENATOR HOWARD: And I will say to you that might be something important for you to look at in the future,... [LB1160]

LISA SNELL: Okay. [LB1160]

SENATOR HOWARD: ...because we do have an early intervention program that I would have to tell you is doing very well. [LB1160]

LISA SNELL: Okay, no, that's... [LB1160]

SENATOR HOWARD: It's preventing a lot of abuse and a lot of harm to very small children by being supportive and getting into the family system early. [LB1160]

LISA SNELL: And I think a waiver probably would help even build up a program like that further, because it would allow IV-E funds to support a program like that. [LB1160]

SENATOR CAMPBELL: Any other questions? Thank you, Ms. Snell, for coming in. [LB1160]

LISA SNELL: Thank you very much. [LB1160]

SENATOR CAMPBELL: I'm sure, like most of us, we've not had a chance to read your report so we'll do that. [LB1160]

LISA SNELL: Oh absolutely. Thank you. [LB1160]

SENATOR CAMPBELL: (Exhibits 23-25) Thank you. Our next proponent. While Ms. Helvey is making her way, we received letters of support from Voices for Children, the Children and Family Coalition of Nebraska, and KVC Behavioral Health, and a support letter from Nebraska Families Collaborative with some, and I think the abbreviation means amendments. Is that correct? Okay. And then we have a letter of neutral testimony from Director Scot Adams. Thank you, welcome, Ms. Helvey, again. So go right ahead. [LB1160]

SARAH HELVEY: (Exhibit 20) Great, thank you. Good afternoon again. My name is Sarah Helvey, that's S-a-r-a-h, last name H-e-l-v-e-y. And I'm a staff attorney and

director of the child welfare program at Nebraska Appleseed. We support LB1160 because we believe it would establish much needed oversight of what is really happening to children and families in the system and to use that data to make informed policy decisions going forward. We think that the LR37 process has been exceptionally beneficial to investigating the privatization, identifying court issues and putting forward comprehensive solutions. And so in our view LB1160 would extend that process in a way by instituting ongoing evaluation, transparency, accountability, and oversight. And when I wrote those words--evaluation, transparency, accountability, and oversight--I felt like maybe I had written them about 100 times. That has been our mantra and I think the message of advocates across...in a wide range of stakeholders since before this reform began. So we just think that that's critically important and that the committee has rightfully identified those issues as an existing, systemic deficiency. Specifically, we believe that the annual report required by LB1160 addresses an appropriately broad range of key issues. And we strongly support that. One suggestion we would offer would be to collect additional information with regard to noncourt involved cases to include some more specific information about what services are actually being provided and the funding source. Appleseed and other advocates have also long called for an independent evaluation of the system by a national expert. And we strongly support that provision as well. With regard to the focus of that evaluation, we would offer two comments. The first is just to reiterate our very strong support for LB961 and therefore to the extent that LB1160 contemplates lead agencies kind of role in case management, you know, if LB961 would move forward, you know, that would need to be adjusted accordingly in our view. Second, we believe the evaluation's focus on residential treatment should be broader to include an evaluation of cost shifting that is occurring at all levels of care. In addition, in our experience it would be important to examine not only the percentage of children denied the level of care originally requested, but also the percentage of children denied reauthorization requests or subsequent review of initial authorizations as denial of services often occur at later points in time. We also offer the same suggestion with regard to the annual report in a separate section of the bill. Finally, while we strongly support the data collection, we want to be clear that other solutions and changes in the Medicaid program are imperative, as the committee has recognized, and that we need to address deficiencies in children's behavioral health and that there's no time to wait on that front. And so for the record, we also strongly support LB1060, which I think is scheduled for hearing before this committee tomorrow. We think that that bill would begin to do that and would be providing strong support of that measure as well. Finally, we support the provision in LB1160 that provides for annual surveys. We think that was a very beneficial process, we hope, as part of LR37 and think it's great to continue that. In conclusion, time and time again from the State Auditor's report to the many individual stories you've heard from children and families, again it's clear that we need to create mechanisms for evaluation, transparency, accountability, and oversight. And once again, we thank the committee for all your hard work on this issue and would respectfully request that you vote to advance the bill out of committee. [LB1160]

SENATOR CAMPBELL: Are there questions for Ms. Helvey? Thank you very much. [LB1160]

SARAH HELVEY: Thank you. [LB1160]

SENATOR CAMPBELL: Our next testifier in support of the bill. Good afternoon. [LB1160]

LINDA COX: (Exhibit 21) Good afternoon. My name is Linda Cox, L-i-n-d-a C-o-x. I'm data coordinator for the Foster Care Review Board. The Foster Care Review Board agrees with the goal of increasing the reliability and usability of the data maintained on the DHHS SACWIS computer system, N-FOCUS. From firsthand experience, we concur that N-FOCUS is difficult to use and does not integrate with other systems. And we found that to make changes or improvements is a slow and expensive process. I'd like to summarize that experience. By law, the Foster Care Review Board is to receive reports from HHS regarding children entering, leaving, or changing status while in out-of-home care as part of our tracking process. We also review data on the N-FOCUS system as part of the review process. Since HHS switched to the N-FOCUS system in '95-96, the FCRB has expressed concerns to HHS officials regarding the amount of untimely, erroneous, and omitted data on the HHS system. We continue to work with Vicki Maca, her staff, and lead agencies on identified data deficits. And we thank them for being responsive when we have provided information on specific instances that need to be addressed. However, it's important to recognize that these issues have affected the time and energy that the FCRB has had to spend to verify data it inputs on its independent tracking system, the data that FCRB provides to you, stakeholders and the public. Our experience with N-FOCUS goes farther than just the reports that we've received and review. In 2003, we learned that the federal Department of Health and Human Services had notified Nebraska that in order for the HHS SACWIS system to be compliant with federal regs, it needed to support the FCRB review function. Federal officials determined that this meant that both HHS and FCRB data had to sit on the N-FOCUS platform. And I've put a chart illustrating kind of how that works on the back page of this testimony. I was the lead for the FCRB in this project. The planning phase took some time due to a number of challenges. It was a challenge to put our independent data on a system we did not control. It was difficult to get HHS to build our data structure to be independent and to be built so that we could retrieve our information. It was difficult giving up the flexibility and functionality of our former system. And it was challenging to move through these issues on a fast pace, which we needed to do since the federal government held the prospect of heavy fines if changes did not occur. In March of 2006, the FCRB's independent data was placed on the N-FOCUS operating system. Immediately thereafter I had to quickly learn to write the complex queries for reports in the unique manner necessary to be able to extract data from N-FOCUS. Thankfully, HHS allowed me access to one of their best analysts during this

process, who was absolutely essential in that learning curve. The experience of both putting data on the N-FOCUS platform and retrieving that data has given me some unique insights into some of the ways that we could make that system more user-friendly and improve responsiveness. And the board again offers to share those insights with HHS. We're asking that this legislation explicitly include the FCRB in the planning process, because any system changes that HHS makes will have an impact on our data system and because we have some important quality control insights to share. Many of the members of this committee have had an opportunity to learn more about the quality control steps that we take to ensure reliable, meaningful data. There were lessons learned along the way that could be valuable to HHS as they work to improve their data system. We ask that the N-FOCUS improvement plan be required to be shared with the FCRB and any other stakeholders that are going to be impacted in terms of fiscal cost or personnel needs before, during, and after the transition. And we ask that HHS be required to acknowledge or address these costs in the plan that it's required to provide to the Legislature. We commend the Legislature for asking for more specific types of information and for expanding oversight of the child welfare system. The FCRB will continue to provide members of the Legislature with as much meaningful, high quality data and analysis as possible as you make decisions regarding Nebraska's abused and neglected children. We offer our assistance to the nationally recognized evaluator called for in this bill. By improving the SACWIS computer system, this bill should improve the data available to you and to the FCRB, and thus prove to be highly beneficial to the children and families we all serve. I'd be happy to answer any questions. [LB1160]

SENATOR CAMPBELL: Questions? I'll take Senator Howard and then Senator Krist. [LB1160]

SENATOR HOWARD: Thank you, Senator Campbell. I remember one of the issues that you were really struggling with was when there is a change of placement, if the change is not recorded by the agency as a move and a new placement for the child, if it's listed as respite care, a respite placement. Have you overcome that problem because I could see where it would be really difficult to know whether it is just a brief respite care or that child's going to be there for awhile. [LB1160]

LINDA COX: That is still one of the issues that we're working our way through. And that remains, I believe, a training issue on the part of the people who are initially inputting that information onto the HHS system. [LB1160]

SENATOR HOWARD: So you think it's more of a training issue than an issue of different definition of placement or... [LB1160]

LINDA COX: I think it's some of both. I think it's also making sure that those who are actually doing the input are understanding what needs to go where and how. [LB1160]

SENATOR HOWARD: And have the same definition of respite as the rest of us? [LB1160]

LINDA COX: Exactly. [LB1160]

SENATOR HOWARD: Okay. Thank you. [LB1160]

SENATOR CAMPBELL: Senator Krist. [LB1160]

SENATOR KRIST: Part of your task is to also forward data to the federal government in regards to our systems. You are monitored in that process. You start a new inspection cycle or oversight cycle, does that start in August, when you expect them to come look at the systems again or am I off? [LB1160]

LINDA COX: Our agency does not directly provide information to Washington. That is an HHS function that they directly do the federal government. We do provide the information that we provide in our annual report to them, but we don't do a direct data transfer to the federal government. [LB1160]

SENATOR KRIST: So your data is going back to DHHS and they're reporting upstream. You have no federal communication requirement in your tasking? [LB1160]

LINDA COX: Right, we don't have a direct link to federal from the FCRB. [LB1160]

SENATOR KRIST: What I was getting at I think was just a question in terms of if this process were put in place and you were a part of the planning process, there's no sense of urgency then in terms of changes that would be made. You could walk through this system as part of the planning process of this system in setting up the process? [LB1160]

LINDA COX: We certainly could assist them in setting up the process and provide some of the lessons that we've learned along the way and some ways of being able to structure it so that you get better quality of the data going in. And then structure it so that you have oversight of the data that's into the system before it ever goes out to any external parties. [LB1160]

SENATOR KRIST: Thank you, Linda. Thanks for coming. [LB1160]

SENATOR CAMPBELL: Any questions? Ms. Cox, I just have a couple of them. I first of all, want to compliment you. I think it's always very helpful to have the chart, and that's...I mean, all of us are looking at that going it's just a very... [LB1160]

SENATOR GLOOR: Wish we would have had it earlier. [LB1160]

SENATOR CAMPBELL: ...simple way to understand this. At this point in time are we SACWIS compliant? [LB1160]

LINDA COX: I am not fully versed on all of the SACWIS compliance requirements. So I don't feel that I'm the person who would be able to answer that. As far as having the FCRB's tracking system onto that same operating system, that part, yes. But there's many, many other things in a SACWIS compliance audit and I'm not fully versed in all of that. [LB1160]

SENATOR CAMPBELL: Okay. And we'll check with the department on that because they would be the ones that would have to be accountable for that compliance. Am I...that right? [LB1160]

LINDA COX: Right. [LB1160]

SENATOR CAMPBELL: And on behalf of all the senators here, I'm sure I know how much of your job entails getting the right data to us and helped enormously during LR37. So a personal thank you to you too. [LB1160]

LINDA COX: You're welcome. [LB1160]

SENATOR CAMPBELL: Thank you for coming today. Other proponents for LB1160. Anyone else? Anyone who is opposed to LB1160? Anyone who wishes to testify in a neutral position? Okay. Actually, Senator Gloor and colleagues, I'm not going to have any further closing on that. I think we're all well aware of LB1160 and what it proposes to do. So with that, we will close the public hearing on LB1160 for the day. And thank you all for coming. [LB1160]