[LB1028 LB1063 LB1083 LB1122 CONFIRMATION]

The Committee on Health and Human Services met at 1:30 p.m. on Thursday, February 9, 2012, in Room 1510 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public hearing on LB1028, LB1063, LB1083, LB1122, and gubernatorial appointments. Senators present: Kathy Campbell, Chairperson; Mike Gloor, Vice Chairperson; Dave Bloomfield; Tanya Cook; Gwen Howard; Bob Krist; and Paul Lambert. Senators absent: None.

SENATOR CAMPBELL: Good afternoon. We will welcome you to the Health and Human Services Committee hearings for this afternoon. I'm Kathy Campbell and I serve District 25, which is east Lincoln and northern Lancaster County. And before we start in to our afternoon's agenda, we'll have the senators introduce themselves. Senator?

SENATOR LAMBERT: Good afternoon. I'm Senator Paul Lambert. I serve District 2, which is portions of Otoe County, portions of Sarpy County, and all of Cass County.

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 Legislative District 13, which is Omaha, northeast Omaha, and Douglas County.

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

MICHELLE CHAFFEE: I'm Michelle Chaffee. I serve as the legal counsel.

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

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

SENATOR CAMPBELL: And with us today are Phoebe and Michael. Phoebe is from Lexington and Michael is from Columbus and they serve as the pages for our committee. And coming through the door is Senator Krist...

SENATOR KRIST: Sorry. (Laughter)

SENATOR CAMPBELL: ...who represents an Omaha district, and we have everyone here. I'm going to go ahead and proceed with our gubernatorial appointment interview, and then we will open with the usual hearings. So, Mr. Jirak? And Lois is right there. Mr. Jirak, you are in good hands because I found out this week that Lois has thrown people out of hearings, so if she is helping you, you are in great hands. She is... [CONFIRMATION]

JAMES JIRAK: Well, I was...I'll be honest, I was kind of nervous the other day and I called down and talked to Diane because this is my second go-around being considered for appointment to the commission board, and the first time I wasn't able to come because of illness and so on. And so I called Diane Tuesday and I said, now what's exactly involved in the process? I said I'm scared to death. She said well, it's a very nice committee, very friendly; they haven't thrown anybody out yet. (Laughter) [CONFIRMATION]

SENATOR CAMPBELL: And we don't intend to start to with you, sir, I'll tell you. [CONFIRMATION]

JAMES JIRAK: Yeah, I hope not. [CONFIRMATION]

SENATOR CAMPBELL: Your appointment is, I believe, for a return appointment to the Commission for the Blind and Visually Impaired. And you have served before? [CONFIRMATION]

JAMES JIRAK: Right. [CONFIRMATION]

SENATOR CAMPBELL: And how long have you been on the commission? [CONFIRMATION]

JAMES JIRAK: Two thousand eight is when my first term kicked in. [CONFIRMATION]

SENATOR CAMPBELL: It might be helpful if you could give us a little background about: your interest in serving on the commission and some of the topics that they are involved with that you feel is important for us to know. [CONFIRMATION]

JAMES JIRAK: (Exhibit 1) The Commission for the Blind is the state rehabilitative agency that serves blind and visually-impaired Nebraskans. What they primarily do is if folks have lost their sight or are in the process of losing their sight and they have concerns about how to adapt to everyday living, the agency has trained staff that will come in and will work with individuals on, i.e., cane travel and Braille skills, cooking skills, how to use computers with adaptive technology to be productive citizens in society. They've been around. They were initially under the Health and Human Services, and back in 2000, they became their own independent separate agency because of LB352. I think that some of the things that are important that Nebraskans need to know is they do good work. Obviously, you know, we have an executive director that's been with the agency since '79 in one role or another. She's got some knowledge and know-how to make things work and overall, they do a good job and it's...I think it's Nebraskans' responsibility to ensure that there's quality of service delivery, not just by that agency but any agency. And that's one of the reasons why I want, you know, to be

considered for a second appointment is because, you know, just to make sure that we have the services people need to function in society. [CONFIRMATION]

SENATOR CAMPBELL: Excellent explanation, thank you. Are there questions from the senators? Senator Gloor. [CONFIRMATION]

SENATOR GLOOR: Thank you, Senator Campbell. Thanks for your service. I'll start with a comment. You're wearing a great looking pair of glasses, but I note that you're wearing a pair of glasses. Does that mean that you are visually impaired as opposed to legally blind or both? [CONFIRMATION]

JAMES JIRAK: Oh, I suppose it's a matter of how you phrase things. Blind, visually impaired, it's a matter of...you know, it's like "potato/potahto." It's all, I suppose, one and the same. A number of years ago...I'll answer your question this way, a number of years ago, I could read, for example, what was e-mailed to me by Diane in this letter with no problem. My vision eventually became worse and I could read it with magnified material. Now, if you...you know, if you give me a piece of paper and say read it, I couldn't do it, not even with magnified material. I have a lot of--not a lot--I have some vision by perception, so on and so forth. The glasses, mainly, are more of a, you know, protective type...I don't want to use the word decoration, but they're more just protective so as to, you know, not have any, you know, debris or what-have-you when I'm outside, flying and poke me in the eye, what-have-you. [CONFIRMATION]

SENATOR GLOOR: Okay, thank you. [CONFIRMATION]

SENATOR CAMPBELL: Other questions or comments that you have? How often, Mr. Jirak, does the commission meet? [CONFIRMATION]

JAMES JIRAK: Quarterly. [CONFIRMATION]

SENATOR CAMPBELL: Quarterly. [CONFIRMATION]

JAMES JIRAK: We meet quarterly. Of course, we had our recent meeting scheduled for last Saturday cancelled, not going to be rescheduled until, you know, our next one, but we do meet quarterly. [CONFIRMATION]

SENATOR CAMPBELL: And do you...do members of the commission visit with citizens in the state? [CONFIRMATION]

JAMES JIRAK: Absolutely. [CONFIRMATION]

SENATOR CAMPBELL: And I'm assuming from past testimony that that's one of the most important duties of the members of the commission. [CONFIRMATION]

JAMES JIRAK: Well, it's good if you're on staff or it's good if you're a commissioner to get public input. You know, it's always nice to know what people are thinking. It's always nice to have people question state government not, you know, just to make sure that they're doing what they're supposed to be doing and when they're not, you know, make sure there are checks and balances in place to...you know, if there's not, then we need to correct it. [CONFIRMATION]

SENATOR CAMPBELL: Exactly. And the number. Do you happen to know the number of members on the commission, sir? [CONFIRMATION]

JAMES JIRAK: You mean staff or commissioners? [CONFIRMATION]

SENATOR CAMPBELL: Commissioners. [CONFIRMATION]

JAMES JIRAK: There's actually five. There's two that are guaranteed by state law. One is the organization I represent, which is the American Council of the Blind. The other one is the National Federation for the Blind, and I understand he'll be here next week for his hearing. And then the other three are basically at-large memberships. They can or don't have to belong to a national blindness consumer group, but there is a provision in state law that three out of the five do need to have some sort of visual impairment. [CONFIRMATION]

SENATOR CAMPBELL: Mr. Jirak, my colleagues all have, I think, a copy of your application and I just want to say you are involved on a lot of boards and that's very impressive that you provide that much service. And I hope my colleagues take a look at the very back page because Mr. Jirak's got a lot of volunteer activities that you are involved with, and also that you were awarded the employee of the month and you work at the Hyatt--am I saying that correct... [CONFIRMATION]

JAMES JIRAK: Right. [CONFIRMATION]

SENATOR CAMPBELL: ...reservation center. [CONFIRMATION]

JAMES JIRAK: Right. [CONFIRMATION]

SENATOR CAMPBELL: So... [CONFIRMATION]

JAMES JIRAK: Twenty-two years. [CONFIRMATION]

SENATOR CAMPBELL: Senator Krist? [CONFIRMATION]

SENATOR KRIST: Thank you. Welcome, and I just have a very quick question for you.

In terms of employment opportunities for the blind, particularly in the greater metropolitan area, do we need help there? Are there enough opportunities? [CONFIRMATION]

JAMES JIRAK: Well, there's always room, I suppose, for, you know, more opportunities. I...the opportunities are there, I think. It's just a matter of looking for them, I think. When I first became gainfully employed back in '89, there...the opportunities weren't there as they are now. Case in point. When Marriott was approached with the concept of having a...someone with a vision impairment, you know, on staff, you know, doing what I do, taking reservations worldwide, Marriott basically told them it wouldn't work and don't waste our time. The state services--now the commission--approached another company in Omaha and they said the same thing. They finally approached Hyatt and Hyatt, you know, being the company that they are, they...there's a lot if you have somebody that, you know, can do the job and thinks you can--come on and we'll give it a shot. And 22 years later, it's still working out. I think, though, that there are opportunities now that there weren't back then because technology is evolving. There's, you know, screen reading material that will, you know, audibilize what's on the screen. There's, you know, programs out there that will enlarge the print and that sort of thing, so it's just a matter of finding the right applicant for the job. [CONFIRMATION]

SENATOR KRIST: Thank you. And I noticed that you're a Web master. That's...that, to me, is amazing, so the technology obviously is helping in that area. [CONFIRMATION]

JAMES JIRAK: I tell anybody if they know Word, they can have a Web page. [CONFIRMATION]

SENATOR KRIST: Thank you so much; thanks for your service. [CONFIRMATION]

JAMES JIRAK: All right, all right. [CONFIRMATION]

SENATOR CAMPBELL: Any other questions or comments? Mr. Jirak, it's been delightful to meet you and thank you very much for taking time to come down and talk to the committee. [CONFIRMATION]

JAMES JIRAK: Okay. [CONFIRMATION]

SENATOR CAMPBELL: The next process will be that the committee will vote to send your nomination to the floor of the full Legislature, and I'm sure that you will be notified. But we are very impressed with the service that you give, so thank you. [CONFIRMATION]

JAMES JIRAK: Okay. All right, thanks. [CONFIRMATION]

SENATOR CAMPBELL: And Lois is here and she will help you. [CONFIRMATION]

JAMES JIRAK: All right. Appreciate it. Thanks. [CONFIRMATION]

SENATOR KRIST: Now she gets to kick you out. [CONFIRMATION]

SENATOR CAMPBELL: Yeah, she does. [CONFIRMATION]

JAMES JIRAK: Not yet, but I'm about ready to get kicked out. (Laughter) Okay, thanks. [CONFIRMATION]

SENATOR CAMPBELL: Thank you for coming. We will go ahead with the afternoon hearings, and before we do, I want to just give my usual reminders for everyone in the audience, and that is please turn off your cell phones or put them on silent. It's very disconcerting to testify and hear a phone ringing in the background. If you will be testifying today, you need to find on either of the tables the bright orange sheets, and please spell your name very legibly. And when you come up, if you have testimony, you do not need to have a handout, but if you do, we'd like 12 copies, and you give the orange sheet and the copies to the clerk. And then as you sit down to testify, we will ask you to state your name for the record and spell it. And I'm sure a number of people have gone, why do I have to do both? Can't you just read what my name is? The form is for the clerk because she enters it into the computer and follows as you give your testimony, but the transcribers need to have you hear your voice, spell your name for their records. And if you do not wish to testify, that's fine. You can leave a notation on the white sheets that are there. We do use the light system, five minutes, and when it gets to yellow, you will be at four, you've used up four minutes, and when you get to red, you'll probably look up, and I'll be going time, time, time. We so appreciate your courtesy in that five minutes, because it helps us get to everybody. And I see that Senator Cook is already up and ready to go, so we'll open the first hearing on LB1028, Senator Cook's bill to require the Department of Health and Human Services to apply for a grant relating to long-term care services. Senator Cook, we're ready when you are. [CONFIRMATION]

SENATOR COOK: Thank you very much, Madam Chair, fellow members of the Health and Human Services Committee. My name is Tanya Cook, and that's spelled C-o-o-k. I'm the State Senator representing Legislative District 13, and I'm here to introduce LB1028, the State Balancing Incentives Payment Program. This is a bill that enhances Nebraska's home- and community-based services for our seniors. The question before the committee with LB1028 is this: Should Nebraska take steps to improve the care of our elderly by seeking to serve more individuals in home- and community-based settings? Should the state apply for a noncompetitive grant to assist seniors in assessing the care that they require? Should we apply for $6 million that will be applied to reforms that the state is already undertaking? LB1028 requires that the Department

of Health and Human Services apply for the Balancing Incentives Payment Program grant. The balancing incentive program will provide Nebraska with approximately $6 million to assist our state in transforming services for our elderly. As I stated, Nebraska is already taking many of the steps required under the program, but the funds under the grant will greatly assist in the efforts already underway. The monies to implement these improvements come in the form of a two-percentage-point increase to Nebraska's federal medical assistance percentage payment. The balancing incentive grant is a noncompetitive grant available to all the states. The balancing incentive program payments will be used to improve seniors' access to home- and community-based services by standardizing assessment of seniors' needs and ensuring that there is no wrong door for a senior seeking assistance. I've been working with Nebraska AARP and the Visiting Nurses Association to identify this opportunity, and you'll hear from each of them about how this legislation will help improve the lives of Nebraska's seniors. AARP will testify to the steps that the state is already taking that can be augmented with these funds. The department has issued a fiscal note, which, in my opinion rarely to be not stated, is in gross disproportion with the analysis of our legislative fiscal note. I don't expect any of you to be surprised particularly by that, but I would like to point out a key assumption that is false that is represented in the agency's note. Their fiscal note assumes that the state would build an entirely new infrastructure of assessment for the seniors, and the whole point of being able to take advantage of it, the whole point of the balancing incentive, is to reform what we're already doing. The funds will augment the work of the area agencies on aging and the Aging and Disability Resource Center. Therefore, while some additional staff may be required, the hugely inflated figures of the department should be disregarded. It's not a particularly burdensome grant. Again, you'll hear more about that. Senators, we're living in an aging state. I'm not aging, but maybe some of you around the table are (laughter), and we even talked about that a little bit this morning on our floor debate about the judgeships. Let's set a policy that is prepared for the demographic shift of our state. We can take advantage of this grant opportunity to build a strong infrastructure for accessing home- and community-based services for our seniors. I appreciate your thoughtful consideration and support of LB1028. [LB1028]

SENATOR CAMPBELL: Questions for Senator Cook? I know that you will be around to close, so please resume. Oh, I'm sorry, did you have a question? [LB1028]

SENATOR GLOOR: Just a short question. Thank you, Senator Campbell. Did you say they're noncompetitive grants? Are they competitive or noncompetitive? [LB1028]

SENATOR COOK: Noncompetitive grants. [LB1028]

SENATOR LAMBERT: Noncompetitive. [LB1028]

SENATOR GLOOR: Thank you. [LB1028]

SENATOR COOK: Thank you. I'm falling asleep. [LB1028]

SENATOR GLOOR: I couldn't hear. [LB1028]

SENATOR COOK: Thank goodness someone was listening, because clearly, I wasn't listening, necessarily, to my own speech. (Laughter). [LB1028]

SENATOR GLOOR: My hearing has aged, so that's my... [LB1028]

SENATOR COOK: See you are... [LB1028]

SENATOR CAMPBELL: It's a good thing we have that little voice from the side, isn't it, that helps us out? Thanks, Senator Cook. [LB1028]

SENATOR COOK: (Laughter) Thank you. So I guess I'll go back there and then come back here later. [LB1028]

SENATOR CAMPBELL: Oh, Senator Howard. [LB1028]

SENATOR COOK: Oh, I'm sorry. [LB1028]

SENATOR HOWARD: Thank you, Senator Campbell. Senator Cook, you mentioned that this fiscal note is inflated. I see there... [LB1028]

SENATOR COOK: Not ours, the administration's fiscal... [LB1028]

SENATOR HOWARD: Well, am I looking at the right one with the administration saying that they'll need 12 to 13 positions... [LB1028]

SENATOR COOK: Okay. [LB1028]

SENATOR HOWARD: ...the first year, and the second year 13 to 14 positions? [LB1028]

SENATOR COOK: I don't agree with that. [LB1028]

SENATOR HOWARD: So this is the department's? [LB1028]

SENATOR COOK: Correct. [LB1028]

SENATOR HOWARD: All right. [LB1028]

SENATOR COOK: The fiscal note that I was talking about was the...the one that I like is

the legislative fiscal note. [LB1028]

SENATOR HOWARD: Well, what I want to ask you, what I'm trying to ask you is where do they get these, all these vacancies or these positions? How would that... [LB1028]

SENATOR COOK: I wish that I could tell you that. Perhaps the department can address that. [LB1028]

SENATOR HOWARD: Oh, I see the department is here. (Laugh). They will shed some light on it. [LB1028]

SENATOR COOK: I saw Director Chaumont's vehicle parked over by the door, so she perhaps can offer to shed some light on that. [LB1028]

SENATOR HOWARD: I see her here in person, so thank you. [LB1028]

SENATOR COOK: Okay. Thank you very much. [LB1028]

SENATOR CAMPBELL: Thank you, Senator Cook. With that, we will proceed to the first proponent for LB1028. Good afternoon. [LB1028]

MARK INTERMILL: (Exhibit 2) Good afternoon. Thank you, Senator Campbell. My name is Mark Intermill, M-a-r-k I-n-t-e-r-m-i-l-l, and I'm here today representing AARP. We support LB1028. I have about 50 AARP members who advise me on issues that we need to become involved with. It's a diverse group. Sometimes we have spirited discussions; but on this issue, there was unanimity that this is something that we should work to support. I have a written statement. I'm not going to read that. I'll probably refer to it a couple of times, but I want to get into some handouts that I provided to you. The first one is a graph that shows the growth in the 80-plus population that we're likely to encounter in Nebraska. I celebrate my 80th birthday on September 5, 2035, so I'm a little bit beyond this chart, but starting about 2027, we're adding about 4,000 80-plus-year-olds per year. By the time I'm 80, we'll probably have about twice as many 80-year-olds-plus as we have today. We need to prepare for that, and the Balancing Incentives Payment Program grant allows us to do that. It gives us some focus in preparation for the future. The second handout that we have is a survey that AARP has done of our members. We have asked them their opinions, their experiences with long-term care services. These are four of the questions that were included in that survey that I think are pertinent to this issue. The first tells us that people aren't very confident about being able to find services that they need. The second one tells us they're even less confident of being able to afford them. And then the third and fourth tell us they really are looking for a place where they can go to get information about services and also somebody to help guide them through the system, to navigate the system. The balancing incentive payment program addresses that navigation process

by looking at things like conflict-free case management and single-entry points or no-wrong-door systems of helping people navigate the systems of long-term care. The next item is a summary of a long-term services and support scorecard that has Nebraska's rankings. We had 25 different dimensions of long-term care that AARP looked at of ranked states accordingly. The ones that are in the pink color are ones that we're not doing so well in. The ones in blue are the ones that we are doing well in. You can see quality of life, quality of care, we do well in Nebraska. And I would point out some of the nursing home resident scores are exceptionally good. The number of nursing home residents with pressure sores or physically restrained, we're at the top of the list. The ones that we don't do well in are choice of setting and provider. Things like looking at the percentage of nursing home residents with low needs, also the percentage of Medicaid long-term service supports users first receiving services in the community, meaning they're going directly to a nursing home. Those are the areas that we need to do some work in. Again, the Balancing Incentives Payment Program will allow us to do that. The next chart that I have is the Medicaid spending for people over the age of 65. This is something that I think has some bearing on this issue because we had, in the late '90s an implementation in the early 2000s, a similar type of process to try to assess the growth and spending in Medicaid in long-term care. And as you'll see on the chart, beginning about 2002, spending for people over 65 flattened out, and we've actually bent the cost curve. We're actually going down, because we have been able to address these issues. I want to just move to...skip the next one, and the fiscal notice is something that I think I would like to spend a little bit of time on. And I've highlighted some of the sections of the note in different colors. And I'm going to start from the bottom, the section that's in blue, which indicated that system changes are estimated at $192,000, that Web-based assessment products and Web site design for community-based, long-term care services would need to be developed. We are actually in process. These things are already in process. And I would mention www.adrc.ne.gov Web site for the Aging and Disability Resource Center that's in process that we are already engaged in. In the yellow section, we have the case management expense. And I've included just a list of...this is from an implementation manual that's been developed by CMS, that lays out what the states have to do in order to qualify for the project. And on page 60, this is obviously not the whole thing, but on page 61 of the handout, it talks about conflict-free case management and what's required there. And what the state has to do is to describe its current system of case management, including conflict-free policies and areas of potential conflict, and that has to be done by December of 2012, and establish a protocol for removing conflicts, and that's by 8-30-2013. It doesn't require the state to provide case management. It just...the idea is that if we have case managers, we want to make sure that they're not directing people to a service that they might have a financial interest in, so that's what we're looking at. So I noticed that my light is on, my red light is on; but those are...we think this is...makes a lot of sense. It's an additional $6 million that the additional FMAP would provide. [LB1028]

SENATOR CAMPBELL: Okay. Questions? Yes, Senator Krist. [LB1028]

SENATOR KRIST: I'm going to ask you a question, but I want you to continue with your assessment on the fiscal note, because I think it's important. What you're telling me, or what you're telling us, is that you don't believe that the fiscal note is as dramatic as it needs to be because we are already accomplishing these things currently? [LB1028]

MARK INTERMILL: In the first case, I think we are. With the Web-based assessment products in the protocols, there is no requirement that we go to a Web-based protocol. And also in the Web site for community long-term-care services, I think we are...really are well on our way to getting there with an aging disability resource center grant that we've already received. With the case management, I don't...as I look at what CMS is requiring, it doesn't match up with what I see on the paper highlighted in yellow. In terms of the additional staff to implement and monitor, I think we absolutely need the additional staff to do this. That's something I think we do need. HHS, in my opinion, is understaffed. They need the support to be able to do some of these things, so I think that in the green is something that is required. The pink one, $80,000 to prepare an application. Where do I sign up? (Laughter). That's...I would say this is probably about a week's worth of work. [LB1028]

SENATOR KRIST: Does AARP have the capability of assisting in this endeavor? [LB1028]

MARK INTERMILL: We absolutely would be happy...AARP nationally has, is working closely with CMS with the technical assistance providers. We have linkages to those organizations, and we would be happy at no charge to provide assistance. [LB1028]

SENATOR KRIST: Thank you. [LB1028]

SENATOR CAMPBELL: Other questions that we have for Mr. Intermill? [LB1028]

SENATOR HOWARD: Senator Campbell. [LB1028]

SENATOR CAMPBELL: Senator Howard. [LB1028]

SENATOR HOWARD: Thank you, Senator Campbell. You shouldn't be so quick. (Laugh) $80,000, and you're not going to charge anything? Kind, very kind. That is just incredible to me. I have to agree with you. When Health and Human Services doing initial intake for people coming in and applying for any kind of benefit and they had case managers available, that was page after page after page of application. I'm sure you've seen them. And at that time, if you would have asked the price tag on what those case managers were doing, I'm sure it would be very, very low, so $80,000 is unimaginable. [LB1028]

MARK INTERMILL: And the...CMS has done a good job of laying out what the grant, what needs to be in the grant. It's fairly straightforward. I've got it back at my seat. It's a pretty simple process. [LB1028]

SENATOR HOWARD: Good. Good. Well, thank you for coming down. [LB1028]

SENATOR CAMPBELL: Mr. Intermill, if you have it with you, have you completed it? (Laughter). [LB1028]

MARK INTERMILL: No, I haven't. (Laugh) [LB1028]

SENATOR CAMPBELL: I just had to ask. [LB1028]

SENATOR HOWARD: Could you give us that Web site once again? I didn't...I wasn't fast enough to get it written down. [LB1028]

MARK INTERMILL: Yes. It is www.adrc.ne.gov. [LB1028]

SENATOR CAMPBELL: Thank you. [LB1028]

SENATOR HOWARD: Thank you. [LB1028]

SENATOR CAMPBELL: Thanks, Mr. Intermill, and for the handouts. [LB1028]

MARK INTERMILL: Thank you. [LB1028]

SENATOR CAMPBELL: Our next proponent for the bill? Welcome. [LB1028]

BETTY CERNECH: (Exhibit 3) Hello. Thank you. My name is Betty Cernech. B-e-t-t-y C-e-r-n-e-c-h. I remembered it today. I didn't spell it yesterday. And I am here representing the Visiting Nurse Association of Omaha in support of LB1028. LB1028 assures that the Department of Health and Human Services apply for a grant under the State Balancing Incentives Payment Program to develop a comprehensive and coordinated system of home- and community-based, long-term services that were described very completely in prior testimony. VNA has been providing community-based services in Omaha for 115 years. Our mission is to deliver community-based care that provides peace of mind, quality of life, and independence. We deliver care wherever people reside. And we have found, and the literature shows, that people want to stay in their homes as long as possible where they are most comfortable surrounded by familiar things and people. The literature tells us that people stay more healthy, are independent, and actually live longer when supported in their home. It also saves money to state systems. Often people come to need supportive services to stay in their

home, so medication management, assistance with bathing and simple food preparation, and changing and washing of bed linens, for example. These are basic needs that are not currently funded, but actually keep people from moving to facility-based care. This program provides a strong financial incentive to stimulate greater access to non-institutionally based long-term services and supports for our state. The structural changes that are required are actually positive components which ensure access statewide and make the application process streamlined along with the standardized assessment that is so important for the elderly. The cost of institutionalized care is exponentially higher than care provided in the home. There are home healthcare providers across the state, like VNA, who have the expertise and experience to provide the kinds of services that would be covered in the home. We believe it would be beneficial to Nebraskans to take advantage of this opportunity. LB1028 is a positive step in the right direction for Nebraska to take a forward-thinking approach to dealing with the looming problems of Nebraska's aging population. With proper planning by the state of Nebraska and working with the many Nebraska home healthcare providers, we can ensure that our citizens can maintain a more cost-effective method for keeping this population safe and well as long as possible in their homes. [LB1028]

SENATOR CAMPBELL: Thank you, Ms. Cernech. Are there questions? Senator Krist. [LB1028]

SENATOR KRIST: Part of the fiscal note on the legislative side, and I'll just read you the last line, net impact of this bill is not known since more information is needed on any shifts from institutional care to home- and community-based care. That, to me, is a sentence that says that we don't know how much we actually would shift out of a high-priced care mode into a lower-priced care mode. Do you concur with that? [LB1028]

BETTY CERNECH: Well, you know, one of the things we know is that when folks have to leave home-based services and move into either assisted living or skilled care, the cost starts from $67,000 to $75,000 a year. We do know that depending on the kind of support that people need in their homes, we can do it less than that, but it would depend on what the services were required to keep them in their home. [LB1028]

SENATOR KRIST: So you concur. [LB1028]

BETTY CERNECH: Um-hum. [LB1028]

SENATOR KRIST: Thank you. [LB1028]

SENATOR CAMPBELL: Any other questions? Thank you for coming today and for your testimony. [LB1028]

BETTY CERNECH: Thank you. [LB1028]

SENATOR CAMPBELL: Our next proponent. Anyone else who wishes to testify in favor? Okay. Those who are opposed to LB1028. Those who are in a neutral position. [LB1028]

VIVIANNE CHAUMONT: Hold the chair. I'm slow. [LB1028]

SENATOR CAMPBELL: Oh, okay. I need to make sure you're in the right column. [LB1028]

VIVIANNE CHAUMONT: (Laugh) Yes, please. [LB1028]

SENATOR CAMPBELL: Good afternoon, Director. How are you? [LB1028]

VIVIANNE CHAUMONT: (Exhibit 4) Well, I'm good, and I've got my fiscal note right here in case anyone has any questions. [LB1028]

SENATOR LAMBERT: All right. [LB1028]

VIVIANNE CHAUMONT: (Laugh). 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. I'm the director of the Division of Medicaid and Long-Term Care with the Nebraska Department of Health and Human Services. I'm here to testify in opposition of LB1028. LB1028 directs the department to apply for a federal grant under the Balancing Incentives Payment Program, also called BIPP, by September 1, 2012. BIPP would require Nebraska Medicaid to make substantial changes in three areas. First, we must implement a single-entry point for Medicaid clients wanting to access community-based long-term services and create a new standardized assessment to determine if the client qualifies for the service requested. In addition, we would need to provide conflict-free case management to all clients who are approved for community-based long-term services. In return for making these structural changes to the program, Medicaid would be eligible for an additional 2 percent match for certain long-term services and supports. Our estimates are that this would result in an additional $5.9 million in federal funds. The enhanced match would be available through September 2015. Although this sounds good, BIPP actually results in a Medicaid expansion and is projected to increase expenditures by nearly $42 million through fiscal year 2014. First, the enhanced match must be spent to add new services or to increase existing services. It cannot be used to reduce Nebraska's cost of existing services. Second, it is CMS's expectation that the additional services and the structural changes continue after the increased match is no longer available. Third, the enhanced match cannot be used to pay for any of the state's administrative expenses in

implementing the program and cannot be used to pay for the costs associated with the required case management, the single-entry point, or the assessment. Nebraska's Medicaid program already offers a robust set of community-based, long-term care services through the state plan and through home- and community-based waivers. Based on that, Nebraska has the services available to reduce nursing home placements. What would be more useful to Nebraska are programs that manage clients who are in need of long-term services by managing their total health in order to keep them heathier longer in the community. We have evaluated the BIPP grant and do not believe this is the most cost-effective tool to accomplish those goals. Thank you for the opportunity to testify. I would be happy to answer any questions, and I would be happy to walk through my fiscal note. [LB1028]

SENATOR KRIST: Sure. [LB1028]

SENATOR CAMPBELL: Senator Krist. [LB1028]

SENATOR KRIST: Absolutely. The unevaluated part of this whole thing is that last line in there, the shift from what is an inevitable institutional care program or community-based, keeping people at home on the front side. I don't see that either implied or on...I don't see it calculated in yours. What...is there an advantage, obvious? [LB1028]

VIVIANNE CHAUMONT: Um, we are firm believers in the...in community care, in care in the community. I think that is one of the few areas where we think it's a win-win. Clients like it and it saves money. So absolutely, we believe that community care is saving money. There is no way to gauge how much...how much savings we would have if we implemented this at these costs, so we can't, you know, we can't put a number on that. [LB1028]

SENATOR KRIST: Okay. And the price tag we see on this side, how would you evaluate philosophically how one analyst comes to this point and one analyst comes to this point? [LB1028]

VIVIANNE CHAUMONT: I don't think that Ms. Hruska's fiscal note is that different from ours. [LB1028]

SENATOR KRIST: And how do you mean that? [LB1028]

VIVIANNE CHAUMONT: Well, she says right there that we've identified costs totaling $5.8 million and $11 million. Those are the costs that are basically in the third paragraph about case management and the other and the administrative-type costs that we're talking about. The rest of the fiscal note has to do with having to the...I think, to increase the services. So she doesn't say that the net impact, you know...I think that the costs

that we identify are pretty much the same, $5.9 million in enhanced and then the administrative costs. They are the same. [LB1028]

SENATOR KRIST: So paragraph three and four of her fiscal note should, if I get a calculator out, match your expenditure and line items on... [LB1028]

VIVIANNE CHAUMONT: The paragraph four, yeah, where she cites the agency's fiscal note. She's not arguing with it. [LB1028]

SENATOR KRIST: Enhanced match does not apply to the structural changes, and the grants are available through September of 2015. So what you're saying is that at some point, the escalation of the match or the match is going to end, and we're going to end up with the services on the backside. [LB1028]

VIVIANNE CHAUMONT: That's exactly right, sir. I mean, we can add $5.9 million in services. The $5.9 million can't be used to offset our current costs or any of these additional costs. You have to add $5.9 million worth of services, and the $5.9 million goes away September of 2015. [LB1028]

SENATOR KRIST: Okay, so follow me through this for just a second and tell me where my logic is flawed. [LB1028]

VIVIANNE CHAUMONT: Okay. [LB1028]

SENATOR KRIST: If I have three years to try to bring down 60 to 70 percent of the institutional care and/or out-of-home care, let's just call it, if I reach...if I try to...let's just use 50 percent. [LB1028]

VIVIANNE CHAUMONT: Um-hum. [LB1028]

SENATOR KRIST: If we try to reduce our out-of-home placement by 50 percent and keep them in, at the end of the day, with the figures that you've shared with us and that I think I've seen where we're talking about roughly half the money, it costs us about 50 percent more to put somebody in an out-of-home placement roughly. Aren't we preparing or won't we see that advantage when we reduce the out-of-home care and we have that period of time in order to do that? [LB1028]

VIVIANNE CHAUMONT: If, capital "I", capital "If", if in fact the out-of-home placements decrease by some amount, that will be a savings in the budget. But what we are talking about here is adding. For the waiver, we already have care management. What we're talking about here is adding the care management to clients who don't currently get care management. So those are clients that are already in the community, already receiving home health, already receiving PAS services. They're already not in an institution. So

where are the additional savings that we're going to be getting? [LB1028]

SENATOR KRIST: That goes to...and I don't mean to interrupt, but if I follow this logic through, that goes to...I'm not using a prop (laugh), but that goes to the increase of the aging community that we're talking about that AARP...and you can take this one for your use if you'd like to. [LB1028]

VIVIANNE CHAUMONT: No. I'm pretty...I think I...I think we can argue on the fact (laugh) that people are getting older, except us, Senator Cook. [LB1028]

SENATOR KRIST: Yeah, okay. So I...except you and Senator Cook, so the point being that if I see an increase in the number of people who are aging who are going to need this care, and I have a period of time that I can try to capture those and put them in that lower cost area, that that's what the fiscal notes...that's what this fiscal note highlights as potential savings, I think. I don't think we're talking about trying to capture. I understand your point. You're saying we're going to spend money on people we're not spending money on right now. But the edge that I see is that we're preparing ourself for a point where that aging community is going to be up here. [LB1028]

VIVIANNE CHAUMONT: I would agree with that, Senator, in some states. Nebraska...for instance, there are states, I don't know where they are now, but let's say three, four years ago, there were states, I can think of one back east with a lot of Super Bowl rings, that they were about 80-90 percent nursing home and about 10 percent in the community. So you do a program like this, you really shift that curve. They didn't have the services to keep people in the community. We luckily are not in that. We have services that other folks don't have. We have a very vital home- and community-based services program. We have a very strong home health program as we talked about, you know, through the budget cuts thing. We have stronger, you know, private-duty nursing programs than some people. Mostly, the home- and community-based services programs. We have personal assistant services as a state plan services that a lot of states don't have at all. So we are in a very different...you know, I think in some states, this would really help to shift to community care as opposed to nursing home care, a shift that everybody wants. I don't think that we are in that kind of a situation, and I just...I like the idea, trust me. If there's things that save money as painless as keeping people in the community might be, I'm all for that. I just don't see that this bill, that this grant does that. [LB1028]

SENATOR KRIST: Okay. Thank you. [LB1028]

SENATOR CAMPBELL: Senator Howard. [LB1028]

SENATOR HOWARD: Well, I'm trying to process this and you know, project ahead to both the aging population and then the resources. It occurs to me, if I can kind of boil it

down, what you're saying is it's cheaper for us to continue the way we are than to shift and then risk losing funding in just a few years for this program. Is that sort of on the trail here? [LB1028]

VIVIANNE CHAUMONT: No, I...no, no, and yes. Okay (Laugh). [LB1028]

SENATOR HOWARD: Okay, tell me what...(laugh). [LB1028]

VIVIANNE CHAUMONT: I think that there are things that we could do with our long-term care programs that would be really helpful. I think that we...well, you know one thing is at-risk managed care for the long-term care services. In states like Arizona, that has shifted the...you know, they have reduced nursing home placements by quite a large percentage. That saves money. I think that that's something that we should definitely explore. I think programs...that if we move along those lines, I think programs that CMS is starting to be interested in and helping, they call it their office of innovations, and you'll all be happy to know that the innovation is that Medicare should talk to Medicaid. After 45 years, that's the innovation. [LB1028]

SENATOR HOWARD: (Laugh). More silos. [LB1028]

VIVIANNE CHAUMONT: You know, we were very excited, but you know what? Those are good programs. A lot of our clients are dual eligibles. They're eligible for Medicare and Medicaid, and the incentives within each system are totally different. So when you bring those together and you talk about cost share...can't talk...that's a first. (Laugh). I know what you were thinking. (Laughter). When we're talking about sharing savings between the Medicare program and the Medicaid program, because Medicaid can do a lot of things that ends up saving Medicare a lot of dough that we don't get back at all. We get the expense, but not the savings. Those are the kinds of things. The PACE program, that's a kind of thing that we should be doing. I just don't see this...I'd like to see, I don't see this as the answer. This doesn't even set up an appropriate single-entry point. I think that we should have...that we should seriously look at an actual single-entry point to get to long-term care services. This doesn't really set that up that way. So I think it's a lot of expense. You know, it sounds like a good idea, but when you start really looking at implementing it and applying it, I just don't think it's where we need to be. [LB1028]

SENATOR HOWARD: Let me follow up with...there's a part two. Just yesterday, someone, and I wish I could remember which Senator it was, came to me and said that the nursing home facility in his community had given the notice they're going to be closing, because with the cuts that are coming down, they can't stay in business. Are we looking at losing more of those...aside from people obviously should stay and want to stay in their own homes; but for people that are, that's not really an option, are we going to be losing more of these facilities due to the cuts, and when you factor that in, does

this put a better light on this? [LB1028]

VIVIANNE CHAUMONT: Well, no, and I've testified (laugh) in this committee before to the horror of pretty much all of you that we're over-bedded in the state of Nebraska. We have more nursing home beds, I've said that before. We have way more nursing home beds than, in fact, we need. And actually, having a bunch of little homes that are, you know, 40 percent full, costs the Medicaid program a lot more money than having more full homes. So, no, I don't see that. [LB1028]

SENATOR HOWARD: Thank you. [LB1028]

SENATOR CAMPBELL: Senator Cook. [LB1028]

SENATOR COOK: Thank you, Madam Chair, and thank you, Director Chaumont. I have a question from the fourth paragraph of your fiscal note. To clarify some of your testimony, I thought I understood you to say that your estimate was based on some of the same people that are currently receiving state services being able to be served through this plan. But how I'm understanding the--one, two--third sentence in that paragraph, it is estimated that to provide ongoing conflict-free case management for clients not currently receiving this service, but who would be eligible for it under BIPP requirements. And then I think I...I'm not a gambling woman, but I think I'm going to have to play the number $42 million, because it's like my second bill that costs (laugh) exactly $42 million. Would you answer that question? [LB1028]

VIVIANNE CHAUMONT: We put $42 million on everything just as a matter of course. There. (Laugh). [LB1028]

SENATOR COOK: Okay. It is like Senator Cook, and then you threw a dart and it landed at the $42 million one. [LB1028]

VIVIANNE CHAUMONT: No. Let me. [LB1028]

SENATOR COOK: Did I misunderstand you with that third sentence? [LB1028]

VIVIANNE CHAUMONT: Yeah. Let me explain that again. Okay. What BIPP requires is that folks receiving community services get case management, okay? So we have to provide, in order to qualify for this grant, we have to provide these people with case management. Home and community-based services clients already get case management. They are not in this fiscal note. What are the other community services that BIPP requires us to provide case management for? Home health. We do not provide case management for home health except if they are in a managed care company which obviously provides care management for all of their services. So in order to qualify for this grant, we have to start providing the, however many it says

there, people that the...I see 7,768 clients were receiving personal assistance services. The clients receiving home health, we have to now start providing...yes, they're getting home health. Yes, they're getting PAS, but no, they are not getting case management, which they have to get, the state has to say they're going to get, in order to qualify for the grant. And that addition of providing them case management at the AAA rate of $193 per month is the fiscal note. That's what AAAs get, and that's what the other folks that do HCBS and things do for care management, the League of Human Dignity, the Independent Living Centers. So that service isn't free, and it's required under the grant. [LB1028]

SENATOR COOK: Okay, and it has to be a brand new human being, not somebody who's already doing case management? [LB1028]

VIVIANNE CHAUMONT: We reimburse per person. We pay the AAA, for instance, $193 per month per client. So you're going to bring in 10,000 new people, you're going to pay the AAAs or the League of Human Dignity or the ILC $193 per month for each and every single one of those people. That's what this grant requires. [LB1028]

SENATOR COOK: Thank you. [LB1028]

SENATOR CAMPBELL: Other questions? [LB1028]

VIVIANNE CHAUMONT: Can I just say one tiny little thing? [LB1028]

SENATOR CAMPBELL: Oh, sure. [LB1028]

VIVIANNE CHAUMONT: Just as we were walking through, the $192,000 is for N-FOCUS changes, so. [LB1028]

SENATOR CAMPBELL: I'm sorry, is what? [LB1028]

VIVIANNE CHAUMONT: N-FOCUS changes. [LB1028]

SENATOR CAMPBELL: N-FOCUS changes. [LB1028]

VIVIAN CHAUMONT: So those are the systems that we deal with. [LB1028]

SENATOR CAMPBELL: And, Director, do we have people who are currently in our community-based programs that request a case management service? [LB1028]

VIVIANNE CHAUMONT: Home and community-based services waiver clients, that is part of the package. [LB1028]

SENATOR CAMPBELL: Okay, so they get that. [LB1028]

VIVIANNE CHAUMONT: So I don't know if we get requests from anybody else. [LB1028]

SENATOR CAMPBELL: How many people would that be who don't have any case management? Do we know that number in community based...? [LB1028]

VIVIANNE CHAUMONT: That get what? [LB1028]

SENATOR CAMPBELL: That get community-based services that are not in the waiver. [LB1028]

VIVIANNE CHAUMONT: Yeah. I think this is some of the numbers here that we were talking about. [LB1028]

SENATOR CAMPBELL: Is the number there? [LB1028]

VIVIANNE CHAUMONT: And I don't know. I can't see it. [LB1028]

SENATOR CAMPBELL: That's okay. We can double-check that. [LB1028]

VIVIANNE CHAUMONT: Right, 7,768 who received PAS services, home health, private duty nursing, who weren't enrolled in the HCBS waiver, they would now get... [LB1028]

SENATOR CAMPBELL: They would now get it. Okay. [LB1028]

VIVIANNE CHAUMONT: ...case management. [LB1028]

SENATOR CAMPBELL: Okay. So one of the programs that you talked about that I have to say I know you really like and that I really like is the PACE program... [LB1028]

VIVIANNE CHAUMONT: Yes. [LB1028]

SENATOR CAMPBELL: ...which would we be better off to make a greater investment in PACE? [LB1028]

VIVIANNE CHAUMONT: PACE, we are working to get PACE. I really do like the PACE program. But the problem with the PACE program is...that is the one currently existing program where Medicare and Medicaid come together to provide overall care for a client. And you have to have a provider willing to do that. We are working with Alegent? Immanuel? I can never remember which one. [LB1028]

SENATOR LAMBERT: Immanuel. [LB1028]

SENATOR COOK: Well, it's Alegent Immanuel. It's part of... [LB1028]

VIVIANNE CHAUMONT: One is part of, yeah, yeah. [LB1028]

SENATOR LAMBERT: Yeah. That's in Council Bluffs now. Yeah. [LB1028]

VIVIANNE CHAUMONT: Yes, and they are doing the PACE program in Council Bluffs, and then they're going to...getting that approved, it is a horrendous encounter with CMS, very, very difficult. And then, it's just time consuming. I won't say it's difficult, but...and so then they are...we are scheduled to have them go...and we hope to be live in the Omaha area in a year, 18 months. And then, they have talked about...they have talked about then expanding, once they get going, expanding to Lincoln. And now there's other programs called...part of the problem with PACE, it's a very capital-intensive program, because you have to have, you know, just the way they do it with clinics and adult day care and all kinds of things in a facility. For rural communities, that doesn't work, and so there is sort of a developing PACE without walls, it's called, so that it works in the rural communities, and that...once we get this going, that would then be another thing to explore. [LB1028]

SENATOR CAMPBELL: Senator Lambert was kind enough, you visited one of the PACE centers? [LB1028]

SENATOR LAMBERT: Yes. Very impressed with the one in Council Bluffs, outstanding. I understand what you say about rural areas, but they run buses out. And I was impressed, because even the bus drivers are trained to you know, well, Mary was slurring her words today or it took her longer to get her coat on. [LB1028]

VIVIANNE CHAUMONT: Yes. [LB1028]

SENATOR LAMBERT: I mean, it's a full-fledged team effort and I was very impressed with it. [LB1028]

VIVIANNE CHAUMONT: Yeah. It really is an overall care in every aspect... [LB1028]

SENATOR LAMBERT: Yeah. [LB1028]

VIVIANNE CHAUMONT: ...behavioral health, drugs, institutional care, everything for a client. I'm glad you were impressed. I haven't seen the Council Bluffs one. I would like to go out... [LB1028]

SENATOR LAMBERT: Yeah. And they had that day, I think there were four or five

patients in there with Alzheimer's just to give the caregivers some time off. And you know, they may come one day a week, three days a week, and it's just a co-combined thing and was very, very impressive. And I think what they're looking at one place in Omaha and another in the metro area, and then come this way. [LB1028]

VIVIANNE CHAUMONT: Yep. Yep. [LB1028]

SENATOR CAMPBELL: That's why I bring it up every chance I get. [LB1028]

SENATOR LAMBERT: Yeah. [LB1028]

VIVIANNE CHAUMONT: (Laugh) I appreciate that. [LB1028]

SENATOR CAMPBELL: Because I really like the program. [LB1028]

VIVIANNE CHAUMONT: Yeah. Uh-hum. [LB1028]

SENATOR CAMPBELL: And I think that it's the program for the future for a lot of our citizens. [LB1028]

SENATOR LAMBERT: Well, and...oh, excuse me. [LB1028]

SENATOR CAMPBELL: No, finish out, Senator. [LB1028]

SENATOR LAMBERT: It keeps the people at home that want to be home. You know, provide so much that they aren't in a nursing home. They can be where they want to be. The quality of life, it appears to me, is much greater. [LB1028]

VIVIANNE CHAUMONT: And it is like a managed-care contract like, you know, we talked about. That company is at risk. They get a per member per month from Medicare. They get a per member per month from Medicaid. And they are at risk, so if the person gets, you know, has poor health and has to go in the hospital, that company's at risk. If they can't stay in the community anymore and they have to go to the nursing home, that company's at risk, so they have every incentive to keep people healthy, happy, and at home. [LB1028]

SENATOR CAMPBELL: Senator Gloor. [LB1028]

SENATOR GLOOR: Just curious. Your experience with PACE comes from Colorado, your experiences. [LB1028]

VIVIANNE CHAUMONT: Yeah. Huge, huge PACE program in Denver. [LB1028]

SENATOR GLOOR: Yeah. I'm well aware of it. [LB1028]

VIVIANNE CHAUMONT: And the little buses all over the place. (Laugh). [LB1028]

SENATOR CAMPBELL: Senator Howard. [LB1028]

SENATOR HOWARD: Thank you. Thank you, Senator Campbell. Just an inquiry. Can this program be put...can it be utilized in community...senior facilities that are already operating? I'm thinking of the Heartland Family Services as a senior center, and it's very personal. I mean, a lot of the things that you're describing, they know everybody personally. And I'm just wondering how that would work. [LB1028]

VIVIANNE CHAUMONT: You know, I haven't brushed up on my...exactly how PACE works in a long time. They do contract with various... [LB1028]

SENATOR HOWARD: Existing. [LB1028]

VIVIANNE CHAUMONT: ...existing providers, but I don't know that. I don't want to say, because I don't remember for sure. [LB1028]

SENATOR CAMPBELL: Any other questions for the director today? Thank you for your testimony. [LB1028]

VIVIANNE CHAUMONT: Thank you. [LB1028]

SENATOR CAMPBELL: (Exhibit 5) Anyone else in the hearing room who wishes to testify in a neutral position? Seeing none, Senator Cook, would you like to close on LB1028? And while she's making her way there, we received a letter of support for LB1028 from the Nebraska Hospital Association. Senator Cook. [LB1028]

SENATOR COOK: Thank you, fellow committee members. And I agree PACE is a great program. There's going to be one coming up in Legislative District 13, very excited about that. This, however, is a hearing about a program through the federal government that I'm hoping that we will be able to take advantage of. Certainly not to...we could go back and forth on where the numbers came from and the assumptions that go into the...that calculus. What I wanted to reinforce are some kind of essential...an essential philosophical reason why I think this is a good approach or a good idea for us to consider. First of all, I think that we as policymakers, and we as people in general, should make action in the direction of a longer term approach to all of the state's challenges. We are attempting to do that with child welfare, even in an emergency situation, in my case. So most certainly as you age, the people around the table are very thoughtful, you've been very active in your communities your entire life. You're going to want to continue to do that to the degree that you can determine on your own

terms in your own homes. So I'm hoping that as we set policy it doesn't continually fall back on long-term care or family care giving, that we set policies that drive in the direction of keeping people in their own homes. And secondly, I...when we talk about the ongoing conflict-free case management for clients, of course, each of us would love one of those for whatever issue we are undertaking as a citizen or resident with the state. In my opinion, many of the people who are doing casework, not that they're not overworked, could probably take additional cases, be assigned to work additional cases that are things that are already going on. So with that, I would ask that you consider it, and there are some questions that have emerged, and we'll get you some follow-up information on those differences. Maybe a nice colored graphic of a side-by-side comparison of the fiscal notes for Senator Cook, the $42 million woman. Thank you. [LB1028]

SENATOR CAMPBELL: Thank you, Senator Cook, and we will close the hearing on LB1028 and proceed to LB1063, Senator Cook's bill to adopt the Children's Health and Treatment Act. And Senator Cook is in the right spot, so whenever she's ready, we'll start. [LB1028]

SENATOR COOK: Seat's already warm. That's my audience... [LB1063]

SENATOR CAMPBELL: I know. They're very quiet today. They're good. [LB1063]

SENATOR COOK: ...going out to the lobby. (Exhibit 6) Thank you again, Senator Campbell and fellow committee members. I am Tanya Cook, spelled C-o-o-k. I am the state senator representing Legislative District 13, and I appear before you as the introducer of LB1063, the Children's Health and Treatment Act. Nebraska, in short, is shirking a major responsibility to our low-income children by denying the behavioral health treatment prescribed by their doctors. Federal law is very clear that if a state participates in the Medicaid program, they must provide medically necessary treatment to children eligible for Medicaid. The requirement for a state to provide medically necessary treatment is shown through the plain meaning of the federal Medicaid Act. The requirement for a state to provide medically necessary treatment is shown through federal court of appeals cases where parents challenge a state's denial of care, care which would correct or ameliorate a condition prescribed by a physician. The LR37 study made all of us, including our constituents, made it clear that there are major problems with the delivery of behavioral health treatment to Nebraska's most vulnerable children. The members of this committee who participated in the LR37 process heard from across the state that Medicaid is denying needed and prescribed behavioral health treatment. Too often, Medicaid-eligible children are denied behavioral health treatment by the state. As a result, parents are placed in the untenable position of making their children wards of the state in order to get the treatment prescribed by that child's physician. In the LR37 report, it was noted that 25 percent of our children in foster care are there because of their own behavior, not because they were abused or neglected.

Given this fact, it should be no surprise that lead contract agencies are having trouble meeting the needs of the contract and meeting their expenses. The state is quite simply shifting the cost to providing this care from the Medicaid budget to the child welfare budget. With the passage of LB1063, Nebraska will provide the prescribed care before another crisis occurs. If we're serious about lowering the numbers of our children in the child welfare system, this is a solution. Passage of LB1063 will go a long way to prevent crisis and will provide the care that our children need. Not only is defining medical necessity the right thing to do for Nebraska's Medicaid-eligible children and a much needed part of child welfare reform, LB1063 will ensure that Nebraska is in compliance with the requirements for states participating in the Medicaid program. Let me address the fiscal note for a minute and offer an amendment. Can the pages help me out? You can all look at it at the same time, being careful to keep one for myself. Thank you, Phoebe. Let me address the fiscal note for a minute and offer an amendment to alleviate the impact noted in the fiscal analysis. The introduced legislation included children up to age 21. For those benefits, that was an inadvertent expansion, and the amendment takes it to our current ages, up to that 19th birthday that we've been using. This will prevent this being viewed as an expansion and alleviate the fiscal impact that you see. The testifiers to follow will outline further the needs for these reforms. They will share with you the mechanics of implementing the policy. James Goddard with Nebraska Appleseed will testify following the opening statement to detail the complexities of the legislation and to clarify our legal requirement to provide care under this federal standard. In addition to that, we will hear from some advocacy groups and parents, so with that, I appreciate your careful consideration of LB1063. Thank you. [LB1063]

SENATOR CAMPBELL: Questions? Senator Howard and then Senator Krist. [LB1063]

SENATOR HOWARD: Thank you, Senator Campbell. I'm not sure I heard you correctly. Did you say 25 percent of children who are state wards are... [LB1063]

SENATOR COOK: That is the number that we are... [LB1063]

SENATOR HOWARD: ...in the system due to no fault of the parent, not due to neglect or abuse? [LB1063]

SENATOR COOK: I'll read you the exact words, and that is how maybe your knowledge of the system would interpret that differently, but from our analysis of that...of the report, it is noted that 25 percent or one-fourth of the children who are in foster care are there because of their behavior as opposed to maybe the perception of the greater world that there would be neglect or abuse on the part of their family member or their caregiver. [LB1063]

SENATOR HOWARD: So these are children with a court filing, they're state wards.

[LB1063]

SENATOR COOK: Well, you're talking about where the number... [LB1063]

SENATOR HOWARD: I'm asking you. Are these...that's how you're defining this? [LB1063]

SENATOR COOK: These are children that are...that we have in the system, because they're foster care children, so 25 percent of them according to the LR37... [LB1063]

SENATOR HOWARD: Are filed under what category? [LB1063]

SENATOR COOK: I don't have the report in front of me, and I don't have all of the categories memorized. (Laugh). [LB1063]

SENATOR HOWARD: Okay. So I think what you're talking about are dependency filings. [LB1063]

SENATOR COOK: Okay, well... [LB1063]

SENATOR HOWARD: That's a no fault for the parents. Are we on the same wavelength here with that? [LB1063]

SENATOR COOK: Okay. All right. I think you're very much more familiar with the language of the courts and the language of the system and the language of the...what they're called in the reports, and I guess I... [LB1063]

SENATOR HOWARD: Well, is the intent here that children will receive services without being made state wards? [LB1063]

SENATOR COOK: Yes. That's what the testimony goes on to say that. [LB1063]

SENATOR HOWARD: Okay. [LB1063]

SENATOR CAMPBELL: Senator Krist, was that your point? [LB1063]

SENATOR KRIST: I'm going to make it a little...I hope I will make it clearer. The first point of this is that we, the state of Nebraska, give to an independent contractor the definition that they use to qualify a person for treatment. That definition is what you're changing here in terms of medical, the medical definition, urgency, or medical necessity determination. [LB1063]

SENATOR COOK: Medically, yeah, medically necessary or a medical necessity.

[LB1063]

SENATOR KRIST: Okay, and we have talked in LR37 and in the committee that that definition needs to change, because children can be, if the definition fits...then they can be assisted through the Medicaid program, which you and I both agree on. It's a wonderful bill. To the point,... [LB1063]

SENATOR COOK: Thank you. [LB1063]

SENATOR KRIST: ...we are trying to do everything we can with other bills to make sure that kids do not become wards of the state, and this goes back to an original conversation and conclusion that we were drawn in. They cannot receive treatment unless they are made wards of the state, because of the definition. That would follow that if we change the definition and we qualify them to be treated and keep them out of being wards of the state, we are saving money. There is no question about it overall, and you said it very well. [LB1063]

SENATOR COOK: Right, that and just...thank you. And the idea that we, even though we are bound to serve these children and families, would ask that of parents in order that...I think of, I guess, the biblical story of King Solomon. The two mothers show up, it's my baby, no it's my baby. This is obviously the new version of the Bible, and how the king was wise enough to know that the real mother is going to say absolutely, because he was going to cut it in half. Putting in our parents in a position where they have to make their child a ward of the state... [LB1063]

SENATOR KRIST: Absolutely. [LB1063]

SENATOR COOK: ...when they would never have brought the child into the world to abandon it in any way, even on paper. [LB1063]

SENATOR KRIST: Thank you. [LB1063]

SENATOR CAMPBELL: Senator Howard. [LB1063]

SENATOR HOWARD: Thank you, Senator Campbell. A follow-up question. When, say that we enact this bill and the children do not have to be made wards of the state in order to access services that they need, would the...we like to call them the gatekeeper in Health and Human Services, Magellan be a player in this? Would the families have to go through the Magellan portal in order to receive services? [LB1063]

SENATOR COOK: My assumption, not really. [LB1063]

SENATOR HOWARD: So it would be a decision between the family and the doctor that

recommends the services? [LB1063]

SENATOR COOK: It's my understanding that the family, the state would pay for the services that they are eligible for but not having it being shift to Medicaid. They would not have to give up their... [LB1063]

SENATOR HOWARD: Custody. [LB1063]

SENATOR COOK: ...custody of the child. So however the state pays for that, whether it's Magellan, or maybe another contractor comes along, or maybe through some miracle the state does it in a different fashion. [LB1063]

SENATOR HOWARD: But there would be a managed care piece in this. [LB1063]

SENATOR KRIST: Magellan. [LB1063]

SENATOR COOK: Yes. [LB1063]

SENATOR CAMPBELL: I think there...perhaps we wait and hear all the testimony and then come back to this issue. [LB1063]

SENATOR COOK: Right. [LB1063]

SENATOR CAMPBELL: Because I'm hoping that some of the testifiers will get to some of the questions... [LB1063]

SENATOR COOK: As am I. [LB1063]

SENATOR CAMPBELL: ...or puzzled looks (laugh) on people's faces. If that's okay, Senator Cook, and then we come back... [LB1063]

SENATOR COOK: Oh, it's fine. I can understand that. [LB1063]

SENATOR CAMPBELL: Did you have anything else you wanted to add before we go to testimony? [LB1063]

SENATOR COOK: No, I did not. [LB1063]

SENATOR CAMPBELL: Okay. All right. [LB1063]

SENATOR COOK: I think Appleseed is going to come up next and address some of those questions. [LB1063]

SENATOR CAMPBELL: Okay. Thanks, Senator Cook. [LB1063]

SENATOR COOK: Thanks. [LB1063]

SENATOR CAMPBELL: We will now take the proponent testimony for LB1063. Welcome, good to see you. [LB1063]

JAMES GODDARD: (Exhibit 7) Thank you. Good afternoon. My name is James Goddard, that's G-o-d-d-a-r-d. I'm an attorney at the Nebraska Appleseed Center for Law in the Public Interest. I'm here today to testify in support of LB1063. As this committee is well aware, the child welfare system is in great need of reform, and a vital component of effective reform is preventing children from entering the system unnecessarily. LB1063 addresses gaps in Medicaid services for children, gaps that needlessly force children into the child welfare system to get the mental health services they need. This bill ensures Medicaid plays its vital role in providing services, preventing the breakup of families. I first just want to emphasize that this bill draws together a number of pieces of federal law current obligations. It pulls from statutes, from regulations, and from case law. It's meant to be consistent with federal law, not to create new obligations that don't already exist. But nevertheless, the bill is still important for three reasons at least. One, we're not currently following the federal rules. That's obviously a problem. Also, current department policies and regulations are contrary to federal law. And, third, this will clarify our obligations, prevent harm to children, and avoid liability for the state. With that, I'd like to give just a little bit of background. EPSDT is a special component of the Medicaid program, and it's special and intended to provide preventative screening, diagnosis, and treatment for children's physical and mental health conditions. It mandates that every single type of coverage or medical assistance category allow, that's 29 categories, a child can access if they need it. Importantly, states must provide all treatments necessary to correct or ameliorate a child's physical or mental health condition. LB1063 affirms that this is the standard that must be applied in Nebraska. Under the correct and ameliorate standard required by federal law, the department must provide necessary treatment, whether it cures or simply makes a disorder better or more tolerable. In making that decision, there's a presumption in favor of the medical judgment of the treating provider. That's based on Eighth Circuit precedent, but the department does not apply this standard. Instead, it applies broad exclusions based on diagnosis and age, which I'll talk about more in a minute. It also systematically overrules the recommendation of the treating provider. In reviews of treatment denials from July 1, 2010, to June 30, 2011, outpatient treatment was denied 73 percent of the time; day treatment was denied 80 percent of the time; inpatient treatment was denied 69 percent of the time. That is alarming. In addition, the department has a practice and policy of giving only short-term, problem-focused treatment for behavioral health. This means if a child isn't progressing as quickly as the department thinks the child should, then they're not going to get any more treatment or they're just going to bump them down a level of treatment. In short, when the

department determines whether or not to grant a service to a child, they're not applying the federal standard. Children are being denied services that they need, and parents are being put in a position to choose whether or not they can keep the child that has all these needs in their own home or put them in the child welfare system. LB1063 aims to correct this by requiring the department to follow the appropriate federal standard and presume that the treating provider's medical judgment is correct. In addition, LB1063 prohibits discrimination based on the basis of condition and diagnosis. Under federal law, limitations on services have to be reasonable, and you can't discriminate arbitrarily solely on the basis of diagnosis or condition, but current state regs do just that. Services for developmental disabilities or pervasive developmental disorders such as autism are not covered. That is not reasonable under federal law. The department also has a policy and practice of denying services to young children or children under five. This is also not consistent with federal law, because the types of medical assistance or the categories of medical assistance should provide services for those young children. I can see that I'm running out of time. I just briefly want to mention that it also requires a transparent process. Currently, there are clinical guidelines that are used to determine whether or not a child gets a service, but those guidelines are not developed in an open or transparent manner, they are not promulgated under the Administrative Procedure Act, they can be changed overnight and have been. These criteria are very important to determine whether or not a child gets the care that they need, so LB1063 would require public input on these guidelines and that they must be promulgated according to the Administrative Procedure Act. Thank you. [LB1063]

SENATOR CAMPBELL: Questions. I'm going to take Senator Gloor, and then we'll come back to Senator Krist. [LB1063]

SENATOR GLOOR: Yeah, I'm still trying to figure this out, James. The medical necessity issue is a nice clean one for me; but after that, it gets a lot more uncomfortable. [LB1063]

JAMES GODDARD: Okay. [LB1063]

SENATOR GLOOR: For us to say, if I'm understanding this right, that if you're a medical provider, the presumption is you say this needs to be done, it's going to be done. But, you know, one of the reasons that we...and I have to think this is in place in managed care contracts for Medicaid all across the country, is that if the provider said we need one more diagnostic examination when the patient is already showing up having already had that medical diagnosis, or that examination, there's a degree of redundancy there. And some would say, in some cases, even profiteering if that provider also owns a, let's say, imaging center. That is inappropriate management of taxpayer dollars. I'm also concerned about not flat out denying services that are necessary; but I am concerned that we are basically saying, provider, you can order anything you want, even if you're going to make extra money doing it, that's the way it should be, because it's in the best

interest of the patient. So that's the area where I'm concerned we may be backing into. [LB1063]

JAMES GODDARD: I can see your concern on that, Senator. It's not intended to be a blank check. That's not, it's a presumption, and a presumption can be overcome. The actual language here, presumption in favor of the treating physician or provider, comes directly from an Eighth Circuit case; so that is the current good law on how the balance is struck between the state saying yes or no and what the provider is asking for. Currently, we have an ASO, not an MCO, and so it's possible that the way things work in an MCO might be somewhat different; but it's not intended to be a blank check where, hey, anything you want you get it. It's a presumption, and any presumption can be overcome. What I see right now in the investigation we've done is the flip side, is that the presumption is that the provider is wrong and that we're not going to get the service. And this is not only following Eighth Circuit precedent, but it's trying to rebalance how these decisions are made, and not giving a blank check, but presuming that the treating provider who works with the child is correct versus a Magellan case manager or peer reviewer that's doing a cold-case review without having even met the child most of the time. [LB1063]

SENATOR GLOOR: But how common is that in...let's just go into the private sector, how common is that with managed care companies that people may enroll with? [LB1063]

JAMES GODDARD: The presumption? [LB1063]

SENATOR GLOOR: Yeah. [LB1063]

JAMES GODDARD: I really couldn't tell you that. I don't know if it works that way in the private sector, but I can say that this is the Medicaid program, and the way it's been interpreted in many courts in the U.S. is the presumption in favor of the treating provider. That doesn't mean that there's no role for the state to determine the necessity of treatment. As I said, presumptions can be overcome; but part of what I think you might hear after me is the reasons we see from Magellan for denying services are completely vague, are not helpful to a trained provider nor to a parent that has difficulty understanding what...you know, what the reasons even are. And so this is an attempt to balance out, rebalance how decisions are made so that we don't just assume the doctors are wrong, but that we assume that they know what they're doing. And if...you know, if you order a service, an x-ray day one, you get the x-ray, then day two you order another one, well there's a pretty good reason not to presume that that's the right thing to do, if you follow what I'm saying. The presumption can be overcome. [LB1063]

SENATOR GLOOR: That part I'm not so, I have to be made more comfortable with the presumption being overcome. Again, I'm looking at this as a former provider, and so I

have enough experience in this to be concerned about that, clearly. But we probably need to talk more. I need a little more hand-holding and understanding of this. [LB1063]

JAMES GODDARD: Happy to do that. [LB1063]

SENATOR CAMPBELL: Senator Krist, you had a question. [LB1063]

SENATOR KRIST: In making a medical necessity determination, this is straight from the change that you gave us which replaces the green copy of the bill, is that correct? [LB1063]

SENATOR COOK: Yes. [LB1063]

SENATOR KRIST: In making a medical necessity determination, there shall be a presumption in favor of the medical judgment of the treating physician or treating healthcare provider, and b) medical necessity shall be determined on an individual case-by-case basis for each child. That's not being done right now. There's a clear, cold-case checklist that says these are not, these are. Is that correct? [LB1063]

JAMES GODDARD: There is certainly some things where the policy is if you're trying to treat symptoms related to autism, you don't get it, period. [LB1063]

SENATOR KRIST: Okay, so categorically. [LB1063]

JAMES GODDARD: Right. [LB1063]

SENATOR KRIST: The Children's Health and Treatment Act does not limit the authority of the department to limit coverage of treatments or services that are unsafe, experimental, or not generally accepted as treatment within medical community, so we've thrown out the witch doctors. [LB1063]

JAMES GODDARD: Absolutely. [LB1063]

SENATOR KRIST: And we've also said at this point that...actually, the next one was redundancy, so the department may not arbitrarily deny or reduce the amount, duration, or scope of the required service to an otherwise eligible recipient solely because of the diagnosis type or illness of the condition. Explain that to me. [LB1063]

JAMES GODDARD: Well, it's meant to...well first of all, it is a direct quote from a federal regulation, and it's meant to not...to disallow a Medicaid department from providing a service to one group but not providing it to another that's equally needy. For example, we're going to give...I think there are cases on this, we're going to give people with an astigmatism glasses, but people who have some other eye problem, we're not going to

give them glasses, even though the second group is just as needy. [LB1063]

SENATOR KRIST: The department shall not deny, reduce the amount, duration, or scope of the required service to an otherwise eligible recipient under 19 years of age based solely on the recipient's age. That's straight out of the federal language as well. [LB1063]

JAMES GODDARD: That actually is an addition. That is not straight out of federal language. And that is something that we thought was important, as I think you'll hear from other testifiers. The department doesn't have a policy that's written down as far as I know; but they have a policy in practice that denies very young children services, and it seems to be, the reasons I hear is what you're doing there is parent education or what you're doing there is behavior management. And from what I understand about those sorts of services, those are services under the Medicaid act, and if they're medically necessary, you have to provide them. So it's not enough to say it's this type of service, I'm not giving it to you. [LB1063]

SENATOR KRIST: And I think it's important too. And for the record, we challenged treating a child under the age of five with a psychotropic drug and then denying the child the services going to a psychiatrist or a psychologist for therapy, which you would think would help get him off of the psychotropic drug, never mind the fact that they're not recommended for pediatric use under that age. So I think that's an important point. Thank you. [LB1063]

JAMES GODDARD: Thank you. [LB1063]

SENATOR CAMPBELL: Other questions at this point? Mr. Goddard. [LB1063]

JAMES GODDARD: I did just want to mention to Senator Howard's questions, Magellan, this doesn't take Magellan out of the picture. Magellan is still the gatekeeper as long as they have a contract with the state to do that, but this gives them different rules within which to operate. [LB1063]

SENATOR CAMPBELL: Senator Howard. [LB1063]

SENATOR HOWARD: Just a follow-up question. And they would operate with...under these different rules both for wards and nonwards? [LB1063]

JAMES GODDARD: Yes, this applies to any child Medicaid eligible. [LB1063]

SENATOR CAMPBELL: Any other questions? Thank you, Mr. Goddard. [LB1063]

JAMES GODDARD: Thank you. [LB1063]

SENATOR CAMPBELL: Our next proponent. Good afternoon. [LB1063]

AMY RICHARDSON: (Exhibit 8) Good afternoon. Senator Campbell and members of the Health and Human Services Committee, my name is Amy Richardson, A-m-y R-i-c-h-a-r-d-s-o-n, and I'm vice president of program at Lutheran Family Services. I'm here today on behalf of the Nebraska Association of Behavioral Health Organizations, which is a statewide organization representing 49 members. I'm also here for CAFCON, Children and Family Coalition of Nebraska, representing 11 members. The simple truth today is that it's very sad we're in this state of affairs that we need to have legislation defining medical necessity. Early intervention is critical in treating the children seeking services. The ramifications of children not being treated early and not receiving the services they desperately need are staggering. Providers deal with changing guidelines on almost weekly basis. It's time that we all know the parameters we must work under and not arbitrarily deal with changing ways to deny care to children. There is a handout, and I believe Pat Connell will speak more about this. This is a draft regulation. This is an example of a regulation that was received and then changed and working under a draft regulation that has been, I think, out since July. Lutheran Family Services provides what they call evidence-based treatment for very young children. Please let me note that it is very difficult to treat children that have had significant trauma in their lives. They have experienced sexual assault, death of a parent. When we call in, we may be authorized for just an assessment for that child and maybe three sessions. Very, very seldom do we receive anymore authorizations for sessions. And those treatment sessions, parents cannot be treated alone. Those sessions are not allowable, as it is not medically necessary. We have a federal grant right now, and it is what we call the RSAFE, and it is to treat victims and children with sexually reactive behaviors. Sexually reactive behaviors are children that themselves have most likely been sexually abused. They sexually may abuse or inappropriately behaviors with other children. These children, because it's behavior, do not meet medical necessity. And they do not meet the guidelines, and it is not deemed as their treatment is necessary nor are their parents allowed to have separate sessions to talk about that behavior or meet as a group, as a treatment group, to talk about how to remedy this situation in their homes to keep children safe. To date, we have served 47 children in this federal program, and this program is being evaluated. Our sexually reactive children's program is being evaluated by a set of evaluators from another university in another state. Out of these children in these two years that have completed the treatment with their families in full wraparound treatment and care, not one has had another incident of sexually acting out on another child. On behalf of NABHO and CAFCON, we thank Senator Cook for the introducing of LB1063 and urge the advancement of this very important legislation. [LB1063]

SENATOR CAMPBELL: Questions? Thank you very much for your testimony. [LB1063]

AMY RICHARDSON: Thank you. [LB1063]

SENATOR CAMPBELL: (Exhibit 9) And we also do have a letter from CAFCON. Our next proponent. [LB1063]

PATRICK CONNELL: (Exhibits 10 and 11) Good afternoon. My name is Pat Connell, that's spelled C-o-n-n-e-l-l, and Pat as in Patrick, P-a-t-r-i-c-k. I am here today on behalf of the Nebraska Child Health Alliance which is a group of Building Bright Futures, Boys Town, Creighton University, and other healthcare providers who are interested in not only providing healthcare but making sure kids are successful in school. And we see good health as a precursor to being successful in school. I have also submitted a letter on behalf of Boys Town National Research Hospital in support of this bill. I'm going to be very brief, because I do not want to repeat what has already been said. I do want to emphasize two things. Amy Richardson just handed out testimony from NABHO, which Boys Town is a member of. In there, there's an attachment to that. In the attachment, it says Magellan statements of denials. These are the common explanations that are given by Magellan to families and to healthcare providers as to why they're not...why they're denying services. And I do not go a week without getting a call from a family member who says, we've applied for getting services or my child is in services someplace in the state, and Magellan comes back and says we're denying on the basis that the child is not making reasonable progress. And you can see the exact language in this attachment. That is really disconcerting to families, because what happens is then they get a reason from Magellan which has...it's on the second document where it says Psychiatric Residential Treatment Facilities as an example, and it will say, well, we're denying care on the basis of one, two, four, seven, and eight. So then they go out, and they say, well, where do we find this? So you go out to the Magellan of Nebraska Web site, and as of this morning, this is what you find there. It's a document that says draft on it. So then the families come back, and they say, wait a minute, my child is being denied access to care based upon draft regulations. Well wait a minute, that's not fair. You're making public policy by using draft regulations and interpreting draft regulations without going through the normal process. The second thing they say is, if my child had diabetes, or if my child had cancer, or if my child had an orthopedic problem, we would be outraged if a managed-care company denied continued care on the basis of that they're not getting better. So if the blood sugars on diabetic patients are still through the roof after the third day, do we throw them out of the hospital or do we try alternative treatment strategies in order for them to get better? The last thing is, is that I feel very personal...I have a personal connection to these families that make these calls. I have served in the past as president of NABHO. I am currently chair of the Nebraska Behavioral Health Coalition. And years ago, I had a personal family member not needing mental health services, they needed medical services, and I had to argue with the managed-care company in order for that person to get treatment access. And what that really taught me was that if I wasn't a Medicaid official or an administrator, if I wasn't a managed-care executive, or if I wasn't a healthcare professional, I as an individual would have real problems trying to navigate these systems. So clarity in

language is critical. It should be addressed and written as if the family member is first and foremost in trying to understand how they access care, when they can access care, and how do they access care. I appreciate your time today, and I thank Senator Cook for introducing this bill. It's needed, and whatever we can do to help you, we stand ready. Thank you. [LB1063]

SENATOR CAMPBELL: Questions for Mr. Connell? Senator Krist. [LB1063]

SENATOR KRIST: In your testimony, you alluded to Magellan denying. Isn't it true that Magellan doesn't do anything that's not called for in the contract in terms of the screening process that's put in place by the state? [LB1063]

PATRICK CONNELL: Well, this screening process that's put into the state, this criteria is still draft. It is not official policy. [LB1063]

SENATOR KRIST: No, I understand, but... [LB1063]

PATRICK CONNELL: They're operating as an agent of the state, I'm sorry. [LB1063]

SENATOR KRIST: ...they're hired as a gatekeeper. [LB1063]

PATRICK CONNELL: Yes. [LB1063]

SENATOR KRIST: And the criteria that they're using are the criteria that the state gives them to use in terms of approving or denying, as it was stated on a cold-case basis. [LB1063]

PATRICK CONNELL: Right. So if that's true, then they shouldn't be draft. [LB1063]

SENATOR KRIST: We'll see. We'll ask a few more people, and I agree with you. [LB1063]

PATRICK CONNELL: Yeah, and it's been draft since July. [LB1063]

SENATOR KRIST: Thank you. [LB1063]

PATRICK CONNELL: Um-hum. [LB1063]

SENATOR CAMPBELL: Other questions? Mr. Connell, I know that you've served on several national committees and been very involved and have taken a look at the definition of medical necessity in other jurisdictions, and at one point, also provided some information to us with regard to that definition as it may have been used by Magellan in other states. Does the definition that's included in Senator Cook's bill more

accurately reflect other states or what Magellan uses in other states? [LB1063]

PATRICK CONNELL: We did a 15-state comparison, as per your request, Senator Campbell, and presented that in December. And that report that was provided indicates that the definition that we're using for medical necessity in the state of Nebraska is much more restrictive than what we found, for the most part, with other states. [LB1063]

SENATOR CAMPBELL: Okay. Anything else you want to add about that study? [LB1063]

PATRICK CONNELL: Well, I think the other thing I would add to that is that, so then what happens? Okay. A family that is eligible for Medicaid applies for, they go through the Medicaid application process, they get denied, and you're right. What happens is they look at the way the current system is designed, and they decide to make a child a state ward. Well then the child's a state ward, and Magellan denies, and they go before the judge. As part of making this child a state ward, the judge orders treatment. And then that treatment is shifted to the child welfare system, which is the other part of Boys Town, and KVC and NFC and the state, and we lose the federal match. [LB1063]

SENATOR CAMPBELL: I want to go back to Senator Gloor's question at the very beginning of Mr. Goddard, and that is, in your research of other states that you've looked at, how many would have the kind of presumption that Senator Gloor was questioning Mr. Goddard about? Do you remember that exchange, Mr. Connell? [LB1063]

PATRICK CONNELL: Yes, I do. You know, all states have a very similar process in which, and I would say some are more collegial, and more than others, but there is a definition of what kind of services are provided. There is an opportunity to fully interact, and there's chances to appeal, etcetera. And I would tell you that Nebraska providers are very much doing those appeals on behalf of patients and families. I don't know if that answers the question. [LB1063]

SENATOR CAMPBELL: Well, and I think we'll probably have to do some more research in terms of Mr. Goddard's testimony and Senator Gloor's question. I just thought you might know in your research how other states might handle that. [LB1063]

PATRICK CONNELL: We can look into that for you. [LB1063]

SENATOR CAMPBELL: That would be great. Thank you very much. Thanks, Mr. Connell. Any other questions? [LB1063]

PATRICK CONNELL: Thank you. [LB1063]

SENATOR CAMPBELL: Our next proponent. Good afternoon. Go right ahead. [LB1063]

JUDY DOMINA: (Exhibit 12) Good afternoon. Good afternoon, Senator Campbell and council. I'm Judy Domina, D-o-m-i-n-a, first name Judy, J-u-d-y. The current criteria used to determine if treatment is meeting medical necessity is causing families in Nebraska to take extreme measures. I'm executive director of Nebraska Family Support Network. This nonprofit organization is a family organization created by families, staffed by families, working with families that are affected by mental, emotional, and behavioral health issues, and we do this through peer mentoring, education, and advocacy. Families calling the Helpline are referred to our agency for peer mentoring. The families we are assisting navigating the system of care are frustrated and stressed with the difficulty they are having accessing and receiving treatment for their children. To illustrate a current case that is unfortunately not unusual, I'd like to share my own family story. Ten days prior to his 13th birthday four years ago, and 127 days after his adoption, my son was made a state ward. He was made a state ward because authorization for his care was denied. I have been advocating for my adopted son for two years on mental health issues. It's been a constant struggle to get authorization for treatment that professionals treating him recommended. He was sent home in August 2011 with me receiving the threat, after calling DHHS for help, to either pick him up, bring him home, or face charges of abandonment. I was promised in-home services that would wrap our family, provide services needed, by the DHHS family permanency specialist. These services were not in place for the first week, and at the end of the second week, my son needed to be transported to the hospital by police in handcuffs from his therapist's office. September 1, 2011, he was admitted to Boys Town residential treatment. Three days prior to Christmas, my son became violent and assaulted a staff member at Boys Town. This violent behavior continued until it was necessary to hospitalize him. I was advised to make him a state ward to ensure he would continue to get treatment he needs due to constant struggles to get authorization from Magellan for his care. Reasons for his denials have been not responding to treatment, not meeting medical necessity. This child had a forever home and is now another child in the system. He will always have a forever home in my heart, and I will not abandon him. I was there for his 13th birthday on January 28, and I attend family therapy, call him to say good night, take pictures of his cats to him, and advocate for him. A team meeting was held this morning at 7:30. I was informed that his authorization at the hospital runs out Monday. Magellan has denied residential treatment. This level of care was recommended by three psychiatrists who have been treating him for over the past six months. This level of care has also been ordered by the court. Due to the current July 1, 2011, draft regulations, my son's care is not being determined by his treating physicians. His healthcare is being determined by a group of people sitting in an office building that have never seen him, talked to him, examined him, or experienced one of his violent rages. My son celebrated his birthday in the hospital. Due to the location, we were not allowed to light the candles on his birthday cake. I wonder what his 13th birthday would have been like if he had received the level

of care he needed and was recommended by professionals treating him when it was requested, if he had not had to continually suffer through failures before getting authorization for a higher level of care. His candle has been snuffed out. To light his candle, he needs treatment, treatment that is determined by the physicians treating him. His treatment should not be in jeopardy if he does not show a certain amount of progress in a certain time frame, not responding to treatment. If he were suffering from cancer and was not responding to treatment, his treatment would not be halted. My son is ill. He has pain. He needs treatment. Thank you. [LB1063]

SENATOR CAMPBELL: Thank you, Ms. Domina. Any questions? Thank you for coming. Oh, sorry, Senator. I can't see your hand sometimes. (Laugh). [LB1063]

SENATOR HOWARD: I know, I know, I wave, wave. Thank you, Senator Campbell. Now that he's a state ward, you made him a state ward to get services for him,... [LB1063]

JUDY DOMINA: Yes. [LB1063]

SENATOR HOWARD: ...do you have any input into his medical care? Are you a decision maker? [LB1063]

JUDY DOMINA: Yes. I still have medical and educational rights. [LB1063]

SENATOR HOWARD: Maybe I'm not asking this correctly. Who makes the medical decisions? Do you or the case manager or...? [LB1063]

JUDY DOMINA: Well, medical decisions that have been made thus far, I've been making, and I was asked today to look at the options that we have for his treatment this morning and will be looking at those options. [LB1063]

SENATOR HOWARD: Okay. Do you... [LB1063]

JUDY DOMINA: When it comes down to the bottom line, I don't know. [LB1063]

SENATOR HOWARD: Do you have a case manager? [LB1063]

JUDY DOMINA: Yes. [LB1063]

SENATOR HOWARD: He has a case manager? [LB1063]

JUDY DOMINA: Yes. NFC is... [LB1063]

SENATOR HOWARD: Okay, and you work with that person? [LB1063]

JUDY DOMINA: Yes. [LB1063]

SENATOR HOWARD: Okay. [LB1063]

JUDY DOMINA: Yes. [LB1063]

SENATOR CAMPBELL: Any other questions? Thank you, Ms. Domina. Our next proponent? Welcome. [LB1063]

LEE SEARCEY: Thank you. I don't have a fancy title. Sorry. I'm just a dad of seven, so (laugh). My name is Lee Searcey, L-e-e S-e-a-r-c-e-y, and I'm concerned about the Magellan issues that other people are talking about, but my situation is more with the young child that we have in our home. I am a foster parent, been a foster parent since 2005. Since then, we have adopted four children ages one, four, five and six. We also have three biological children as well. We've had many other children temporarily in our home throughout the year since then. Many of those children, because of the chaotic situations they came from, were removed and exhibited many behavioral mental disorders, even at a very early age. This shouldn't be a surprise to most people. In dealing with this, you know that. A child's mind is very fragile, and dealing with these issues that they come from at a very early age causes a variety of mental issues. One child in particular is my own daughter, Lydia Angel Searcey, who has been with us since she was born. She is now five. She had her last visit with her mental health provider yesterday that Magellan authorized, and she is being cut off from that. But her mental provider, Dr. Judith Bothern, Ph.D., on January 5, 2008, said that, this was when Lydia was two years of age, quoting here she referring to Lydia, "exhibits significant signs of anxiety along with many other mental disorders." On her BASC test, which is the Behavioral Assessment System for Children test that she, that we provided...that she provided, excuse me, from two other family members independent of each other rated her at at-risk range for anxiety and social skills. On the other assessment, in the clinical range for anxiety and social skills. Both ratings indicated that she is much higher than normal for a child her age. This was at two years of age. On October 14, 2009, from her family physician, Dr. Matthew Jacobsen, M.D., Lydia...this is quoted from him, "Lydia's family history indicates that she will most likely have mental issues to include, but not limited to, the same ones her biological mother exhibited." Her mother was diagnosed with schizophrenia, bipolar disorder, and anxiety disorder. Her family physician, Dr. Matthew Jacobsen, quoted again here, "I want to bring these things to your attention, because both her current problem list as well as her family and social history, which was reviewed above, will have lifelong implications." He continues, "This problem is not expected to be cured, but will hopefully be managed to the best of her ability as well as her new family and multiple specialists involved." There seems to me...this is my opinion, it seems to me that the link to mental disorders from inherited traits, even at an early age, that lead to higher-than-normal tendencies to these disorders. Couple this

with the higher-than-average likelihood of mental disorders from the traits that the kids get from their parents with an abnormal social life these children come from, it seems to me that these children are at a very high risk and in need of help, even at an early age. Diagnosing and treating these children early is key to growing productively to adults, which will save the taxpayers in the long run. Like I said, she's been diagnosed with these issues at age two, and we're already being told by Magellan at age five that she's done. I think that going on, plus some of the other children we have in our house are exhibiting some of the same issues, that we're going to have to deal with this, and I think that denying them at an early age like this, knowing that our family physician and our behavioral specialist is saying we are going to be dealing with this probably for a long time, needs to be reevaluated. That's all I have. [LB1063]

SENATOR CAMPBELL: Thank you, Mr. Searcey, for your story. Any questions that the senators have? We very much appreciate you bringing your information. The next proponent. Good afternoon. [LB1063]

CONNIE KROKSH: (Exhibit 13) Good afternoon. Thank you for allowing me to speak. My name is Connie, C-o-n-n-ie, Kroksh, K-r-o-k-s-h. I am from Ashland. I've spoken previously to this committee of my two adopted daughters whom I will refer to as Lynn and June. They are biological sisters aged 14 and 16, respectively. Both were considered special-needs children; and, thus, we adopted them under a subsidized adoption agreement. Identified in that adoption agreement were their diagnoses and at-risk behaviors. As I told you previously, life continues to be challenging for them because of the sexual abuse they were subjected to as young children. They have consistently been in need of mental and behavioral health services. They require very close supervision due to their struggle with perpetration, boundaries, safety, and other issues. Approximately two-and-a-half years ago, my daughter Lynn was placed in a residential treatment center out of state. This placement was approved by Magellan, because unfortunately, there were no facilities in Nebraska who could provide the care and treatment she needed. Late this fall, as her discharge date from that facility neared, her treating mental health therapist strongly recommended that she needed to remain under 24-hour supervised care, the least of which should be in a therapeutic group home setting. Even after numerous meetings involving myself, representatives from Omni Behavioral Health, Magellan, DHHS, Nebraska Family Support Network, Right Turn, the Ombudsman, and the treating therapist, the authorization for residential care ended on January 16, 2012. I was informed around that time that if I were to make her a state ward, I could then access child welfare funds that would assist in paying for care in a therapeutic group home or possibly a high level of foster care. I picked my daughter up from the out-of-state facility and brought her back to Nebraska. I, as well as representatives of Right Turn and Nebraska Family Support Network and the Ombudsman, contacted my county attorney, which is Saunders County, to request that he do a dependency filing so that my daughter could get the care her therapist recommended. My county attorney has refused to do so. A DHHS worker was assigned

to us at that time, and we met with her on January 19. She and a Saunders County deputy sheriff, after meeting with my daughter for 20 minutes that day, determined that we needed to take her home, and they would not make her a state ward. So I am caught in the middle. I cannot get services. I cannot get her made a state ward. On the evening of January 30, we were at home when my daughter began cutting herself. This was a recurrent behavior she was exhibiting at the residential treatment center. It was one of the reasons her therapist said she still needed 24-hour supervised care. I took her to BryanLGH where she proceeded to ransack the emergency waiting room. She had to be restrained by two police officers who happened to be there, one of whom she assaulted. She was immediately admitted into the adolescent psychiatric unit where she remained until February 3. Requests were then made to the Lancaster County Attorney's Office and again to Saunders County Attorney to do a dependency filing in order for my daughter to receive the recommended level of care. The treating psychiatrist at BryanLGH even wrote a letter on February 3 and submitted it to Lancaster County wherein she stated she agreed with the recommendations of the therapist at the out-of-state treatment facility for a higher level of care, that being therapeutic group home. To date, no dependency filing has been made. So you see, my family is falling apart. Magellan will not approve a level of care recommended, and my county attorney will not do a dependency filing so that I can access child welfare funds. The toll this is taking on my family is immense. It is unbelievable to me that no one is giving us the help we need. I took these children in, I've attempted to give them a loving home, and I was assured at the time I did that that I would get all the services I would need. I implore you to consider and pass legislation that will change what is happening to my family and other families across this state. Families are not getting the recommended help they so desperately need, and they are falling apart. We need help. Thank you. [LB1063]

SENATOR CAMPBELL: Questions? Yes, ma'am, did the county attorney in Saunders give you an idea why he denied the request? [LB1063]

CONNIE KROKSH: Initially, before my daughter was brought back to Nebraska, he said he did not have jurisdiction. That was disputed by a Douglas County judge, but that judge could not intervene. When I brought her back into the state, they said there was no need. What she had done was two years prior. There was no need, she hadn't committed a crime. We needed to take her home. And I don't know the reason why the Lancaster County Attorney will not file. Now Saunders said because that incident occurred in Lancaster County, Lancaster needs to do it. Lancaster will not. [LB1063]

SENATOR CAMPBELL: They're probably looking at the jurisdiction of the person, but we can follow up and make some inquiries in terms of the county attorney. [LB1063]

CONNIE KROKSH: That would be great. [LB1063]

SENATOR CAMPBELL: I was just questioning if they had written a letter or stated something to you as to why. [LB1063]

CONNIE KROKSH: I have gotten nothing in writing. [LB1063]

SENATOR CAMPBELL: Okay, Senator Krist. [LB1063]

SENATOR KRIST: Was there an assault charge filed? [LB1063]

CONNIE KROKSH: There was a police report made. There was no charge filed. If they would have, maybe that would have gotten...they said they would do a report and file it with the Lancaster County Attorney's Office. [LB1063]

SENATOR KRIST: But they... [LB1063]

CONNIE KROKSH: I got confirmation that the report was received at Lancaster County Attorney's Office along with a letter from the psychiatrist at BryanLGH. [LB1063]

SENATOR KRIST: And they told you that they were filing an assault document? [LB1063]

CONNIE KROKSH: They haven't told me anything. [LB1063]

SENATOR KRIST: Okay, thank you. [LB1063]

SENATOR CAMPBELL: Was the request to the Lancaster County Attorney to declare a dependency? [LB1063]

CONNIE KROKSH: That was my intent, yes. [LB1063]

SENATOR CAMPBELL: Okay. But do you know that that's what was in the letter that went to the Lancaster County Attorney? [LB1063]

CONNIE KROKSH: The letter that went to the Lancaster County Attorney was from the psychiatrist... [LB1063]

SENATOR CAMPBELL: Okay. [LB1063]

CONNIE KROKSH: ...indicating and agreeing with the therapeutic group home level of care that was being recommended. [LB1063]

SENATOR KRIST: And the Ombudsman's Office has been involved since that time? [LB1063]

CONNIE KROKSH: Yes. He has tried to put pressure on the county attorneys, and we are getting nowhere. [LB1063]

SENATOR CAMPBELL: We will follow up for you on that one. [LB1063]

CONNIE KROKSH: Thank you. [LB1063]

SENATOR CAMPBELL: Because the Ombudsman would have a report, and we can check on that for you. [LB1063]

CONNIE KROKSH: Thank you. [LB1063]

SENATOR CAMPBELL: Go ahead. [LB1063]

SENATOR HOWARD: Thanks, Senator Campbell. Did you have an adoption agreement with the department? [LB1063]

CONNIE KROKSH: Absolutely. [LB1063]

SENATOR HOWARD: And did it make a note in there, did it note what the children had been...if they had a prior diagnosis? [LB1063]

CONNIE KROKSH: Absolutely, yes. [LB1063]

SENATOR HOWARD: And that the department would remain involved and provide services? [LB1063]

CONNIE KROKSH: Absolutely. They would provide the services recommended by their mental health professionals. That is not happening. [LB1063]

SENATOR HOWARD: Okay. I think that's your leverage. [LB1063]

CONNIE KROKSH: Yep. [LB1063]

SENATOR CAMPBELL: Any other questions? Thank you very much for coming today. [LB1063]

CONNIE KROKSH: Thank you. [LB1063]

SENATOR CAMPBELL: Other proponents? Good afternoon. [LB1063]

JUDITH BOTHERN: (Exhibit 14) Good afternoon. I'm Judith Bothern, and that's

J-u-d-i-t-h B-o-t-h-e-r-n. Thank you for listening to me and, Senator Cook, thank you for the bill. You have seen me before. I'm going to avoid things I've already testified on, and I'm going to testify on something different, and that's the children under the age of five. And I have in my letter outlined where the literature shows that even infants can show depression, anxiety, and posttraumatic stress response. There is increasing evidence that they can respond to psychotherapeutic intervention or psychological interventions, and it can return them to a normative developmental level. These children, when they're traumatized for whatever reason, it interrupts their development, and that interrupts their brain development. If we can intervene and we can help these children, we can often move them forward. Mr. Searcey was testifying, what I'm not sure he made clear was her treatment was interrupted from age two to age five because they wouldn't service this child. She may not be in services today had she been treated. What I find when I apply for a child under the age of five is I have to send it to a special person. They have special criteria, I guess, that they use to determine whether these children can have treatment; but they won't give it to me in writing. They will give me afterwards the verbal comments of the person who reviewed it, but they won't give it to me in writing. I've demanded it, and they won't give it to me. I have been told the last six months for a child under the age of five, six months ago, family therapy. That works for me, supported by the literature. Then I was told parent-child interaction therapy. I don't do that. And the last thing I was told was play therapy. I said where did the change come from? Our medical director, that would be Dr. Fetters (phonetic). I said, can you get me that in writing? Nope. Will you put it on your Web site? Nope. I'm sorry, tell me what you want from me, and I will give it to you. Nope. I'm sorry, that's the truth. That's what we deal with day in and day out. Now they say, six months ago you couldn't do this, you can't have family therapy; but you can go back and get a CAP session, which is Community Assistance Program, which pays about two-thirds of family therapy, and you're capped at five sessions. So I was told at one point, well, we're not going to give you that; but you can have these. However, if you appeal it, it's off the table. So of course, being me, I appealed it (laughter), and it wasn't off the table. And I was told, well, do the five, and if you need more, apply for more services. So I said to the family, this is what they've offered us. At the end of five sessions, if we can't address this child's problems, who happened to have hormonal situation at the age of three had already started menstruating, so we have medical necessity, I think; and they said then you can apply for more, except my treatment plan had already been denied. It's not going to be approved after five sessions later, so we appealed again. We finally won that one, the first one in 19 years I have ever won on reconsideration. There's something wrong with that appeal system. The first one. I'll stop. [LB1063]

SENATOR CAMPBELL: Questions? Thank you very much for your testimony, and we will take a chance to read through the letter, and if we have any questions, I hope you won't mind if we follow up,... [LB1063]

JUDITH BOTHERN: Please do. [LB1063]

SENATOR CAMPBELL: ...because I'd like a chance to take a look at the letter. [LB1063]

JUDITH BOTHERN: And if you want the research, I will provide it for you. [LB1063]

SENATOR CAMPBELL: Thank you very much. Do you have it electronically? [LB1063]

JUDITH BOTHERN: I don't know. I'm electronically impaired. (Laughter). Maybe. [LB1063]

SENATOR CAMPBELL: Oh (laugh), well then any copy would be fine. [LB1063]

JUDITH BOTHERN: All right. [LB1063]

SENATOR CAMPBELL: Because we'll take a look at it. [LB1063]

JUDITH BOTHERN: Okay. [LB1063]

SENATOR CAMPBELL: And don't apologize... [LB1063]

JUDITH BOTHERN: Thank you. [LB1063]

SENATOR CAMPBELL: ...for being electronically... [LB1063]

JUDITH BOTHERN: I am terribly electronically impaired. Computers hate me. Thank you. [LB1063]

SENATOR CAMPBELL: Thank you. Any other proponents? Good afternoon. [LB1063]

KELLY BREY LOVE: (Exhibit 15) Good afternoon. Thank you very much for allowing me to speak today. My name is Dr. Kelly Love, L-o-v-e. I don't know Dr. Judy Bothern, but I think I need to get to know her, because I think that we would get along very well. (Laughter). I have never testified before, so this is obviously an issue that I'm very passionate about to actually get me here in front of everyone. So I'm not going to rehash the things that Dr. Bothern just spoke about, but I am pretty e-savvy, and I do have a lot of those references and research demonstrating the efficacy of early intervention and how that actually works for kids under the age of five, so I can definitely send that to you if that would be helpful, so I'll make a note of that. I am a licensed psychologist here in Lincoln. I currently am employed as a behavioral health faculty member at the Lincoln Family Medicine Program. I practice as an outpatient psychologist at the Lincoln Behavioral Health Center, and I also am a supervising psychologist at an intensive outpatient program here for children in Lincoln, so I have a

couple jobs, and I have a two-year-old, so I like kids. I'm testifying on behalf of myself, however. So we know, well, we know from my work, but you've also heard today, early intervention is very, very, very valuable regarding management and amelioration of behavioral and mental health disorders for children. In the last several years, though, DHHS has dramatically limited the diagnosis and ages of patients it will provide reimbursement for treatment for us in the mental health community. Examples of diagnoses that I personally have had deemed not suitable for coverage from DHHS have been autistic disorder, which the research has demonstrated without a doubt, if you miss that critical window between the ages of two and five, it's really unfortunate for the children, so that's a really unfortunate one that they don't serve. Adjustment disorders of any type, disruptive behavior disorder not otherwise specified, sexual abuse of a child, as testified earlier, and ADHD. So any of those have had just refused because they're not suitable for coverage. For decades, research has evidenced these disorders and conditions are extremely amenable to treatment. However, as a psychologist, I can't help them. I can't...if they come in, if the family actually has transportation to get them in there, if the family presents and shows up, I can't help them because I can't get reimbursement for the sessions for the kids who are Medicaid eligible. The rationale, as has also been stated, I don't want to beat a dead horse, it's extremely variable. Some common denials that I've seen are that the child is not showing any symptoms for a mental illness. One that I particularly like is a child I was seeing, she was two-and-a-half-years old at the time, I had diagnosed her with adjustment disorder with disturbance of conduct. She was born addicted to meth. She had lots of other behavioral concerns, but we had documentation that she had bit other children 92 times in a six-month period at day care in addition to lots of other things, but that apparently wasn't enough to constitute a behavioral concern. Another child, there was a reviewer at Magellan that determined that the child's behaviors appear to be autistic. I don't know the credentials of this reviewer that superseded my way too many years in college that I'm still paying the loans on, but they decided this child appeared to be autistic even though I had no concerns for any kind of autistic spectrum disorder for this child whatsoever; so therefore, I wasn't allowed to treat him because they thought he was autistic. Or another child, lots of my children they say they think the presenting problems are covered under the umbrella of parent training, which is also not covered. And they have often been told that I should recommend the family find and attend free parenting groups in the community or to...my favorite is to read a book on parenting, so that's something I've been told quite a bit. Regardless of diagnosis, I can't get authorization for kids under the age of four years, nine months, haven't been able to do so for several years. It's not just me, it's providers throughout the Lincoln community. Unfortunately, I know several practitioners, several practices that no longer even attempt to treat any children under the DHHS insurance under the age of five, because it's just not...they can't get reimbursed for it. I'm going to skip ahead because I've got my yellow light on. Lincoln has been declared an underserved area for mental health needs by the federal government since 1978. We have an increasing shortage for the pediatric mental and behavioral health needs in the last several years. If DHHS continues to limit

who we are able to treat, what diagnoses we're able to treat, this already significantly limited pool of providers, it's going to completely go away. These kids are going to have no one to actually treat them. It's going to most assuredly cause significant strain on families, schools, and communities left to manage children with untreated psychopathology. Passage of LB1063 ensures youth and families in Nebraska will receive services needed to treat emotional, behavioral, and mental health disorders in a timely manner to best maximize youth and family functioning. Thank you very much. [LB1063]

SENATOR CAMPBELL: Thank you, Dr. Love. Are there questions? Senator Krist. [LB1063]

SENATOR KRIST: Dr. Love, in your opinion... [LB1063]

KELLY BREY LOVE: Yes. [LB1063]

SENATOR KRIST: ...as a doctor, what I've read is in the last few years when we have started to understand autism, a lot of those tendencies are in special-needs kids and kids who act out in different ways. It seems to me that we hear a lot about they might be autistic, they might be autistic. In reality, we're finding out that there are some of those traits that are...we've thought would be autistic that are in those kids. Can you comment on that? [LB1063]

KELLY BREY LOVE: So what's your question? [LB1063]

SENATOR KRIST: Well, the question is, if they continue to deny for tendencies of autism, they will continue to deny, because we're now seeing some of those tendencies, some of those characteristics in kids that didn't have a diagnosis of autism to begin with, but almost any one of those tendencies could throw them out of the system for treatment. [LB1063]

KELLY BREY LOVE: Yeah, that's a concern. What I say is...I have the very lucky position that I actually work in the...at the Lincoln Family Medicine Program, so I actually supervise the family practice residents, and so I get to actually see the screenings that they do in the physicians, the appointments that they have there. So, I mean, I advocate for the early screenings, you know, starting at the age of 12 months. So you can catch a lot of those autistic disorders at that point. Do I think that diagnosing a kid with straight-up autism at 12 months of age, do I do that quite often in my practice? No, I don't, but I definitely flag that as something that is causing impairment, likely in their social and their communication, in their overall functioning. But if I even have that as a rule out on my diagnostic criteria, if I even identify that as I'm watching it, it's flagged and it's out of the system. [LB1063]

SENATOR KRIST: That's... [LB1063]

KELLY BREY LOVE: If I don't do that, then I'm remiss as a practitioner. I mean, then it shows that I'm completely missing some, so I'm kind of...I'm out of luck either way. [LB1063]

SENATOR KRIST: That's answering the question. Thank you very much. [LB1063]

KELLY BREY LOVE: There you go. Um-hum. [LB1063]

SENATOR CAMPBELL: Thank you, Dr. Love, for your testimony today. [LB1063]

KELLY BREY LOVE: Thank you. [LB1063]

SENATOR CAMPBELL: Other proponents? Good afternoon. [LB1063]

MARY FRASER MEINTS: (Exhibit 16) Hello. Hello, Senator Campbell and members of the Health and Human Services Committee. My name is Mary, M-a-r-y, Fraser, F-r-a-s-e-r, Meints, M-e-i-n-t-s, and I'm here in support of LB1063. Thank you, Senator Cook, for introducing this bill. I'm the president of Uta Halee, which is in Senator Cook's district. We provided services to the public population for 60 years. We provided residential services for girls and community-based services for boys and girls. We have now closed, as of December 16, our services to the public population. However, we continue to provide services to girls whose parents can pay, and that program is now full, has been for a while. I'm here to talk about what happened with the Nebraska Medicaid decision to change medical necessity without public input. In 2011, Nebraska Medicaid asked the administrative services organization they contract with, Magellan, to develop a criteria for medical necessity for the highest level of care called psychiatric residential treatment facility. This level of care was...this medical necessity was developed without any input, discussion, public hearing from providers or parents. It was just decided on. It was hospital-based criteria, and PRTF is subacute, just a step below hospitalization. The providers have expressed concerns about this criteria. We asked Medicaid to use a previous criteria. We asked for a workgroup on this, and there was finally a workgroup set up on conduct disorder, but not on the restrictiveness of this care. There was a dramatic decline in referrals when this PRTF started in July 1. Uta Halee received our first referral from Magellan on August 26. We had received...we had been admitting one to two girls a week prior to that. A little bit different level of care, and we had a smaller number of beds. We went from 48 to 36, but there were kids not coming through the system. I've testified before that in April, May, June--actually Magellan testified to this--there were 97 applications for PRTF or RTC before July 1, and 90 percent of those were approved. After July 1, 47 applications were submitted, and 34 percent were approved. These kids didn't get better. They shifted somewhere else. What happened to them? We still don't know. We've been asking that question for

quite a while. I did a survey of all the providers of PRTF in mid-September and found out that half the beds were empty. This is after reduction in the beds. When I talk about medical necessity for PRTF, there's a difference between hospitalization. Those are kids who need immediate attention, suicidal, homicidal, and they need the care right now, and it's three to five days. PRTF is a longer term, three to four months. It addresses the trauma, the longstanding issues we've heard about from other folks. And the PRTF definition that was developed arbitrarily by Magellan and Medicaid was not used for this level of care. The arbitrary change negatively impacted all providers, but was devastating to Uta Halee. We couldn't recover from this change. At the same time, we were still continuing to grow our community-based services, and our day treatment criteria changed, and the referrals to day treatment stopped. And we tried to develop IOP treatment, and that took two months to get that set up. So, again, the medical necessity criteria was developed without public input, without the input of providers, and you heard from Pat Connell that other states do other things. We all have been part of committees, and we know what other states do. I support this bill because it sets the standard of correcting or ameliorating defects or physical or mental illnesses or conditions and requires all treatment to be individualized. Nebraska's goal should be to provide access to the right level of treatment when a young person needs it rather than excluding and denying treatment. This bill is vital to ensure that the children of Nebraska receive the treatment services they need. There must be a public process for determining medical necessity. Uta Halee is an example of what can happen without an open and transparent process, without input from public and professionals, from families. Uta Halee won't be the last program to close unless you take action. The need for treatment services continues. We still get faxes every week from two or three workers across the state and county attorneys requesting our services. We're not there, but they are still requesting our level of care. So thank you for this opportunity to share my perspective. I'd be glad to answer questions. As you can tell, I did not read my letter, so there is more information in there (laugh) that you can read later at your own convenience, so I'd be glad to answer questions. (Laugh). [LB1063]

SENATOR CAMPBELL: (Laughter) Senator Krist. [LB1063]

SENATOR KRIST: Where do the preponderance of the faxes come from? Outstate? [LB1063]

MARY FRASER MEINTS: They're coming from the non...yes, from the noneastern and southeast service areas, so I don't think those workers know yet. [LB1063]

SENATOR KRIST: Where we destroyed the services during the privatization process, and now... [LB1063]

MARY FRASER MEINTS: Where we don't have services, yeah. [LB1063]

SENATOR KRIST: Now they're needing services, so they're...okay. [LB1063]

MARY FRASER MEINTS: One was from York. The York County Attorney called and said, Mary, "da da da da da," can you take this girl? I said, no. (Laugh). Sorry. Unless they can pay privately, we can't, so. [LB1063]

SENATOR KRIST: Thank you. [LB1063]

SENATOR CAMPBELL: Any other questions? Thank you very much for your testimony. [LB1063]

MARY FRASER MEINTS: Thank you. [LB1063]

SENATOR CAMPBELL: Other proponents? While we're getting set up, are there those who wish to testify in opposition? Okay. And those in a neutral position? Neutral? [LB1063]

CAITLIN PARDUE: (Inaudible). [LB1063]

SENATOR CAMPBELL: Oh, okay. No, I was just trying to get there. We won't leave you out. Yes, go right ahead. [LB1063]

CAITLIN PARDUE: (Exhibits 17 and 18) Good afternoon. Thank you, Senator Campbell and the committee for hearing me. I will be very brief. My name is Caitlin Pardue, C-a-i-t-l-i-n P-a-r-d-u-e, and I'm the behavioral health policy associate at Voices for Children in Nebraska. I'm providing my written testimony as well as a letter of support from Munroe-Meyer Institute. Voices for Children wants to ensure that all children have access to health services, what they need at the right time; and we are very encouraged by the efforts made by this committee, and I want to especially thank Senator Cook for supporting this bill. We think that this is a very important bill that will address all the things that have been said previously and that LB1063 would clarify Nebraska's obligation not to discriminate the availability of appropriate and quality services on the basis of diagnosis or age. Not only is this a good ethical policy, but it's also a wise economic policy. We urge you to support this bill, and I'd be happy to answer any questions. [LB1063]

SENATOR CAMPBELL: Are there any questions? Thank you for bringing your letters. [LB1063]

CAITLIN PARDUE: Thank you. [LB1063]

SENATOR CAMPBELL: (Exhibits 21, 22, 23, 24, 25, and 26) While Mr. McBride is getting set up, we'll note for the record that we received letters of support from the

National Association of Social Workers Nebraska Chapter, the Nebraska Medical Association, Early Childhood Services, and Building Bright Futures, as well as the Nebraska Hospital Association. We received a letter from Blue Cross Blue Shield of Nebraska and Coventry in opposition. Good afternoon, Mr. McBride. Go right ahead. [LB1063]

TOM McBRIDE: (Exhibit 19) Good afternoon. Thank you. My name is Tom McBride, T-o-m M-c-B-r-i-d-e. I'm the president and chief executive officer of Epworth Village located in York, Nebraska, but we receive and work with children from all over the state. Senator Cook, thank you very much for bringing LB1063 forward, and I would like to thank Mr. Goddard for his work on this as well in the Appleseed Center. I feel somewhat like I'm representing a dying breed. As far as Epworth Village is concerned, we work with children from the whole array of services from in-home, community-based, foster care, up to the higher level of need in residential psychiatric treatment facilities. Currently, Epworth operates the furthest west psychiatric residential treatment facility and therapeutic group home in the state of Nebraska save for the substance abuse program that's from YRTC-Kearney that's housed in Hastings. You know, when I look at medical necessity, there are some people that think that the definition should be there so that we keep people out of receiving services and keep that door closed. And I look at it from a standpoint of, you know, medical necessity ought to be defined to enable access of care for young people for, you know, whoever is in need of that. Everybody recognizes that we've got federal regulations that we have to follow, but those federal regulations don't place us in a choke hold on what medical necessity is defined at. To put things in a little bit of perspective, you know, there are those that think that the medical necessity, we've got to redefine that and keep it down to a...you know, so it's so restrictive, to keep kids out of higher levels of care. There are over 420,000 kids under the age of 17 in Nebraska today. Using the President's New Freedom Commission study, they found that between 5 to 9 percent of the population of youth in the United States is going to have a severe emotional disturbance, and underline severe. So if you use 7 percent in that, there's 29,400 youth in Nebraska that are going to...that need treatment for a severe emotional disturbance. If there's 350 beds in psychiatric residential treatment facilities and therapy group homes combined, that represents the ability of less than 1 percent of those 29,400 kids to be placed in a residential program. You know, it's not like, you know, they're, you know, the vast majority of kids that meet medical necessity are going to be at that level of care. When I think about the other things that this bill does, is it requires a process for regulations to change, and as a provider, that's tremendously important that the regulations go through a hearing process and go through that Administrative Procedure Act, as they should. Previously, we had families refer youth that were Medicaid eligible into our program, be approved by Magellan, and we would treat them and, you know, and the family on a voluntary basis to date in 20 kids in PRTF services and 10 kids in therapeutic group homes services, every one of them is a state ward. We have no voluntary placements, you know, receiving treatment through families. Everybody has found that to get those

services, the youth has to be a ward. I have a huge concern with the restrictiveness that we're seeing that the huge cost shift between Medicaid approved and provided services over to the lead agencies. If a judge finally has to order that a child is going to receive services that are medically appropriate and then the lead agencies or the state themselves in the north-central and western service areas have to provide that, we're paying 100 percent of that out of the state budget rather than capturing that 60 percent or 70 percent, you know, federal match, so it's a significant loss to the state for youth that would be, you know, Medicaid eligible. You know, I hope that we look at this not as an opportunity for...you know, an opportunity to further restrict youth, seniors, whatever, you know, to receive care; but we really make that medical necessity determination, that definition, based on how we can appropriately and effectively and efficiently give them the physical and mental health treatments that, you know, that they need. [LB1063]

SENATOR CAMPBELL: Thank you, Mr. McBride. Any questions from the senators? We'll take a look at the letter, because you covered a lot in the letter too. [LB1063]

TOM McBRIDE: Thank you. [LB1063]

SENATOR CAMPBELL: Thank you, Mr. McBride. Our next proponent? Welcome. [LB1063]

JONAH DEPPE: Good afternoon. My name is Jonah Deppe, J-o-n-a-h D-e-p-p-e, and I'm representing NAMI Nebraska today. I find it very regrettable that Senator Cook has had to introduce a bill like this, because I'm old enough to know the history of EPSDT, and EPSDT was...and I think that's one of the biggest issues that we're looking at here, that this state, as well as several other states, are not really implementing what CMS is requiring. If the child is on Medicaid, they are eligible for EPSDT, the early periodic screening diagnostic and treatment. And also, their families are to be informed that this is eligible, their child is eligible, and that they should have access to it. One of the things about EPSDT when it began many years ago was that the assumption was that the docs would be the people who were determining the medical necessity, determining the kids needed this. And, in fact, I was looking through my old box of books, and CMS had even worked with Georgetown University in Washington, D.C., and developed guides for doctors on how to do the screenings for mental illness and for the physical piece of it. And, Senator Gloor, a number of states have questioned what you were concerned about, is this an open door? But I think the assumption in the beginning was that doctors would be the ones determining, and there was a trust in the medical community for that. So what's happened is that, at least in Nebraska, we're seeing that medical necessity is getting to be what opens and closes the door. So it becomes a little more necessary to have...and I'm also thinking that from just listening to people that we're looking at persons besides the doctors making the determination that the child needs the screening, the diagnostics, and the treatment as is prescribed. The one thing that isn't happening is these kids are not getting the screenings on prescribed basis that

EPSDT requires. And part of that is I don't think that doctors and families are even aware of that. They look at it as a health check. That's what it's called in Nebraska, so it's a healthy child check. And there are certain other things that should be done at certain times in that child's lifetime up through age 21 which then makes them eligible for services. And I just felt like we've listened to stories, but I think still the biggest piece of this is we need to be implementing the EPSDT, and that's what Senator Cook is trying to get us to do, of the way that it's required by the federal government. It's not that it's something new that we're trying to get done here, but we are trying to say we need to define the medical necessity because that's become the opening or shutting the door. I have spent most of my professional life working with really young children and their families; and I have been kind of...more than kind of, I've been very concerned that we're kind of saying that kids that young aren't going to benefit. I happened to leave Nebraska in the eighties and move on to Iowa and then to Illinois, and it was partially because of what was happening in Nebraska, we were really looking at services for young children. I was kind of surprised not long ago to find that there are over 400 children age...or five and under in this state who are receiving psychotropic meds. They're not being prescribed through the behavioral health piece with Magellan. They're being prescribed through the medical piece with other doctors. These kids aren't getting treatment. They're getting drugs, and are they appropriate? No one's looking at that, yet we're denying them the kind of treatment that we know does work. And so I just want to commend Senator Cook for taking this on, because it is something that we need to be looking at, and why are we not following what the federal government is requiring us to do? Why are they not saying, why are you now following this? Thank you. [LB1063]

SENATOR CAMPBELL: Thank you, Ms. Deppe. Any questions? Thanks for coming today. Other proponents? Okay. Oh sir, you are? Do you need a page to pick up the...? [LB1063]

ROGER MEYER: Oh, I've got to give you my... [LB1063]

SENATOR CAMPBELL: Thank you. [LB1063]

ROGER MEYER: I'm Roger Meyer, R-o-g-e-r M-e-y-e-r. I had no intentions of saying anything today. I'm physician of the day here, and I happened to be sitting here; but I had some...I do have a few comments that came to mind as I heard all this. I don't know how long ago it's been, but during my practice, and I have been out of everyday practice now for about eight years, but I still do locum tenens work, fill-in work, but at one time I know Nebraska was considered to be 49th out of 50th as far as mental health care. That's really sad, you know. On the other hand, as far as cardiac care is concerned, I would say Nebraska's probably got the best cardiac care of any state or as good as any state. There seemed always to be such a big discrepancy there. Most of the third-party payers, as I remember, they would have a limit on how many mental health visits you could have. You know, maybe you could have 12 visits a years. And, well, that's not

enough, you know, I mean if you've got a psychiatric illness, you need a lot more than that. Kind of had to chuckle when Blue Cross Blue Shield doesn't want this bill to pass, that's pretty obvious, you know, because it's going to cost them more. There's also, I feel, not near enough providers of mental health care in Nebraska; and, you know, maybe that's because the climate for doing good mental health care is not here. If you can only see the patient 12 times a year, your hands are tied on how many times you can see this patient. I happened to be out where Rivendale was, and I don't know if you people remember the Rivendale episode or not, I don't know. I thought they were doing a wonderful job, and then apparently there was some fraudulent activity, and it came to an abrupt halt. But the thing where I was involved was that these kids would come in, they all needed a general physical. So we took turns from the Seward Memorial Healthcare system taking care of these...or doing exams on these kids. I can't just remember the age levels, but it seems like it was like five to nine or something like that; but the appalling thing was that these five- and six-year-old kids would be coming in because they had attempted suicide, they had threatened homicide, you know, sexual abuse, and on and on and on. And I made the comment, where in the world do these kids come from; and the answer was, well, most of them come within a radius of 50 miles of here. Now I was wondering who took care of those kids before Rivendale. Now I'm wondering who in the world sees them after Rivendale. It's obvious that if these kids were taken care of early on, that would be, there would be a lot less problem later on. And you know, I know psychiatric care is expensive; but how expensive is it to have someone be on the Medicaid system for the rest of their life because they didn't get taken care of early on? I happen to have a lady who lives in a trailer house close by me that was told she just as well leave high school because she wasn't paying attention and she was doing drugs and that sort of thing. Well, at any rate, she got into some problems and was put on probation, and I learned after they sentenced her to go to prison for three years because she hadn't followed the probationary thing, what this probation thing was. I'm not so sure I could have followed it. Her caseworker didn't really help her, so she was in jail, whatever you want to call it, for three years because she hadn't followed her probation for being on drugs. I mean, this woman needed psychiatric help. All she got was put in jail for that length of time. Now I have no idea what it costs to take care of her, I've heard anyplace from $70,000 a year to $200,000. I have no idea what it is, but why wasn't that spent on psychiatric care? I think all of Nebraska is at fault here. I think physicians have come to assume that mental health care is something that we aren't going to pay too much attention to. Apparently, Nebraskans don't expect mental health care to be equivalent with cardiac care or anything else. I think we really have a problem, and so I only heard half of your bill; but I kind of got the gist of it from everybody else. So that was pretty disjointed, but thank you. (Laughter). [LB1063]

SENATOR CAMPBELL: Thank you, Dr. Meyer. Any questions? Thanks for testifying. Any other proponents for the bill? Those who oppose LB1063. Madam clerk, how are you doing, Ms. Johnson? Okay. I'm just trying to figure out if we're going to take a quick

break after we finish this bill. Okay, (laugh) I'm seeing her nod. For the audience, I mean, we can all leave at certain periods of time; but obviously, the clerk cannot, so I pay very close attention to if she tells me she needs a break. Director, welcome once again. [LB1063]

VIVIANNE CHAUMONT: (Exhibit 20) Good afternoon, Senator Campbell, members of the Health and Human Services Committee. My name is still Vivianne Chaumont, V-i-v-i-a-n-n-e C-h-a-u-m-o-n-t, and I'm the director of the Division of Medicaid and Long-Term Care for the Department of Health and Human Services. I'm here to testify in opposition to LB1063. LB1063 appears to try to do two things. First, it requires the department to provide early and periodic screening, diagnostic, and treatment services known as EPSDT to all Medicaid-eligible children under the age of 21. Second, it legislates a definition of medically necessary for all services provided to children. You should first note that in Nebraska, children are eligible for Medicaid and CHIP to age 19. The reference to 21 in the statute is confusing and could be misleading, and it's my understanding that that's going to be amended. Every state Medicaid program is required to offer EPSDT services to eligible children. Nebraska already recognizes that mandate in Section 68-911 of the Nebraska statutes which states that medical assistance shall include EPSDT services for children. It is a mandatory service under federal law. It is a mandatory service under Nebraska law. Medical necessity is a fundamental concept underlying all health insurance programs including Medicaid. Although federal law does not define medical necessity, the state's definitions of medical necessity are strikingly similar. The medical necessity definition of Nebraska's Medicaid program is similar to that of many states and is almost word for word the definition of the largest health insurer in Nebraska. Nebraska Medicaid defines medical necessity with a comprehensive definition set forth in the Nebraska Administrative Code. Medical necessity is defined as healthcare services and supplies which are medically appropriate and 1) necessary to meet the basic needs of the client; 2) rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the covered service; 3) consistent in type, frequency, duration of treatment with scientifically-based guidelines of national medical research, or healthcare coverage organizations, or governmental agencies; 4) consistent with the diagnosis of the condition; 5) required for means other than the convenience of the client or his or her physician; 6) no more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency; 7) of demonstrated value; and 8) no more intense level of service than can be safely provided. Additionally, health insurance companies as well as other Medicaid programs specifically state that the fact that a provider has prescribed, recommended, or approved medical care, goods, or services does not in and of itself make such care, goods, or services medically necessary. This concept has been upheld by federal courts which have upheld state Medicaid determinations of medical necessity where the program and the physician disagreed. I provide you with two examples. There are more. In 1979, the United States First Circuit Court of Appeals held that federal Medicaid statutes grant states some discretion to limit

medical services based on their judgment as to whether a particular medical service is medically necessary. The court rejected the argument that a state Medicaid program must cover any medical procedure certified by a doctor as medically necessary. In 2009, the United States Court of Appeals for the Eleventh Circuit made short shrift of the argument that the physician's opinion regarding medically necessary treatment was the end of the discussion. The court held that the Medicaid agency may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures. It stated, "A private physician's word on medical necessity is not dispositive." We are, therefore, very concerned about the provision in the bill that states that in making a medical necessity determination, there shall be a presumption in favor of the medical judgment of the treating physician or treating provider. A presumption assumes that the provider's opinion is correct. Is the presumption envisioned in the bill rebuttable? Is there room for the department to do prior authorization? Is there room for utilization control? Every state's Medicaid program is required by federal statutes and regulations to have a utilization review program that safeguards against unnecessary or inappropriate use of Medicaid services. This is particularly true of admission to and continued stay in institutional care settings such as hospitals, ICF/MRs and mental health facilities. A presumption that a provider is correct is contrary to those requirements. If the inquiry ends with the presumption that the provider's opinion is correct, there are several important consequences. First, Nebraska Medicaid could be in violation of federal law as discussed above. Also, the bill establishes a standard of medical necessity for children. This standard is different than that would be applied to adults. I know of no insurance company or other state Medicaid program that creates different standards of medical necessity for children and adults. Federal regulations require comparability of services to clients within categories. There is a good chance that federal regulations do not allow different medical necessity criteria between adults and children, and we would be out of compliance with federal requirements on this issue. Second, if the discussion on medical necessity begins and ends with the opinion of the provider, there are serious implications to the Medicaid program. The rationale for managed care programs would disappear. If we were to take children out of the managed care contracts, it would be difficult to sustain managed care contracts only for adults. This is equally true for physical health and behavioral health managed care contracts. Physical health managed care contracts save money. Without a behavior health at-risk contract, our Medicaid program will not be able to comply with our corrective action plan related to Institutes for Mental Disease. Lastly, there would be a fiscal impact to the state, the extent of which cannot be determined today. In fiscal year '11, Nebraska spent approximately $500 million providing services to children through the Medicaid and CHIP program. This bill appears to be intended to provide children with more services. If the bill results in a 10 percent increase in services, that's $50 million fiscal dollar impact; if it's a 5 percent increase in services, that's a $25 million fiscal impact; if it's a 1 percent increase, that's $5 million fiscal impact. To these numbers, add the loss of savings from managed care and other programs to review utilization that the department currently has for children and adults. LB1063 overturns

standard practices of health insurance companies and Medicaid programs around the 50 states. It puts the Nebraska Medicaid program at risk of being out of federal compliance, and it will cause an indeterminate, but substantial fiscal impact. For all the mentioned reasons, the department opposes LB1063. I appreciate the opportunity to voice our concerns, and I'm happy to answer questions. [LB1063]

SENATOR CAMPBELL: Thank you, Director. We'll start with Senator Krist. [LB1063]

SENATOR KRIST: The definition that you currently have for medical necessity, and we have to disagreed...to agree to disagree on this issue, you and I personally, and your staff. It needs to be changed. It needs to be more flexible to allow an interpretation that would give treatment where treatment is due and needs to be there. I disagree with your presumption that just because the doctor goes in with some credibility that you can't fight back. The department shall adopt and promulgate rules and regulations to carry out the children's health treatment on page three, and then as it goes on on page four, the department may establish premiums, copayments, and deductibles for goods and services provided in medical assistance program limits on the amount and the duration of scope of goods and services that are received. I mean, the language here says pretty clearly you can as a department, and I'm talking to the amended copy, not the green copy, so if I'm putting you at odds because you're not prepared for it, I understand. But it's my personal opinion that Magellan, who does exactly what we tell them to do, nothing more, nothing less. It's a cookie-cutter approach on who's qualified and who's not qualified for service. They, in other states, have different interpretation for the same services. So someplace, and we again, we had this discussion on the mike before, someplace between where you are and where other states are more lenient is someplace we need to be. If in this program Magellan continues to do what they're doing right now, and you've heard all the horror stories, and they're all probably very, very true, and they touch you as much as they touch me. But if we continue to do this, then we are telling kids in the state that the only way you're going to get any treatment is if you are made a ward of the state, which is taken out of another pot of money, understandably; but there is some federal match on the Medicaid side that we're not seeing in general funds when a judge says, I don't care what you say, this kid needs to have treatment. So, you know, I understand it's your job to come in and disagree with the bill; however, I think there has to be some middle. [LB1063]

VIVIANNE CHAUMONT: Two things, I think. The first thing that you were talking about, and the testimony seemed to be focused on admissions to PRTF, basically. That's what the providers here, other than the ones that talked about the under five, those two things. That is one tiny part of the Medicaid program for children. This isn't talking about PRTFs. This isn't talking about mental health services. This is talking about Medicaid services for children. That's $500 million worth for children. The behavioral health services are not even half of that. So if we want to talk and we have actually in response to the committee's urging and hearing the input that we have, we have been working on

revising the criteria that you need to get into a PRTF, and we are more than willing to work with that. And that's the standards that, you know, the side by side that had been offered before by Mr. Connell and others. But this isn't what this bill is about. This bill isn't about admission to PRTFs or for behavioral health services. This bill changes the medical criteria to look at all Medicaid services for children, and I don't believe...and you know, I meet with state Medicaid directors and see what other states are doing, and I can tell you that that definition in my testimony is pretty standard among the states. [LB1063]

SENATOR KRIST: Okay, so what you're saying is that we're applying the definition in this bill, we have changed the definition to be so broad that we're going to see an increase of kids coming into the system. [LB1063]

VIVIANNE CHAUMONT: See, you're focusing on behavioral health. This bill is about Medicaid and CHIP for children. I believe, you know, are we going to see more kids come in the system? Yes, we might see more kids. I can tell you this. We are looking at everything that we can to make sure that we are in compliance with federal regulations and are stretching the limits for the behavioral health services. [LB1063]

SENATOR KRIST: I just don't see that I'm focusing on mental health. I see that...I see the total system and the total program being, if we have to treat a kid and we can't do it because a parent can't get the child treated in their home, then the obvious, the obvious, and the state is...it's not your office that's saying it; but in conjunction with another office, we're saying if you can't qualify it, if Magellan can't put you into some kind of system, and we can't use part Medicaid funds and part maybe something else to treat you, you don't have a choice. You're going to make them a ward of the state. [LB1063]

VIVIANNE CHAUMONT: And I don't...I understand that part of it, but what also comes at play in this, and we've gone through this before, is that we had to come into compliance with federal requirements. Our previous children's behavioral health system was out of compliance with federal law, and the threat was we were going to lose all the money, so we had to move this, the system to a system...that's right, we don't pay for the same things that we used to pay for prior to July, because we have to comply with federal law. And the way we were doing it previously didn't comply with federal law, and they told us so, so that's why some of the change has been. But this definition, so we can talk about the definition to get admitted into a PRTF, which is basically set out in federal law, and we're going to be sharing our revised criteria here shortly, but this we're talking about a definition for services in the medical program, which is the underlying definition. And then for particular services, there might be a particular additional criteria, and we are focusing on the bill that just is talking about Medicaid services for children, all $500 million of it. [LB1063]

SENATOR CAMPBELL: And Director, I guess what I would like to add here, and it was...I know you think it was an unfortunate day for you (laugh); but on the day that we were supposed to discuss this is, of course, the day that you had your accident. And I honestly think that the discussion among the committee members was, do we need to look at the definition of medical necessity? And one of the things that was talked about at that meeting was, we'll go back to the department, and we'll look at this issue. And I know...I take you certainly at your word that you're working on it; but at some point, I think the committee and Senator Cook probably said, well, let's put something in here, because we have to know where we're going on this issue. And so I guess I would implore that there be perhaps another discussion here in terms of all that you're working on here and all that we might be seeing in the bill. I understand your duty today is to raise the issue of how this affects the total program; but certainly from that day, we've not heard anything. And to Senator Cook's defense, I think she was listening to the committee and said, let's put a bill in. [LB1063]

VIVIANNE CHAUMONT: I understand that. And I just want to say that in my defense, I thought we were going to schedule another hearing. We have been working on it. We're about ready. I have the data regarding the drugs for children under five that I know was raised on December 5, when I wasn't here. So I am more than happy to send the information to you in writing or to schedule a hearing, either way. [LB1063]

SENATOR CAMPBELL: I'm going to let Senator Gloor in here, because he has to leave, and I have some follow-up questions, but... [LB1063]

SENATOR GLOOR: Got to go to a funeral. That will be sort of the fitting ending to the way this whole week has been. (Laughter) [LB1063]

VIVIANNE CHAUMONT: I'm sorry. [LB1063]

SENATOR GLOOR: No. It's been interesting to sit here watching you in the back bounce around. I can tell you're getting better, because you're starting to move around a lot more in your seat. (Laugh) And so I'm not so sure I liked you... [LB1063]

VIVIANNE CHAUMONT: (Laugh) You have very uncomfortable chairs I think. [LB1063]

SENATOR GLOOR: Well, you're bouncing around based upon some of what was being said here in the testimony. [LB1063]

VIVIANNE CHAUMONT: Uh-huh. Yeah. [LB1063]

SENATOR KRIST: And I understand your frustration. And you know from my line of questioning that I have this uncomfortableness about the presumptive issue. But that wasn't what this bill was really focused on. And your whole response to us, written

response, was almost solely on that issue. I would reiterate the comments made by Senator Campbell and I think others that there are bigger issues here that are I think more important to what we're interested and what you can help us with. And it's unfortunate that our focus has drifted towards that. And I think there is opportunity for us to sit down and maybe have a lot more productive dialogue about this. This is a sticky, sticky issue that I would hate to see us sink good dialogue about some of the things that we, I think, all would like to try and accomplish. [LB1063]

VIVIANNE CHAUMONT: Thank you, Senator. I totally agree with you that, you know, I read the bill and it's this...you know, it's not a focused bill on the issue that we're talking about. It's a bill that establishes different standards, that appears to change things completely. And I'm very, very uncomfortable with that. If we want to focus on the issues about the residential care for children and how that's changed since the federal...since that corrective action plan with the feds and the work that we've done on it, I'd be more than happy. And I think that the conversation would probably be better if we were focused on that. [LB1063]

SENATOR CAMPBELL: But in all honesty, though, Director, at the end of that conversation that day we did sit and visit about the definition of medical necessity. And I think part of the idea was to come back and try to talk about that issue. So just so that you know that was a part of it. And I also think we wanted to set a briefing, and that's certainly remiss on my part, on the issue of the waivers and I think probably Senator Bloomfield's, that issue. I didn't think that we were to come back with the review, but we will set it up. The question I want to follow up, though, is on...in the note you talk about the EPSDT. And yet we continue to hear from people that some of the behavioral health services for children should be covered under EPSDT and we are not covering in certain...I think Mr. Goddard's testimony. So can we go back to that? [LB1063]

VIVIANNE CHAUMONT: Sure. EPSDT requires services to be medically necessary. EPSDT has a whole screening, you know, vision, all of that. There's that part of EPSDT. And then there's the part of EPSDT that says if a child...if there is a medically necessary service for a child that the plan doesn't cover for adults, you still have to cover it for a child. So let's say that this is why when we make benefit changes most of the time we're not talking about children. Let's say dental, just to take a nice noncontroversial topic, because there are no dentists in the room... [LB1063]

SENATOR CAMPBELL: Today. [LB1063]

VIVIANNE CHAUMONT: ...today. We don't...if we...okay. If a state doesn't cover dental services for adults, all states cover dental services for children through PSDT if it's medically necessary for a child to have a procedure that that will get paid for. If it's medically necessary for a child to be in a PRTF, you don't need to go to EPSDT, because that is a service already in the state plan that we cover. But EPSDT doesn't

eliminate the need for medical necessity. Every Medicaid service needs to be medically necessary. And EPSDT is a class of medical benefits. [LB1063]

SENATOR CAMPBELL: So in other words, the children who are under the age of five, who we've talked about today, who some have said to me should be covered on EPSDT, you're still saying that meets the medical necessity. So those children under five aren't covered because they don't qualify under medical necessity? [LB1063]

VIVIANNE CHAUMONT: Right. And... [LB1063]

SENATOR CAMPBELL: Am I following that train correctly? [LB1063]

VIVIANNE CHAUMONT: That's exactly right. That's exactly right. And we do cover services for children under five. We don't cover probably services to the extent that some might want us to cover the services; but we do not say, you are under five, you don't get a service. We do cover services for children under five... [LB1063]

SENATOR CAMPBELL: And I think that... [LB1063]

VIVIANNE CHAUMONT: ...if we find that they're medically necessary. [LB1063]

SENATOR CAMPBELL: Yeah. And I'm just going to finish and then we'll come back. But part of the concern that I think this committee has seen is one of the comments when a physician is prescribing psychotropic drugs for children under five, and yet we can't get behavioral health services for them. And I know that that's been brought up here and greatly bothered by it. [LB1063]

VIVIANNE CHAUMONT: And that's...there is some data about how many kids under five were getting, at a certain point in time, were getting psychotropic drugs. And we have that data and exactly what they were getting and whether or not, you know, we can agree to disagree again, whether or not, you know, whether or not they need it. The large...there were...I don't...I have the correspondence ready to go to Senator Krist, it just needs to go out. Well, I figured he...I thought we were going to have a hearing. But I figured I better get it to him quick. [LB1063]

SENATOR CAMPBELL: Senator Krist, you want to follow up on that, and then I'll come back to Senator Cook? [LB1063]

SENATOR KRIST: Your stand-in who came to that meeting on the fifth, that immortal day, and the Magellan person who sat next to her when we asked the question, I was sitting over there on that side and I said, the definition of medical necessity needs to change. And we need to take care of more kids. We're taking care of them over here or we're taking care of them over here. So we need to come to a new definition. And she

said, and you can check the records and the transcripts, we don't agree, I'm just following the directions. [LB1063]

VIVIANNE CHAUMONT: Who said that? [LB1063]

SENATOR KRIST: Your person sitting at the table the day you had your accident. We don't agree, we think the definition is fine. And I said, well, I'm going to tell you I don't agree. Now we can argue about whether there should have been a hearing. We can debate or talk about whether,... [LB1063]

VIVIANNE CHAUMONT: Yeah. It doesn't matter. [LB1063]

SENATOR KRIST: ...there should have been a hearing there was a...you know. But the Magellan person sitting right next to her said, you're telling me that it's the definition that you're listening to, and that if the definition changed you could approve more services? And she said, we approve more services in other states based upon different definitions. So I'm just telling you from my perspective that I don't think we're doing everything that we can to help the people who need help. And I'm not suggesting that we have to expand this into a $100-million program, but that is the crux of my frustration with this whole thing and the fact that we're handing out candy to kids, but we're not trying to get them off of the candy. And that goes back to the point on the five-year-olds. [LB1063]

VIVIANNE CHAUMONT: And I think when you see the data we can have the discussion. [LB1063]

SENATOR KRIST: Okay. [LB1063]

VIVIANNE CHAUMONT: We'll have more basis for data. But I think the lesson is not to ever have an accident before I'm supposed to be here. (Laugh) [LB1063]

SENATOR CAMPBELL: Senator Cook, did you have a follow-up or was that your question? [LB1063]

SENATOR COOK: I've got maybe more of a... [LB1063]

VIVIANNE CHAUMONT: And I'm sorry, because... [LB1063]

SENATOR CAMPBELL: Oh, I'm sorry. Go ahead. [LB1063]

VIVIANNE CHAUMONT: ...I am on the record as saying that we were trying to look...I mean I've said that in letters to people, to look at what we can be in federal compliance of and, on the PRTF issue anyway, and expand that. [LB1063]

SENATOR KRIST: And in all fairness... [LB1063]

VIVIANNE CHAUMONT: And be as flexible I think are my words,... [LB1063]

SENATOR KRIST: I understand. [LB1063]

VIVIANNE CHAUMONT: ...as flexible as possible. [LB1063]

SENATOR KRIST: I understand. And I can appreciate the fact you're a professional, you're doing exactly what you think you need to do. But we've been hearing that from the Department of Health and Human Services for a long time--we're getting better, we're working at it, we're moving ahead. It's just time that we...I don't know what it takes. But we're getting to the end of a 60-day period here where we can't do anything. And then we're not going to be able to help the people that do. So I... [LB1063]

VIVIANNE CHAUMONT: I will get you the revised criteria for PRTF next week. [LB1063]

SENATOR CAMPBELL: Senator Cook, did you have a follow-up? [LB1063]

SENATOR COOK: I think I have a question. Thank you, Madam Chair. I have a question, and I think it is probably a question on the minds of many constituents and parents and advocates. And it goes to the idea that one would get approval through this rubric for a psychotropic drug, a drug therapy, and not get approval for a different kind of nondrug therapy, whether it's talk therapy or some of the behavioral therapies that we've learned about. So...and I understand the changes that happened at the federal level. We've also heard testimony today with families that have been, way before we saw that piece of letterhead from D.C. in 2010, have been struggling with getting their children served. So to the extent that you'd be able to help us understand that or...I'd appreciate it. [LB1063]

VIVIANNE CHAUMONT: Well, the psychotropics for...and I wish I had the letter and I wish, you know, that we had that data in front of us. We actually do things through prior authorization to try to keep the psychotropics out of young children, not five-year-olds, I think it's to seven. We have a drug utilization review board. There are instances where...well, I can tell you that the large majority of drugs that are prescribed to adults and children, psychotropic drugs, are prescribed outside of the mental health system. So they are prescribed...and I haven't done it here; but we did a data poll one time in Colorado. And, I mean, you had dermatologists prescribing psychotropic drugs, you had, you know, pathologists, all kinds of people. And the large majority of them were family practice and I guess that's what they're called, not GPs, but family practice doctors. So there is that kind of disconnect between our...but the data that we have, I don't think we're in as bad a shape as we think that we are on that. The issue with

providing therapy for under five years old is this, if we believe the experts that we hire...and don't forget, you know, that we think that it's Magellan sitting in some building, but it's...but the prior authorizations are done by Nebraska psychiatrists who are in private practice. They review a lot of the things. Depending on the type of therapy that's offered, some you can say, you know, is helpful and some isn't. Now I know that sometimes, you know, parental education is really what the therapy that someone is asking for. Well, that is not a Medicaid-covered service. So that is not a medically necessary service for the child. Could we all sit here and talk about whether that's a good idea or a bad idea? Yeah, I'm not going to disagree with you that that's a good idea. And managed care will help with that because they can pay for things that fee-for-service can't pay for. So it's that kind of thing. If there is talk therapy or family therapy or play therapy or any other kind of therapy that's helpful for a child, even a young child, we will authorize that. And if we're not authorizing it, and I know we are authorizing it. But I will go back and make sure that we are authorizing it because we should be authorizing it. [LB1063]

SENATOR COOK: Thank you. [LB1063]

VIVIANNE CHAUMONT: It should...every determination needs to be made based on that individual. You know, you shouldn't have five-year-olds get this, six year, you know. You look at every child that comes in the door. [LB1063]

SENATOR COOK: And so the reports of getting kind a tick, a punch list and then not being able to understand that because the interpretive document is stamped draft? [LB1063]

VIVIANNE CHAUMONT: No. I'm guilty as charged on that one. I'm sorry. [LB1063]

SENATOR COOK: Oh... [LB1063]

VIVIANNE CHAUMONT: I have seen the Magellan...some of the denial letters. I'm a lawyer, I work in healthcare, and I find them hard to understand. And I have asked Magellan to redraft and we are working on redrafting to make those more understandable to your average person. And that I hate to, you know, say we're working on that. But you know, there's a lot of things on our plate. And that's one of the things that we are working on. And actually hearing that testimony reminded me that I need to check what is the status of that project, because I have a hard time arguing on that one. I'm not going to argue that one. [LB1063]

SENATOR COOK: Okay, thank you. [LB1063]

SENATOR CAMPBELL: We can identify with a full plate. [LB1063]

VIVIANNE CHAUMONT: Um-hum. [LB1063]

SENATOR CAMPBELL: Senator Lambert. [LB1063]

SENATOR LAMBERT: Comment and then I need some help understanding something. You said we're not in as bad a shape as we think we are. I hope that's true, but I've not seen anything to tell me anything different. [LB1063]

VIVIANNE CHAUMONT: About the drugs. (Laugh) [LB1063]

SENATOR LAMBERT: You know? [LB1063]

VIVIANNE CHAUMONT: About the drugs. [LB1063]

SENATOR LAMBERT: Well, any of it. I've not seen anything to show me that we aren't...I guess and maybe I think the sky is falling. But I don't have anything to tell me that the sky isn't falling. This change in medical necessity criteria, I see that we were approving 90 percent of the applications; after July we're approving 34 percent by this letter. I assume it's correct. [LB1063]

VIVIANNE CHAUMONT: I don't know what letter that is, but I can tell you that July was when the federal government gave us to come into compliance with the new service definitions. And the service definitions of what CMS will cover, we were paying for a lot of residential care that we simply cannot cover any longer. If you want to get Medicaid services in a residential setting, you're basically limited to places that aren't an IMD, so less than 16 beds, or being a PRTF. And that's why the change, why those requirements, because the level of care that is needed to be in a PRTF is an inpatient psychiatric level of care. The level of care prior to that, in a bunch of different facilities, was a much lower level of care so we could approve people. But they're not reimbursable under federal law. We had to change our children's behavioral health, our entire system basically, to come into compliance with federal law or we would have lost our Medicaid funding. [LB1063]

SENATOR LAMBERT: So this care that we're not giving these people is because of the federal government. Is that what you're telling me? [LB1063]

VIVIANNE CHAUMONT: The care that the...some of it is, some of it is. When we had... [LB1063]

SENATOR LAMBERT: What is the rest of it then? [LB1063]

VIVIANNE CHAUMONT: Well, the rest of it, some people will argue, is that we are being too strict with the definition to a PRTF. And that's the...those are the criteria that

we are...that we have taken a look at and tried to make as flexible as possible. But the biggest portion, I mean I believe that the reason why the services went down is because we had to come into compliance with federal law. That's the experience of every state that's had to come into compliance with those requirements. [LB1063]

SENATOR CAMPBELL: Director, I'm giving you...you can take that with you, that's the letter that Senator Lambert is referring to. And, Senator Lambert, we probably should set up a separate orientation for you, only because this committee has had like three or four on the PRTF issue. And so it would help I think. Perhaps the Director can sit down with you... [LB1063]

SENATOR LAMBERT: Well, yeah, I don't understand a lot of what's going on here. [LB1063]

SENATOR CAMPBELL: And we'll get some information for you. Director, were you...I know you were here. Did you hear Doctor, and I'm not going to say, Bothern's, I think, report that she had one approved in 19 years? I mean, do you think that's... [LB1063]

VIVIANNE CHAUMONT: You know what, I don't know. I don't know. [LB1063]

SENATOR CAMPBELL: Yeah, you might want to look at that one. That's... [LB1063]

VIVIANNE CHAUMONT: I can sure look that up. Right. [LB1063]

SENATOR CAMPBELL: That might be... [LB1063]

VIVIANNE CHAUMONT: Well, I...you know, after today, I'm going back and asking questions. [LB1063]

SENATOR CAMPBELL: Okay. How long would you like us to set up to come back and talk about the work that you've done on PRTF and follow up anything that you might find on medical necessity? How long should we plan? An hour to visit with you or 45 minutes or 10? (Laugh) It's not going to be ten, but we'll try to get something set up next week when...just think about it, and I'll have my staff e-mail you. We'll probably come back to this pretty quickly in order to know what we need to do with Senator Cook's bill. She would probably like to know that too. Anything else? Thank you, Director. [LB1063]

VIVIANNE CHAUMONT: Thank you. [LB1063]

SENATOR CAMPBELL: Anyone else in the room who wishes to testify in opposition? Okay, with that, we will close the public hearing. Oh, sorry. Senator Cook, would you like to close on your bill? [LB1063]

SENATOR COOK: No, I don't think I will close today. [LB1063]

SENATOR CAMPBELL: Okay. Wise woman. [LB1063]

SENATOR COOK: I think I'd like to follow up with the committee in writing, follow up on that. Thank you. [LB1063]

SENATOR CAMPBELL: Okay. That will be great. And we will take a five-minute break here. So run, Diane. (Laugh) (See also Exhibits 21-27) [LB1063]

BREAK

SENATOR CAMPBELL: Okay, we have the clerk, we have four senators, we're ready to go. And we do apologize; it's just the nature of hearings. We just never know when we're going to get to people, so we apologize. We will resume, for the record, the hearings of the Health and Human Services Committee. And our next bill up is LB1083, Senator Bloomfield's bill to clarify permitted practices under the Nurse Practice Act. Senator Bloomfield? [LB1083]

SENATOR BLOOMFIELD: Thank you, Senator Campbell and colleagues, members of the Health and Human Services Committee. I have already apologized to the people that are here behind me for our delay, but they are aware that it is part of what we do. My name is Senator Dave Bloomfield, spelled B-l-o-o-m-f-i-e-l-d, and I represent Legislative District 17. I am here to introduce LB1083 to the Health Committee today. This bill would clearly instruct the Nebraska Department of Health and Human Services that they may hire nurses who hold current licenses through the department to provide home healthcare to family members and be reimbursed for these services. I am familiar with a licensed Nebraska nurse who has cared for her son for the past five years in her home. Late last year, she was informed that she could no longer be considered among the pool of nurses who could be hired to care for her son. She was told there was a change in statute and, therefore, could not be considered to be rehired to take care of her son. She is here today to provide testimony on her situation. After referring to statutes, I believe licensed nurses may currently work as healthcare providers in their homes for family members. There was a change in the statute; but to my understanding, it did not affect the subsection dealing with home healthcare. This bill is introduced to send a clear message to the Department of Health and Human Services that licensed nurses may indeed provide care to family members for pay in their home. It is my firm belief that no one can or will provide the extra-touch care of a family member, and the idea that we would sacrifice that special care when it costs us nothing seems foolish, at least in my eyes. Thank you for your consideration. I'll try to answer any questions you may have, though it is probable the people behind me who have been involved with this for years are more likely to have the answers you deserve. [LB1083]

SENATOR CAMPBELL: Okay, thank you, Senator Bloomfield. Any questions? We'll go ahead and take the testimony this afternoon. Our first proponent. Good afternoon. [LB1083]

LINDA SCHMIDT: (Exhibits 28-30) Good afternoon. Madam Chairwoman, members of the Health Committee, my name is Linda Schmidt, L-i-n-d-a S-c-h-m-i-d-t, and I am here today as a proponent of LB1083. My appearance is somewhat unusual because as you all know, I work as a legislative aide for Senator Bloomfield. I am here, however, today on behalf of my former boss, Senator "Cap" Dierks, who unfortunately cannot join us today. I spoke with Senator Dierks this morning, and he gave me his blessings to be here for him and asked that I give you all his warmest regards. LB1083 was introduced on behalf of a woman Senator Dierks, and now Senator Bloomfield, have tried to assist. Dee Shaffer of Ashland, Nebraska, is a licensed LPN. Dee contacted several senators in 2006, asking for assistance to help her to take care of her son, Brian. In response, Senator Dierks introduced LB605 (sic) in 2007, which you have copies of now, which would have allowed her to take care of Brian in her home for pay. Shortly after LB635 was introduced, the Department of Health and Human Services asked if Senator Dierks and Dee Shaffer would meet with the department to see if we could work things out for Dee. A meeting was held, which I attended, and an agreement was reached to allow Dee to work as Brian's private-duty nurse. A copy of that agreement has also been handed out to you today. In return, Senator Dierks withdrew LB635 back in 2007. I have also provided a copy to the committee of a letter of support for Dee Shaffer to take care of her son, and this letter was written by Brian's primary care doctor, Dr. John Deck. There have been many issues going on for Dee and Brian in the number of hours needed to take care of Brian and compensation; so this is somewhat a complicated situation, but the doctor is fully in support of Dee and the care she gives to her son. Let me close by saying it has been my pleasure to meet and work with Dee Shaffer. She is a single mom and a nurse who provides 24/7 care for her son Brian and during the last five months, she has provided this care for no compensation. Thank you very much to the committee and I will try to answer any questions if you would have them. [LB1083]

SENATOR CAMPBELL: I just want to make sure, just because I was trying to follow, and you said for the last...has not received compensation. What did you say? [LB1083]

LINDA SCHMIDT: For the last five months. [LB1083]

SENATOR CAMPBELL: Oh, five months, okay. [LB1083]

LINDA SCHMIDT: Yes. [LB1083]

SENATOR CAMPBELL: I just...I didn't want to write it down in my notes unless I had it correct. [LB1083]

LINDA SCHMIDT: Yes. [LB1083]

SENATOR CAMPBELL: Are there any questions from the senators? Senator Bloomfield, did you have a comment? [LB1083]

SENATOR BLOOMFIELD: Yeah, just briefly as a point of clarification. It was at five months ago when the department told her that she was...due to changes in statutes that they could no longer pay her, and from what we've been able to find in statutes, that's not the case. [LB1083]

SENATOR CAMPBELL: So you haven't been able to find in your research what specific statute they are referring to? [LB1083]

LINDA SCHMIDT: It's the statute that is in the bill, in LB1083. Back in 2007--and this is verified by the Bill Drafter who helped me draft this bill--changes were made to that specific part in statute; but it was not made to the home healthcare part of statute. It was made to a later part which would not have affected Dee. So what they told her in essence is true. Changes were made to this section in statute; but it was not a change, to the best of our knowledge, that would have affected Dee's ability as a licensed nurse to take care of her son. [LB1083]

SENATOR CAMPBELL: Okay, thank you. [LB1083]

LINDA SCHMIDT: And Dee is here today to talk with the committee as well. [LB1083]

SENATOR CAMPBELL: Yes, and thank you for that clarification. Okay, let's go ahead, and thank you for your testimony today. Our next proponent? Welcome, and I'm sorry for your long wait. [LB1083]

DEE SHAFFER: Please excuse me. I thank you for hearing me, Senator Campbell and senators, and especially for Senator Dave Bloomfield, who has been gracious enough to present this bill. [LB1083]

SENATOR CAMPBELL: And you want to state your name and spell it for us? [LB1083]

DEE SHAFFER: It's Dee Shaffer, D-e-e; and Shaffer is S-h-a-f-f-e-r. I leave my phone on here because in case my caretaker that is a friend of mine needs to call me, I've got to go. I'm in support of LB1083 for clarification. I was in a pay-for-fee services and it changed to a managed care with no explanation. The ball just got dropped. I received no direction as to why or what to do next. I was told that I could no longer work with my son due to the law saying that nurses could not work and be paid for taking care of their family members, although I did it for five years. The monies I earned in this position I used to support my special-needs son's many needs. He is on a special diet. He has

three pages of allergies that we know of. I...he's been to allergists here in Nebraska. He's been to the Mayo Clinic. He's been to an environment authority allergist in Kansas City, Missouri, and he checked him and he said he's allergic to the seven most basic things in life. He would...he refused to even check him further. He said that his allergies are so severe that he could come across a chemical that actually could kill him in the minute amount in testing; therefore, he would not test him any further. The only thing that we have is avoidance. My son requires 24/7 care. When he has an allergic reaction, he's up throughout the night. You had a break and you got to relieve your bladders. Just imagine not being able to pee. My son can't do that sometimes when these allergic reactions happen. One doctor in his past thought he had a neurogenic bladder and he explained that chemicals, when you breathe them in or take them in, will shut down the bladder and it just fills up and it could burst and that could be the end of him because it could cause an infection. There are no antibiotics he can take. There are no pain medications he can take safely. He has fragrance allergies. Dr. Burgess (phonetic) was the first doctor that brought this to my attention. I said, well that's why he's been losing all these pain medications and why they're ineffective, is because the two are chemically related and I...he told me that make sure that I was fair to the doctors that...to make sure that they knew about this because if they tried to treat, they could kill him. Pain medications don't work and he's in excruciating pain when he has allergic reactions. Just imagine your liver swelling up inside and you can't see it and you can't scratch it. It impairs the liver from even doing its functioning and it swells and it causes pain inside his body. And his behaviors are not because he's autistic; they are because he is in pain and having allergic reactions. This is one thing that the five years has allotted me to see, that I can go ahead and look at and observe observations. That what a skilled nurse does. We record observations, and this is what I have seen and been able to report to doctors. It isn't that I...that it's just my opinion. I have had other nursing staff in my home at times and they have seen some of these reactions. An ear infection, Dr. Deck ordered an ear drop and we went ahead and used it. It had a preservative and I checked with the pharmacist and he said that minute a dose won't hurt him. I put the drop in his ear. I told the nurse I was very uncomfortable. I didn't even get the cap on the bottle and it...from his head down to his chest on over, he turned beet red and it swelled up immediately and she panicked. I had to yell at her to keep her in control for what we were going to do next. These...I have held my son in my arms and he...purple, anaphylactic shock with seizures. Since I have been caring for him, he has not had any seizures. We've only had to go to the emergency room once. I...with me caring for my son, we...I'm saving the state a lot of money. There is no way that they can try and shove him in with somebody else without him having problems. He can't breathe in the chemicals what somebody else wears. There are toiletry articles. There's laundry soap. He can't eat the foods that they eat. If he picks up something they have, it could be the end of him. He's not literally supposed to be here. His heart specialist said he wouldn't even make it to 25. He's 32 right now, and I praise God for each and every day. [LB1083]

SENATOR CAMPBELL: Thank you, Ms. Shaffer, for your testimony, and we always appreciate when a family member has to talk about their son or daughter because we know that's very difficult, so thank you. Are there any questions? [LB1083]

SENATOR BLOOMFIELD: Again, I'm going to go for a point of clarification. And thank you, Dee, for coming in. You're baby-sitting the phone so closely because Brian had a reaction to something the other day. [LB1083]

DEE SHAFFER: Yes. [LB1083]

SENATOR BLOOMFIELD: Would you tell the committee how minute and what that was, just so we get a feel for what's going on? [LB1083]

DEE SHAFFER: I...thank you, Senator. I had two scheduled appointments with doctors. I have to use alternative doctors because they're the least risk for giving Brian. I went to see Dr. Kevin Coughlin, and he had a patient in his waiting room, prior to us coming in, that was heavily scented with fragrance. Just us walking through that, Brian exploded into hives, and I had him in the room. I bring in an air-cleaning machine that cost me $800 and it takes 20 minutes for it to take the chemical out; and I told the doctor that I almost got up and left because I didn't know for sure what I was going to have next. My son was up through the night because of that reaction. I never know how long it's going to take. Some of his reactions take months. His detoxing mechanism does not work in his biochemistry. He can't...what normal person does is 24 to 48 hours, they get rid of any kind of chemicals you breathe in. That's a normal functioning body. But his is not normal in that way and it doesn't work that way. It can take months. That's where that's at. I've found that acupuncture/chiropractic have helped tremendously. It helps to his body with pain issues and anxiety issues. [LB1083]

SENATOR CAMPBELL: That's good; that's very good. Well, thank you for coming today and we certainly appreciate your testimony. [LB1083]

DEE SHAFFER: Thank you so much for hearing me and thank you, Senator Bloomfield. [LB1083]

SENATOR CAMPBELL: Are there others in the room who wish to testify in support of LB1083? Is there anyone in the room who wishes to testify in opposition to LB1083? Anyone in a neutral position? Senator Bloomfield, do you wish to close? [LB1083]

SENATOR BLOOMFIELD: I don't think we need to close. We'll waive that for now. (See also Exhibits 31-32) [LB1083]

SENATOR CAMPBELL: Okay. With that, we will conclude the hearing on LB1083 and proceed to LB1122, which is also Senator Bloomfield's. And LB1122, Senator

Bloomfield brings to change the Medical Assistance Act with respect to certain home health services. Thank you and welcome again. [LB1122]

SENATOR BLOOMFIELD: Thank you again, Senator Campbell, colleagues. My name hasn't changed, it's Senator Dave Bloomfield, District 17; Bloomfield being spelled B-l-o-o-m-f-i-e-l-d. I'm here today to introduce LB1122 to the Health Committee. This bill would give instructions to the Department of Health and Human Services as to legislative preferences regarding Medicaid home healthcare services. LB1122 directs the department that when making cuts in Medicaid services, they are to look at home healthcare services offered by private-duty nurses only after they make cuts in other places. I am pleased to have constituents here today to tell you about their children. They contacted me in December when learning about proposed cuts in health services that would directly affect their two children. Unfortunately by statute, this letter is sent out yearly, just before Christmas, telling them that there are going to be things that affect their family. They are told of proposed cuts that could mean the difference between life and death for their kids, and this just seems wrong to me. I understand that the Legislature cannot directly tell the department where to make cuts and I do respect the separation of powers between the legislative branch and the executive branch of government. However, families should not be told annually that their way of lives will soon change because of the state's financial concerns. Honorable children and family members who require medical attention should not be on the chopping block when the state is making cuts to balance the budget and save a few dollars. This is a matter of life and death for many of our families. We should not and must not let the most fragile among us continue to be used as bargaining chips in the game of who gets the money. With that, I will end my testimony and allow you the privilege of meeting the family behind me. [LB1122]

SENATOR CAMPBELL: Okay. We'll save any questions and have the family testify. Thank you, Senator Bloomfield. [LB1122]

SENATOR BLOOMFIELD: And if you have any questions, yeah, I'll take a shot at them, but they're a lot better. [LB1122]

SENATOR CAMPBELL: Okay. Those who wish to testify in support of LB1122? Good afternoon. It's still afternoon. [LB1122]

CINDY MEYER: Yes. [LB1122]

SENATOR BLOOMFIELD: Yes. [LB1122]

SENATOR CAMPBELL: Thank you for your patience and we're sorry it took so long. [LB1122]

CINDY MEYER: Thank you for having me. [LB1122]

SENATOR BLOOMFIELD: You've never told me, Senator Campbell, when it officially become evening down here. [LB1122]

SENATOR CAMPBELL: 6:00. [LB1122]

SENATOR BLOOMFIELD: Okay. [LB1122]

SENATOR CAMPBELL: That's really arbitrary, I know. We're glad you're here; go right ahead when you're ready. [LB1122]

CINDY MEYER: (Exhibit 33) Thank you. My name is Cindy Meyer. I'm a registered nurse who has two terminally-ill children. I contacted Senator Bloomfield after receiving the letter in December stating that private-duty nurses would be eliminated. My husband and I have two children that were born with a rare genetic disorder--nonketotic hyperglycinemia--and failure to thrive. The life expectancy of children with this disease is six months. Ashley (phonetic) is 28 years old; she is one of the longest-living people with this disease. And her brother Derek (phonetic) is 22. There are 23 known cases in the United States of this disease. They also have experienced grand mal seizures, ulcerative colitis, apnea, scoliosis, and they are blind. They have very brittle bones. They can't walk, talk, or feed themselves. They depend on nurses who care for them to meet their daily needs. They both have an immune deficiency, so they did not receive any childhood shots. They need to be isolated from children and sick adults so that they don't get sick. Ashley (phonetic) ended up getting the mumps when her school teacher left her home where her daughter was sick with the mumps, came into our home to provide school for her. Ashley (phonetic) caught the mumps from the teacher and ended up in the hospital on a ventilator for a month. Both children received school services in our home: physical therapy, occupational therapy, and vision services while they were school aged. Once they turned 21, those services all ended. At the time when Ashley (phonetic) and Derek (phonetic) were going to school, the school was building a new special education building in Wayne. The administrator came to our home, talked to us, and they developed a room for our children that was specially designed for them with a ventilation system that they thought that they could provide services for them. Once the building was done, the administrator came back with the teachers to meet the children. They were in our home for a half-an-hour, and after that time they told us they could not serve our children. They said they were too medically fragile and it would not be safe for them to be in the building, but they would continue to provide services in our home as long as there were nurses there to care for the children. Derek (phonetic) also has an ileostomy and has frequent problems with skin break down and secondary infections. Due to his brittle bones, he has had many broken bones: his right femur, his left foot, his left ankle and his left arm. His femur broke when he was being lifted out of the bathtub. If it hadn't been a nurse there caring for Derek (phonetic), it would have ended up being

a compound fracture with the bone going through the skin, with more complications. Derek (phonetic) suffers from malnutrition and weight loss. Both children are fed with a nasogastric tube. Derek's (phonetic) feedings run 24 hours a day. Both of the children are at risk of aspiration. Placement of the nasogastric tube must be verified by a nurse before each use and every hour, to make sure the tube is still in the stomach and not in the lungs. Derek (phonetic) is weighed weekly and his formula is calculated to help maintain his weight. Both children receive respiratory treatments every four hours around the clock, followed by percussion and a cough-assist device. Then they are nasally tracheally suctioned to get the secretions out of their lungs. Both children are monitored with a pulse oximeter continuously. They have increased amount of oral and nasal phlegm. Derek (phonetic) sleeps approximately 15-30 minutes every night. During the night, he is vomiting phlegm, coughing, having grand mal seizures, and coughing his feeding tube out of his mouth. He has had night nurses his whole life. With this disorder, children are missing enzymes in their liver and brain. Their liver does not metabolize medication properly, so an EpiPen is available for both children to have in case they run into any complications. Both children have been on the Katie Beckett program since birth and both children have been cared for their whole lives by nurses. It is very hard to find and keep nurses to work in your home in Wayne, Nebraska. We are lucky to have these nurses. We have modified our home and we have devoted our lives to our children. We can't go to family functions because our children's immunity prevents that. They can't be around other children. We are isolated. Our friends don't come over because they feel uncomfortable around our children. I once asked a friend of mine why she didn't come to my house and she told me it was because when she sees my children, she knows it could have happened to her. It's that simple. It could have been me, it could have been you, it could have been anyone. My children didn't ask to be sick. My children didn't ask to have nurses take care of them day in and day out. I just want them to have the best life possible. [LB1122]

SENATOR CAMPBELL: Thank you, Mrs. Meyer. And, again, we very much appreciate your sharing your story and the pictures of your children. I can tell you that in the preliminary budget that has come out from the Appropriations Committee, they have restored the cuts that had been proposed, and after talking to one of the folks who are on our Appropriations Committee--I'm sorry, I was trying to think of the word--this morning, I mean, he anticipates that that will continue. We also have several bills in our committee, so we're very hopeful that the cuts that are being proposed will not go forward, so I just wanted you to know that as you travel home today. [LB1122]

CINDY MEYER: I appreciate that. [LB1122]

SENATOR CAMPBELL: So you not only would have this bill, but there are a number of other bills that are dealing with the Medicaid cuts. [LB1122]

CINDY MEYER: Well, my concern is that if I don't have nurses to take care of my

children, then I can't work; and if I can't work, I can't provide health insurance for my children. [LB1122]

SENATOR CAMPBELL: Right. [LB1122]

CINDY MEYER: And Derek's (phonetic) medication cost this last year was over $30,000. My health insurance paid 90 percent of that. Ashley's (phonetic) medication bill this year was over $11,000, which my insurance paid 90 percent of. Ashley (phonetic) was in the hospital this last year for two-and-a-half weeks. Her bill, being at the University of Nebraska Medical Center--for the hospital alone, not including the doctors--was over $310,000, which my health insurance paid 90 percent. Derek (phonetic) was also in the hospital last year for four days. His bill was over $18,000, which my health insurance paid 90 percent again. If I lose my job, I lose my health insurance. My job pays health insurance on my children as long as they are alive, living in my home, and I continue to work. [LB1122]

SENATOR CAMPBELL: And I appreciate that very much. Any other comments or questions? Senator Bloomfield? [LB1122]

SENATOR BLOOMFIELD: Yeah. I'm going to ask you, Cindy, to very quickly run through some of these pictures and tell us what we're seeing here. And again, in the interest of time, be as brief as you can, but let us know what's going on. [LB1122]

CINDY MEYER: On the first page, the top left-hand picture is a registered nurse checking tube placement to make sure that his feeding tube is in his stomach and not in his lungs before she feeds him, so that the food goes into his stomach instead of his lung. Over on the right upper picture is a picture of Ashley (phonetic) and she is checking residual because before you feed them, if you don't check to see what's in their stomach and you dump more food in and they've got a stomach full of food, they're going to vomit it and it's going to go into their lungs. So it's quite a process in order to feed them and make sure that the tube that was inserted into their nose by the nurses is in the proper place so that they're getting the food where it needs to go. And then the bottom picture is just a picture of Derek (phonetic) with his feeding tube and the right-hand picture is his continuous feeding with the Kangaroo pump. On the second page, it shows the standing equipment that we have, which helps prevent them from getting blood clots and keeping them upright, which helps their lungs. The upper left-hand picture is a picture of Derek (phonetic) in his standing frame, the right hand is Ashley (phonetic) in her wheelchair, and in the bottom, it's Derek (phonetic) in his wheelchair and Ashley (phonetic) in her standing frame. Their whole day consists of continuous activities and keeping them moving and keeping things going so that they stay active and they don't end up with aspiration or pneumonia or blood clots or other complications that you get from just laying around. The next page is a nurse giving Derek (phonetic) his nebulizer respiratory treatment. He gets those every four hours. He

ends up getting three different medications and nebulizer treatments a day. Then, they put him in a prone position and they do percussion on his back, which helps mobilize the secretions so that he can bring them up and they can be suctioned out. The bottom page is the same concept with Ashley (phonetic). She is on a piece of equipment that's called a jet mobile, which puts her in the prone position and does percussion. And then there is a picture showing her using the cough-assist device. That pushes in positive pressure into her lungs and then it has a negative pressure that pulls the air out of her lungs. If those settings are not set properly on that machine by trained personnel, she could end up having a pneumothorax and needing a chest tube put in. [LB1122]

SENATOR BLOOMFIELD: Cindy, would you please flip to the last page and just describe what we're looking at in the medicine cabinet? I guess it's the next-to-the-last page. [LB1122]

CINDY MEYER: Our house has been modified to take care of our children. We have a lift system throughout it. This is their medication area, where they have all their medications stored, and they are administrated from this cabinet. That is Ashley (phonetic) and Derek's (phonetic) medication that they receive every day in that cabinet. [LB1122]

SENATOR CAMPBELL: Thank you, Ms. Meyer. [LB1122]

SENATOR BLOOMFIELD: If your children were to be deprived of the nursing system and forced to go into a facility, what's going to happen to your children? [LB1122]

CINDY MEYER: I don't know how a facility could take my children because they can't be around anybody else. So if they were put into a facility, they would have to be put into a room by themselves where no one else came in where there was a personnel in there with them all the time that when they vomited, they could clear their airway, when they had seizures, that they protected them. I don't how they physically could take care of these two individuals in an institution. [LB1122]

SENATOR BLOOMFIELD: Thank you, and thank you for coming in and testifying again. And I do briefly want to close on this one. [LB1122]

SENATOR CAMPBELL: Okay. Thank you, Ms. Meyer, very much for bringing in your pictures and telling us your story. [LB1122]

CINDY MEYER: Thank you very much. [LB1122]

SENATOR CAMPBELL: (Exhibit 34) We did receive a letter of support on this bill from the Nebraska Nurses Association. Senator Bloomfield, do you want to go ahead? [LB1122]

SENATOR BLOOMFIELD: Thank you, colleagues. And, Senator Campbell, you and I have had several conversations off the mike about this situation. True, they are telling us now that under the budget, that it looks like will probably be approved, that the cuts won't be made. That's well and good for this year. The idea behind this bill that I have introduced is that if they make cuts in the future, these kinds of needs are the last that they cut. We cannot continue to let HHS, willingly or unwillingly, hold over these families with these children the hammer of we're going to quit what we're doing and your children are going to be put at risk. Thank you. [LB1122]

SENATOR CAMPBELL: Thank you, Senator Bloomfield. With that, we will close the public hearing on LB1122, as well as all of... [LB1122]

SENATOR COOK: (Inaudible) [LB1122]

SENATOR CAMPBELL: Oh, I'm sorry. [LB1122]

SENATOR COOK: Sorry. Sorry to interrupt... [LB1122]

SENATOR CAMPBELL: No. [LB1122]

SENATOR COOK: ...but there was a letter that came in late in support of one of my bills. Do you want to...do you need to read that into the record? [LB1122]

SENATOR CAMPBELL: We just give that to the clerk? [LB1122]

SENATOR COOK: Just give it to the clerk. [LB1122]

SENATOR CAMPBELL: And it will be on the record. [LB1122]

SENATOR COOK: Thank you. [LB1122]

SENATOR CAMPBELL: Okay. With that, we'll close that public hearing and all hearings for today and thank you all for coming. [LB1122]