[LB344 LB347 LB625]

The Committee on Health and Human Services met at 1:30 p.m. on Wednesday, February 27, 2013, in Room 1510 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public hearing on LB344, LB625, and LB347. Senators present: Kathy Campbell, Chairperson; Bob Krist, Vice Chairperson; Tanya Cook; Sue Crawford; Mike Gloor; Sara Howard; and Dan Watermeier. Senators absent: None.

SENATOR CAMPBELL: Good afternoon and welcome to the hearings for the Health and Human Services Committee. I'm Kathy Campbell, and I serve District 25 which is east Lincoln and eastern Lancaster County. And we're really glad you're here for our three public hearings. The procedures of the committee; basically, if you're going to testify, you need to fill out one of the bright orange sheets which are located on either side--I'm sort of like the stewardess--on either side of the hearing room. And if you want to leave a comment, but not testify; you can just leave a comment on the white sheets that the clerk has left for you. As you come forward, you give the bright orange sheet and any handouts that you have to the clerk, Diane Johnson, and she and the pages will make sure that we get all of the material. As you sit down, please state your name for the record and spell it. And you go, I've just given you my name legibly printed. Why do I have to say my name and spell it? It's for the transcribers so that they can hear you spell the name correctly. We do use the lights in this committee. You'll start out green. The total amount you have is five minutes. It'll be green for four, and then it goes to yellow and you have one, and then it goes to red and you'll look up and I'll be trying to get your attention to close. And while we don't have a roomful of testifiers, we try to ensure that no matter who testifies, first of the day and last, has the same opportunity for the committee's attention. Today our two pages are Deven and Kaitlyn, and they're over there and can help you with anything that you might need. And as is our practice, we'll have the senators introduce themselves. So, Senator, would you start out for me?

SENATOR WATERMEIER: Dan Watermeier from Syracuse.

SENATOR HOWARD: Sara Howard, I represent District 9 in midtown Omaha.

SENATOR COOK: I'm Tanya Cook from District 13 in northeast Douglas County and Omaha.

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

SENATOR CRAWFORD: Good afternoon. I'm Senator Sue Crawford from Legislative District 45, and that's eastern Sarpy County.

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

SENATOR CAMPBELL: We have several senators who are missing. They are in other meetings, and some of them may be introducing bills; so they'll kind of come and go. With all of that taken care of, we'll start on our agenda today, LB344, Senator Sullivan's bill to change the moratorium exceptions for long-term care beds. And welcome, Senator Sullivan.

SENATOR SULLIVAN: Thank you, Senator and members of the Health and Human Services Committee. I'm Senator Kate Sullivan, that's K-a-t-e S-u-l-l-i-v-a-n, of Cedar Rapids, representing the 41st Legislative District. I'm here today to introduce LB344, an improved version of a bill and an interim study on long-term care issues that we discussed in 2012. For those of you who are new to this committee, a little background. In 2009 the Legislature passed a bill that allowed owners of long-term beds to sell those beds outright or transfer them to other facilities owned by the same company. Municipally owned facilities are also allowed to sell long-term beds. The sale or transfer of long-term care beds was allowed outside of the statutory moratorium on the licensing of new long-term care beds in health planning regions. As a result of the 2009 law, a long-term care facility in my district closed in 2011, and the beds were transferred to other facilities owned by the same company. Although there was no opposition to the bill's passage four years ago, rural communities have been negatively affected by the bill's provisions in the last two years as their long-term care facilities have closed. The closure of the facility in my district left that community without a long-term care facility. The facility was one of the largest employers, so the closure also had a very negative impact on the local economy. Since the closure, the community has explored their options to rebuild or replace and reopen a long-term care facility in that community. I will say community leaders from that town are here today, and they'll follow me with an update on the efforts that are transpiring as we speak. The statutory moratorium on licensing of new long-term care beds in Section 71-5829.04(1)(b) is the largest obstacle blocking any community from proactively addressing long-term care needs at the local level. LB344 creates an exception to the moratorium for long-term care facilities developed and licensed by a political subdivision or nonprofit organization in a city of the second class or a village if specific conditions are met. The exception applies when all long-term care beds in a city of the second class or village were sold or transferred to a facility or facilities located outside a 25-mile radius from the city or village resulting in no long-term care beds within the corporate limits of the city of the second class or village. Since I was last before you, I've worked with organizations that expressed public concern about creating an exception to this moratorium. As a result, we have before us LB344; and it contains three additional provisions. First, the number of beds allowed under the exception would be limited to the same number--same as the number of licensed beds sold or transferred out of that city or village. Secondly, new beds licensed under the exception could not be sold for five years after first occupancy. And thirdly, additional beds above the number of licensed beds sold or transferred could not be added under subdivision (2) of Section 71-5829.03 for five years after first occupancy. On a technical note, the bill language on page 3, line 11, refers to subdivision (3). But it

should actually refer to subdivision (2), which is long-term care beds; and counsel is aware of that error. A long-term care facility must comply with all state and federal licensing and code requirements, but creation of new long-term care beds would not be permitted--prohibited rather--by the moratorium under this very specific exemption. There are those here in this room that do not believe we have a long-term care bed shortage in Nebraska. My guess is most of these folks don't live in rural Nebraska nor do they represent a rural district. Although the population in small communities is declining, baby boomers are aging and want to live closer to home where their families and friends live. In my small town of Cedar Rapids and other small towns in my district, there's a growing trend of retirees coming back to their hometown communities. All the more reason, in my estimation, to have long-term care facilities in the communities where they're needed by this new aging population. LB344 creates a very narrow and controlled exception to the moratorium. The exception applies--again, I repeat--only when: (1) long-term care facilities are developed and licensed by a political subdivision or a nonprofit organization in a city of the second class or village; all long-term care beds in the city or village were sold or transferred outside a 25-mile radius from the city or village; and the sale or transfer resulted in no long-term care beds within the corporate limits of the city or village. Furthermore, the number of beds is limited to the number of licensed beds sold or transferred. New beds could not be sold for five years after first occupancy, and additional beds above the number of licensed beds originally sold or transferred could not be added for five years after the first occupancy. LB344, I believe, is tightly drafted. The moratorium exception applies only in very specific situations. Hindsight is 20/20. Our actions in 2009 continue to exact a toll in rural Nebraska. Elderly residents were uprooted from the communities where they'd lived their entire lives and moved 30 miles away to facilities filled with people that they don't know. The economic toll of job loss in communities that have lost their long-term care facility is another blow for rural Nebraska. We should not be afraid to examine and assess our past decisions. Perhaps with further examination our decision will have a further outcome and a different one. I encourage you to advance LB344 to General File, and I thank you for your time and interest. [LB344]

SENATOR CAMPBELL: Questions? Senator Crawford. [LB344]

SENATOR CRAWFORD: Thank you, Senator Campbell, and thank you, Senator Sullivan. I'm curious if the problem we're experiencing right now was caused by the sale of beds, why you would allow these beds to be sold in five years. [LB344]

SENATOR SULLIVAN: Well, first of all, you have to take into consideration the particular situation. The legislation allowed this entity, this company... [LB344]

SENATOR CRAWFORD: Uh-huh. [LB344]

SENATOR SULLIVAN: ...to...and they're a for-profit company, they're looking out for

their bottom line. And in that situation, they determined that it was going to not be cost effective to add a sprinkler system to the facility. Not only that, they were interested in going to more populated areas where they were wanting to build new facilities. Hence, they moved the beds and could do it. [LB344]

SENATOR CRAWFORD: And my question was why would we, if we're adding beds in this bill to replace those that got sold, why would we allow them to sell these beds? Why leave in a provision (inaudible)? [LB344]

SENATOR SULLIVAN: We aren't...oh, you mean the initial ones that were sold under my... [LB344]

SENATOR CRAWFORD: No, no, no. I mean, if I understood it correctly in LB344, they have to agree not to sell the beds for five years. [LB344]

SENATOR SULLIVAN: Right. [LB344]

SENATOR CRAWFORD: But why allow them to sell the beds at all? [LB344]

SENATOR SULLIVAN: I think you will hear from the people that will testify after me from the community that they are on a path that they hope to be successful and either build or renovate the facility and have an active, going concern. That may not work out. It's probably going to take five years for that to be determined, in which case then let them have the opportunity to sell the beds where they are needed. [LB344]

SENATOR CRAWFORD: If the facility...so that's, in part, so that the facility doesn't...isn't successful, they have...they are able to sell the beds. [LB344]

SENATOR SULLIVAN: Exactly. [LB344]

SENATOR CRAWFORD: But the bill itself allows them to sell the beds in any case, just as a five-year...is really the only the restriction is five years. Correct? [LB344]

SENATOR SULLIVAN: Right, right. [LB344]

SENATOR CRAWFORD: Thank you. [LB344]

SENATOR CAMPBELL: Other questions on the bill? Senator Sullivan, are you planning to stay? [LB344]

SENATOR SULLIVAN: Uh-huh. [LB344]

SENATOR CAMPBELL: Okay. Thank you so much for your opening. We will start with

the first proponent of LB344. Good afternoon. [LB344]

RON JENSEN: Good afternoon. Chairman Campbell and members of the Health and Human Services Committee, my name is Ron Jensen, R-o-n J-e-n-s-e-n. I'm a registered lobbyist appearing before you this afternoon on behalf of LeadingAge Nebraska, which is an organization made up exclusively of nonprofit and government-owned nursing homes, assisted living facilities, and low-income housing facilities, and here to testify in favor of LB344. We feel we have almost an ethical obligation to give this testimony because our association and the other long-term care association, Nebraska Health Care Association, were instrumental in loosening up--actually expanding--the geographic areas in which beds could be transferred in the state's CON law so that beds could go where the people are. I thought that was good public policy then; I still think it is. But it had the usual unintended consequence that always accompany arbitrary policies, moratoriums, across-the-board cuts. We throw the baby out with the bathwater. And, indeed, in this instance we did. We made it possible for a for-profit concern that was operating that facility to administratively pick those beds up and move them to the Omaha area where, in their view, they would be more profitable. So that leaves this community kind of high and dry. I don't think opening a window of opportunity in the certificate of need program just wide enough for this community to reestablish a nursing home, if they're able to do it, will do violence to the health planning program and, indeed, gives them an opportunity to try to have this facility in their community. I can say to you that there is a considerable distance, in my mind, from obtaining that certificate of need to having an open, operating, staffed, populated, Medicaid-certified facility. I've had the experience in my career of opening a hospital from scratch, staffing it, getting it licensed, getting it in operation, and finally getting it Medicare and Medicaid certified. It is not a small or an inexpensive undertaking. But without this legislation, these folks can't get out of the gate. We think that just simple fairness argues for advancing LB344 to General File. [LB344]

SENATOR CAMPBELL: Questions? Senator Krist. [LB344]

SENATOR KRIST: I understand your testimony and, for what it's worth, I would agree with your logic. But talk to me for just a minute about this request, okay, in terms of moving forward, giving these folks an opportunity to do the right thing within the community. And what I see would be another request. You're aware that Alegent took over--Creighton merged--and you're aware that the Catholic Services, CSI, is taking over the entire thing, and they're going to manage this all from Denver. So the next request that's going to come in is going to be from CSI to say, I own all those beds--all of those Alegent Creighton hospitals all over--so I'm going to move my beds within my jurisdiction where I want to; not necessarily brick and mortar, not necessarily 25 miles. But where does it stop? You've been there, worn that T-shirt, so talk to me about that. [LB344]

RON JENSEN: Well, it's an easy question to answer, Senator Krist. Hospital beds aren't under certificate of need. The only remnant of the old certificate of need program that continues to exist in Nebraska--Senator Gloor is smiling. We both did service in that program--is this moratorium on nursing home beds. So what you described could happen conceivably and they wouldn't have to pass go or collect $200. [LB344]

SENATOR KRIST: So when I talk about the certificate of need for long-term care facilities, you're saying that those beds that are owned at Immanuel Hospital for long-term rehab can be moved anyplace they want to put them within the CSI scope? [LB344]

RON JENSEN: If they're licensed as a hospital bed, they can do whatever they wish. They can add beds, they can subtract beds. [LB344]

SENATOR KRIST: Long-term rehab? [LB344]

RON JENSEN: If it's licensed as a nursing home, if they are licensed long-term care beds, then there's a limit on the distance to which they can be moved. They can only be moved within a service area. And the legislation that has caused this problem for Spalding made those areas larger. At the time of the original moratorium back in the '90s, you know, we had these little coffee cans of regions all around the state that allowed really no flexibility. You could about move beds across the street and that was it. So we loosened that up because, let's be honest about it, the population of the state is shifting. And we felt that the industry needed to have the ability to have those beds track the population. We didn't think about this particular situation. No one, in all of the discussions and the negotiation...and it was when Don Wesely was the Chairman of the Health and Human Services Committee at that time that jettisoned the balance of the CON program, put this moratorium on nursing home beds. This situation was never envisioned. [LB344]

SENATOR KRIST: All right. Thanks. [LB344]

RON JENSEN: Sure. [LB344]

SENATOR CAMPBELL: Other questions? Senator Gloor. [LB344]

SENATOR GLOOR: Thank you, Senator Campbell. Mr. Jensen, does your association think there's still an abundance...overabundance of long-term care beds? I mean, the reason that we're dealing with this issue is a moratorium on any additional beds. Is that still considered to be the case? [LB344]

RON JENSEN: No. I don't have a good sense of it, Senator Gloor. Frankly, I don't hear a lot of complaining about it. It doesn't seem to be barring anyone from doing what they

want to do or what they perceive that their community needs. We've got a lot of old plant on the books across Nebraska. Many, many of these facilities were built in '60s and '70s; but as you know, replacement beds are not reviewed. You don't need a CON to replace an old bed with a new one. We...in my personal view, we've only...even though we've been at it a long time, we've only begun to develop home and community-based services as an alternative. So if I were to conjecture, I'd conjecture that our overall supply of beds is adequate. [LB344]

SENATOR GLOOR: Okay. Thank you. [LB344]

RON JENSEN: You bet. [LB344]

SENATOR CAMPBELL: Senator Crawford. [LB344]

SENATOR CRAWFORD: Thank you, Senator Campbell. I'm going to ask you a similar question I asked Senator Sullivan. I'm trying to understand why we would leave in a provision to sell the beds in five years. It seems the community might be in the same position then in five years or it might be setting up incentives for gardening beds to be sold. Not that extreme but just, why if the problem's created by the beds being sold, why create the provision to allow the beds to be sold in five years? [LB344]

RON JENSEN: Sure. I asked the same question. My association wasn't behind the introduction of the bill. I say my association. The association I represent and formerly directed. And the answer that I got, and it kind of made sense, is if for five years this community and the people involved invest the time and a lot of money and effort and so on and so forth to make this thing work, you know, they would have these beds to sell. And in my personal view, one of the things that argues for that is that they'd have a corpus of money that they could start an adult day services program or something like that that could, to a certain degree, replace the long-term care facility. [LB344]

SENATOR CRAWFORD: Thank you. [LB344]

SENATOR CAMPBELL: Any follow-up questions for Mr. Jensen? Thank you very much. [LB344]

RON JENSEN: Thank you very much. [LB344]

SENATOR CAMPBELL: Our next proponent? Hello. [LB344]

KURT CARRAHER: Hello, Chairman Campbell, fellow committee members. My name is Kurt J. Carraher, C-a-r-r-a-h-e-r, registered pharmacist in the state of Nebraska, license 12862. I have the pleasure to be able to work, interact, and be a part of an extremely progressive healthcare system located in central Nebraska. I'm the pharmacy manager

at Spalding Pharmacy and Wells Drug located in Spalding and Albion, Nebraska. It is through this interaction with patients, family members, caretakers that I became so involved in the process of reestablishment of long-term care in Spalding. I believe rural Nebraskans have the same right to quality healthcare as the rest of the citizens of this great state. The people of central Nebraska had access to the entire spectrum of quality care until October of 2011 when the owner of the long-term care facility decided to exercise their rights to close the facility and transfer the beds to a larger urban area with great ease under the current legislation. The closure of the 33-bed facility placed a crippling blow on the community and healthcare system in the area. The community lost over 45 full- and part-time jobs. It was the largest employer of women in the community, and the residence many called their home away from home. Also lost with the discontinuation of long-term care in Spalding was the $2 million that the facility generated in income annually and the $1 million in wages, benefits, salaries paid to employees. The local pharmacy and medical clinic have also felt the loss as the closure took with it a significant amount of patients. Local businesses, schools have also felt the impact due to the loss of residents, people coming to town to conduct their business. Let's not forget about the residents and families that have had their lives altered because of the closure. A few residents found available rooms in Albion, which is 20 miles away from Spalding, but that facility is now at capacity with a long waiting list. Some were forced to relocate 30 to 45 miles away. Many are trying to get by at home with their children taking care of them along with some respite care the children have hired to come in and take care of mom and dad for a few hours a day while they're away at work. Spouses of these residents continue to commute 20 to 35 miles on a daily basis to see their loved one, only to return back to their home in Spalding later in the day, which used to only be 2 or 3 blocks away for them. The community has not given up hope as they've explored the possibility of reopening the facility. Feasibility studies project $1.5 to $2 million to reopen, renovate, and purchase the licensed bed commodity for the facility at an average of $10,000 to $14,000 a bed. Because of the costs associated with renovating an old building, the community has visions of constructing a new community health center. Another feasibility study is nearly underway tailored to new construction. The local hospital, the Boone County Health Center, has pledged $500,000 to construct a new medical clinic to be attached to the long-term care facility. Discussions are ongoing to possibly add physical therapy, day care, and maybe a fitness center to this project. The community has the dream, but could use your help in securing long-term care beds for the facility. At the current rate of $14,000 a bed times 33 beds equals $460,000; that's a pretty big coupon that we could clip. The need for long-term care in the Spalding community and surrounding areas has been there for over 50 years. The previous owners had one of their most successful years in their final year of operation. Quality care has been the norm as people have always been very supportive of the facility. And baby boomers are moving back to their rural roots every day. We see many throughout central Nebraska that move home to enjoy the lower cost of living, slower pace, and down-home friendly atmosphere. They're not looking to enter these facilities today, but it is part of their plan. Having a

facility like this in our community shows a long-term commitment to healthcare and the future of rural Nebraska. Questions? [LB344]

SENATOR CAMPBELL: Any questions? Thanks for the update. [LB344]

KURT CARRAHER: You're welcome. [LB344]

SENATOR CAMPBELL: Sounds like you're moving. Sounds like you're trying to generate some partners. [LB344]

KURT CARRAHER: We are. It's quite a process, but we're trying to explore every option, open every door, and do what we can to make this work. [LB344]

SENATOR CAMPBELL: How many beds did the original facility have? [LB344]

KURT CARRAHER: Thirty-three. [LB344]

SENATOR CAMPBELL: And then are you intending... [LB344]

KURT CARRAHER: Thirty-three, right. [LB344]

SENATOR CAMPBELL: Thirty-three. What percentage of the 33 were in the last year? Was it full? [LB344]

KURT CARRAHER: Right. It ran an average...I think it was 29--just under 30 was their average for the year. [LB344]

SENATOR CAMPBELL: Okay. And that was pretty consistent at that? [LB344]

KURT CARRAHER: It ranged anywhere from 26 to 30 on average within the last 5 or 6 years I guess you might say. [LB344]

SENATOR CAMPBELL: Okay. Pretty consistent. [LB344]

KURT CARRAHER: Yeah. [LB344]

SENATOR CAMPBELL: Did you have a question, Senator Crawford? [LB344]

SENATOR CRAWFORD: No. That was the question I was going to ask, so thank you. [LB344]

SENATOR CAMPBELL: Okay. All right. Thank you very much for your testimony today. [LB344]

KURT CARRAHER: Thank you. [LB344]

SENATOR CAMPBELL: Our next proponent? Good afternoon. [LB344]

TOM BOYER: Good afternoon, Senator Campbell, members of the committee. My name is Tom Boyer, T-o-m B-o-y-e-r. I've been a community banker in Nebraska for 42 years, and this situation in Spalding is a deja vu all over again. We had a nursing home in Fairmont, Nebraska, where I was working as a young man, and it closed due to regulations. It was an old two-story building and regulations just forced it to close. And so in 1973, I became the city clerk and we built a new nursing home that was owned by the village of Fairmont. That nursing home is still open today and has expanded several times, been very successful, and remains today one of the largest employers in the community. So when the nursing home was...the word was out that we were closing the nursing home in Spalding, I jumped on the opportunity to become a member of the...what we call the Spalding long-term care committee to see if we couldn't either reopen the facility that currently sits in the community or to build a new one. And we started looking at the old one, and after many discussions with architects and consultants, we decided that that was the wrong way to go. I guess I hear concerns about whether or not the community is doing this with the idea of gardening those beds off. [LB344]

SENATOR CRAWFORD: I don't think that you're... [LB344]

TOM BOYER: I can assure you that that was not the case of my almost 40 years in Fairmont, and quite sure that nobody that's sitting on this committee has any intentions of doing anything other than providing for the elderly residents of our community and the surrounding area. And so having done this once before and successfully built a facility that's still open, will be 40 years, I believe, in September that that facility has been open. So with that, I would just like to ask for your consideration. I think that Senator Sullivan has done a marvelous job of getting this written to help us out, and I think she's tightened it up to the point where we think it's very workable. So with that, I thank you for your time and attention. [LB344]

SENATOR CAMPBELL: Questions? Senator Gloor. [LB344]

SENATOR GLOOR: Thank you, Senator Campbell. Thanks for coming down again for another hearing on this. It's good to see you. Just a comment that I need to make that the committee--your committee--needs to keep into consideration and that is I know that there is an inevitability within the Department of Medicaid to change reimbursement formulas. And so whatever numbers are being plugged in by the consultant as relates to financial projections looking forward, I would be cautious. I don't think that there's necessarily going to be a reduction in the traditional sense of less money paid out. I just

think the whole system of how reimbursement changes might be disadvantageous to you, depreciation numbers and such that figure into cost. I can see all of that undergoing some sort of a change and maybe even a change in risk going to managed-care contracting. I think it's inevitable. I don't know how soon, but that would be a concern for me if all of a sudden current projections--or I should say--current numbers used for future projections as opposed to looking at something that may erode some of the numbers that you currently have out there. Just a heads-up. [LB344]

TOM BOYER: One of our consultants is here today as a presenter, and we've talked about some of that at length. I think it's probably a little early. I guess we don't know what those changes are going to be... [LB344]

SENATOR GLOOR: No. None of us do. Yeah. [LB344]

TOM BOYER: ...but we're aware that there's possibilities out there that could affect us negatively. So thank you for that. [LB344]

SENATOR GLOOR: Thanks. [LB344]

SENATOR CAMPBELL: Senator Crawford. [LB344]

SENATOR CRAWFORD: Thank you, Senator Campbell. Thank you for your testimony, and my comments about gardening were not about your effort which I can see is a very well community-based effort to solve the issue in Spalding. But I think always as we look at laws, we always have to ask how someone else might use them. So we create it for a very well-intended purpose and there are often unintended consequences that, you know, we're experiencing. [LB344]

TOM BOYER: Yes. [LB344]

SENATOR CRAWFORD: And so that was part of why I was just raising the concern about selling the beds in five years. And I don't want other communities to end up, you know, with their beds sold after they've gone to a lot of effort... [LB344]

TOM BOYER: Yeah. [LB344]

SENATOR CRAWFORD: ...to address the problem in their community. [LB344]

TOM BOYER: I understand the unintended effort because...or unintended consequence because I think that's where we're at right now. [LB344]

SENATOR CRAWFORD: Exactly. [LB344]

TOM BOYER: And that's been hard on our community. So, okay. [LB344]

SENATOR CRAWFORD: Thank you. [LB344]

SENATOR CAMPBELL: Questions? Other questions? Mr. Boyer, the original...the former nursing home that closed in Spalding,... [LB344]

TOM BOYER: Yes. [LB344]

SENATOR CAMPBELL: ...was it a stand-alone facility or was it a part of a group? [LB344]

TOM BOYER: Part of a large group. [LB344]

SENATOR CAMPBELL: Part of a large group, okay. Do you think that there were any economies of scale to that large group? I mean, I'm assuming that the consultant has taken that into...I mean, did they do like billing... [LB344]

TOM BOYER: Yes, they had... [LB344]

SENATOR CAMPBELL: ...and HR and, you know, that kind of thing--their company system-wide? [LB344]

TOM BOYER: Our facility was owned by Vetter Healthcare. [LB344]

SENATOR CAMPBELL: Oh, okay. [LB344]

TOM BOYER: And all of the back room work, the policy work, etcetera, etcetera, came out of, I believe, it's Elkhorn is actually the address of Vetter. But we've talked about that with our consultants because we have looked for consultants to provide those same services to us because we have the cost analysis reports that show that the nursing home was profitable over and above the administrative fees that they paid to the central office of Vetter; significantly so. At least in the five years that we have in our hands, there was more than adequate earnings over and above those costs. [LB344]

SENATOR CAMPBELL: Okay. So do you see a possibility of being able to outsource some of those services, or do you think you'd just handle everything pretty self-contained in the new one? [LB344]

TOM BOYER: Well, I can only speak for myself, but we have a consultant that we've been working with and they offer those services. And I'm certainly in favor of getting those services because they provide those services now, I believe, to about 20 facilities. Is that about right? [LB344]

_____: Twenty-two. [LB344]

TOM BOYER: Twenty-two facilities. [LB344]

SENATOR CAMPBELL: Okay. That helps. Thank you very much. Any other questions? Thanks, Mr. Boyer, for coming. [LB344]

TOM BOYER: Thank you. [LB344]

SENATOR CAMPBELL: Our next proponent? Good afternoon. [LB344]

MIKE HARRIS: (Exhibit 1) Good afternoon. Good afternoon, Senators. My name is Mike Harris, that's M-i-k-e, Harris, H-a-r-r-i-s. I'm here in support of LB344. I am representing Ron Ross who is president of Rural Health Development. Ron is in...working in Wyoming and the western part of the state this week; otherwise he would be here giving this testimony. The nursing home industry is very challenging, especially in rural Nebraska. Medicaid funding continues to be reduced at an alarming rate, population is decreasing, the percentage of elderly continues to climb, and sensitivity to rural problems by some is not good. Legislation was passed only a few years ago to transfer nursing home beds anywhere within the state. This has caused some providers the opportunity to get a much better return on their investment and, at the same time, it puts some rural communities in jeopardy of losing their nursing homes. I'm speaking on behalf of Ron here. When I was director of Health and Human Services, I made it a point to try to be fair and sensitive to all of Nebraska, from rural to urban. Rural Nebraska needs your help. We need to make sure that our small communities can continue to meet the needs of their elderly, and I'm willing to work with this committee, the entire body, and the administration to improve services for our elderly. And thank you all for your commitment to serve all of Nebraska. [LB344]

SENATOR CAMPBELL: Senator Gloor. [LB344]

SENATOR GLOOR: Thank you, Senator Campbell. And I know Ron pretty well. When you see him, tell him Senator Gloor said he was in charge and, in part, responsible for the moratorium, and I don't want him to get away squeaky clean. (Laughter) I understand the issues though. [LB344]

SENATOR CAMPBELL: Other questions? Mr. Harris, I just want to be very clear. Your firm does work with 22 other facilities. [LB344]

MIKE HARRIS: Twenty-two other nonprofit facilities here in Nebraska, Wyoming, Kansas, and Iowa. [LB344]

SENATOR CAMPBELL: Okay. Do you, by offhand, know the range and the number of beds in those facilities? Would this be one of the smaller bed numbers or about average? [LB344]

MIKE HARRIS: You know, it is about average. It might be just a little bit less than average. We have some facilities that have a maximum of 26 beds. I think the largest is around 60, so it's kind of right in the middle. [LB344]

SENATOR CAMPBELL: Okay. When you look at facilities across the state that you're going to work with, is there a break-even point for a number of beds like, you know, under 10 you really can't make it or under 15 you can't make it or... [LB344]

MIKE HARRIS: You have some built-in costs and expenses at a facility and--these are kind of estimates--but it's going to cost about $120,000 to $140,000 a month just to keep the place open with adequate nursing staff, dietary staff, and so forth. And it varies. These are estimates but, you know, you would hope that you could get between 20 and 25 residents a month to break even or, perhaps, make a small profit. Anything less than 20, it's just not going to work because census drives everything; you have to have census. So... [LB344]

SENATOR CAMPBELL: Exactly. And you watch those numbers pretty much and you watch all the regulations. When you run a nursing care facility like that, regulations become such a critical part of staying in business. [LB344]

MIKE HARRIS: They really are. [LB344]

SENATOR CAMPBELL: I learned that firsthand when I was on the county board; how difficult that is at times. [LB344]

MIKE HARRIS: Yeah, it is a daunting task to manage a facility on a day-to-day basis. It's not as easy at it looks. [LB344]

SENATOR CAMPBELL: Exactly. And I'm certainly feeling from the number of times that we've talked to the community, that the community's commitment is very strong here to making such a facility work. And you absolutely have to have that, do you not? The community has to back a facility. [LB344]

MIKE HARRIS: Oh, absolutely. I had the opportunity to work with the communities of Wauneta and Callaway in the past year. And in both cases, similar things had happened. And it was kind of up to the city or the 501(c)(3), in the case of Callaway, are we going to try to take over this nursing facility? And they had town hall meetings and I attended one in Callaway and it was amazing. The community rallied around and actually come up with the funding that was needed to continue operations. And so it's...

[LB344]

SENATOR CAMPBELL: I think you would see that in a lot of small communities across the state. [LB344]

MIKE HARRIS: I've had the opportunity to serve as an interim administrator at seven different facilities in rural Nebraska and, without exception, the community feels like these facilities are a very, very valuable asset. [LB344]

SENATOR CAMPBELL: The...I'm going to go back to Senator Crawford's questioning on the five...on the beds after five years. Is that sufficient protection for the community that if they run into difficulty and had to cover debt or bad debt or whatever they get themselves into that can happen, is that sufficient to help them out of it by that number of beds? [LB344]

MIKE HARRIS: You know, I don't...I have to be quite honest with you. I haven't really given that portion of it a lot of thought other than to the extent that after five years, you would have at least some equity there that you wouldn't have if that provision wasn't a part of this bill. It just seemed to me like that was...it was fair. The community...you never know what's going to happen with census and after five years, your census could decline and you may be in the position of having to close. And it would be nice for a community to have some equity there. So... [LB344]

SENATOR CAMPBELL: If the market stayed pretty much the same--let's just assume that all things progressed over the course of the five years--and they had to do it, I'm really thinking, you know, worst-case scenario for them, is there a market for 30 beds in the state? [LB344]

MIKE HARRIS: I...honestly, I don't know the answer to that, Senator Campbell. [LB344]

SENATOR CAMPBELL: Okay. [LB344]

MIKE HARRIS: There are times, and other times...so I really don't feel I'm too qualified to answer that. [LB344]

SENATOR CAMPBELL: Yeah. I think that when we've had the interim study hearing, we just wanted to make sure that those points, as a help to the community, would be on the record because you want to think about all the possibilities. [LB344]

MIKE HARRIS: Absolutely. [LB344]

SENATOR CAMPBELL: I mean, you need the best case where the community is behind you; but if something goes wrong, you want to make sure that they can get

themselves out of it financially. So thank you. [LB344]

MIKE HARRIS: You're welcome. [LB344]

SENATOR CAMPBELL: Other questions, follow-up? Senator Gloor. [LB344]

SENATOR GLOOR: Thank you, Senator Campbell. Mike, just a short question. Your estimate of 20 to 25 to break even, does that include some sort of a historical patient mix that you see in your homes that you manage of Medicaid to private care or private pay to somebody that might have long-term care insurance? I mean, can you make a go of it with 20 to 25 Medicaid patients? [LB344]

MIKE HARRIS: Be tougher. Right now the percentage, generally speaking in the facilities where we have contracts, it's about 35 percent private pay compared to 65 percent Medicaid. And it's my understanding that that figure continues to become more imbalanced as time goes along compared to like what it was maybe five, ten years ago. [LB344]

SENATOR GLOOR: That's what we hear too, yeah. Not a surprise when you consider the way the economy has been, but maybe with the growth in the ag economy people will just, you know, be dancing in dollars we can invest in these sorts of things. Thank you. [LB344]

SENATOR CAMPBELL: Any other follow-up questions? Thank you, Mr. Harris. [LB344]

MIKE HARRIS: Thank you. [LB344]

SENATOR CAMPBELL: Did a good job filling in. You tell Mr. Ross that. [LB344]

MIKE HARRIS: Thank you. [LB344]

SENATOR CAMPBELL: Good afternoon. [LB344]

NICK FAUSTMAN: (Exhibit 2) Good afternoon. I'm Nick Faustman, N-i-c-k F-a-u-s-t-m-a-n. I represent the Nebraska Health Care Association which is the parent association of a family of entities including the Nebraska Nursing Facility Association which I refer to as NNFA, and the Nebraska Assisted Living Association which I'll refer to as NALA. Both NNFA and NALA represent nonproprietary, proprietary, and governmental long-term care facilities. NNFA and NALA both support LB344. LB344 is almost exactly like LB1002, introduced by Senator Sullivan last session, in that it permits a facility in a city of second class or village whose beds have been sold or transferred to another facility outside the 25-mile radius to create long-term care beds for a political subdivision or nonprofit with three main differences. First would be the

newly created beds. They cannot be sold for five years. This was added to the bill in order to prevent a political subdivision or nonprofit from creating beds at a rapid pace for the sole purpose of selling them to other facilities. NNFA and NALA would feel most comfortable if this was a longer time period such as ten years, but we understand that Senator Sullivan and the community prefers five years and NNFA and NALA can live with that. The bill caps the number of created beds at whatever number the initial facility previously had. This was a suggestion by our organization, actually, and it's a provision that we feel quite strongly about. Third, LB344 also creates an additional criterion under what is known as the ten/ten/two rule. The bill states that the facility's number of beds cannot be increased by more than ten or more than ten percent of the total long-term care bed capacity of such facility, whichever is less, over a two-year period until that facility has been in business for five years. NNFA and NALA fully understand that Senator Sullivan has introduced the legislation in an attempt to help the community of Spalding address a desire to re-create a long-term care facility. That said, we feel that these requirements established by LB344 are sufficient for specifically defined, small communities who feel they have a need to do so. And thank you for your consideration on this matter. [LB344]

SENATOR CAMPBELL: Questions? Senator Crawford. [LB344]

SENATOR CRAWFORD: Thank you, Senator Campbell. And thank you for your testimony. [LB344]

NICK FAUSTMAN: You're welcome. [LB344]

SENATOR CRAWFORD: Are there any other communities that you know of from your work in these organizations that might also be in a similar situation? [LB344]

NICK FAUSTMAN: Currently, there are roughly six that might fit the criteria, but I'm not aware of any that are currently pursuing opening up or re-creating a facility at the time. [LB344]

SENATOR CRAWFORD: Thank you. [LB344]

SENATOR CAMPBELL: Okay. Any other questions? Thank you, Mr. Faustman... [LB344]

NICK FAUSTMAN: Thank you. [LB344]

SENATOR CAMPBELL: ...for your testimony today. Our next proponent for LB344? Those who wish to testify in opposition to LB344? Those who wish to testify in a neutral position? Okay. Senator Sullivan, I think we're back to you for any comments that you would like to make to close. [LB344]

SENATOR SULLIVAN: Sure. Well, a couple of things that came to mind as questions were being asked and one is that...regarding that five-year limit. Remember that, in the way I've written the bill, it would...the clock would start ticking, so to speak, after first occupancy. It doesn't start "tocking" now in the process of them doing the feasibility study or construction or anything like that. And also regarding whether we have an overabundance of beds, you know, I will tell you that--and I think it was mentioned by Mr. Carraher--that some of the people from the Spalding facility went to Albion. That is, I think, at capacity right now as we speak. I think Mr. Carraher mentioned that, and it has a very deep waiting list. And one of the things that they've done in the remodeling of their facility, every single room is a private room. And so that's made a difference too. And you know, we talk a lot about in the Legislature--at least I do--of the declining population in rural Nebraska and how we're concerned about that. But I've also learned too, having lived in a rural community now for nearly all my life and in a very small town and seeing all the different communities in District 41, they all have their own complexion and their own culture. And I will tell you, if anybody can do it, Spalding can; they are really a can-do community. And it shouldn't be overlooked that Mr. Carraher mentioned that they're reaching out and building lots of relationships. And another shining star in terms of healthcare in District 41 is the Boone County Health Center. And the fact that they have made a commitment to be a partner in this venture is very significant because they are not only a well-run facility, but they are very much in the black and have money in reserve. So I think that needs to be noted as well. But in closing, I don't think there's any harm in revisiting past decisions and looking at them. Certainly all our decisions have consequences, but as the story unfolds then we realize that perhaps there have been unintended consequences as well. I'd like to think that in crafting LB344, it has been tightly crafted and very specific. I'd like to think also that it doesn't allow for exploitation, that we can really be...it's fairly well defined so that we can almost predict an outcome or lack thereof. And so I think that it does bear credibility to revisiting a past decision and certainly in so doing, with the passage of this bill, would give a leg up to a community who's really wanting to step up to the plate and help not only the current elder citizens of its community but those that will be there in the future. So I thank you for your consideration. [LB344]

SENATOR CAMPBELL: Any follow-up questions? Senator Sullivan, I just have to say that when we did LB600 two years ago I think, I lose track of the years, and that was the bill that allowed long-term care facilities to pay in, in order to draw down more federal dollars. [LB344]

SENATOR SULLIVAN: Uh-huh. [LB344]

SENATOR CAMPBELL: And I think what I saw in working with the senators and all across the state of Nebraska is how important the nursing care facilities were to the communities and to the families... [LB344]

SENATOR SULLIVAN: Yes. [LB344]

SENATOR CAMPBELL: ...to be able to keep grandma close to them and when they needed that kind of care. And those communities spoke quite eloquently, I think, to the Legislature about that piece of legislation. And I learned a lot from that experience. [LB344]

SENATOR SULLIVAN: And maybe you could say this is purely selfish on my part because I want it to be there for me. [LB344]

SENATOR CAMPBELL: I'm sure you could reserve a room now. That might help. [LB344]

SENATOR SULLIVAN: Not for quite a long time, though, I might add. [LB344]

SENATOR CAMPBELL: Yes, of course. Oh, we wouldn't think that at all. [LB344]

SENATOR SULLIVAN: One hundred twenty is my goal so (laugh). [LB344]

SENATOR CAMPBELL: (See also Exhibit 3) Okay. And with that, we'll close LB344 of the hearing today. And we will move...and I don't see Senator Conrad. She's on her way? Okay. We'll just wait for a minute until she comes. How many people are planning to testify on LB625, Senator Conrad's bill? One, two, three, four. Okay. Either way, pro or neutral? Still got the same four. Okay. All right, we will just wait a minute. We'll go ahead and open the public hearing for LB625, Senator Conrad's bill to change income eligibility provisions relating to federal childcare assistance. Good afternoon and welcome. [LB344]

SENATOR CONRAD: Good afternoon, Chairman Campbell and members of the committee, my name is Danielle Conrad. That's D-a-n-i-e-l-l-e C-o-n-r-a-d. I represent, as you know, the "Fighting 46" Legislative District of north Lincoln. I'm here today to introduce LB625. LB625 restores childcare eligibility to 185 percent of the federal poverty limit. First, a little background on this program, particularly for some of our new members who I welcome to the committee and the Legislature. In 1996, Congress passed the Personal Responsibility and Work Opportunity Reconciliation Act which set up a block grant for childcare assistance called the Child Care and Development Block Grant. As part of this act, Congress also allowed states to use TANF funds--Temporary Assistance for Needy Families funds--for childcare subsidies. Federal law established a set of requirements that states must meet in order to receive those federal dollars. But states do have discretion in determining which children and families are eligible for assistance. In the spring of 2002, Governor Johanns used a line-item veto to cut funding for this program, reducing eligibility for the program from 185 percent--which I'm

proposing to restore today--to 120 percent of the federal poverty level. Eligibility for the program has remained at 120 percent of FPL ever since. In 2012 numbers, a family of three would qualify at 120 percent if they earned income of $22,908 annually. Under LB625, my legislation, a family of three could earn up to about $35,000 a year to qualify for assistance. There is a range of income eligibility for the program. Some families are eligible at about 47 percent with no cost sharing. Other families are eligible at 120 percent and have to pay a portion of the cost, like a copay, to ensure the childcare to the provider. Beyond income eligibility, families also have a need for service, which includes they have to be employed, searching for a job, or participating in ADC work requirements like attending vocational or educational training. Nebraska is currently ranked last--dead last--nationally in terms of income eligibility for this critically needed program that rewards work. And the current eligibility limit is out of touch with the reality our working families face. Nebraskans also have a very high percentage of working mothers at about 73 percent, and families where both parents are in the work force at about 74 percent. So that provides kind of a policy...disjointed policy parameter to look at when giving consideration to this legislation. Childcare is a large expense--believe me, I can tell you that from personal experience--but especially for low-income families who proportionately spend more of their income on day care than higher income families do. As a result, childcare assistance is one of the most critical work-support programs we have available for low-income families. Making childcare subsidies available to all families at 185 percent would be a positive move forward for Nebraska. Childcare subsidies make day care more affordable, meaning children will be in safe environments while their parents are working which helps the economy as a whole because without this needed service, individuals are forced to quit jobs, decrease their hours, use more forms of public assistance, and/or quit school or spend less time with their children. I urge your favorable consideration and am happy to answer questions. I know these are not new issues to many members of the committee, but they remain important issues. And I'm hopeful that we'll get some forward progress in the realm of childcare this session. And thanks to the Chairman's leadership, that very well may be possible. [LB625]

SENATOR CAMPBELL: Questions? Senator Howard. [LB625]

SENATOR HOWARD: Thank you... [LB625]

DANIELLE CONRAD: Yes. [LB625]

SENATOR HOWARD: ...Senator Campbell. Thank you, Senator Conrad. Can you speak to the fiscal note on this? You had mentioned that TANF funds were previously used for subsidy. Can you speak to the use of General Funds instead of TANF funds? [LB625]

SENATOR CONRAD: Sure. And I'll tell you that our office has been in contact both with

the folks who prepared the fiscal note and some advocates in this area who provided some insight based upon previous introduced legislation. And I think it's fair to say that it's a work in progress. And that we can probably work together to address some questions that have arisen based upon what previous fiscal notes look like and what this fiscal note looks like to make it a little bit more amenable with our overall budgetary picture. [LB625]

SENATOR HOWARD: Thank you. [LB625]

SENATOR CONRAD: Thank you. And I'd be happy to forward those specifics to the committee if that would be helpful. [LB625]

SENATOR HOWARD: I would love that, thank you. [LB625]

SENATOR CAMPBELL: Any other questions? I think whatever updates you have, Senator Conrad, that would be great. [LB625]

SENATOR CONRAD: Okay. Absolutely. It's just a few pages long and I didn't want to take the time to read it into the record. [LB625]

SENATOR CAMPBELL: That's fine. [LB625]

SENATOR CONRAD: But I think that they are good questions that we're going to make sure to follow up with fiscal about. Thank you. [LB625]

SENATOR CAMPBELL: Okay. Thank you. Will you be staying, Senator Conrad? Sorry. [LB625]

SENATOR CONRAD: Yes. I'm running back and forth between Revenue and Appropriations and HHS this afternoon, but we're trying to make it work. [LB625]

SENATOR CAMPBELL: Okay. [LB625]

SENATOR CONRAD: Thank you. [LB625]

SENATOR CAMPBELL: Our first proponent for LB625. [LB625]

JAMES GODDARD: (Exhibit 4) Good afternoon. [LB625]

SENATOR CAMPBELL: Good afternoon. [LB625]

JAMES GODDARD: My name is James Goddard, that's J-a-m-e-s- G-o-d-d-a-r-d. And I'm the director of the economic justice and healthcare access programs at Nebraska

Appleseed. I'm here today to testify in support of LB625. I would first like to take a moment to thank Senator Conrad for her continued commitment to improving access to childcare for working families in Nebraska. As you've heard today and as you've heard the last couple weeks, affordable childcare is vital to allow families to work and to keep children safe. The childcare subsidy program provides assistance to low-income families by helping them cover the cost of childcare. The program helps parents find work, maintain employment, or get the education and skills that they need to find a job. In short, without the program many families would not be able to pay for childcare and would be unable to work. Sadly, the eligibility levels for the program are inconsistent with the experiences of low-income families who spend more of their income proportionately on childcare than higher income earners. In fact, Nebraska has a dismal ranking nationally in terms of eligibility. Specifically, a family of three can earn only around $2,000 a month and remain eligible for the program. At the same time, families earning slightly more than that number still struggle to pay for the cost of childcare and that affects their employability and potentially the safety of their children. This bill would remedy this problem by reestablishing eligibility for the program at a level that is much more realistic with the current costs of childcare. This would allow more low-income working families earning between 120 percent and 185 percent of the federal poverty level to access the program while also requiring them to pay for a portion of the cost of the care. The bill would go far to ensure that Nebraska children are in safe environments while their parents are working, and may enable families to find work or take a pay raise. This is not only good policy for Nebraska's families, it's also good for Nebraska's economy and its continued fight against unemployment and underemployment. And with that, we would urge you to advance the bill. [LB625]

SENATOR CAMPBELL: Questions from the senators? Seeing none, thank you, Mr. Goddard. [LB625]

JAMES GODDARD: Thank you. [LB625]

SENATOR CAMPBELL: Our next proponent? Good afternoon. [LB625]

SARAH ANN KOTCHIAN: Good afternoon, Chairwoman Campbell and the members of the Health and Human Services Committee. My name is Sarah Ann Kotchian, S-a-r-a-h A-n-n K-o-t-c-h-i-a-n. And I am the director of early childhood policy for Building Bright Futures and Early Childhood Services, organizations in Omaha committed to comprehensive and community-wide efforts to create educational excellence and equity. I am here today on behalf of these organizations in support of LB625. We would like to thank Senator Conrad for the introduction of this bill. I believe it has been since around 2007 that a bill has been introduced to return our childcare income eligibility level directly back to where it was in 2002, and we are grateful for this opportunity to speak to you today. Through our work at Early Childhood Services, we have created a network of childcare providers dedicated to effective learning experiences for children

because it is not just about accessing care, but about accessing quality care. The providers we work with all serve high populations of children through Title XX. And it has been made abundantly clear through our meetings with these directors and owners and my conversations with parents they serve that great and worrisome divisions have been created of the system since 2002. There are the parents who are working hard and living under great stress to barely make ends meet to maintain their childcare subsidy and pay a copay while living at or below 120 percent of poverty. These parents have been known to turn down raises and promotions to live under this threshold. Many of them know to the hour how much they can work to stay under the limit. And unfortunately, some are too often surprised by a loss of their childcare assistance because of even a few hours of sometimes required overtime that take them over the income threshold. Then there are the parents who just give up the struggle or who give in, quit their jobs, and fall back on full government assistance. And then there are the parents who are successfully transitioning off of TANF with an income above 120 percent of poverty only to realize that because of their income they will lose their childcare assistance once they are off of TANF only to fall back into either figuring out how to make ends meet below 120 percent of poverty or return to full government assistance. If ever a cycle were to be termed as "vicious," this is one. The Nebraska Department of Education categorizes a child as "at risk" if they live in a family with an income at or below 185 percent of federal poverty because economic status is an indicator in disparities in academic performance. In our work examining data across grades, it is clear that poverty is the greatest influence on academic success. When the academic achievement gap is measurable and apparent as early as 18 months of age, and our childcare assistance system is one where parents are purposefully living below 120 percent of poverty to access childcare so they can work or far worse, purposefully not working at all because of their inability to afford childcare, this should be of great cause for concern. LB625 can improve our childcare subsidy system for families and serve as a critical piece in addressing expanded access to quality, early childhood care and education statewide. And we would continue to encourage your support of an increase to childcare income eligibility limits this session. Thank you. [LB625]

SENATOR CAMPBELL: Questions? I should have asked Mr. Goddard this question too, and I just thought of it. In your research--and I don't doubt that we are dead last--but what are the increments or the greatest number of states as they move up? Are most of the states at 185 or does it range from where we are to 185? You've probably got that statistic somewhere. [LB625]

SARAH ANN KOTCHIAN: You know, it varies, and it's in a range. And I can send you a one-page, at a glance look... [LB625]

SENATOR CAMPBELL: Perfect. [LB625]

SARAH ANN KOTCHIAN: ...of all states that was just released on the National

Women's Law Center late last year that I'd be happy to send to the committee. [LB625]

SENATOR CAMPBELL: That would be excellent. And if you'd just send it to my office, we'll make sure the committee gets a copy of everything. [LB625]

SARAH ANN KOTCHIAN: Sure, I'd be happy to. [LB625]

SENATOR CAMPBELL: That would be great. Any other questions that the senators have? Thanks for your testimony. [LB625]

SARAH ANN KOTCHIAN: Thank you. [LB625]

SENATOR CAMPBELL: And I appreciate your willingness to get that. [LB625]

SARAH ANN KOTCHIAN: Sure. [LB625]

SENATOR CAMPBELL: Our next proponent for LB625? Okay. Good afternoon. [LB625]

AUBREY MANCUSO: (Exhibit 5) Good afternoon. Thank you, Senator Campbell and members of the committee. My name is Aubrey Mancuso, A-u-b-r-e-y M-a-n-c-u-s-o. And I'm here on behalf of Voices for Children in Nebraska. We're here in support of LB625, and we appreciate the opportunity to discuss the childcare subsidy program again this year with the committee. And I think we're encouraged by the growing attention to this issue. I think what's important about Senator Conrad's bill is that it restores eligibility to a level that is near what we know from research is what families actually need to make ends meet in this state. I've pulled some data that comes from a 2009 report that we produced called the "Family Bottom Line." And this report attempted to look at what different families needed in different areas of Nebraska to really make ends meet. And on the second page, attached to my testimony, is a chart that looks at proportions of family expenses. And these are defined by census track as nonmetropolitan rural, nonmetropolitan urban, and metropolitan counties. And we've taken a representative county in each case for this comparison. So the urban county is Douglas, and then the nonmetropolitan urban county is Adams County, and the rural county is Nance County. And that's because those were closest to the median income across the state for that county group. And you'll see that for every county, the cost of childcare has come to exceed the cost of housing, the cost of food, the cost of transportation, and this is true both for two-parent families and for single-parent families. And so we would urge the committee to give this bill serious consideration for that reason. And, Senator Campbell, to your question, I did happen to have that chart that Sarah Ann mentioned in front of me. There are 13 states that set eligibility for childcare assistance above 200 percent, so some of those are 285, 250, and there are an additional 22 states that set eligibility at or above 150 percent of the federal poverty level. And with that, I'm happy to take any questions. [LB625]

SENATOR CAMPBELL: Thank you very much. [LB625]

AUBREY MANCUSO: Okay. [LB625]

SENATOR CAMPBELL: You must just have a briefcase full of charts back there. That's...at least we now know who carries around all the charts. Any questions? Senator Crawford. [LB625]

SENATOR CRAWFORD: Thank you, Senator Campbell. I wonder, since I imagine Voices for Children was pretty active in trying to fight this cut when it was happening at the time, if you've been tracking availability of childcare facilities since it was dropped back in...since that change was made or if you have any information about how that has impacted the availability of quality... [LB625]

AUBREY MANCUSO: Yeah, I don't have the numbers in my briefcase. [LB625]

SENATOR CRAWFORD: Okay. Uh-huh. [LB625]

AUBREY MANCUSO: But I...we...but I do know there has been a slight increase...decrease in licensed care and that there is generally not enough licensed care available for the number of children with parents in the work force. But I can get you more specific information on that. [LB625]

SENATOR CRAWFORD: Thank you. [LB625]

SENATOR CAMPBELL: Any other questions from the senators? Senator Gloor. [LB625]

SENATOR GLOOR: Thank you, Senator Campbell. Aubrey, if I--I just want to make sure I understand. [LB625]

AUBREY MANCUSO: Sure. [LB625]

SENATOR GLOOR: If I add the appropriate column across... [LB625]

AUBREY MANCUSO: Uh-huh. [LB625]

SENATOR GLOOR: ...I should come up with a number. And it won't be 100 percent... [LB625]

AUBREY MANCUSO: Right. [LB625]

SENATOR GLOOR: ...because there would be a variety of other expenses. [LB625]

AUBREY MANCUSO: There's some expenses that are left out of this. And then below the chart there's an explanation of where those numbers came from as well. [LB625]

SENATOR GLOOR: Okay. Thank you. [LB625]

SENATOR CAMPBELL: Senator Crawford. [LB625]

SENATOR CRAWFORD: Thank you, Senator Campbell. I wonder if you would just help us connect the dots... [LB625]

AUBREY MANCUSO: Sure. [LB625]

SENATOR CRAWFORD: ...because you said that the...this bill puts childcare subsidies at an appropriate level based on this family bottom line information. And so I get the point that childcare expenses are high; I see that from this. [LB625]

AUBREY MANCUSO: Right. [LB625]

SENATOR CRAWFORD: But is there something else that we can read in this figure or that you can tell us about the study that helps us understand how the amount of subsidy is appropriate given what we understand about bottom line...this bottom-line study costs? [LB625]

AUBREY MANCUSO: Sure. Well, one of the things that this research found is that in most cases, and it varied by family type and by geographic region, that what families really needed to make ends meet is closer to about 200 percent of the federal poverty level. So 185 is closer to that number. So what that means is that a family transitioning off the program would then not experience what we probably referred to before this committee before is the cliff effect where they fall off that cliff of eligibility and lose an amount in subsidy that is significantly more than what their increase in earnings was. But at 185 percent, we know that from this research that they're closer to that point of being able to make ends meet without any public assistance in most cases. [LB625]

SENATOR CRAWFORD: But is it correct...do I understand you correctly that the study would really set the limit at 200? [LB625]

AUBREY MANCUSO: In most cases, and it does vary by family composition and by what region of the state we're talking about. So... [LB625]

SENATOR CRAWFORD: Thank you. [LB625]

SENATOR CAMPBELL: Any further questions? Thank you. Our next proponent?

[LB625]

JEN GOETTEMOELLER: (Exhibit 6) Good afternoon, Madam Chair, members of the Health and Human Services Committee. For the record, my name is Jen Goettemoeller, G-o-e-t-t-e-m-o-e-l-l-e-r. Senator Conrad has brought an important issue before you today, and I'm here to express First Five Nebraska's support of LB625. The latest 2010 census numbers show there are 59,825 children ages birth to five in Nebraska who are at risk of failing in school. Geographically, these children live all across the state, and the map at the back of your testimony will show you where those children are. This number of children at risk is growing at a pace too rapid for us to ignore. According to the census, from 2000 to 2010 the total birth to five population in Nebraska increased by 13,600 children. So we're slowly gaining a few young people here in the state, and that's certainly good news for us. The bad news is that of that 13,000 increase, the number of those children who are already at risk of failing in school rose 11,600. When a certain segment of the population grows by about 13,000 and 11,000 of them are already at risk of failing in school, you don't need to be a fiscal analyst to know that that is not good. We must look ahead, we have to know what's coming, and we need to be prepared with an answer. LB625 is part of that solution. Of the nearly 60,000 at-risk children ages birth to five in Nebraska, the childcare subsidy reaches less than half of them. LB625 would reach the remaining children who are at risk of failing in school. It's an important piece of the puzzle, and I'm grateful for Senator Conrad's leadership on this bill. Another part of the solution is ensuring that publicly funded early childhood services do, indeed, provide the level of care found to reduce the achievement gap. That's where LB507 comes in, and I wasn't able to be here last week when this committee heard that bill. But I did want to thank Senator Campbell for her leadership and vision on that piece; it is critical. That bill will provide the accountability we need to begin serving children well, inform parents, equip and reward providers, and also justify our actions to the taxpayer. The third part of the solution is investing in what we know already works. Next week, Senator Harms is offering LB190 to the Appropriations Committee, building on infrastructure that is already in place and expanding proven and accountable early childhood services statewide, targeted during the window of opportunity where science shows we can have the biggest impact and yield the greatest return on dollars invested. A sound fiscal strategy isn't just about knowing where to invest, it's also about knowing when. And LB190 addresses both. Together with LB190 and LB507, LB625 is an important piece of addressing not only the growing number of children at risk across the state, but ensuring that those children can succeed in school and fill Nebraska's employers' needs. First Five Nebraska urges your support in advancement of both LB507 and LB625. Thank you. [LB625]

SENATOR CAMPBELL: Questions? Senator Krist. [LB625]

SENATOR KRIST: Hi. Thanks for coming, and thanks for your testimony. [LB625]

JEN GOETTEMOELLER: Sure. [LB625]

SENATOR KRIST: I would be interested, if you have it available... [LB625]

JEN GOETTEMOELLER: Uh-huh. [LB625]

SENATOR KRIST: ...I'd like to see an overlay of the school districts in this distribution. [LB625]

JEN GOETTEMOELLER: Okay. [LB625]

SENATOR KRIST: It seems to me like I see clusters of counties. And I wonder if that's consistent with the academic performance of a particular school district. I'd be very interested in seeing that. The other thing I'll ask you and I'm sure you know, when we talk about 28 percent of kids being at risk in Blaine County, Blaine County doesn't have a big population. So 28 percent is a significant number of kids that are at risk in that particular county. And so I'm reading that correctly, right? [LB625]

JEN GOETTEMOELLER: Absolutely. [LB625]

SENATOR KRIST: It's the at-risk percentage of the kids who are in that district? [LB625]

JEN GOETTEMOELLER: In that county that are zero to five, that's the percentage of at-risk children. Absolutely. [LB625]

SENATOR KRIST: Wow. [LB625]

JEN GOETTEMOELLER: Yep. So... [LB625]

SENATOR KRIST: I'd also love to see what happens when you project this out, you know, 5 to 10 or a 5 to 50 or whatever that next measurable category would be. I hate to give you homework, but I think... [LB625]

JEN GOETTEMOELLER: Glad to do it. [LB625]

SENATOR KRIST: ...it might be telling. It might be telling. [LB625]

JEN GOETTEMOELLER: We have overlaid...as you know, school district boundaries don't follow county boundaries. [LB625]

SENATOR KRIST: Right. [LB625]

JEN GOETTEMOELLER: So there are some different lines that are drawn there. But we

have laid the data that shows the counties that have very high numbers of children birth to five with the school districts who have more than 70 percent of the state's high school dropout population. And it may be a surprise, but it is really no surprise if you think about it, that the counties that have the highest numbers of birth to five children at risk of failing in school also are the same school districts that have over 70 percent of our high school dropout population. [LB625]

SENATOR KRIST: Uh-huh. [LB625]

JEN GOETTEMOELLER: So I can absolutely get you some of that information. [LB625]

SENATOR KRIST: Thank you so much. [LB625]

JEN GOETTEMOELLER: Uh-huh. [LB625]

SENATOR CAMPBELL: Senator Crawford, did you have a question? [LB625]

SENATOR CRAWFORD: Yes. Thank you, Senator Campbell. And thank you for your testimony. Could you for the record and for us indicate what at-risk of failure in school means? How is that determined or measured? [LB625]

JEN GOETTEMOELLER: Absolutely. So we utilize the same definition that the Department of Education has used for decades, and it was referenced in earlier testimony. There are four criteria that the department uses. One of those is the measure of poverty--which is free and reduced-price lunch--185 percent of poverty which is, as you know, what the bill would increase eligibility to. The second criteria is being born of low birthweight, 2,500 grams or less as verified by a physician. The third is not speaking English as the primary language. And the fourth is being born into a home with a teen parent or a parent who has not completed high school. To calculate these numbers, we want to make sure that we're not duplicating because as you can imagine, children who fall into maybe that second or third or fourth category of at-risk is also very likely to be in that first category of poverty. And so in order to make sure we don't have a duplicated count here, we only count the children on the poverty measure who fall into that at-risk category of poverty and not the other categories, to make sure that we're not duplicating any numbers or counting a child twice. [LB625]

SENATOR CRAWFORD: So what we're seeing is a percent of zero to five children who are in families of 185 percent of poverty. [LB625]

JEN GOETTEMOELLER: Or below. [LB625]

SENATOR CRAWFORD: That's what these numbers are. [LB625]

JEN GOETTEMOELLER: Correct. [LB625]

SENATOR CRAWFORD: Thank you. [LB625]

JEN GOETTEMOELLER: Right. [LB625]

SENATOR CAMPBELL: There also is a map that we've talked about earlier at the public health in which they do like seven overlays. I'm saying that right, aren't I? [LB625]

JEN GOETTEMOELLER: I think it's seven, yes. [LB625]

SENATOR CAMPBELL: When they spoke to us, I think it's seven overlays. And at some point, we may need to sit down with folks because they've identified, is it 11 or 14 counties--do you remember--that they're watching from lots of different...based on those 7 segments. It was really quite interesting the day that we talked to them because... [LB625]

JEN GOETTEMOELLER: Yes. [LB625]

SENATOR CAMPBELL: ...we talked about your map and then they talked. And what was interesting is they indicated that your map very closely reflected some of the data on their map. [LB625]

JEN GOETTEMOELLER: The same that they're counting, right. And they're counting some other things, tracking some other indicators. [LB625]

SENATOR CAMPBELL: Right. [LB625]

JEN GOETTEMOELLER: But they still line up, the same counties, those 14 counties really show some very high needs. So we have some concentrated pockets. I mean, certainly the early childhood issue is a statewide issue. Many people are surprised to know that the number of at-risk children are growing just as fast--actually a little bit faster--in rural Nebraska than they are in urban Nebraska. So this is not just a north Omaha issue, this is a statewide issue. But the good news is, we have some concentrated pockets where we could really get our arms around this, and we have a lot to gain if we get this early childhood piece right. [LB625]

SENATOR CAMPBELL: Any other questions or follow-up? Thank you. [LB625]

JEN GOETTEMOELLER: Thank you. [LB625]

SENATOR CAMPBELL: And on a personal note, we were really sorry to hear about your grandmother. [LB625]

JEN GOETTEMOELLER: Thank you, Senator. [LB625]

SENATOR CAMPBELL: Any other proponents for the bill, LB625? Those who wish to testify in opposition to LB625? In a neutral position? Senator Conrad, I think we're back to you. And she's waiving, and she'll put her track shoes on to go to the next. Thank you, Senator Conrad, for rushing over. We appreciate it. All right. We know that our next testifier is here, so we will move to LB347, Senator Gloor's bill to provide for a moratorium on issuance of licenses under the Health Care Facility Licensure Act. (See also Exhibit 7) [LB625]

SENATOR GLOOR: Sure you don't want to take a break? We've been here for so long. [LB347]

SENATOR CAMPBELL: I know. I'm going to take a break after this one, actually. Thank you. Whenever you're ready. [LB347]

SENATOR GLOOR: (Exhibit 8) Good afternoon, Senator Campbell, fellow committee members. My name is Mike Gloor, G-l-o-o-r. LB347 was a bill that was developed because of my concern about unintended consequence of Medicaid expansion. And so LB347 is attached at the hip with Medicaid expansion. There is no need for this bill if we don't expand Medicaid. The mechanism that I propose in LB347 is a three-year moratorium on the expansion of healthcare facilities beginning September 1, 2014. Facilities affected by the green copy of the bill are ambulatory surgical centers, critical access hospitals, general acute hospitals, hospitals, mental health centers, psychiatric or mental hospitals, rehabilitation hospitals, substance abuse treatment centers, and healthcare practitioner facilities or health clinics if the primary service provided in that facility or clinic is diagnostic imaging. Those would be imaging centers. I have an amendment. When we...I'll ask the page to hand those out. What this amendment does is take us back to what I think are the most significant facilities that we should be looking at under this bill. And so this amendment would strike mental health centers, psychiatric or mental hospitals, rehabilitation hospitals, and substance abuse treatment centers. I'm striking those because they're such a small subset in the grand scheme of facilities that this bill was designed to take a look at. And, frankly, reimbursement or the lack of reimbursement for some of those facilities provides its own degree of deterrents. And so I've decided, in the grand scheme of things, let's focus on those facilities that would be ambulatory surgery centers, hospitals, and imaging centers that I'm particularly concerned about. If a facility had begun the application process with the Department of Health and Human Services and had a signed contract by February 1--this past February 1--2013, they are exempt from this bill. The reason that we slapped that February 1 date on, even though this would begin in September 1, 2014, was concerns about an artificial demand. In other words, people who would stampede to actually go ahead and construct something because of concern that this bill is in

existence or may move forward. By putting a signed construction contract date on there, we don't have to worry about that. The September 2014 date is when somebody would actually need to have a license issued by the Department of Health and Human Services. So we' talking about an 18-month period of time that people would be able to move forward and complete projects that they already have signed contracts for. Approximately 120,000 Nebraska residents may be obtaining insurance coverage through Medicaid expansion. This increase in demand for services could spur an unsustainable growth in facilities with an inflationary impact on the overall cost of healthcare when we currently have utilization capacity available to us. I believe it's in the best interest of the state of Nebraska and our residents that if optional Medicaid expansion is authorized in Nebraska, healthcare facility license be curtailed for a period of time--that being three years--to avoid the inflationary cost spiral that comes with uncontrolled growth and provision of services, and to allow for unintended consequences, and unknown costs to become known, and sustainable growth to be planned for as we move forward into the future. Full disclosure: conspiracy theorists rise up at times like this, and I've heard two things. One is that the Hospital Association has talked to me about this and as a process, that it would stifle competition. Understand, this also affects hospitals. And so I can assure you that I have many former acquaintances in the industry who are less than excited about this, and I would expect that the Hospital Association will be testifying in opposition. The other theory is that my former employer, CHI, Catholic Health Initiatives, who have been referenced already in one of the previous bills, have also been involved in dialogue with me about this. I've had no conversation with anybody from CHI other than friends I have who still work within CHI--but as relates to this or any other legislation--for years. So there is...this is strictly something that I'm quite capable of drawing on based upon my own 30-plus years of experience in the healthcare industry. The debate on Medicaid expansion so far has fallen into two camps. Gross generalizations here, but bear with me. Those who, for ideological reasons and distrust of the federal government and their ability to deliver on promises of picking up the tab, think we should say no to Medicaid expansion. And those who believe we should expand Medicaid to tens of thousands of Nebraskans with a hope, that I think is overly optimistic if not simplistic, that this will improve health and save money. I'm currently opposed to expansion. My argument and the basis for both LB347 and a bill we'll hear next week, LB338, is that as much as I wish we could increase access to traditional healthcare models, I am concerned about unintended consequences because of the complexity of our healthcare system. My institution received national awards when it came to reaching out to the unserved and underserved in my community. A quick Google could come up with things like community-based clinics and student-wellness centers and a health-education center in the community mall where we had Spanish-speaking health educators present to educate the population. And we didn't care whether they were citizens or not; we cared about providing those services. So I say that so that you'll understand, or the record shows, I certainly would love to expand it, but I have a passion for unintended consequences. And I was concerned and lobbying against safe haven when it came

down the pike because I knew legislation as was drafted and passed relating to emergency rooms and being able to drop children off there was likely to run into problems. I didn't foresee they'd be as bad as they were, but I knew this was going to be problematic. I am telling you, I am worried about unintended consequence as relates to Medicaid expansion in one fell swoop. I believe adding 120,000 more Nebraskans to the roles of the insured will result in an explosion of new diagnostic facilities, surgical suites, acute hospital beds. These capital expenditures will drive up utilization and correspondingly the cost of healthcare for all payers and all patients without a commensurate improvement in the health status of Nebraskans. It's an important point. I think providing these services is no guarantee--and history proves that this is the case--that we will see it in commensurate improvement in health status. Unlike operating expenses, staff, supplies, medications, which can be adjusted quickly, when we build multimillion dollar imaging suites and ambulatory surgery center suites or hospital wings, we're talking about bricks and mortar costs or equipment purchases that have to be paid for over years and years and years. A moratorium would allow, if nothing else, for us to take a deep breath before we make that jump. The case for my growth concerns: we used to have certificate of need. Senator Sullivan's bill was a nice preamble to talk a little bit about certificate of need. It went away for everything but long-term care and some of the rehab beds that we have out there. For 20 years this state, as policy, felt that uncontrolled capital expenditures were not in the best interest of taxpayers. What happened back in the late '90s is that a growth in the economy had employers and senators less concerned about inflationary healthcare costs and more concerned about being able to hire enough people and offering a benefits package. Plus, candidly, the biggest push was towards a market-driven healthcare system. Well, here we are 15 years later. And I think it's one of those issues where we say, how has this market-based system worked for us when it comes to cost and improvements in health status? I don't think it's worked well for us. But we used to, as state policy, think that controlling capital expenditures made sense. I am not proposing that we reinstitute certificate of need. I am saying we should have a three-year moratorium so we have an opportunity to slow down and assess to make sure we don't see an inappropriate explosive growth. We already know federal law prohibits provider investment, specifically physician investment in things like hospitals. And there are community-size issues that limit their ability to invest in imaging and ambulatory surgery centers. That's because there's been a recognized...that because we don't pay physicians the way we should with Medicaid dollars and Medicare dollars, I would argue, they have been forced to turn to other sources of income. But if now we take roughly 15 percent of the patient load that for hospitals and physicians used to be charity care or no pay and say those people have insurance, that is a business opportunity. And I'm not talking about profiteering here, I'm talking about the reality of a huge segment of our population already who have gone from the bad-debt, charity-care column to now having-insurance column, there is an opportunity to move into providing more services for those folks. And we have an insatiable appetite for health services. We just have an insatiable appetite for health services. I want to read two articles or just inserts from two

newsletters that have come across my desk--I have others. But this talks about how within the provider community this growth in Medicaid expansion is perceived; clearly not by all, but by quite a few. Here's one newsletter that starts out bemoaning the fact that after the election we're going to have to deal with the reality of the Affordable Care Act. It's not all bad news and, in fact, there is some silver lining in some areas for healthcare providers. Under the Obama health plan there will be more insured who are able to have insurance pay for procedures at surgical centers and hospitals that should, over time, increase volumes at our facilities. This is taken from The Wall Street Journal, interviewing a top CEO for a pharmaceutical company. Question to this individual: how will the new healthcare law affect your organization? Something like 25 million Americans without insurance coverage will be coming into the system. Relative to prescribing drugs, we see it as a pretty substantial upside. I'm not saying these folks are trying to take advantage of the situation. What I'm telling you is, there is a situation here and a vacuum that folks will move into to try and provide more and more services. And if we could be assured that health status would improve, that would be one thing. My concern is it will drive up costs without that improvement in health status. What does three years buy us? I think during that period of time we can look at our utilization. This will be a similar problem in other states across the country, we can see what the experience of other states have. And it buys us time to study it and decide if we do, in fact, need something like reinstituting certificate of need. We have excess capacity. This will give providers an opportunity to start looking at the world a little different. Most hospitals, most surgery centers that I know of, start cases between 7:00 and 8:00 in the morning and they're usually done by 2:00 or 3:00 in the afternoon. There may be a suite or two that carry over into the late afternoon or evening. But for the most part, those surgical suites are empty most of the hours of a 24-hour day. The same is true of imaging suites. I think we have excess capacity so that during a three-year period of time we can absorb that overflow. This allows time for initiatives like patient-centered medical home to take effect as it continues to grow and expand across our state, which I think will more appropriately have us reaching out to diagnostic procedures, utilization of surgeries. I think patients under medical home needs a chance to grow and catch hold. There are programs like medical...meaningful use, electronic health records. All of those are beginning to roll out now; and I think will help us to control some of the inflationary growth of healthcare, but need a little more time. Three years, I think, will give us that time. I don't blame providers here, I want to make it clear. I just know that this sort of an increase of uninsured moving to insured presents an unintended consequence of people who will get services, needed or not, clearly defined or not, whether it will improve their health or not. And I propose this by way of giving us a chance to take a deep breath and see what happens during that three-year period of time. [LB347]

SENATOR CAMPBELL: Senator Krist. [LB347]

SENATOR KRIST: I'm sure, Senator Gloor, that we will have an opportunity to debate

the actual expansion of Medicaid. And I assume that your premise is not to make sure that we deny those services, but to take our time and provide those services... [LB347]

SENATOR GLOOR: Correct. [LB347]

SENATOR KRIST: ...because the Affordable Care Act is the law of the land. So whether we get into this ball game in inning number one and take advantage of a hundred pennies on the dollar, is going to be a question that we're all going to have to wrestle with. [LB347]

SENATOR GLOOR: Correct. [LB347]

SENATOR KRIST: But I guess my basic question...if I want to talk about hospitals, I'm going to come to you. If you want to talk about airplanes, come to me. I understand you're an expert in the field. But after I read this bill and I talked to some providers and some healthcare institutions in the metropolitan area, they have no intention of going into debt because they're overbedded in the metropolitan area. So if I look at this as a regional issue, I see that the growth or expansion in providing care for those who will be eligible for care under the Affordable Care Act in the Omaha area will start filling up those diagnostic facilities. And I think the statistic--and I'm sure somebody who follows you will be able to give it--but I think we're averaging at a 60 percent utilization of beds, 40 to 60 percent, depending upon what the institution is. So we're overbedded in the metropolitan area. We have overbuilt, and the diagnostic facilities are there. Now...so the last part of that--and you can talk to it all--is how long does it take to build a quality institution if we decide in three years we're going to be able to build something? I mean, it's not overnight. So the three-year process I understand, but in about a year or year and a half I think we should be able to see that we're either reaching a capacity level...so I'm having trouble with three years, throw the dart, there you are. So speak to anything you'd like to. [LB347]

SENATOR GLOOR: Well, I'd be happy to get it out of committee with a year and a half or two years. I candidly think, Senator Krist, that at a minimum a year and a half and probably two years would be at the bottom end of what I would shoot for. There's nothing magical about three years for me except sitting down and thinking about how much time will it take for my concerns to rear their head. And if we're starting this in September of '14, we will have already had a jump of about six years in the Affordable Care Act...or excuse, six... [LB347]

SENATOR KRIST: Six months. [LB347]

SENATOR GLOOR: ...seven months in the Affordable Care Act with people having insurance. And so it gives us a good two and a half years before we might want to sit down and introduce legislation that would take effect before this ended. And so I looked

at it from the standpoint of what if we do need to do something at the time this ends? We'll have a good two years under our belt of experience with this, and so that's the number. As it relates to a census, herein lies the challenge with looking at census numbers in hospitals. And that is, it includes all beds. It includes obstetric beds. Heart patients don't go in obstetric beds. Obstetric patients don't go in cardiac beds. Trauma patients don't go in general medicine clinics. And even within general medicine clinics, you have those folks who are recovering from surgery and those folks who are in for pneumonia and whatnot. And so you have different units, different floors that take care of all those things. You may have a lot of patients but in reality, they're spread in different units. And there are times when hospitals can't take any more of one type of patient, but they still have empty beds because they're not coronary patients and they're not pneumonia patients and they're not OB patients. I think most hospitals do have some excess capacity but I agree, not a lot. And some would say, why don't we then increase the number of beds? Why don't we let them increase beds? I think part of our challenge is we don't use beds on Saturdays and Sundays very much. It's not convenient for staffing. It's not convenient for making rounds. If we did, I think we could probably do just fine with the beds we have in the state at this point and period of time. It gets back to that issue of utilization or underutilization of what we have available. That's a wordy answer, but I've taken into consideration as I've thought about this. [LB347]

SENATOR KRIST: I would also say, I'll never make the mistake again. It's not CSI, it's CHI. How's that? It's easy to say CSI though, it rolls off your tongue. [LB347]

SENATOR GLOOR: That's right. I knew what you meant. [LB347]

SENATOR KRIST: Well, that's important. [LB347]

SENATOR GLOOR: I knew what you meant. [LB347]

SENATOR KRIST: Thank you. [LB347]

SENATOR CAMPBELL: Senator Howard. [LB347]

SENATOR HOWARD: Thank you, Senator Campbell. Thank you, Senator Gloor. I...just to build the record--because your advice to me was always build the record--you've attached this bill to Medicaid, but there are actually a lot of...thousands of people who will gain new access to insurance on the Exchange as well. And so why does this bill only speak to Medicaid as opposed to those individuals who are also going to be receiving care on the Exchange? [LB347]

SENATOR GLOOR: It's probably just an ease of definition. I mean, my concern is the expansion overall and the large number, the bolus of insured lives that will all of a

sudden come into the system. If we were easing in over a three-year period of time, if instead of bringing in a 100,000 to 120,000 people and we were bringing 20, 40, 60, 80, if there were a way to do that, I would feel differently about it. But it's, I think, just by ease of definition. My concern is the overall numbers and the impact it will have on us; unintended consequence. [LB347]

SENATOR HOWARD: And then you mentioned health status. Do you feel that health status improves when individuals have access to doctors or medical care? [LB347]

SENATOR GLOOR: Sometimes. [LB347]

SENATOR HOWARD: But not all the time? [LB347]

SENATOR GLOOR: But not all the time. We've...I challenge anybody to come up with the name of a hospital, surgery center, or imaging center that's gone out of business in recent history. We have an insatiable appetite for provision of service. But we pay for procedures, we pay for hospitalizations. We don't pay for outcomes. That's beginning to change, slowly, but surely. I don't think it's changing fast enough for us to avoid this being problematic. A majority of payment is still for just taking care of people and not seeing whether as a result of doing this MRI, as an example, we discovered something or was it protective? I mean sometimes, clearly we get into the area of malpractice and tort reform. And even though we have caps in this state, it's hard for a practitioner not to want to practice defensive medicine. It really is. I'm empathetic to that. My institution was sued for doing all the right things. And still, bad things happen. And so my argument would be I challenge anybody to sit down and tell me that as a result of all the additional hospital beds, imaging pieces of equipment, ambulatory surgical suites, they had seen a big jump in the overall health status of Nebraskans. I've got a way to do that. It has to do with the cigarette tax, but that's another bill for another time. [LB347]

SENATOR HOWARD: And I'm sorry, I had one more. [LB347]

SENATOR CAMPBELL: No, you go right ahead. [LB347]

SENATOR HOWARD: I just wanted to make sure that in your mind, because you've sat with this bill and worked it through, that it wouldn't stymie the potential for things like ACOs and PCMH models to be able to be implemented. Since it's just around capital improvements, it wouldn't stymie the opportunity for us to look at other payment opportunities? [LB347]

SENATOR GLOOR: Good question. And, in fact, it would not, in my opinion, and if nothing else might stimulate looking at those models a little more for those entities that are out there. Instead of money being pumped into bricks and mortar, institutions may have more money to invest in changing the delivery system models. [LB347]

SENATOR HOWARD: Thank you. [LB347]

SENATOR CAMPBELL: Other questions? Senator Crawford. [LB347]

SENATOR CRAWFORD: Thank you, Senator Campbell. And thank you, Senator Gloor. I just first wanted to follow-up on Senator Howard's point because I guess when I initially just saw this bill at first blush and knowing your concern about the ability of the system to handle all these new patients, I was like, why would you have this bill that restricts the creation of new health facilities? But I think especially with the amendment, I think I understand where you're coming from in focusing on what you would see as facilities that have excess capacity currently. And then if we're talking about one of our...one of the shifts in moving to medical homes and ACOs is we're trying to shift care out of some of these facilities that you're talking about and into other kinds of clinics and facilities. And so I noticed that...so if...there's...this bill would not restrict the more urgent care centers or more patient-centered...facilities where patient-centered home care could be delivered. So I just wanted to know if you would speak to that. [LB347]

SENATOR GLOOR: That's a part of it, but the larger part of it for me is the inflationary impact of building and sinking huge amounts of capital dollars into provision of more bricks and mortar--I keep going back to bricks and mortar--or major pieces of equipment that require payback over a prolonged period of time and how that saps monies away from the provision of other services; Senator Howard's question about investing in other things. Well, there's only so much money you have to invest in the healthcare system. And a moratorium that doesn't allow for the bricks and mortar growth makes sure that we aren't spending too much money to drive services or taking money away from things to drive providing services as opposed to having those monies available to look at changes in the delivery system. And, you know, this bill is also a soapbox. I mean, it gives me an opportunity to talk about the healthcare system is a lot more complicated than we recognize, interwoven in a lot of different ways. And we think that spending more money on healthcare improves our health. Well, it depends on how we spend it. And just because we do more diagnostics, just because we do more surgery doesn't mean that we automatically have an improvement in the basic health status of our population. Not to say that we shouldn't do surgeries or do imaging, but right now we pay for doing procedures. We don't pay for somebody leaving our system in better shape than they came in. And I am concerned with the 100,000, 120,000 more people who will be driving more procedures, sucking up capital monies that could be used elsewhere, and not getting anything for our dollars. [LB347]

SENATOR CAMPBELL: Any other questions? Senator Gloor, one of the things...I mean, I should be the last person to raise a question about a moratorium since I had a bill several years ago that put a moratorium on at least some of the facilities that you identified in order for the federal government to sort of figure out where they were going.

And so, you know, I'm going to take a strong look at this. One of the questions that I have just looking at the bill is...and the very end in which if someone has applied for a license or has a signed construction contract, do we have any idea how many there are in that category right now? Do you know? [LB347]

SENATOR GLOOR: No. But I know of two because they were friends who contacted me and said, you're killing me. I know that there are a couple of folks...well, you're asking who have signed contracts. [LB347]

SENATOR CAMPBELL: Well, or who have applied for a license. I'm assuming that comes into play with the question on the Madonna Rehab beds. [LB347]

SENATOR GLOOR: Well, but the rehab beds don't fall...wouldn't fall under this... [LB347]

SENATOR CAMPBELL: Because you're taking them? [LB347]

SENATOR GLOOR: ...because I'm taking them out, yeah. I'm taking out rehab subject to this... [LB347]

SENATOR CAMPBELL: So you're dealing mainly with somebody who's planning? [LB347]

SENATOR GLOOR: Acute-care hospitals. We haven't heard...of course, we wouldn't necessarily hear from people who this wouldn't affect because they have started construction, they have the signed contracts. We're more likely to hear from people who are close, but missed the February 1 deadline. And we've heard from a couple of people that are saying, now we have to wait to see what happens with this bill. [LB347]

SENATOR CAMPBELL: Got it. [LB347]

SENATOR GLOOR: And so I know that it's affected a couple of folks who were starting to undertake projects. [LB347]

SENATOR CAMPBELL: And you know, one of the issues that I want to piggyback off what Senator Howard said, I mean, I think that the change that we now have the ACA and Exchanges with the number of people, it's not just going to be Medicaid expansion that's going to change how we look. And to think--probably a line I'm going to use tomorrow--the way we looked at healthcare two or three years ago is not the way we're going to look at it now. And part of the thing that I think that we do have to keep in mind is that there are parts of the ACA that are going to cause hospitals and other of these facilities to look at things different. This whole idea of what's the readmission rate? And do you lose...I mean, there are other components that have been put that may put the

kind of break that--on this acceleration that you are concerned about--that may also put a break there and not just, well, we want them to stop on the capital part of it. And I think that's one thing we need to keep in mind. We're not going to...there's a lot more components to this. And I do think that some of our hospitals have started to be way ahead of this. And if you look at the scope of CHI across the state of Nebraska, I think you're seeing a system that started looking out that distance and already started making some changes. And not necessarily building either, but trying to build networks of existing hospitals. I don't know that hospitals are thinking so much about boy, we're going to build, build, build, like we used to think. But as much as they're thinking, how do I build the networks of existing in order to stay competitive looking into the future? And I just raise those issues because I think they're issues we need to think about. [LB347]

SENATOR GLOOR: And I couldn't agree with you more. Those are excellent points. And, you know, I don't think the bus with my supporters has pulled up out front yet. But, you know, I've not done anything to try and get people to line up behind this because my hope is that it will generate its own level of discussion; along with that, a level of education. There may be some in opposition who carry your comments further and talk about that very issue. But it provides us an opportunity to maybe educate other senators and the broader public about the fact that there are things, very complicated things, with larger systems being formed to try and address some of the concerns this might point to. But there's not enough of that going on. And there's also not enough of an understanding, as I said in my, I think, introductory comments. There's a degree of naivete, I think, from both camps. One being we shouldn't do anything because it's going to be very costly. On the other hand, we ought to just offer these services to X tens of thousand more people and everything will work out, without a clear understanding of this is a very complicated system--healthcare--with a lot of different moving parts that we need to pay attention to. I think the discussion on a moratorium brings to light some of these issues. And I don't think a moratorium is a bad idea either, whether three years is the right number or a year and a half or two. I still think there is an argument to be made for a moratorium as part of that overall take a deep breath, think a little deeper about this process. [LB347]

SENATOR CAMPBELL: Any other questions? Senator Howard. [LB347]

SENATOR HOWARD: Just some practical matters about the moratorium. If a hospital closed and another hospital wanted to reopen it, would this bill impact that reopening? [LB347]

SENATOR GLOOR: Wouldn't make any difference. [LB347]

SENATOR HOWARD: It wouldn't make any difference because it's just on capital improvements. [LB347]

SENATOR GLOOR: I mean, yeah. [LB347]

SENATOR HOWARD: And then if a hospital wanted to build, say, a satellite clinic to test out the PCMH model but it was a hospital clinic, would that impact that as well? [LB347]

SENATOR GLOOR: Well, this doesn't affect medical clinics. [LB347]

SENATOR HOWARD: But say, you know, a hospital owns multiple satellites. [LB347]

SENATOR GLOOR: Yeah, each of those clinics has to get its own license and would be licensed as a clinic. And as long as that clinic was, you know, a doctors' clinic, it doesn't affect it even if it's owned by a hospital. [LB347]

SENATOR HOWARD: Okay. [LB347]

SENATOR GLOOR: We're really talking about licensed hospitals, licensed beds in hospitals as opposed to clinics, as long as that clinic wasn't set up as an imaging clinic, as an example. [LB347]

SENATOR HOWARD: Okay, perfect. Thank you. [LB347]

SENATOR CAMPBELL: So I, just to clarify what Senator Howard is asking here, so in (i) you're really trying to get at the imaging clinics... [LB347]

SENATOR GLOOR: Yeah. Yeah. [LB347]

SENATOR CAMPBELL: ...not necessarily... [LB347]

SENATOR GLOOR: A primary care clinic. [LB347]

SENATOR CAMPBELL: ...a federally qualified clinic or some of the issues because... [LB347]

SENATOR GLOOR: And that's taken from licensure. [LB347]

SENATOR CAMPBELL: ...when you first look at that I went, man. I mean, we should hope to have more federally qualified clinics in the state at some point. [LB347]

SENATOR GLOOR: Yes. [LB347]

SENATOR CAMPBELL: I mean, we're trying for that. [LB347]

SENATOR GLOOR: I agree, yeah. [LB347]

SENATOR CAMPBELL: So maybe we need to...at some point you may want to look at (i) just to make sure that it...we don't mislead people. [LB347]

SENATOR GLOOR: Well, we took the language from licensure. So I think when it comes to definitions we tried to pull it directly out of the licensure and use the terminology licensure would have. So... [LB347]

SENATOR CAMPBELL: Okay. [LB347]

SENATOR GLOOR: ...that we weren't being overly confused about it. But we certainly can take a look at it. [LB347]

SENATOR CAMPBELL: Okay. All right, any other questions? Thank you, Senator Gloor. [LB347]

SENATOR GLOOR: Thank you. [LB347]

SENATOR CAMPBELL: And we know you're going to be around. [LB347]

SENATOR GLOOR: Yes. [LB347]

SENATOR CAMPBELL: Those in the room who wish to provide testimony in favor of LB347? Senator Gloor was right, the bus has not pulled up. Those who wish to testify in opposition to LB347? Okay. Whoever wants to go first. How many people wish to testify either in opposition or in neutral position? One, two, three, four, okay. Thanks. Good afternoon. [LB347]

SHARON TREAT: (Exhibit 9) Good afternoon, Senator Campbell and fellow senators. This is my first time at one of these, so you're going to have to bear with my ineptness. [LB347]

SENATOR CAMPBELL: Oh, you're doing fine. [LB347]

SHARON TREAT: My name is Sharon Treat, S-h-a-r-o-n T-r-e-a-t as in trick or treat. And I am representing 17 ambulatory surgery centers in an organization known as NAIAC. They're the Nebraska Association of Independent Ambulatory Centers. And after Senator Gloor's testimony, I'm not sure we need to be here but that's obviously one place that we need clarification. I personally work at Gastroenterology in Lincoln's Endoscopy Center which is G.I. and does all those wonderful colonoscopies. I have several concerns I have, which I have hopefully outlined for you in some organized manner. I'm not...while many of our NAIAC facilities are not planning or haven't planned

on expansion, we certainly do have a concern that there would be any kind of a moratorium put on our...or limited to do so. We know, I know, from our experience that if this many patients come into the market, they're going to want services. And they need to...if they need to have services, they should get those services. I know that we can't handle an influx of as many potential patients that either the Medicaid bill would pass, Medicare, or the uninsured that we know that we've been covering out at the hospitals for a total loss for a long time. We know that we are going to have to figure some way to expand. Now having said that, we don't do that very lightly. It's expensive, you've got to find a place to put the brick and mortar, there's a lot of regulations that you have to meet. And our state does...we just expanded this last year. In our lifetime since 1997, we've expanded twice. And we did it as a result that we couldn't any more get patients into our practice. The practice is driven, too, by the patients, when they want in, when they want to schedule, and where they want to schedule. And that's an important choice I don't think we should limit any patient to. If they want to schedule at the hospital, fine. That's also a regulatory standard now that we have to meet. It's a Medicare standard, and if they want to schedule at an outpatient center, they should be allowed to do so. They have to be provided the same choice that we have provided every other private-payer group patient. We're not sure what we're going to get. Nobody in this room is sure what numbers are going to come out of all this. We're pretty sure that if there's as large a Medicare population as there seems to be--and I'm one of those that's going to reach that--they're going to continue to want their colonoscopies. I can tell you for sure that of the procedures we do, we know that we have reduced colon cancer from number three to number two in this state. I can also tell you for sure that 50 percent of people that should be getting screened, don't. I'm pretty convinced that some of that has to do with the coverage they have or haven't had. So I think this is a big dilemma, and I'm glad you guys are the ones sorting it through. Whatever the number is, we will strive to provide the same level of quality care we have since 1997 in our facility. We have to. That's important that we do that. We will know that our facility has been recognized by payers in this state as providing a high level of quality care and so do the facilities that belong to NAIAC. They achieve accreditation beyond what's expected, they meet all the Medicare investigations--which is getting quite interesting. They're getting really more detailed about everything. And we know that we're going to have to deal with those patients that want in, and we're not going to be able to get them in. So we aren't going to make meaningful use, because we aren't going to meet the standard of care expected out of us in a turnaround, I need an appointment. And we're going to say, well, gee, that's going to be six weeks down the line, sorry. Hope they don't have a cancer we should be dealing with. So we have big concerns as do our other NAIAC facilities that provide just as critical a service, and timing becomes important. We need a turnabound...I can get a contractor in in a six-weeks' time and sign off on the plans with that contractor. And then I have to go to DHHS which signs off on it. This state has developed its regulatory standard for looking at facilities to a very high quality of care, and I don't know that you're aware of that. We have to meet engineering standards in state departments of engineering, we have to meet construction standards, we have to

meet airflow standards. That's all governed already by your state. You don't build brick and mortar very easy. You are committed to providing that service and you're committed to providing a quality-care facility. As far as Senator Gloor's comment about expanding the schedule, I don't think I can convince my docs that start at 6:30 every morning, and some at 5:00 o'clock out at the hospitals, that they should expand their hours beyond what we do. We are in our center at 6:30 every morning. We start working with the patient at that time, at 6:45. And we leave at 5:30. I don't know that you want doctors looking at longer days. That's part of your decision making. These docs are pretty stretched. [LB347]

SENATOR CAMPBELL: Ms. Treat, we should probably wrap up here. [LB347]

SHARON TREAT: Okay, I will. The other thing that we do very, very, very seriously is if we take on building anything, we do a search to see if it's going to come back as far as capital. We do ROI searches. This bill does bring along with it--and finally--that this looks to me like we're going back to certificate of need process. That did not work for freestanding facilities before. It gave the advantage to hospitals who have much bigger budgets, already have lawyers on board, and already have the staff. And with that, I close. With that, I thank you for your time. I will be glad to answer any questions. [LB347]

SENATOR CAMPBELL: Questions? Senator Howard. [LB347]

SENATOR HOWARD: You mentioned meaningful use and Senator Gloor did as well, but could you speak to what that means for those of us on the committee who are new to that phrase? [LB347]

SHARON TREAT: Well, we're a facility that's geared up already to meet meaningful use and already have developed our quality standards and charting and...that we can send out to CMS to qualify that we are truly going to meet meaningful use, which means we've committed to providing the quality of care that CMS is going to require of us. And it covers everything. It covers the safety of your facility, what you're doing to make sure that you don't have a high-risk patient, for example. It covers how quickly, you know, how quickly can you get patients in, how can you service their needs. All this data is already being reported. And I think it will be available much quicker than three years. I think because we're going to have to have it to get the incentives that we're after. [LB347]

SENATOR HOWARD: Thank you. And so if you don't meet meaningful use and you don't see patients quickly enough, then you don't get your incentives? [LB347]

SHARON TREAT: You won't get your incentives or if they look at it and...you may get it an incentive, but they'll review it and it could easily mean that you get lowered on the

payment rate list. You know, you get less, get knocked out after...it's kind of working with us for a couple of years and then after that it'll be definitely on those measurements. [LB347]

SENATOR HOWARD: Thank you. Thank you. [LB347]

SENATOR CAMPBELL: Other questions? Thank you for your testimony. [LB347]

SHARON TREAT: Thank you for having me. [LB347]

SENATOR CAMPBELL: You did just great for the first time. [LB347]

SHARON TREAT: Huh? [LB347]

SENATOR CAMPBELL: You did just great for the first time. [LB347]

SHARON TREAT: Thank you, I needed to know that. [LB347]

SENATOR CAMPBELL: Our next opponent? [LB347]

DOUGLAS WYATT: Thank you, Senator Campbell, senators on the committee. My name is Douglas Wyatt, D-o-u-g-l-a-s W-y-a-t-t. I'm the administrator at Lincoln Orthopedic Center and the LOC Surgery Center, which is a freestanding ambulatory center that's adjacent to our clinic. We have two beds...I should say two ORs that our physicians operate in. Thank you for the opportunity to speak to you today on behalf of our group, and also we are a member of the association that Sharon just mentioned. And we're speaking today in opposition of LB347. This bill begins by offering up the number of potential Nebraska residents that may be obtaining insurance coverage through Medicaid and accessing healthcare services. While this is one of the focal points behind the reasons for the request for a moratorium, I would argue that these individuals are already living here and using or accessing healthcare services regardless of their enrollment in Medicaid program. My point is that this is not necessarily the sole cause for consideration for the need of additional facility capacity. The fact that an even more alarming number of our Nebraska residents are entering the age--yes, are the baby boomers--where the need for healthcare services are going to be on the rise. By restricting the ability to expand or create new facilities to meet this impending demand puts citizens of our state at a disadvantage and could potentially put those needing healthcare services at risk for delayed treatment or care or the inability to get care that is needed. This is one of the concerns that the Affordable Healthcare Act has created in the public's mind and this bill could bring that concern to reality. A portion of this bill reads: it is the best interest of the state of Nebraska and our residents if the optional Medicaid expansion is authorized in Nebraska, healthcare facilities' licenses must be curtailed for a time to avoid the inflationary costs spiral that comes with

uncontrolled growth and provisions of services. I would argue that by implementing this requested moratorium, you would create a situation where the supply will not meet the demand and, therefore, creates a situation that allows for increased charges due to limited healthcare facility space. In essence, you are placing government control to limit the competitive healthcare market. This competition is healthy and assists in controlling, if not driving down, the healthcare costs for all Nebraskans. The final concern that I'll raise is that the facilities you list that are included in the moratorium--and it sounds like we've already had some change of this and partially a part of my concern--encompasses a broad spectrum of healthcare services. To limit all these facilities that may be in a current planning process of building or expansion to meet the current or anticipated patient load is dangerous. That would be even more detrimental if the legislative body to start creating exemptions to the list of this piece of legislation if it moves forward, which we already have heard. This action would create an unlevel playing field and takes the free market out of the equation. We would ask that you would reject this bill. Thank you. [LB347]

SENATOR CAMPBELL: Questions for Mr. Wyatt? Thank you for your testimony today. Our next opponent? Good afternoon. [LB347]

ANN FROHMAN: Good afternoon, Madam Chair and members of the committee. My name is Ann Frohman and I am an attorney and registered lobbyist here today on behalf of the Nebraska Medical Association. The Medical Association has asked me to testify in opposition to LB347. In light of the earlier discussions, we do understand and can appreciate the cost concerns that may or may not occur with expansion of Medicaid. And we do think that that's an issue that needs to be watched, but don't necessarily believe that LB347 is the solution to it. Competition among facilities, as we just heard, is positive for both patients and physicians delivering care. We're uncertain that freezing the growth would create a less expensive system necessarily and, in fact, could have the opposite effect where capacity is at issue and we are at capacity, allowing facilities to control market share, recognizing that they are in an area where there will not be expansion. And they will have the ability to dictate price where demand outstrips supply could be another unintended consequence of this bill. So we are struggling. I mean, there's a lot of unknowns going on here, and we have to be very careful and cognizant of that. In addition, as regards competition, physicians can perform services often at a less expensive cost in the smaller, new facility than in a larger hospital system. We just, you know, we just don't know, but there are times when that shouldn't be, you know, something that is an option that's removed. We do know that cost with Medicaid expansion is a large concern. Healthcare reform in many ways is trying to deal with that at the federal level and under the Affordable Care Act. You know, we've talked earlier and I've listened earlier talking about the models of delivering care. The ACOs are, you know, coming and changing that. The payment-bundling projects, the value-based purchasing, and all of these alignments in the marketplace that are changing and shifting at a rapid pace that we hope and we are focusing on for

the purposes of finding efficiency both in delivery of care and in the cost of care. Many of these models should be watched, I believe, for spillover effect to Medicaid. And, in fact, one of them that I think will be very interesting for all of us to watch is the IPAB, the Independent Payment Advisory Board. These ideas and concepts won't operate in silos. In fact, they will be in the systems and where they impact Medicare. I do believe those models will carry over into the Medicaid system; they just don't operate in a vacuum. The way you administer delivery of care, they can't. It would get too convoluted to do so. I also think it's worth pointing out that under the Affordable Care Act they did touch upon this issue, they didn't disregard it entirely. And there is an issue of facility expansion as it specifically focuses on physician-owned facilities. And in physician-owned facilities, there is a prohibition from expansion in the number of operating rooms, procedure rooms, and beds. So they took it on, looked at it, and now that's a narrower issue than what we have here today. But they did look at it, and there is one area where they've touched upon it. So I think you need to keep that in mind as you're looking at this. They also enhance the oversight of imaging services, requiring disclosure of alternative imaging services to increase competition. So they were trying to take steps looking at that. And I do know that there's probably in this arena much more deliberation and dialogue that our members can have with you to find maximum efficiency in the delivery of care through the physicians' networks and how they approach it. It is one where we recognize that they're going to be practicing to their credentials, practicing in maximizing out their services to make sure this can be done. Any questions? [LB347]

SENATOR CAMPBELL: Questions for Ms. Frohman? Thanks for your testimony? [LB347]

ANN FROHMAN: Thank you. [LB347]

SENATOR CAMPBELL: Our next opponent? Good afternoon. [LB347]

BRUCE RIEKER: Good afternoon, Chairman Campbell, members of the Health and Human Services Committee. It's going to be tough for me to get through this in five minutes, but I'm going to do my best. A lot has been put out on the table. But my name is Bruce Rieker, B-r-u-c-e R-i-e-k-e-r, testifying on behalf of the Nebraska Hospital Association in opposition to LB437 or, excuse me, LB487. What number am I doing here? [LB347]

SENATOR GLOOR: LB347. [LB347]

BRUCE RIEKER: LB347. [LB347]

_____: Any one you want. [LB347]

BRUCE RIEKER: Any one--we're opposed to all of Senator Gloor's bills. How's that?

[LB347]

SENATOR CAMPBELL: Which day is this? [LB347]

SENATOR KRIST: That's a great testimony. [LB347]

SENATOR CAMPBELL: And on that note. [LB347]

BRUCE RIEKER: I was studying so many back there. So I'd better get to business here. Okay. First, to us, it seems counterintuitive to put a moratorium on at this stage of the game. One, I agree with the gentlemen from the ASCs that...or the Lincoln Orthopedic Center that said that these patients already exist and, in many regards, we're already providing care to them in an uncompensated fashion. So we're not having 200,000 or 100,000 people moving to this state that we've never cared for before. They're coming in ways that some of them contribute to the nearly $1 billion of uncompensated care that we provide on an annual basis between the 89 hospitals we represent. So we think at best, it would be best to study this if this were incorporated into LR22 between the Banking and the Health and Human Services Committee. If that's something that you wanted to take a look at, we need a lot more data to make decisions. There's an inflationary aspect, no doubt about it. We do have some hospitals that are on the drawing boards, a couple of critical-access hospitals. I appreciate Senator Gloor's amendment. If he had just amended all of the other hospitals out, we'd have been in support of this. But there are some critical-access hospitals that if the moratorium were to go into place, and on a $40 million facility for...well, if they weren't able to construct until 2017, that facility could cost $7 million or $8 million more than it would cost right now. So we have not seen the cost of construction go down. Let's see. Capacity exists: we've heard already discussion about we're overbedded. Some of our hospitals say that this is not going to lower the overall expenditures in healthcare. But it will lower the cost per patient because we would have some efficiencies of scale that in some areas our hospitals would be utilizing some beds more than they have been to this point. But once again, I can't tell you exactly to what level that would be, but our members are saying that this is something we need to look at. When it comes to Medicaid reimbursements, on average our hospitals lose 26 cents on every dollar of care that they provide; not the charge, but the cost. So it is, like I said before, somewhat counterintuitive that any of our hospitals are going to rush out and build anything where they're losing money on a certain area. In one way, we feel that it would tighten the noose or it would make the pressures more difficult to actually add facilities that may help us offset the additional costs that are associated with the uncompensated care with Medicaid patients. The time lines are definitely too tight and unworkable, especially the February 1, 2013. That gives absolutely no notice to some of our hospitals, such as the hospital in Sidney. They have not signed the agreement for their new facility, but I know that they're well on their way. But they're done now. I mean, if this were to go through. We would also suggest that it would be better to look at ways to control the costs of care through patient-centered

medical homes, maybe looking at the Oregon model and the care management that they have. Let's see. I found it interesting that there was some testimony about the fact that this could drive up the costs in areas where there would be no ability to add supply of beds. But then also from a federal level through healthcare reform and cuts that have been imposed in coding adjustments as well as sequestration, our hospitals are going to incur a reduction in Medicare reimbursements of $1.25 billion between now and 2022. So there are enough financial pressures or already many financial pressures on there that our hospitals need the latitude to be able to adjust to a lot of things that are coming to us from Washington, D.C. And to have such a limit placed on our hospitals as a moratorium, to be able to react to market forces would make it somewhat problematic to ensure access and quality of care. [LB347]

SENATOR CAMPBELL: Questions for Mr. Rieker? That was pretty good, close to five. [LB347]

BRUCE RIEKER: I tried. If I knew what bill I was talking about, I would have saved 30 seconds. [LB347]

SENATOR CAMPBELL: We'll put this down and note this when you come for the other bills. [LB347]

BRUCE RIEKER: Yeah. [LB347]

SENATOR CAMPBELL: Thanks, Mr. Rieker. [LB347]

BRUCE RIEKER: You bet. [LB347]

SENATOR CAMPBELL: Our next opponent? Anyone else? Okay. Those who wish to testify in a neutral position? Seeing none, Senator Gloor, we're back to you. [LB347]

SENATOR GLOOR: I think it would be a shame if we finished up before 4 o'clock so I'll try and keep the clock running. It might be a new record for this committee. I actually... [LB347]

SENATOR CAMPBELL: We still have Exec to go, sir. I just want to remind you. [LB347]

SENATOR GLOOR: Well, this is true. That wasn't bad at all. In fact, I'm a little disappointed because I thought there would be a little more conversation about it. But some of this fits into the general comments that I've gotten from former peers that have been, I know what you're trying to do, but, or, you know, this is a subject worth discussion, but I hope your bill doesn't go through, and whatnot. So, you know, the comments fit into that category. From an educational standpoint, the supply and demand issue really doesn't work and hasn't worked for a while as relates to the

healthcare model. That's part of the challenge we have because the price is set by the payers. And so you can negotiate all you want, but especially when it comes to Medicaid and Medicare, you're on a set fee. And you can negotiate on that, but the three-year moratorium isn't a long enough period of time to change that kind of a reimbursement system. So sadly, and for better or for worse, the supply and demand model doesn't work as one of the concerns. I would point out as relates to Ann Frohman's comment, the fact is that the Affordable Care Act--the folks who put it together--recognized that this might be a problem, which is the reason they tried to put in some small provisions that tried to address it. So it isn't as if I'm dreaming up something that others haven't recognized as this could be a challenge for us. In my case, I'm only talking about a moratorium to let the dust settle and take a deep breath. Some of what they put in the Affordable Care Act were permanent, permanent provisions that they felt would slow down unnecessary growth. Good discussion. I'm still concerned that the individuals that we're talking about here--that would be the hospitals or ambulatory surgery centers or imaging centers--still have and still will be paid according to providing services, not the outcome of those services. It's going to take a long-term fix and it's going to take Medicare and Medicaid to change that system. The private payers will follow suit, but we're not there yet. I think within three years we'll be a long way on that direction. My concerns will have gone away as will the moratorium and we can move forward happily, feeling like we're making more appropriate decisions when it comes to capital expenditures. And with that, unless somebody wants to ask me questions, which is the main reason I came up here in case anybody had additional questions. I'd be glad to field any final questions. [LB347]

SENATOR CAMPBELL: Any other questions? [LB347]

SENATOR KRIST: Three, two, one, click. [LB347]

SENATOR CAMPBELL: It is 4:00 o'clock. Thank you, Senator Gloor. [LB347]

SENATOR GLOOR: Thank you. [LB347]

SENATOR CAMPBELL: And we will close the public hearing. For the committee, we will take a ten-minute break. (See also Exhibit 10) [LB347]