[LB333 LB411 LB516]

The Committee on Health and Human Services met at 1:30 p.m. on Wednesday, March 11, 2015, in Room 1510 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public hearing on LB516, LB411, and LB333. Senators present: Sara Howard, Vice Chairperson; Roy Baker; Tanya Cook; Sue Crawford; Mark Kolterman; and Merv Riepe. Senators absent: Kathy Campbell, Chairperson.

SENATOR HOWARD: Good afternoon and welcome to the hearings for the Health and Human Services Committee. I'm Senator Sara Howard. I serve as Vice Chair of the committee. Senator Campbell is out today for surgery. She's having cataract surgery today. So I will be covering in her place. As always, we start with introductions. And I'll start with my right.

SENATOR KOLTERMAN: I'm Senator Kolterman, from the 24th District, Seward, York, and Polk Counties.

SENATOR BAKER: Roy Baker, senator from District 30, Gage County, part of southern Lancaster County.

SENATOR CRAWFORD: Good afternoon. Senator Sue Crawford from District 45 which is eastern Sarpy County, Bellevue, and Offutt.

JOSELYN LUEDTKE: Joselyn Luedtke, committee counsel.

SENATOR COOK: Hello. I'm Tanya Cook. I'm the state senator from District 13. That is northeast Douglas County and Omaha.

BRENNEN MILLER: I'm Brennen Miller. I'm committee clerk.

SENATOR HOWARD: And we have two pages with us today. Jay is from Dalton, Nebraska, and he's studying at UNL. He's studying ag economics at UNL. And Brooklynne is from Omaha and she's also at UNL studying advertising, public relations, and political science, so this is a good place for that. We do have a few rules here. We ask that you turn off your cell phones or anything that makes noise so as not to disrupt the hearings. And handouts are not required to testify, however, if you do decide to bring a handout, we ask that you have 15 copies. Each witness appearing before the committee needs to bring up a florescent orange form found at either entrance in the room and the form must be given to the committee clerk before you begin presenting your testimony because he uses it for his recordkeeping as the hearing proceeds. We

do use the light system in this committee so every testifier gets five minutes. So you'll have four minutes with a green light, one minute with a yellow, and then at the red, I'll start waving my arms to get your attention to have you conclude your testimony. We also ask that when you come to testify, you begin by stating your name clearly into the microphone and then, please, spell both your first and last name even if it's Jane Smith because it's not for the clerk, it's for the transcribers so that they know how to spell your name appropriately. And with that, we will open the hearing on LB516, Senator Bolz, to create the Brain Injury Council and the Brain Injury Trust Fund and provide powers and duties. Good afternoon, Senator Bolz.

SENATOR BOLZ: (Exhibits 1, 2) Good afternoon, Vice Chair Howard, glad to be with you today and pleased to be introducing LB516. A brain injury can happen to anyone through a car accident, a sports injury or, in a lot of cases, through military service. As the senator who represents Madonna Rehabilitation Center, I have a special interest in serving individuals with a brain injury because I've seen the great work that they do not only in rehabilitating an individual who has had such an injury but also in rebuilding skills and, really, rebuilding lives after such a traumatic event. In Nebraska, we do provide assistance to individuals who have experienced a brain injury before the age of 22 through the developmental disability system. And those services are of high quality and they provide significant support. However, those that experience a brain injury after the age of 22 do not benefit from the same system. And those who experience brain injury in adulthood really struggle to find support systems. In fact, the Brain Injury Council of Nebraska implemented a statewide brain injury survey that found several things. First, they found that case management, access to resources, information about brain injury, and lack of access to services were the top concerns for individuals who experienced brain injury in adulthood. For those who are providing such services, for the human services providers that meet those needs, the biggest challenges are lack of training, lack of awareness, and related funding barriers to serving the over 36,000 Nebraskans with a brain injury. So LB516 formalizes some of our work around developing systems and support networks for adults with brain injuries. LB516 establishes in statute a Brain Injury Council and Fund to develop stronger strategic initiatives to serve individuals with brain injury in Nebraska. This approach develops leadership and a strategic approach for developing stronger systems for brain injury support. Specifically, the fund will provide for the needs identified in the assessment completed by the Brain Injury Council of Nebraska related to supports and services, resource facilitation, maintaining the brain injury registry, public awareness campaigns, and peer support. The bill as it stands is currently funded through an existing federal grant. The grant is a four-year grant from the federal government that will establish the purposes of this council and this fund. It is a competitive grant and so in four years we will need to reapply. But regardless of whether we continue to receive those federal funds or not, the strategic initiative, the systems-level approach, the state investment in understanding what our system of support for individuals with brain injury should be is essential in stabilizing and looking towards the future of serving these folks. In the future, we will have to recompete for the federal funds. But whether we do so or not, this creates a structure and a

system for accepting private dollars and helps us to leverage those federal funds by illustrating our efforts on the state level. So that is the bill in a nutshell. I'm happy to answer any questions or clarify any issues that the committee may have. [LB516]

SENATOR HOWARD: Are there questions for Senator Bolz? Senator Crawford. [LB516]

SENATOR CRAWFORD: Thank you, Senator Howard. And thank you, Senator Bolz, for bringing this bill. I was just reading it quickly in terms of some of the lists of people to include. And I guess I would wonder if you would be open to considering some specific mention of a group like the Veterans Brain Injury Task Force or just veterans groups in particular, because they tend to be a population that has quite a bit of traumatic brain injury. [LB516]

SENATOR BOLZ: Certainly. I think that's a great amendment, be happy to. [LB516]

SENATOR CRAWFORD: Thank you. [LB516]

SENATOR HOWARD: Senator Riepe. [LB516]

SENATOR RIEPE: I just came in late and I apologize for that. But the question that I have is we're hearing this in HHS and yet the advisory council is in the Education Department. I'm a little confused about that. [LB516]

SENATOR BOLZ: And I do not serve on the Exec Board so I can't specifically articulate what the conversation in the Exec Board for referring it to you might be. However, I think that the main responsibilities for serving individuals with brain injury are more related to Health and Human Services in terms of assessments, providing appropriate rehabilitation and care. And there may be other people who serve on the council who can speak to that in more depth. [LB516]

SENATOR RIEPE: Okay. Thank you. [LB516]

SENATOR HOWARD: Any other questions? Seeing none, thank you, Senator Bolz. Brennen, are there items for the record? [LB516]

BRENNEN MILLER: (Exhibits 3, 4) Yes, Senator, two support letters, one from the Nebraska Brain Injury Advisory Council and the other from the Nebraska Medical Association. Thank you. [LB516]

SENATOR HOWARD: Thank you. We will now open the floor for our first proponent testifier. Good afternoon. [LB516]

LORI TERRYBERRY-SPOHR: Good afternoon. Let me know when you're ready for me to start. [LB516]

SENATOR HOWARD: You start whenever you feel like it. [LB516]

LORI TERRYBERRY-SPOHR: Okay. Hello, members of the committee. My name is Lori Terryberry-Spohr, and I am a board-certified clinical neuropsychologist as well as the brain injury program manager at Madonna Rehabilitation Hospital here in... [LB516]

SENATOR HOWARD: I'm sorry, could you spell your name? [LB516]

LORI TERRYBERRY-SPOHR: I sure can. I'm sorry, I forgot to do that part. It's Lori, L-o-r-i, last name is Terryberry-Spohr, which is spelled T-e-r-r-y-b-e-r-r-y, hyphen, S-p-o-h-r. I apologize. [LB516]

SENATOR HOWARD: Thank you. [LB516]

LORI TERRYBERRY-SPOHR: (Exhibit 5) Okay. As I just mentioned, I'm a clinical neuropsychologist by training and background. I'm also the brain injury program manager over at Madonna. I'm here on my own behalf as well as on behalf of Madonna to speak as a proponent of LB516. In the over 20 years that I have worked with patients with brain injury, I have become acutely aware of the unmet needs that often go under the radar for these individuals. What I find most surprising about this fact is that brain injury affects more persons than breast cancer, HIV/AIDS, multiple sclerosis, and spinal cord injuries all combined. In addition, many don't realize that 5.3 million Americans live with a long-term disability as the result of a brain injury with at least 36,000 of those living in Nebraska. Unfortunately, the reality is that many of these individuals struggle with finding what they need in terms of resources for housing, respite, employment support, medical care, behavioral, and psychological care. In 2010, the Legislature commissioned a needs assessment of this population in order to more fully identify the gaps in service for those with brain injury in our state. Lack of awareness of available funding sources, knowledge of services and resources, and case management were all identified as large barriers to services. Yet despite this, the Legislature had requested this information, they have received it, and that this is indeed an issue, there has been nothing done yet to formally address this gap. Last week I was contacted about a resident of our state who needs services for a brain injury. He was not born in Nebraska but he and his family were legally resettled here after he served as an

interpreter for our military in Iraq and he had to flee his home on foot during the middle of the night because they were tipped that ISIS was on their way. The entire family was in danger. In the course of serving in his role as an interpreter, he was injured in multiple blasts and now is struggling with the effects of his injuries. He has no idea how to access services in our state or even a full grasp entirely of what is wrong with him. And it was a professional at the school that his son goes to that was calling me, trying to figure out how to get services for him. It was certainly not within her job description at the school and it was because she was concerned about how his injury was impacting the family that she was trying to reach out for services for him. But yet she reported she had made more than 15 phone calls over the last month and had not figured out where he could go or who could assist with accessing care. Persons with brain injury often struggle with organization, memory, problem solving, and reasoning skills. They also often have difficulties with clearly expressing themselves and may have decreased ability to initiate tasks. In addition, their frustration tolerance is often lower as a result of their injury. It is challenging and often wearisome for many of us without a brain injury to navigate the systems which are designed to help but are not well linked or sometimes even aware of each other. Can you imagine if you struggled with these types of issues and then were trying to navigate your way in our systems, trying to figure out where to turn for help? Even if you have a family doctor, they are unlikely to be aware of what is available, who to call, or the time to provide these types of case management services. While our state has outstanding acute care, very strong acute rehabilitation, and excellent post-acute care for those with severe injuries, we lack the community-based resources for those with more moderate and mild injuries. It is commonplace for an individual with mild injuries to not seek services immediately and then they struggle to understand what is causing their difficulties at work, school, and home. Many of these individuals flounder around, struggling with physical, cognitive, and psychological symptoms that impact all aspects of their life, unsure where to turn. They may even lose their job or have their relationships deteriorate. Resource facilitation could help these persons in many ways including educating existing providers of healthcare, mental health, and aging services, how to identify these individuals and get them to the appropriate service sooner. It has been shown to be cost effective and significantly reduce the burden on other public services. Establishing a Brain Injury Trust Fund, similar to 24 other states that have already done so, would provide a long-term mechanism for coordinating and linking services to the people who so desperately need them. Thirty-six thousand people in our state, along with several thousand each year with new injuries, need this to happen. I encourage you to support LB516. [LB516]

SENATOR HOWARD: Thank you. [LB516]

LORI TERRYBERRY-SPOHR: Thank you. [LB516]

SENATOR HOWARD: Are there questions for the testifier? Seeing none, thank you. [LB516]

SENATOR RIEPE: Can I ask one? [LB516]

SENATOR HOWARD: Oh, oh, sure, Senator Riepe. [LB516]

SENATOR RIEPE: Thank you, Senator. I was a little late on the draw there. [LB516]

SENATOR HOWARD: That's okay. [LB516]

SENATOR RIEPE: My question: Is the candidate or individual that moved or relocated to Nebraska, had served in Iraq or someplace in a high-risk area and was...suffered from it, was this person not eligible for Medicaid? [LB516]

LORI TERRYBERRY-SPOHR: That's correct. He's not eligible for military benefits because he's actually...was originally a resident of Iraq who worked with our military and then was resettled here because his family was in danger. And he is not in...currently in a position where he's eligible for Medicaid either because he's employed part-time, temporary services, and so his income is slightly too high for Medicaid but he's not eligible for insurance. [LB516]

SENATOR RIEPE: So ergo this new category? [LB516]

LORI TERRYBERRY-SPOHR: Well, I hope that we can eventually figure out funding mechanisms for many of these individuals, too, but the first start is resource facilitation to even help this person to identify if there are assistance programs, perhaps, that can be provided, you know, whether there's anything at all out there for them. And he has no way to navigate that on his own. So the school professional was trying to do that. I'm not sure, even with resource facilitation, we can help this individual in the current state of our support services. But that's a place to start, is someone who knows what's out there. [LB516]

SENATOR RIEPE: Okay. Thank you. [LB516]

SENATOR HOWARD: Senator Kolterman. [LB516]

SENATOR KOLTERMAN: Thank you, Senator Howard. Thank you for testifying today. Just a couple of questions: You indicated that there's several other states that have already implemented this type of a program. Are you familiar with some of them? [LB516]

LORI TERRYBERRY-SPOHR: Peggy Reisher is here today. She's the head of the Nebraska BIA and I believe she has all that information with her. But there are 24 other states and we do have a spreadsheet that outlines what types of programs they have put in place in their states. [LB516]

SENATOR KOLTERMAN: Okay, I'll wait to ask. Thank you. [LB516]

LORI TERRYBERRY-SPOHR: Yeah. Yes. [LB516]

SENATOR HOWARD: Any...Senator Crawford. [LB516]

SENATOR CRAWFORD: Sorry. Thank you, Dr. Terryberry-Spohr. Are you currently working with the existing grant in any way? I mean, does that...is that already something that you're...that Madonna collaborates with? [LB516]

LORI TERRYBERRY-SPOHR: I serve on the Brian Injury Advisory Council currently that's supported by the HRSA grant. And then the Nebraska--I'm blanking--Nebraska Brain Injury Association is separate from that although they now have a representative on that as well. And they currently have an ombudsman who is here today to testify as well who is playing kind of the resource facilitation role as best that she can, you know, but that's not really formally her role. But that's the closest that we have right now in terms of established. I'll let them address those questions as well. But I am aware of what's currently available in the state and I address people to Gina as the ombudsman regularly. [LB516]

SENATOR CRAWFORD: But you feel this additional structure would be added value? [LB516]

LORI TERRYBERRY-SPOHR: I think it's an extra step in really helping these people to have somebody formally in place and that role funded and established in statute. It would make a long-term provision for this large population. There's a significant number of people that are kind of falling through the gaps here. And to have this more formally established, I think, would be a big step in the right direction. [LB516]

SENATOR CRAWFORD: Thank you. [LB516]

SENATOR HOWARD: Any other questions? Seeing none, thank you for your testimony today. [LB516]

LORI TERRYBERRY-SPOHR: Thank you. [LB516]

SENATOR HOWARD: Good afternoon. [LB516]

LILY SUGHROUE: (Exhibit 6) Good afternoon. My name is Lily Sughroue, L-i-l-y S-u-g-h-r-o-u-e, and I have a traumatic brain injury caused by repeated concussions. I feel honored to be here representing the estimated 36,000 Nebraskans who are also dealing with brain injury. I am testifying in support of LB516. I sustained my first concussion in 2005 during a basketball game. I was elbowed in the ear, dropped cold to the floor, and was unconscious for several minutes. After the game, my parents took me to the emergency room. The doctor said that I didn't have a brain bleed so I would be fine. I was very sick for an entire week and as I returned to school I immediately knew something was wrong. I was labeled in school as academically gifted and took many advanced courses. After just one concussion, I began failing classes and was diagnosed as various mental health issues. From 2005 to 2007, I sustained a series of four undiagnosed concussions from the basketball game to a car accident and two incidences at school from bullying. I was dealing with double vision, visual spatial disturbances, memory loss, impaired executive functioning, reduced proprioception, and an IQ that had dropped by 40 points. As I silently struggled with these symptoms, I was not able to convey to my parents exactly what was happening to me. They knew something was wrong but didn't know what to do about it. My mother started working at Madonna Rehabilitation Hospital in Lincoln. And because she had no other resources or information from healthcare providers or the schools, she spoke with a neuropsychologist. I went in for two days of intensive testing and was finally diagnosed with a traumatic brain injury. I struggled with a traumatic brain injury for two years because of the lack of resources in the community, the inadequate awareness of brain injuries, and the lack of knowledge about brain injury from medical providers. My brain injury affects my life and my family's lives. However, with the resources I finally discovered through my mom's work, I have been able to learn coping strategies to lessen my daily struggle from brain injury to live my life to the fullest extent. Not everyone receives the services they need like I finally did. I support LB516 as it would give others like me the opportunity to be better informed about brain injury, provide funding to trained service providers to better serve the brain injury population, and bring much-needed awareness to the services available. Thanks. [LB516]

SENATOR HOWARD: Thank you. Are there questions? Seeing none, what grade are you in? [LB516]

LILY SUGHROUE: Well, I'm 24 now. [LB516]

SENATOR HOWARD: Oh, right on. [LB516]

LILY SUGHROUE: But I am actually about a year and a half from finishing my bachelor's which I never thought I could do, so. [LB516]

SENATOR HOWARD: Cool. Where are you at? [LB516]

LILY SUGHROUE: I'm at Doane, their Lincoln adult campus, so. [LB516]

SENATOR HOWARD: And then what's your major? [LB516]

LILY SUGHROUE: Human relations. [LB516]

SENATOR HOWARD: Nice. [LB516]

LILY SUGHROUE: Yes. [LB516]

SENATOR HOWARD: That's a great one. [LB516]

LILY SUGHROUE: Thank you. [LB516]

SENATOR HOWARD: Well, thank you for your testimony today. [LB516]

LILY SUGHROUE: Yep, thanks. [LB516]

SENATOR HOWARD: Our next proponent testifier? [LB516]

ROBERT LANKFORD: (Exhibit 7) Good afternoon, ladies and gentlemen. Esteemed senators, thank you for your time. My name is Robert Lankford, R-o-b-e-r-t L-a-n-k-f-o-r-d. I'm here today to urge you to support LB516. I will share with you my story as an individual who has had multiple brain injuries. Fifteen years ago, I started my day out just like any other. I went to my local blood bank and donated blood. It's a regular routine of mine. At least it used to be. And this time, however, something went wrong. And when they inserted the needle into my arm, the phlebotomist unknowingly punctured my vein and I bled into my arm. Now, reports say that when released, I fainted at the counter, hitting my face and shattering my front teeth. I hit it with such a velocity, it appeared as if I stood back up and then fell back over. I convulsed, vomited, and I awoke in an ambulance. Now, these are what the reports say. I keep saying that because I lost approximately 80 percent of my memory and I don't remember that day. So I only have medical reports to go on. Now, the hospital did their best but with little understanding and lack of resources, I was basically lost. Fifteen years ago, proper x-rays were not even taken of my head trauma due to lack of understanding of the nature of such injuries. LB516 is the first step in providing the level of support, information, and resources needed. Now additionally, LB516

would provide funding to help educate other community providers about brain injury. My experience is not unlike countless others. It was one of slipping through the cracks of an overburdened system that didn't understand my true condition. The only available resources for me were Medicaid and food stamps, for which I'm very grateful for, but these programs, they didn't answer my need for specialized brain injury services. And one can't help but wonder, if I had had the right access to the right services at the right time, would I have needed to be on government assistance for as long as I was? Now, after my second injury from an on-the-job accident approximately two years ago, I couldn't return to work. Rent and other expenses were piling up and I was soon living off the system again. And I was even declared legally exempt from work by the state. But all that were available to me, again, were food stamps and Medicaid. After my injuries, not only was I dependent on the system but also on my friends willing to take me in. I was truly blessed that they were willing to do that for me. And during these early years after my brain injury, I was often told to wait and see and these things take time versus getting the proper help. I was not given the opportunity to have the rehabilitation, provided with the information about a brain injury. I struggled with memory loss, seizures, light sensitivity, migraine headaches, and depression. I was living this new life but didn't know how to cope with my new reality. Additionally, my families and friends had no idea how to deal with this new person which I had become. My memory problems greatly frustrated me and my wife and they destroyed my first marriage. There were times when my daughter would be in school and I would forget that. I would frantically look around the house and call for her time after time only to confirm that she was not there. I flooded the kitchen. I don't know how many times. I gave up on cooking altogether because I started the house on fire. I'm sorry. [LB516]

SENATOR HOWARD: Take your time. [LB516]

ROBERT LANKFORD: My daily life has become and still is a detailed line of sticky notes laid out on the kitchen counter for me by my loving wife so I don't forget my who, what, when, and wheres. And as I look back on it all now, it seems clear that it was only through sheer determination and not because of available resources that I was able to pull through. I continue to be a work in progress as I am getting through rehab that I need for my injuries from 15 years ago. My wife, Courtney, works for Madonna Rehab here in Lincoln and it's...honestly, she's the only reason I know about this amazing facility. It's working with them that I'm hoping to regain some of the motor skills I have lost after my injuries. Physical and occupational therapists at Madonna will soon be helping me get the left and right side of my body communicating again. I share my story today so as to be an example of what didn't go right in my situation. LB516 is so important. We must provide the necessary resources for people like me so that we can live long, healthy, productive lives as Nebraskans. Thank you for your time. [LB516]

SENATOR HOWARD: Thank you. Are there questions for Mr. Lankford? Seeing none, thank you for your testimony. We appreciate personal stories more than anything. Our next proponent? Good afternoon. [LB516]

GINA SIMANEK: (Exhibits 8, 9) Good afternoon, everyone. Senator Howard, members of the committee, I am Gina Simanek, G-i-n-a S-i-m-a-n-e-k. I currently serve as the ombudsperson for brain injury in the state of Nebraska, and I'm contracted by the Brain Injury Association of Nebraska. I request your yes vote on LB516. My reasons for being here today are several: to continue the role I have served for years as a resource facilitator and now ombudsperson for brain injury while advocating for those I work with, to make the state of Nebraska aware of the problem we have with brain injury, and to begin working towards recovery by educating professionals to incorporate practices geared towards brain injury recovery which will enhance this neglected population of people's lives. I was hospitalized after a brutal assault in '92. The damage was profoundly targeted at my head. Thus, I was fortunate to have had medical care to treat what was indicative of a severe traumatic brain injury since many other individuals, as you just heard, who are brought to the ER are either misdiagnosed or the brain injury is not given much, if any, attention. Since the assault, I have been an avid advocate and volunteer for hundreds of survivors and their families by educating them about brain injury and/or directing them towards resources. A formidable problem that I continue to encounter with this outreach work is, why are so many Nebraskans not getting services to support them and their brain injuries? Early on during my own recovery, I pondered that maybe this is perhaps due to a comprehension issue which was a symptom of my own injury. However, I concluded rather quickly that the lack of comprehension and awareness falls on the state of Nebraska and not being able to recognize the medical entity of a brain injury. My role as ombudsperson entails much of what I had been doing for over 20 years as a volunteer yet serving many more individuals with brain injury that have either been diagnosed or not diagnosed. When I receive a phone call which comes from the brain injury registry, an extensive intake is done with focus on what services have been attempted, current symptoms, education, employment, social issues, medical and mental health. Most phone calls I receive, I struggle to find professional services due to the lack of professional training in brain injury and specialized services, the lack of insurance and funding resources, a lack of awareness and insight on the individual with brain injury. Although many survivors often receive hospital and rehab, they and their families subsequently emerge from acute care with limited insight and knowledge on how to overcome the obstacles that they're going to see in the years to come. At least two-thirds of patients who are discharged from rehab after a typical stay of 16 days get no further treatment due to insurance restrictions. Time is needed to allow the individual to become aware of their deficits and then slowly begin to regenerate neurons as well as learn compensatory strategies for these areas that can't be rebuilt. Basically, brain injuries often result in long-term disabilities. Many individuals that I serve could be healthy contributors to our society again if given an ongoing support that they need from providers and professionals. I see individuals that are functioning

adequately after a brain injury but they are not aware of what is different. If you put these individuals back into work, school, or a nonstructured environment, they will likely fail miserably because of the lack of awareness and education of the deficits that they've incurred. They need a continuation of care, yet many are put into a nursing home with no structure or stimuli-driven activities to allow them to work on specific skills. Some individuals go back into a community college and are expected to do the same work as everyone else since they "appear normal" but with cognitive skills that they...that have not been rehabilitated and a brain that can only work at a slower pace. Thousands of Nebraskans, whether they be civilians or soldiers with a brain injury, are misdiagnosed. Undiagnosed brain injuries are a major cause of homelessness, drug and alcohol abuse, secondary psychiatric illnesses including depression, panic attacks, ADHD, bipolar disorder, and potential suicide. A behavior problem from an individual with a brain injury is only an expression of the symptoms that this individual is going to go through in trying to cope. This individual is then given a multitude of different medications which will not assist them in getting better. They need to be rehabilitated and functional again, not medicated and isolated, therefore, continuity of care. I will end by saying, save the state money by voting yes for LB516. There will be less people in the criminal justice system and nursing homes in Nebraska when we begin to invest in Nebraskans with brain injuries. Thank you. [LB516]

SENATOR HOWARD: Thank you. Are there any questions for the testifier? Seeing none, thank you for your testimony today. [LB516]

GINA SIMANEK: You're welcome. [LB516]

SENATOR HOWARD: Good afternoon. [LB516]

DALE JOHANNES: (Exhibit 10) Good afternoon. My name is Dale Johannes, D-a-l-e J-o-h-a-n-n-e-s. I am testifying in support of LB516 on behalf of the Nebraska Planning Council on Developmental Disabilities. Although the council is appointed by the Governor and administered by the Department of Health and Human Services, the council operates independently and our comments do not necessarily reflect the views of the Governor and/or the department. We are a federally mandated independent council comprised of individuals and families of persons with developmental disabilities, community providers, and agency representatives that advocate for system change and quality service. We would like to encourage you to put the Brain Injury Council in statute and create a Brain Injury Trust Fund. I sit on the DD council which is federally mandated as well as the current grant-funded Brain Injury Council because I suffered a brain injury 27 years ago. My injury was the result of a car accident. I was a passenger in a small pickup that ran a stop sign through a 55-mile-an-hour street in Omaha. We were hit directly in the passenger door by a full-sized pickup going 46 miles an hour. Because of that impact, I broke 17 ribs. I punctured both my lungs. I shattered my jaw. I cracked my pelvis, and I extended my

bladder and a few other things. But the worst injury that I suffered was a brain injury. Because my injury was so long ago, it allows me a perspective that few others can offer as to how significant this legislation would be. While brain injury was a central issue in the lives of myself and my family in 1988, very few others had any concept of how all-encompassing a brain injury was. It wasn't until 1998 with the first Gulf War that anyone had even heard about brain injury on a national level because of the injuries that the soldiers were experiencing and returning home with. In Nebraska, it wasn't until 2008, 20 years after my injury, when Mark Schultz wrote a grant for the state focused on the issue of brain injury. And fortunately Keri Bennett, who was also...excuse me, who was with Vocational Rehabilitation, wrote a second grant in 2013 to continue the focus of brain injury in Nebraska. These HRSA grants have been great at laying the groundwork for a comprehensive care system here in Nebraska. However, the focus of each of these grants has been on systems change and they have not allowed any money to be focused on direct services provided to individuals. Again, each of these have been grants that have an ending date where the fund runs out...where the funds run out. Additionally, when a brain injury occurs, it's not just the person that...who suffers the injury that's affected. The entire family's life is forever changed. I've seen this happen countless times with devastating effects for the families because they have nowhere to turn after rehab. To this point, Nebraska has not allocated any money towards brain injury services at all. This is where this trust fund proposed in this bill would be vital in caring for citizens who suffer brain injuries as well as their families. Nebraskans who suffer brain injuries are very fortunate to have two facilities in the state that are recognized nationally for their acute and subacute rehabilitation skill of brain injury, those two facilities being Quality Living in Omaha for adults and Madonna here in Lincoln for pediatric rehabilitation. But after individuals leave those facilities, they and their families are completely at a loss as to how to rebuild a life for the individual who sustained the brain injury. As I mentioned in my opening paragraph, I am testifying on behalf of the Planning Council on Developmental Disabilities. I sit on this council because my injury occurred before the age of 22. Because of this, I qualify under the broad definition of a developmental disability. I say broad interpretation because brain injury is a relatively new condition and people are still trying to figure out where to put us. I also mentioned in my opening paragraph that I sit on the grant-funded Brain Injury Council. On that council I am the lead of a group that is looking at brain injury in the elderly population. The elderly population suffers the highest rate of injury of any group because of falls that occur in that age group. The results of brain injury in this population are devastating. And, as of right now in the state of Nebraska, the only attention that is...that this group is getting is from the grant-funded TBI grant. Because of the limitations of the grant, we have not been able to do what is truly necessary to really assist this group. It would be impossible to overstate the sincere need for both the council as well as the trust fund. The need for this bill is very real and ever increasing because this population will only continue to increase with...or rather, will only continue to grow with advances in lifesaving techniques. Thank you for your consideration. [LB516]

SENATOR HOWARD: Thank you. Are there questions for the testifier? [LB516]

DALE JOHANNES: Seeing none... [LB516]

SENATOR HOWARD: Seeing none, thank you for your testimony. [LB516]

PEGGY REISHER: Good afternoon. [LB516]

SENATOR HOWARD: Good afternoon. [LB516]

PEGGY REISHER: (Exhibit 11) I'm Peggy Reisher. Peggy is spelled P-e-g-g-y, Reisher is R-e-i-s-h-e-r. And I'm the executive director for the Brain Injury Association of Nebraska. I, too, am here to request your support for LB516. You've heard a lot from the others today just about the...how we get brain injuries and some of the effects, so I'm going to skip over that part of my testimony. I want to just take a few moments just to talk about kind of where we are sitting currently with funding in the state. You've heard also a lot about the HRSA grant or the federal grant that we were receiving. There is one other pocket of funds that individuals with brain injury get in Nebraska. And we have a brain injury trust fund in our state. It has the capacity to serve 48 individuals with brain injury and all those funds go directly to a program in Omaha called Quality Living. To date, only about 23 individuals are actually on that brain injury trust fund. And so, you know, hearing those numbers one would think, well, why do we need more? But also keeping in mind that if they can only be provided at Quality Living, it's not always open to a lot of other folks across the state. And last I heard, I think that amount was about $660,000 that was attributed to that. Don't quote me on that, but it's still a small amount compared to some of our neighbors. The things that I attached is a...is kind of a summary of the trust funds that are available or that are being funded across the United States. To date, trust funds kind of come and go, but right now, from the looks of that report, there was right at 24 states that actually have trust funds. I think last I heard there was 40 states that actually had resource facilitation. So resource facilitation is not always funded by a trust fund but it might be...come from other pots of money from the state government. And the other thing that we looked at as far as what other states are spending on resource facilitation or trust funds, I think the average...they said it was usually in the $1 million range to some folks are getting $11 million for brain injury in their state. And we're not necessarily requesting that because I know that I might as well just walk out of here and never dream about ever getting a dime, but at the same time, just to put it in comparison that our zero to their millions is...there's a large span there. And so we're really here today just to ask for some support for those with brain injury. As you've heard the testimony, there's a need for it. At this time, I'd be happy to take any questions. [LB516]

SENATOR HOWARD: Senator Baker. [LB516]

SENATOR BAKER: Thank you. From your knowledge about the trust funds in other states, did they get them via federal grants? [LB516]

PEGGY REISHER: Every state is different. They didn't start with federal grants. It depends upon the advocacy within those states as to how they've gotten started. The reason you're hearing a lot about the federal grant from us is because that's some seed money. The whole purpose behind that federal grant is really to provide some seed money to help get infrastructure started in your state. And that's what we've been doing with those federal dollars but again, keeping in mind that it's a competitive grant. We know it eventually is going to go away possibly. We are one of 16 states to get this federal grant this last time, so it was an honor that we got it. It was a pleasant surprise. But we also know that a lot of states aren't getting those federal dollars, so. [LB516]

SENATOR BAKER: So is it your understanding that LB516 would be dependent upon receiving a federal grant? [LB516]

PEGGY REISHER: Right now what we're saying is, we've got some federal dollars to help kind of seed it and get it started. If we don't continue to get federal funds, then it would be something that we would ask of the state of Nebraska to put some appropriations towards, yes. [LB516]

SENATOR BAKER: Got it. Thank you. [LB516]

PEGGY REISHER: That's the direct answer to your question. [LB516]

SENATOR HOWARD: Senator Cook. [LB516]

SENATOR COOK: Thank you. And thank you for your testimony. QLI is located in my district. They specialize in brain injury. And my question is whether or not you knew the history of their...why they have a brain injury waiver there, and has Madonna applied for that? [LB516]

PEGGY REISHER: I am familiar. I have my version of why they are the unique one. [LB516]

SENATOR COOK: Okay. That's the only one you can offer. (Laughter) [LB516]

PEGGY REISHER: It's just the way it was written for the brain injury waiver. It has some very specific things that they can offer to individuals with brain injury and which is your... [LB516]

SENATOR COOK: QLI, when you say they? [LB516]

PEGGY REISHER: Yeah, Quality Living, which is nothing short of fabulous. The thing is, I think any entity can go ahead and apply to become a waiver provider as long as they meet the criteria that has been laid out for the brain injury waiver. So when I think of Madonna, and Lori could speak on this, but I used to work at Madonna so I know that they don't provide an assisted living level of care. So I would imagine they would not want to be applying for that because it's not considered a residential program. Does that answer your... [LB516]

SENATOR COOK: All right. That gives me some insight. [LB516]

PEGGY REISHER: Okay. [LB516]

SENATOR COOK: Thank you. [LB516]

SENATOR HOWARD: Senator Kolterman. [LB516]

SENATOR KOLTERMAN: Thank you, Senator. Thank you for testifying, Mrs. Reisher. Can you...I just have a couple of questions and a statement to make. Would this trust fund, if we set this up in the state, be eligible to accept foundation and outside monies? [LB516]

PEGGY REISHER: Yes. [LB516]

SENATOR KOLTERMAN: So it could work with the 501(c)(3)s and everybody else that might want to contribute to that? [LB516]

PEGGY REISHER: The way we've asked for it to be written is that, yes, private funds or donations could be put into it. [LB516]

SENATOR KOLTERMAN: And then you'd also ask potentially for state and federal monies as well, right, for grants and things of that nature? [LB516]

PEGGY REISHER: I'm not...I don't know that I can answer the question for how grant...federal grant funds fall into that. [LB516]

SENATOR KOLTERMAN: Okay. [LB516]

PEGGY REISHER: I'd have to ask Senator Bolz how all of that works, but... [LB516]

SENATOR KOLTERMAN: I'll wait and ask Senator Bolz. And then you talk about the trust fund that's already in existence for QLI. [LB516]

PEGGY REISHER: It's not a trust fund at QLI. It's what's called a brain injury waiver program. [LB516]

SENATOR KOLTERMAN: Okay. [LB516]

PEGGY REISHER: So that's different than a trust fund in the sense that it's Nebraska Medicaid but it's an enhanced waiver that gets some enhanced federal dollars to provide an enhanced service for individuals with brain injury. [LB516]

SENATOR KOLTERMAN: Okay. And then finally, I just want to say that I'm familiar with both Madonna and QLI and they're both wonderful programs. We're very fortunate to have both of them right here in the state of Nebraska in the Midwest. [LB516]

PEGGY REISHER: We are. They do wonderful, wonderful work. And what I dream of is that we can provide that level, that state of the art, that type of service for folks in the community beyond the snapshot of rehab. [LB516]

SENATOR KOLTERMAN: And they do so much more for just the communities of Lincoln and Omaha. [LB516]

PEGGY REISHER: Um-hum, they do. [LB516]

SENATOR KOLTERMAN: So thank you. [LB516]

PEGGY REISHER: Thank you. [LB516]

SENATOR HOWARD: Any other questions? Seeing none, thank you for your testimony today. [LB516]

PEGGY REISHER: Thank you. [LB516]

SENATOR HOWARD: Our next proponent testifier? Is there anyone wishing to testify in opposition to LB516? Seeing none, anyone wishing to testify in a neutral capacity? Seeing none, Senator Bolz, you are welcome to close. [LB516]

SENATOR BOLZ: Just a couple of quick things, committee members: Just for the sake of clarity, it's easy sometimes to be confusing when you're at the microphone. We do not have an existing trust fund. We have an existing waiver which is a Medicaid-funded waiver. And to your point, Senator Cook, a lot of great work is done through that waiver in partnership with QLI. Madonna provides the short-term rehab and QLI provides the long-term supports and services and so that's my understanding of why QLI is uniquely positioned to serve that need with the waiver population. So I, you know, I think that there are some waiver slots available but because QLI is located in the Omaha area, some other need remains in other parts of the state. To answer your question, Senator Kolterman, the fund would include...could include appropriations from the Legislature that...that might be something we do. But it would also allow for transfers from cash funds, for example, grants, private contributions, and money from any other source. And while it, you know, may not be likely for...an example of that would be if the Attorney General won a healthcare-related lawsuit, we could transfer that fund from that source. So, I mean, really the idea is that we're pulling through the work that is being done under the federal grant, providing some sustainability and some structure so that if we don't get the federal grant, or even if we...if we don't get the federal grant, we don't have to let all of this good work fall apart and then resurrect it when the need comes up again but also so that whether we get the federal funds or not, we can continue it, stabilize it, codify and sustain it. And then the last point, just quickly, is just for the sake of clarity, this doesn't expand any eligibility. It doesn't create anything new. Rather, it's ensuring that the existing services that we're providing in terms of resource facilitation and the ombudsman, those continue and that we're able to link folks up to other existing resources like the waiver, like peer support networks, like nonprofits. So I hope that is helpful and provides some additional clarity and happy to answer any final questions. [LB516]

SENATOR HOWARD: Senator Kolterman. [LB516]

SENATOR KOLTERMAN: Thank you. Senator Bolz, can you tell me, would this play in with the goal of what's going on at the university as far as their brain injury concussion study? So, you know, does...it seems to me like they might be interrelated. [LB516]

SENATOR BOLZ: Yeah, I think you're absolutely right. And, you know, to Peggy's previous point, how do we become a leader in providing these services and how does something like this cooperate with the aspirational goals of our university system? And I don't know what the current status of this initiative is, but I know we're in the final two or three of a brain mapping

national grant from the Institutes of Health. And so I think, you know, it all contributes to this broader conversation about how we serve this population. [LB516]

SENATOR KOLTERMAN: Thank you. [LB516]

SENATOR HOWARD: Senator Baker. [LB516]

SENATOR BAKER: Thank you. Senator Bolz, do you know to what extent services for people with brain injuries is covered by insurance? Is there...does it time limit out on them or what is the situation? [LB516]

SENATOR BOLZ: You know, you can imagine that it varies depending on what your insurance coverage is and what your plan is. You know, it's certainly...some of the urgent care and the acute care is covered by insurance. But I also know from working with folks at Madonna that there are time limits and sometimes people are moved out of that rehabilitation center more quickly than some of the medical providers would prefer. So resources like this to wrap them around in a community setting can really add value. [LB516]

SENATOR BAKER: Thank you. [LB516]

SENATOR HOWARD: I just have a quick question. Ms. Reisher passed out these handouts; and in the back of it, she went state by state as to how they funded their trust funds. Is...are any of these ideas that you would consider if federal funding wasn't renewed? [LB516]

SENATOR BOLZ: I don't have the same handout in front of you but I'm familiar with it. I think some of the other funding streams are diverting penalties and fees from things like people who do DUIs, that kind of thing, fees on motor vehicles, those kinds of things. I'm willing to have that conversation. One of the benefits of doing this kind of work at this point in time is that we have the resources to build it up and this entity could help us make accurate projections for what the future needs might be as well as help us to develop what those solutions and funding streams might be. [LB516]

SENATOR HOWARD: Thank you. Are there any other questions for Senator Bolz? Seeing none... [LB516]

SENATOR BOLZ: Thanks for your attention, committee. [LB516]

SENATOR HOWARD: ...this will close the hearing for LB516. We ask that if you're leaving, you leave quietly. This will open the hearing on LB411, Senator Cook's bill to change provisions relating to the Supplemental Nutrition Assistance Program. [LB516]

SENATOR COOK: Good afternoon. Senator Howard and members of the Health and Human Services Committee, my name is Tanya Cook, T-a-n-y-a C-o-o-k. I am the state senator representing Legislative District 13 and the introducer of LB411. The purpose and intent of LB411 is to, first, maintain the existing net income eligibility for the Supplemental Nutrition Assistance Program, also known as SNAP, at or below 100 percent of the federal poverty level; and second, increase the gross income eligibility limit of the SNAP program to 185 percent of the federal poverty level. This will represent an increase from the current level of 130 percent of the federal poverty level. To clarify, LB411 will provide greater flexibility in Nebraska's administration of temporary nutrition assistance by allowing for a family's eligibility to be determined after deducting expenses for basic needs such as childcare and housing. LB411 makes commonsense reform to Nebraska's administration of the SNAP program. Under the current SNAP inflexible eligibility standards, working families are not sufficiently able to deduct fixed expenses to show their need for temporary nutrition assistance. There are many working families whose gross income is at or below 185 percent of the federal poverty level. But after expenses for basic needs of shelter, healthcare, and childcare, they struggle to show...to know where their next meal will come from. Establishing a higher gross income limit for the SNAP program as proposed in this bill is specifically authorized by the federal government. This has been allowed since 1980 in recognition of the impact that high fixed costs, especially the cost of safe, quality childcare, can have on the overall budget of a family. LB411 supports working families who are currently ineligible for nutrition assistance because Nebraska's public policy does not currently recognize the way that fixed expenses can result in food insecurity. The current system of disallowing deductions of fixed expenses for basic needs of shelter, healthcare, and childcare is an arbitrary block for critical support for families in need of nutrition assistance. Increasing the gross income eligibility will amend the SNAP program in our state to incentivize long-term economic stability and reflect the reality of working families. While there is a fiscal note attached to this proposal, I would like the committee to consider how this investment can help the lives of working families in an immediate way. For clarity's sake, the SNAP program is federally funded. It's a nutrition assistance program for working families struggling with food insecurity. SNAP is fully funded by the federal government and the federal government pays half of the program's administrative costs. The fiscal note put forward by the Department of Health and Human Services estimates that passage of this bill will assist upwards of 4,000 Nebraska households. That's 4,000 Nebraska's families that will be able to take critical nutrition assistance as they work their way toward their own economic stability. It is my belief that the Legislature should put into place policies that encourage and not discourage career advancement and success. The current policy of limiting the gross income eligibility to 130 percent of the federal poverty guideline does not reflect the economic reality of these families. Testimony to follow

will outline how the current gross income level for SNAP inhibits families from bridging the gap from insecurity to stability. I thank each of your for your attention and your thoughtful consideration of LB411. [LB411]

SENATOR HOWARD: Thank you, Senator Cook. Are there questions? Seeing none, Brennen, are there items for the record? [LB411]

BRENNEN MILLER: (Exhibits 12, 13, 14, 15, 16) Yes, Senator, letters in support from Lynn Redding; Children and Family Coalition of Nebraska; The Arc of Nebraska; Holland Children's Movement; and the National Association of Social Workers, Nebraska Chapter. That's all. [LB411]

SENATOR HOWARD: Thank you. We'll now open up the hearing to proponents for LB411. [LB411]

MARY ANN HARVEY: Good afternoon. [LB411]

SENATOR HOWARD: Good afternoon. [LB411]

MARY ANN HARVEY: (Exhibit 17) Senator Howard and members of the Health and Human Services Committee, my name is Mary Ann Harvey. I'm a staff attorney in the economic justice program at Nebraska Appleseed. And my name is spelled M-a-r-y A-n-n H-a-r-v-e-y. Nebraska Appleseed is a nonprofit legal organization that fights for justice and opportunity for all Nebraskans, and I'm here today to testify in support of LB411. Unfortunately, many hardworking Nebraskans struggle to feed their families. SNAP is a program, the Supplemental Nutrition Assistance Program, that these families can rely on to help put food on the table when money is tight. In fact, thousands of Nebraskans, including children, faced food insecurity: 13.4 percent of all Nebraskans face food insecurity and 20.7 percent of all Nebraska's children are food insecure, meaning they don't know where their next meal is going to come from. It is important to note that SNAP benefits are fully federally funded, like Senator Cook mentioned, and half of all the administrative costs are federally funded. SNAP is a very effective program but it can be even more effective if it's leveraged to allow families to take a raise and still get some of the supports that they get through the program. That's why...that's what LB411 is trying to deal with. It would address the so-called cliff effect. Under SNAP, households currently have to meet two income tests. There is a gross income test, and in Nebraska, that's set at 130 percent of the federal poverty line, and they have to meet a net income test which is at 100 percent of the federal poverty line after allowable deductions. This means if a family takes a new job or a raise while they're on SNAP and increases their gross income over $2,175 per month, even if their net income is under $1,675 per month after their bills are taken into account, they would fall off the

cliff and be ineligible for SNAP. LB411 would encourage work and address the cliff effect by changing the SNAP gross income limit to 185 percent of the federal poverty limit, which would be about $3,100 for a family of three, and maintain the net income test at 100 percent of the federal poverty limit. This would allow more families that prove that their bills make it difficult for them to afford food to be able to stay on the program. Many states have recognized this type of change as a benefit to their working families. In fact, FNS at the USDA has encouraged state agencies to adopt the option to increase the gross increase limit because it improves program access and simplifies administration. Moreover, this option would benefit our economy. In 2014, SNAP benefits put $239 million into Nebraska's economy. Minnesota implemented a higher gross income limit for SNAP in 2010 and by May of 2011, the higher income threshold generated $40 million in economic activity in their state. Since this change would benefit hardworking Nebraska families, we respectfully urge the committee to advance LB411. [LB411]

SENATOR HOWARD: Thank you. Are there questions? Senator Crawford. [LB411]

SENATOR CRAWFORD: Thank you, Senator Howard. And thank you, Ms. Harvey. Can you tell us the kinds of expenses that a family is allowed to count when they're getting down to that net income? [LB411]

MARY ANN HARVEY: Sure. So they can...every family is allowed to take a standard deduction for housing costs. Some families are allowed to take medical expense deductions. Those are out-of-pocket expenses over $35 a month for elderly and disabled people. Twenty percent of earned income can be disregarded. Dependent care expenses like childcare can be disregarded, child support payments. And also there is an excess shelter limit where if your housing and utilities exceed half of your net income after deductions, you get an extra deduction. So I think those are the deductions. [LB411]

SENATOR CRAWFORD: So it would be housing, medical bills... [LB411]

MARY ANN HARVEY: Childcare. [LB411]

SENATOR CRAWFORD: ...childcare, primarily. [LB411]

MARY ANN HARVEY: Yeah, those would be the main things. [LB411]

SENATOR CRAWFORD: All right. Thank you. [LB411]

SENATOR HOWARD: Any other questions? Seeing none, thank you for your testimony today. [LB411]

MARY ANN HARVEY: Thank you. [LB411]

SENATOR HOWARD: Our next proponent. [LB411]

SARAH COMER: (Exhibit 18) Good afternoon, everyone. Thank you for allowing me to speak to you. I'm very honored to be here today. I'm here to provide my support of LB411, to share the stories and voices of Nebraskans facing hunger. My name is Sarah Comer, S-a-r-a-h C-o-m-e-r, and I work for the Food Bank of Lincoln as the SNAP outreach and partner relations manager. The Food Bank of Lincoln belongs to the Feeding America Network which is America's largest food bank network. We, along with the Food Bank for the Heartland, are responsible for the distribution of food to more than 150,000 people across the state of Nebraska. In focusing on our mission to eliminate hunger, we have realized that emergency and episodic food distribution alone will not suffice. This has brought us to become actively involved in outreach to the over one-third of people in the state that are eligible for SNAP yet do not receive this benefit. The Food Bank of Lincoln and the Food Bank for the Heartland currently employ eight full-time staff whose sole functions are to provide information, education, and application assistance to Nebraskans around SNAP benefits. Let me tell you why. Hunger is still a very existent and prevalent issue in Nebraska. Based on a 2014 report from Feeding America, there is an estimated 248,000 food insecure Nebraskans. While the majority of the households that are food insecure are eligible for SNAP, there are between 13 and 16 percent of households that fall between 130 percent and 185 percent of the federal poverty level. Those 13 to 16 percent are not currently eligible for SNAP in Nebraska due to the current gross income eligibility. That being said, I'm not here to discuss data. I'm here to tell a story. A large part of our SNAP outreach is assisting clients with the arduous SNAP application. The first step in that process is an income prescreening. All income is included in the SNAP gross income limits including but not limited to wages, child support, retirement benefits, Social Security, and more. We frequently see people that are over the gross income even by a few dollars. Sally is a 25-year-old single mother with a bright and vivacious five-year-old daughter living in Sarpy County. She has a high school diploma and works full-time at a preschool in Bellevue making just over minimum wage. Sally frequently turned down merit and performance raises because the raise would put her over the gross income limit for SNAP. Sally decided to decline the promotions because her increase in income wouldn't be high enough to cover the loss of SNAP benefits. She was faced with a steep cliff. Sally declined raises and promotions three separate times due to the current gross limits. Sally recently accepted a promotion with the day care and will lose her SNAP benefits in April. Sally states, I had to make a choice, I was tired of living in extreme poverty so that I could receive $250 a month in SNAP benefits. I decided that making more money to try to get out of my situation was better for me and my daughter. Will losing SNAP hurt my budget? Of course,

but I was tired of being punished for wanting to get out of poverty. With the proposed increase to 185 percent of gross federal poverty level, Sally and her daughter will be eligible for SNAP once again. I have seen this cliff effect firsthand as Sally is my sister. The state of Nebraska has many families struggling because they are unable to make their food last between paychecks. Even though they don't have the liquid assets to spend on food, their gross income makes them ineligible for SNAP. This is because you must qualify for gross eligibility before other important household costs are factored in such as medical bills or utilities. We do not believe that Nebraska families should have to choose between food and other basic needs such as electricity, childcare, or rent. Through SNAP benefits, families can access healthy food through local grocers, lessening the burden and expense for the family and supporting their local retailers and economy. Using SNAP benefits also lessens the weight on pantries and community supports. Ultimately, LB411 will allow more working families to utilize SNAP benefits. We at the Food Bank of Lincoln urge your support for LB411 to continue to end hunger in Nebraska. Thank you. [LB411]

SENATOR HOWARD: Thank you. Are there questions for the testifier? I only have to look this way. No one is over there. (Laughter) Thank you for your testimony. [LB411]

SARAH COMER: Thank you. [LB411]

SENATOR HOWARD: We really appreciate you sharing the story. [LB411]

SENATOR KOLTERMAN: Maybe I'll go. [LB411]

SENATOR HOWARD: You can't leave. Good afternoon. [LB411]

LUKE WALTMAN: (Exhibit 19) Good afternoon, Chairwoman Howard and members of the committee. I'm Luke Waltman, L-u-k-e W-a-l-t-m-a-n, and I'm here today on behalf of the Center for People in Need to urge your support of LB411, legislation that would improve the Supplemental Nutrition Assistance Program. The Center for People in Need, as many of you already know, provides comprehensive services for low-income and high-needs individuals and families. It provides food through multiple distributions each week, delivering 3 million pounds of food last year, and it also offers an array of services from job training and education to healthcare access and citizenship. In 2014, the center was visited over 21,000 times by clients for services. The center sees every day the struggles of those in poverty in our community to obtain food to feed their families in our food distributions and programs. Many of these individuals face the struggles that can occur for those on the knife's edge of poverty. An emergency expense often causes a cascade of problems that traps an individual and makes it necessary to sacrifice meals or another important item to make it to the next month. No cash for one emergency such as a flat

tire might mean no transportation for kids to get to school and yourself to get to work. And it could also mean losing a job. In our poverty report last year, the statistics relating to availability of food were shocking. Forty-one percent of those surveyed skipped meals because they could not afford enough food for the week, 56 percent had to choose between buying food and paying a bill, and 26 percent did not have enough food for their family on the day they took the survey. SNAP provides irreplaceable support to these families in helping them to break out of the cycle of poverty. Yet in some cases, families are unable to take advantage of this program or might be kicked off because of their gross income, meaning incomes before things like childcare expenses or rent are taken into account as has been previously said. This is also an example of the so-called cliff effect where there's a sharp drop-off in public assistance when individuals start to earn more. One story that illustrates this issue is Rob, who is a client at the center. He started a painting business and possesses more than 28 years of experience as a professional painter. One of his most important projects was actually paining the Best of Big Red store in the Haymarket in Lincoln. And despite this great experience, he has trouble finding enough work to pay the bills, often paying only enough so that his utilities don't quite shut off. On average, he applies for 10 to 20 jobs per day in an effort to earn more yet even at this low level of income, his wife's housekeeping job keeps his family from being eligible for SNAP. He does not possess many luxuries. He has no cable. His phone is necessary for getting jobs and his businesses...and running his business. And he has to contribute some of his income to help his mom who is on a small, fixed income. He often does not get access to proper nutrition and has to rely upon whatever food he can find. In his State of the State Address in January of this year, Governor Ricketts cited, and I quote: our need for a commonsense approach to government, one that does not create disincentives for people and families to work. SNAP has a cliff effect that is the very disincentive that Governor Ricketts warns us about. A recent study by Voices for Children showed that 52 percent utilize coping strategies to reduce their pay, cut their hours, or some other method to avoid losing this public assistance. Passing LB411 would make improvements to SNAP in order to enable individuals to earn a little bit more and still not be penalized for it. Therefore, we urge the committee to advance it. [LB411]

SENATOR HOWARD: Are there questions for the testifier? Seeing none, thank you for your testimony today. [LB411]

LUKE WALTMAN: Thanks. [LB411]

SENATOR HOWARD: Our next proponent testifier. [LB411]

ERICKA SMRCKA: (Exhibit 20) Good afternoon, committee members. I'm going to apologize for my voice going into this; so if I sound like a teenage boy, just bear with me, please. My name is Ericka Smrcka, E-r-i-c-k-a S-m-r-c-k-a, and I'm here representing Food Bank for the

Heartland in support of the bill to increase the gross eligibility in the Supplemental Nutrition Assistance Program, also known as SNAP. Food Bank for the Heartland serves 77 counties in Nebraska with over 250 agency and pantry partners. Through our work, we've had the privilege to participate in food distribution and SNAP outreach throughout the state, specifically in many rural communities. Even though our reach is deep with 15.8 million pounds in traditional food distribution in 2014, it falls short from meeting the need specifically in these densely populated communities. Our rural agency partners report that they see people from multiple counties needing food assistance because there is no available resources in their community. In Elwood, located in Gosper County, we hold a monthly food pantry and regularly see households with six or more surrounding communities attending. In these areas with limited or no access to charitable organizations, SNAP benefits are critical to overcoming hunger issues. We know that our agencies do absolutely amazing work; but by the sheer size of our state, widely dispersed church pantries alone cannot reach the families in need. We simply cannot food bank our way to ending hunger. SNAP is critical in addressing these issues and not only benefits SNAP recipients but also positively impacts the economic situations in these communities. I'd like to take a moment and share with you about our work in Boyd County, which is a great example of what we do. In the last 30 days, we have assisted five different households in completing SNAP applications in Boyd County. Five households doesn't sound like a significant impact, but this will equate to over $20,000 in food buying for these families over the course of the next year. We see this as a great success but it's really clouded by one family we could not help. One of our team members was contacted by a family from Boyd County for food assistance and they were determined barely over income for SNAP. As we had no pantry partner in Boyd, we had to refer them to a neighboring county over 45 miles away and that was not even open until the following week. I cannot express to you how difficult it is to simply...to see a family that simply doesn't have enough to eat, works hard, and not be able to provide them any resources. This is not the good life that Nebraska touts. By increasing the gross eligibility in SNAP program, we open up families who are qualified with actual funds that they need to have to spend on food versus just their income levels. The requirements for SNAP will not change with this bill. With LB411, a family of three would need to be under $3,050 monthly gross income and $1,650 net income. That is a family of three receiving paychecks of less than $416 a week. LB411 will not impact households that have available funds to purchase food. It opens the ability to our families to look at their specific situations such as childcare and medical bills to be considered in the determination of their benefits. The cases that our SNAP team sees that do not pass the gross eligibility test but would very easily pass the net income test typically falls into one or two categories: one, the working poor barely above the 135 percent poverty level; or working families in crisis situations specifically with medical bills. I would also like to challenge the fiscal note that assumes that 100 percent of the people that will become eligible for SNAP benefits will go through the arduous application process. Currently, only 69 percent of Nebraskans that are eligible for SNAP benefits receive them. It would appear statistically unlikely that the state's caseload would increase as dramatically as the fiscal note reflects. LB411

is a bill about supporting working poor. It is simply unacceptable to have hardworking people unable to provide for their families with nutritious meals. We need to work at giving people a hand up instead of a handout and LB411 is a good initial step in addressing the cliff effect of moving people off of public assistance. We at the Food Bank for the Heartland urge your support in LB411 to contribute to the effort to end hunger and would like to thank Senator Cook for the introduction of the bill and thank you to the committee members for your time. [LB411]

SENATOR HOWARD: Thank you. Are there questions for the testifier? Seeing none, thank you for all your hard work. [LB411]

ERICKA SMRCKA: Thank you. [LB411]

AUBREY MANCUSO: (Exhibit 21) Good afternoon, Senator Howard 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. I'm here today in support of LB411 because it takes steps to improve our SNAP program in a way that encourages steps towards longer-term financial security. The SNAP program is an important work support that helps prevent children from going hungry when their families are struggling. About half of all SNAP participants in Nebraska are kids. Adequate nutrition is particularly important for children because it plays a critical role in healthy development. SNAP also helps to lift families above the poverty line. In 2012, SNAP lifted over 10,000 Nebraska households above the poverty line. As has been mentioned, we know that there's a gap between the poverty line and what it takes for a family to meet all of their basic needs, and this bill serves as another mechanism for addressing the cliff effect. I mentioned to the committee previously that we recently conducted about 300 surveys and four focus groups with lower-income women in Nebraska. One woman, Debra, described her experience with the cliff effect in the SNAP program. She said, when all my kids were in school, things had gotten so bad that I wouldn't take a raise at my job. It was more important to me to keep right now...to hold onto my food stamps. As long as I keep the food stamps and what I'm already making, I'm okay. I can at least keep my head above water. If I take an increase in income, you're going to take my benefits and I still lose. Finally, as this committee is aware, our eligibility for childcare assistance remains among the lowest in the nation and childcare costs remain high. The dependent care deduction in the SNAP program was created by Congress in 1980 specifically to help buffer the impact that high out-of-pocket childcare costs can have on family food budgets. LB411 will assist low-income families who have high childcare costs by allowing them to still qualify for the SNAP program if they receive a small increase in gross income. This is a practical, programmatic change because it encourages working families to increase their earning potential while ensuring that their children are fed as they make the transition to increased financial stability. Thank you for your time and I'd urge the committee to advance this bill. [LB411]

SENATOR HOWARD: Thank you. Are there questions for Ms. Mancuso? Seeing none, thank you for your testimony. [LB411]

AUBREY MANCUSO: Thank you. [LB411]

SENATOR HOWARD: Is there anyone else wishing to testify as a proponent to LB411? Anyone wishing to testify in opposition? [LB411]

MARGARET BUCK KOHL: Not me. (Laughter) [LB411]

SENATOR HOWARD: Seeing none, anyone wishing to testify in a neutral capacity? Seeing none, Senator Cook, you are welcome to close. [LB411]

SENATOR COOK: That gave my heart a little start. Thank you, Senator Howard, and thank you to the committee for listening. This bill was brought within the last couple of years by our dear colleague, Senator Danielle Conrad. And as you heard over and over in the testimony, it is beyond what I might think to be the obvious, that we live in what is, on the whole, a prosperous state in which families still go without food. The irony of that, and also the idea that as we can see statistically through the testimony and through information, for example, that we've gathered with the Planning Committee and...people in Nebraska, on the whole, aren't taking running leaps at applying in the first place for assistance, whether that's SNAP, the federal childcare assistance, Medicaid as it exists now. So the idea that the people who are taking it are turning down raises and promotions, there's got to be a better way to address it in a holistic fashion from a public policy perspective especially when we look at the increasing number...and an increased number of children living in poverty in our state. So with that, I thank the committee for their time and look forward to working with you on this. [LB411]

SENATOR HOWARD: Are there any final questions for Senator Cook? Seeing none, this closes the hearing for LB411 and we'll take a five-minute break so that Senator Gloor can get here. [LB411]

SENATOR KOLTERMAN: Thank you. [LB411]

BREAK

SENATOR HOWARD: All right. We will open the hearing on LB333, Senator Gloor's bill to adopt the Health Care Services Transformation Act. [LB333]

SENATOR GLOOR: (Exhibit 22) Good afternoon, Senator Howard, members of the Health and Human Services Committee. I'm Mike Gloor, M-i-k-e G-l-o-o-r. This is like old home week coming in here for the presentation of my last bill of the session. (Laughter) I've got a handout I'm going to ask the pages to distribute. Thank you. You know, I prepared text that I could run through and in a hot room after busy days, it would probably be problematic for me not to fall asleep as I went through doing it. I think most of you know, ever since I've been down here, based upon either an inoculation or an infection that I got from some family practice physicians that I knew that had to do with the issue of a focus on primary care as one of the ways to undertake a transformational change in the way we provide healthcare in this country, as a way to focus on costs, as a way to focus on quality outcomes. And it rang true to me because of the three decades-plus of work I'd done in healthcare. And it was called patient-centered medical home. And it had to do with a focus on primary care physicians managing and serving as the home for groups of patients, individuals, their families, as well as groups of patients. And you know, I'm not going to get into an explanation of it. I'll let some of the physician testifiers who follow me. But I will say that to me it's one of the ways that we need to change the way we provide services to invert the pyramid rather than paying for the high-end costs for specialists and extensive examinations, to feed a little more energy and resources and money into our primary care practices and primary care physicians and get that pyramid turned over so that we're paying for and incentivizing patients and providers to want to provide care at that first initial contact that the patient and provider and clinician have...made sense to me. And so I introduced a bill that set up a pilot project and what you have is a time frame of what's happened with patient-centered medical home and I'd say even from a broader standpoint, a discussion on dealing with chronic disease through my legislative career. Medicaid liked it. Medicaid rolled it out as a pilot project. We had two clinics in outstate Nebraska that donated both time, energy, and money to this. We had some dollars underwritten by Medicaid to bring it forward. After two years, there was a report back to the Legislature that was a successful report, by the way, of the outcomes of these clinics transitioning to patient-centered medical homes. Part of the challenge, though, was that all we were doing was asking...well, not all we were doing, but what we were unfortunately doing is taking the least reimbursed patient population, Medicaid, or maybe second least to no pay, and asking clinics to transform when, in fact, Medicare, private insurers, were still reimbursing in the traditional fee-for-service basis, a challenge for us. One of my predecessors, Senator Wightman, introduced a bill that would have forced a conversion of all of the third-party payers to accept patient-centered medical home but, candidly, it was, I felt strongly, a step too soon. We were forcing payers and we were forcing practices into something that wasn't quite ready to be set free. We had some work to be done. We did get almost all the providers...I'd say all the major payers then to agree to what we call, that you see down here in 2011...or 2013--where are we at?--2012, an agreement, a participation agreement for two years that they would try and roll out more patient-centered medical homes as a modality of care across the state. And we finished our first year last December. They reported back their progress. There has been progress. In the meantime, Medicaid, through their managed care contracting,

has also continued to expand. There's a listing under 2014 of some of the things that have occurred. These are all good things. These all show Nebraska as a place that people go to, to get information about patient-centered medical home. But here I am in the twilight years of my legislative experience and patient-centered medical home has really been housed in District 35. And I have been the proponent. Margaret Kohl, my LA, has been the expert that people from the state call for help and outside the state call, from other states call, for information about patient-centered medical home. And my concern is, when I am done here, what happens to patient-centered medical home? What's the home for patient-centered medical home? And I have encouraged the Department of Health and Human Services to take a look at this. They're waiting for a green light. You know, the transition from the executive branch has made that difficult. So I introduced the bill, frankly, to force the issue a little more and have it find a home. It doesn't have to be in Health and Human Services. If somebody were to step forward from the Medical Association or the Hospital Association, we've had those conversations with those groups and they're very supportive. But collectively, we feel, you know, the Department of Health and Human Services is, in fact, the right place for something like this to be housed. Now, there's a commission to be formed if you read through the bill. There are those inner workings that would provide some degree of accountability. Let's put it this way: We all had had experiences of passing bills and then it disappears into the bureaucracy and nothing ends up being implemented. But with a commission formed and some reporting back responsibilities, there ends up being an accountability with patient-centered medical home. This, frankly, is tied in very closely with Senator Campbell's LB549 this year which is the outcome of the two years of LR22 and LR422 that she and I, in our respective committees at that time, brought forward. And she's waiting, I'm waiting--I'm a cosigner of LB549--to meet with the new director of Health and Human Services to see if this can be accepted with open arms and without legislation or whether we, in fact, will need legislation that pushes this forward. So I won't be asking this committee to advance this until she and I are both comfortable that our two bills are in a position to do so. But we need a hearing just in case we are going to have to ask for these bills to be advanced. And that's more or less where we're at. I'm happy to answer questions, but there are some folks who are following me who have been involved in this intimately who I think can also speak to some of it. I certainly can speak to the history of it. [LB411]

SENATOR HOWARD: Thank you. Senator Riepe. [LB333]

SENATOR RIEPE: Senator Howard, thank you. Senator Gloor, thank you for being here and thank you for your persistence. You have certainly been persistent. And going back, is this significantly different than the days that you and I remember of the gatekeeper models? [LB333]

SENATOR GLOOR: Absolutely. [LB333]

SENATOR RIEPE: The same? [LB333]

SENATOR GLOOR: No, it's absolutely different. [LB333]

SENATOR RIEPE: Absolutely different, okay. [LB333]

SENATOR GLOOR: It's absolutely different. The...some of the providers who will follow me can explain that a little further. Where it's similar is that in the days of gatekeepers, the payers required you to get a signed chit of some kind from your primary care physician before you could go see anybody else. And, of course, that worked brilliantly because the practitioner, the primary care practitioner, wasn't paid for his or her time. It ended up being a function of staff running around getting physicians to sign pieces of paper that then were...it was a hassle for the patient. It was a hassle for the primary care practitioner. And it ultimately didn't result in any change in the way care was delivered. [LB333]

SENATOR RIEPE: Okay. [LB333]

SENATOR GLOOR: But under patient-centered medical home, I call it a throwback to the days when I was a kid and your primary care physician was where you went to for all your care. You wouldn't dream of taking the broken leg you got in football and hopping in a car and being carted into Lincoln. You went to the local hospital and emergency room and you saw your physician because that's who you saw when you needed healthcare. And they made that referral into Lincoln or they set your leg. Now, I'm not saying in this day and age we're going to have primary care physicians setting femurs. But my point being is that's really where your first focus was. And their focus was on you. Your primary care physician knew what was happening in your family because their office staff knew. Clearly in the days before HIPAA, there was a lot of this back and forth in discussion. But it was likely that you primary care practice knew that the reason that the wife came in with a broken arm is because the husband had fallen off the wagon again because it was a substance abuse problem in the family. And the next time the husband came in, or even if the husband didn't come in, the primary care physician confronted them about the substance abuse problem. There was this "interactiveness," this community that made that practice the center of healthcare within that community. And what...and that's a gross generalization of this, but it gets back to the fact that you looked to that primary practice for your care and they knew what was happening with you and reached out to you for your healthcare. It's not just an issue of getting your immunizations at the right time or your colonoscopies at the right time. That's part of it also. But it's a broader focus on that being your medical home. [LB333]

SENATOR RIEPE: May I ask a follow-up question? [LB333]

SENATOR HOWARD: Certainly. [LB333]

SENATOR RIEPE: Can this be accomplished administratively if one goes into Medicaid and says, primary care doctors, we're going to give you a 20 percent increase, and we're going to get...take that money from, maybe, specialists, if you will, so it's a sum-zero economic piece but you provide more financial reward to the primary care if you want them to be the quarterback? [LB333]

SENATOR GLOOR: No. [LB333]

SENATOR RIEPE: Is that...does that not fit with this, or... [LB333]

SENATOR GLOOR: Well, what's a fit is I think primary care physicians should be paid more for being involved more. But some of the added pay should go toward making sure they have an electronic medical record, as an example. And some of that pay should be for outcomes. Just paying more and getting the same results isn't going to help us with some of our healthcare challenges. And so some of the work that's been done over the past six, seven years has been in developing outcomes criteria. As...Dr. Rauner, who is here, was intimately involved in that through some of our work. And so you need to have "what gets measured gets improved." So in areas that have to do with adult health and pediatric health and obstetric health, certain outcomes that are going to be measured to show that you're getting what you paid for. And there's another example where it's different from the gatekeeper days where we thought if we just forced people to go see their physician, that would take care of the problem. It just put a barricade in place that people figured out ways to go around. And the profit savings, frankly, sometimes didn't go to the physicians, didn't even...went to the insurers or maybe it went back to the employer who was paying the premiums. [LB333]

SENATOR RIEPE: Thank you very much. [LB333]

SENATOR HOWARD: Are there any other questions for Senator Gloor? Senator Kolterman. [LB333]

SENATOR KOLTERMAN: Thank you, Senator Howard. Senator Gloor, this is going on in other states as well. Have there been...where are we at in relationship to the other states and how this is performing for them? [LB333]

SENATOR GLOOR: That's a great question. I think it's safe to say that in the six...when we first started, there were a small number of states that had implemented this. And there were places

like...North Carolina is an example that they converted their entire Medicaid population to patient-centered medical home. And there were a few other states around that were just getting in. Arkansas, as I recall, as part of their Medicaid expansion, tapped into patient-centered medical home. And interestingly enough, Louisiana, where our new director of HHS is coming from, rolled out a plan back around 2010 or 2011, I think, trying to move their entire Medicaid population to patient-centered medical home. This isn't geared towards just Medicaid population. I mean, but it's just that the only thing that we could affect for a pilot was Medicaid which is where we started. But it's encouraging to me that our new HHS director is coming from a state that began rolling out patient-centered medical home. What is encouraging is, even though we have yet to make some of the bigger jumps, we're moving along pretty nicely. And the fact that other states are referred to us because of some of the criteria that we've developed as quality measures, as an example, shows that this is beyond the startup stage. We're at a point where, and it's one of the reasons I'm anxious to make sure that there's a legacy here and it continues to stay alive...because we're on the cusp of, I think, something that could really be transformational in the state of Nebraska and I want to keep it going. [LB333]

SENATOR KOLTERMAN: And then one follow-up question: How does pharmacy play into the patient-centered medical home? Are those...is there a tie-in with the pharmacy community? [LB333]

SENATOR GLOOR: Yes, there is. It's one of the reasons electronic medical records can be helpful. I'll...I have to be careful I not overstep my bounds because I'm not a clinician even though I was a medic in the service. I'm great with bullet wounds and knife slashes but after that I'm...but there is a...certainly a tie-in with pharmacies and a pharmaceutical piece when it comes to managing those patient populations that are out there. Some, you know, some practices now have pharmacies within them. You can do that without being a patient-centered medical home. But certainly the focus on controlling medical expense related to pharmaceuticals working with generics, avoidance of drug interactions that are adverse to patients, all those can be part and parcel of this also. [LB333]

SENATOR KOLTERMAN: Okay. Thank you. [LB333]

SENATOR HOWARD: Any other questions for Senator Gloor? Seeing none, will you be staying to close? [LB333]

SENATOR GLOOR: You know, we are supposed to go into Executive Session in Revenue, so depending on how long this lasts, I may not be around here which is fine. Thank you for your time if I don't see you again. [LB333]

SENATOR HOWARD: Thank you. We'll open up the floor for proponents for LB333. Brennen, are there items for the record? [LB333]

BRENNEN MILLER: (Exhibits 23, 24, 25, 26, 27, 28, 29, 30) Yes, Senator, letters of support from Nebraska Appleseed, Nebraska Association of Behavioral Health Organizations, Nebraska Rural Health Association, Nebraska Pharmacists Association, Aetna, Friends of Public Health in Nebraska, and the Nebraska Hospital Association. I also have a neutral letter from Nebraska Nurse Practitioners. Thank you. [LB333]

BOB RAUNER: Hello, I'm Dr. Bob Rauner, R-a-u-n-e-r, representing Nebraska Academy of Family Physicians and the Nebraska Medical Association. I don't have a prepared handout because I just want it to be, kind of, what you guys want to hear, essentially. I don't know what that is for sure yet, but one...I just want to paint a story of one of the things that's been accomplished by this. So, for example, with this group that's met over the last couple years, we set quality measures for the state. What should we focus on? What should be the common measurement bar, okay? The clinics I work with, all 12 use those to decide what's good quality and how we're going to work on it. By having this group over the last couple of years meet, we are actually...work with insurance companies. And so, for example, at one of our meetings, Dr. Lazoritz, who will follow me, said, you know what, we need pediatric measures and we need obstetric measures because Medicaid, that's what we care about. And so we picked some of those measures. By having everybody in that same room, he was able to work with somebody from another competing insurance, said, you know, if we're doing this for pregnant women, let's both do this because we'll be more effective. If we're going to pick pediatric measures, let's find out what we need to do for our kids and let's put that into our contracts. And literally, it is in our contract. So whether we get paid, and this is one of the differences between gatekeepers, if we don't do it, we don't get paid. We are on the hook and we're accountable and that's the way it should be. If we're not doing a good job with obesity screening, we shouldn't get paid as much. So I don't say...I'd be against a 20 percent increase across the board because what if some people aren't doing a good job? I don't want to pay them 20 percent more. So we've been able to use that. We are now, right now, working on a project where not only is the quality improvement in our contracts fit together, our continuing education for our physicians and PAs and nurse practitioners will fit with that. Their boards recertification will dovetail with that as well. They'll get three birds with one stone with some...one meeting tied in with what the insurers are doing. And that's why in this bill I think that public health needs to be involved. If we identify a public health need, what better way than to get several hundred physicians, nurse practitioners, and PAs all working on the same thing at the same? You would see the bar move very quickly that way. And this is one way to accomplish that. The benefit of having this is that, I guess, my political philosophy, I'm not a big fan of government healthcare. But government needs to be the referee. We literally can't sit in the same room and collude this way without government being there to oversee us to make sure that what we're doing is for the public good because there is a danger to

us doing this on the side. And, frankly, we could get thrown in jail if we did it the wrong way. So we need that ability to be in the same room and talk to each other and do something for the greater good. We literally can't do that without government oversight. That doesn't mean government is running healthcare. But you have...we need a referee. And the other reason why the state needs to be involved is, if there's a bad actor in the room, well, the state really shouldn't put that bad actor as their Medicaid managed care provider or their insurance company for their state employees. And so I think that is what we're hoping the role will be. I think we can fix this if it can be a group effort and if we can work in the same manner that we've been doing over the last couple years. And then like, you know, Senator Gloor is worried about, what's going to happen next? It needs a home. I don't know if that's government, administrative...there is going to have to be a government role because of the antitrust issues, I think. Now, who runs it? It could even be a nonprofit. I don't know. But we need something to do this. And I think it will work if we can do it. And so I'll kind of finish with there and just address any questions. You asked about pharmacy, for example. I think that's really important. Medication reconciliation is the number one quality measure we focus on. It's been that way since we started and it's still there because it's still that big a problem. And so one of the...and it's nice to include the pharmacists. We have them. We try to work on efforts where we do, kind of, all your refills at the same time so they all come up at the same time because med confusion is so common. A couple weeks ago, we had a...I think I may have said this before in a couple weeks, I hope I didn't, but where we had a heart medicine that was accidentally quadrupled in dose during a hospital stay. Our care coordinator caught that at discharge and prevented that from going home and causing a problem. They work with the pharmacy, not just the community pharmacy but also the hospital pharmacy. And those things do need to be addressed. With so many chronic diseases, some of the elderly are on 10 and 12 and 15 medicines. They're so easily confused. And so pharmacies...integral to making this work right. So with that, I'll just open up for questions. [LB333]

SENATOR HOWARD: Senator Kolterman. [LB333]

SENATOR KOLTERMAN: Thank you, Senator Howard. Doctor, you've been working with this and Senator Gloor for quite some time. And you've done a good job of bringing it to where it is today. And you've had the pilot project and it's worked out well. If we were to implement this as a state, and I know we've got to talk through this with our new director coming in. [LB333]

BOB RAUNER: Yeah. [LB333]

SENATOR KOLTERMAN: But if we were to implement something like this as a state, how long would...how long do you think it would take and how would you transition the current system to where we're at into a program like this? [LB333]

BOB RAUNER: I think transitioning is a couple of years, but quality...what you find out with quality improvement is you're never done. So there's not an end, we're there. Everybody can keep getting better, essentially. In terms of improving health, you can see gains within months or a year just on, for example, the progress on medication reconciliation or vaccinations. Cost savings probably take in the two- to five-year range although we...I'm...I think that's the last time...our Medicaid product with Aetna, in a year and a half, we've actually been shown that our costs are lower than our peers. So it could be as...done as early as a year and a half. I think that's surprising and probably because we picked good people to start with and changing everybody is a little harder. So I think cost savings takes two to five years to show up. And then some public health things like, for example, the child obesity screening counseling, some of that stuff is more of a multidecade approach. So I think it's...I guess it's never done. I think we could move pretty quickly. Nebraska already has a set of criteria for what constitutes a medical home. Several of the managed (inaudible), Medicaid, managed care already have a per month arrangements with us and others. Some of that stuff is already getting started. If we can make sure the new Medicaid director keeps that happening, it's just going to keep growing. It's already there in some communities, but it could be statewide within a year or two even. [LB333]

SENATOR KOLTERMAN: And then a follow-up question...is that all right? [LB333]

SENATOR HOWARD: Sure. [LB333]

SENATOR KOLTERMAN: The follow-up question would be, you indicated Aetna, you have a relationship with them. But there's really four...three to four major players in the state. [LB333]

BOB RAUNER: Yeah. [LB333]

SENATOR KOLTERMAN: Are they all on board and willing to work with you on this? [LB333]

BOB RAUNER: No. [LB333]

SENATOR KOLTERMAN: Okay. [LB333]

BOB RAUNER: Most of them are on board. We...ourselves, we currently have contracts with Arbor, Aetna, Blue Cross Blue Shield, and of course Medicare. And that's where we've been able to make our success so far. And I think most of those are contracts we've got good results...I actually know three we have really good results. Arbor is too early to tell, actually. So it will, I think. I'm pretty confident we'll find out. [LB333]

SENATOR KOLTERMAN: I ain't familiar with them, so... [LB333]

BOB RAUNER: Okay. Well, that's that guy. He's coming up next, so. [LB333]

SENATOR KOLTERMAN: Okay, good. [LB333]

BOB RAUNER: So, yeah. [LB333]

SENATOR KOLTERMAN: Thank you. [LB333]

BOB RAUNER: Yeah. [LB333]

SENATOR KOLTERMAN: Appreciate your work. [LB333]

SENATOR HOWARD: Senator Crawford. [LB333]

SENATOR CRAWFORD: Thank you, Senator Howard. And thank you, Doctor, for your work on this. I have two questions. So the first one, just for the record on this transcript, I know you have mentioned these results in another hearing but I thought it would be nice to have it on the record here. [LB333]

BOB RAUNER: Okay. Yeah. [LB333]

SENATOR CRAWFORD: There are like, kind of, three key outcomes, unless somebody behind you is doing that, I don't want to steal their thunder, but... [LB333]

BOB RAUNER: No, I think...I don't think Aetna is here but...yeah. [LB333]

SENATOR CRAWFORD: ...the...I think it was kind of three key outcomes you've mentioned in terms of cost. And I would appreciate it if you would repeat those for the record. [LB333]

BOB RAUNER: Okay. Our costs for our Medicaid are 10 percent lower than our peers. Our ER utilization is 47 percent lower. And our hospitalizations are 9 percent lower for Aetna...Medicaid specifically, yeah. [LB333]

SENATOR CRAWFORD: Thank you. Thank you. That's very impressive. I appreciate that very much. [LB333]

BOB RAUNER: Yeah. [LB333]

SENATOR CRAWFORD: So my second question is, I've had the privilege of seeing these meetings before. [LB333]

BOB RAUNER: Yeah. [LB333]

SENATOR CRAWFORD: But for the other people on the committee who haven't, I think the antitrust piece is something that's really important for people to understand about why there is... [LB333]

BOB RAUNER: Yeah. Yeah. Yeah. [LB333]

SENATOR CRAWFORD: ...a government role here. So you mentioned that but I wondered if you'd just tell the committee a little bit what that looks like in a meeting... [LB333]

BOB RAUNER: Okay. [LB333]

SENATOR CRAWFORD: ...in terms of how we're dealing with not colluding. So... [LB333]

BOB RAUNER: Yeah. This actually came up in our first couple meetings. People were really afraid to talk. Literally, someone kept raising that and raising that. And part of this multistate collaborative that we're a part of, we discussed that at our meeting, I think it was in Denver a couple years ago. And it turned out Colorado, they said they had this preamble. They were...they jokingly called it their antitrust prayer and they'd start with that every meeting. (Laughter) And that was part of their way to stay safe, essentially. And after that, we did get everybody to open up and talk a little bit more, not everybody, but almost everybody. And I think that's part of the issue, because the antitrust restrictions are pretty bad if you run afoul of them. Now, there are exceptions. And actually, our Medicare accountable care contract literally is the exception to that, meaning you have to show how what you're doing is both (1) good for the population and (b) not designed just to simply raise your prices. It has to...it literally has to achieve the triple aim where you are going to improve care and lower costs overall. And that is the goal and we literally write it into some of our contracts, so. [LB333]

SENATOR CRAWFORD: Thank you. [LB333]

BOB RAUNER: So, yeah. [LB333]

SENATOR HOWARD: Senator Riepe. [LB333]

SENATOR RIEPE: Thank you, Senator Howard. I'm trying to get some clarification. Would this commission, which is to...built to be a transformational piece, does this start out as a commission, ends up in a regulatory body, and then is it limited to state programs such as Medicaid? Or is it intended to have influence over all the private insurance carriers, if you will? [LB333]

BOB RAUNER: I think it should involve them. So Blue Cross Blue Shield, we do have a contract with them partly as a result of this. So it is for both commercial and Medicaid and hopefully dovetails with Medicare which we have...don't have much control over. It should work for all of them. Should it involve regulation and legislation? I would say, I hope not. But I think you need that stick there just in case. And I mean, I don't know if I should say this, but a couple years ago, that bill was a little bit just to get everybody to the table, honestly. [LB333]

SENATOR RIEPE: So when that...would this be a new agency within Health and Human Services or is this under the judiciary end? [LB333]

BOB RAUNER: I think that's the hard problem because Health and Human Services obviously has some role but so does insurance because insurance is part of this. So should it be under insurance? But even Administrative Services, because the state itself buys insurance for its employees? I think one of the challenges is, what do you put it under, because it really has roles in administration, in insurance, and healthcare. So I don't know, honestly, what that answer is, and then... [LB333]

SENATOR RIEPE: We were talking...oh, I'm sorry. [LB333]

BOB RAUNER: Yeah, and I think ideally, there would be very little regulation in this because if you can get the group working together, it will probably be adopted by this group. So, for example, Nebraska Medicaid has its own patient-centered medical home criteria which was built in the collaborative process and that is what we use. And I think it's better than the national version which is NCQA. I think it's better. It's a voluntary...some have put it into our contract, so with Aetna actually it is in our contract that we will adhere to that. The others have said, you

know what, if Aetna is doing it and we can see your stuff, that's good enough. We don't need to have another mound of paperwork saying you're good. Just show us this and we're okay. [LB333]

SENATOR RIEPE: When you were talking antitrust, you know, the thing that flashed in my head was...is if you're going to put this under the AG's Office. [LB333]

BOB RAUNER: Yeah, because one of the problems is...the problem with a single-payer approach, it fails almost every time, and that's because I can't transfer my whole clinic for 10 percent of my business. It just doesn't work. And we're literally at the point now, we're at that critical stage, where about 40 to 50 percent of our paid patients are covered under these contracts. It varies on the clinic. If we can't get past 50 percent, this stuff is probably going to fail, because I can't change what we're doing and do it for...unless I develop two clinics and give one group of my patients really good care and the other group not so good care, it's not going to work. And it's really hard morally and ethically to get our physicians and nurses to think in that mind-set, that I'm going to give these people great care and these people not so good care, especially if you're in York, you know, and half these patients you go to church with or they're friends. You can't put them morally in that. And so it's one of those things where the whole country is in this right now. How do you awkwardly work with one foot on the dock, one in the canoe? And I think that's why you need that multipayer work to get a critical mass. And that's where we're at. [LB333]

SENATOR RIEPE: So this being Wednesday, is hump day, is that what you're saying? [LB333]

BOB RAUNER: Yeah, it pretty much is. So, yeah. And it causes a lot of strain internally right now within our organization. [LB333]

SENATOR RIEPE: Thank you very much. [LB333]

SENATOR HOWARD: Senator Kolterman. [LB333]

SENATOR KOLTERMAN: Yeah, thank you, Senator Howard. Another question came to mind: How does this interact with Magellan? They're our current Medicaid behavioral health... [LB333]

BOB RAUNER: At this point, not much. Now, the challenge we ran into early is, actually, one of our Medicaid managed care contracts, we wanted to do something with asthma care. The problem is, they don't control the meds. Magellan does. So unless you get Magellan also at the table, it's hard to take care of asthma if you're not dovetailing medications with what you're

trying to do on the healthcare side. And, you know, Dr. Lazoritz will probably talk a little about that. And so Magellan also has to be involved. And again, mental health issues, one of the biggest reasons for frequent ER visits is mental health issues. So unless you address the mental health issues, you're just not going to get anywhere. A lot of our clinics literally want to bring in a psychologist because this is becoming so common. And most of those frequent fliers, you know, we're usually not surprised. And if we had the right mental healthcare, we could actually prevent quite a bit. And so Magellan needs to be involved. Or that needs to be brought back into the same group again. [LB333]

SENATOR KOLTERMAN: Or whoever the provider is if they...yeah. [LB333]

BOB RAUNER: Yeah. Yeah. [LB333]

SENATOR KOLTERMAN: Okay. Thank you. [LB333]

SENATOR HOWARD: Any other questions for Dr. Rauner? Seeing none, thank you for your testimony today. [LB333]

BOB RAUNER: Okay. Thanks. [LB333]

STEPHEN LAZORITZ: Good afternoon. Senator Howard and members of the committee, my name is Stephen Lazoritz, S-t-e-p-h-e-n L-a-z-o-r-i-t-z. I'm the medical director for Arbor Health Plan. As you probably know, Arbor Health Plan is the managed Medicaid plan for rural Nebraska. As I like to say, we're 100 percent rural and 100 percent Medicaid. And we are the managed care...one of the two managed care organizations for the 83 rural counties of Nebraska. The other managed care organization for rural Nebraska is Aetna. And Aetna does cover the urban counties as well. The other managed care organization is UnitedHealth which just covers the urban counties. So there are three managed care organizations for Medicaid. And all...most Medicaid beneficiaries fall under managed care, and that's been for the past three years. I don't want to duplicate what Dr. Rauner and Senator Gloor have said, but I do want to say that Senator Gloor is very modest. Listed here under 2013, "participation agreement finalized and signed," that is a truly historic event. Getting into a room like this all of the payers and providers of healthcare, signing an agreement which basically says, the model of care that we endorse is the patient-centered medical home. And that...looking back 20 years from now, we're going to say, that is a turning point for healthcare in Nebraska. As you heard from this...earlier bills, Madonna, our two medical schools, we have phenomenal resources in medicine in the state of Nebraska. The problem is it's not universal. And I look out for the rural counties of Nebraska. And the rural counties have a real problem of access to care for many things. For instance, before coming to Arbor, I worked for the federal government. I was the medical officer for the government

organization that evaluated people joining the service including the National Guard. And I would see young men and women coming to join the military from rural Nebraska. And the most common things wrong with them would be they were obese, they had poor teeth, and poor vision. Those are all things that could be managed under the patient-centered medical home. The patient-centered medical home has 5 tenets. One of them is it's comprehensive. It doesn't say, oh, you know, you have an ear problem, we don't do ear problems here. A comprehensive patient-centered medical home takes care of all problems. It's patient centered. It's not, well, my convenience is to see you from 9:00 to 5:00. Patient-centered medical here is, we'll see you when you're available. For instance, if people work, they can't come in in the morning, so patient centered. Coordinated: coordinating all the services--mental health, dental, pharmacy. Accessible...and accessibility of the care is a major problem in Nebraska and that's something that a committee like this, a commission on transformation of care, that's one of the first things I think they should address is access to care especially in rural Nebraska. And the last tenet of patient-centered medical home is quality of care. And you've heard all of us talk about quality of care. Indeed, I spend most of my time looking at quality of care issues. We don't want to take the state's money and give it to providers of poor care. We want standardized quality measures that everyone adheres to. And that meeting that Senator Gloor so innocuously said, "participation agreement finalized and signed," basically, all of the payers were agreeing and the providers present were agreeing on certain quality measures that we all have to follow. And that's one of the beauties of the patient-centered medical home. To answer your question, Senator Kolterman, in the next RFP from DHHS, Medicaid will be required to carve in behavioral health. And starting in July, we're carving in dental. And so the Medicaid managed care organizations will have the stark reality of having to deal with inadequate dental care in rural Nebraska which is a real problem. So Senator Gloor understates what he has done. He has really taken the reins and tried to transform medical care in Nebraska and to make sure all members, all Nebraskans, receive high-quality, comprehensive medical care. And the question, as he said, was, where is its home going to be now that he's leaving? And that's what this commission will try to address, is where will this sit and what does transformation mean? So thank you for giving me the time. And I open for any questions you have. [LB333]

SENATOR HOWARD: Are there any questions? Senator Riepe. [LB333]

SENATOR RIEPE: I, of course, have one for Dr. Lazoritz. Thank you for being here, Dr. Lazoritz. [LB333]

STEPHEN LAZORITZ: Thank you, Senator Riepe. [LB333]

SENATOR RIEPE: My question is this, is, does the patient centered...is that the core problem, the absence of a patient center? Or is it, when you...I'll go back to the military of obesity, dental,

and eye--I believe that's what you said--that is that a problem of an absence of this patient-centered medical care or an absence of one of two other things: (a) medical resources with or without a...you know, just not having access, or the...not having the insurance or the resources in pocket to be able to go to those practitioners? [LB333]

STEPHEN LAZORITZ: You know, it's interesting you ask that. Just last week, our plan has been working with one of the SERPA clinics, Plum Creek, to put together an obesity program for the younger kids. One of the quality measures that we're looking at this year is obesity screening in children to try to identify children who are obese early so that they don't go on so they can join the National Guard and serve the state and not be excluded because they're obese. And, boy, that was a standing joke among the medical people in our agency is the rate of obesity among young people joining the military. Again, nationally, it's the number one reason for being excluded from military service. And I will say that the young people of Nebraska are really dedicated to serving this country and to serve the state through the National Guard and it was gratifying to see them and that's one of the fringe benefits of working in that organization, seeing the young people who wanted so much to join but were handicapped for prior poor medical care. [LB333]

SENATOR RIEPE: And Senator Crawford's LB107 will solve all those problems. [LB333]

SENATOR HOWARD: Any other questions? Senator Kolterman. [LB333]

SENATOR KOLTERMAN: Yes, Doctor, would you expand a little bit? I'm...I wasn't familiar with Arbor. But would you expand a little bit on the different organizations that are currently...you know, because you said 85 counties and rural counties you're in... [LB333]

STEPHEN LAZORITZ: Eighty-three rural counties. [LB333]

SENATOR KOLTERMAN: ...83 rural counties you handle now. How did it come about that we have three different providers? Was there not enough capacity with one, or... [LB333]

STEPHEN LAZORITZ: Well, the state decided that there...that in each area there should be more than one so there's competition. And so three years ago, DHHS went from a straight "the state pays the money" to giving the managed care organizations the money per member, per month, but we're...responsibility for their total care. So we're...responsibility for the total healthcare of all of our members. And so in rural Nebraska, the bid was won by Arbor and then Coventry but now Aetna. And urban, the bid was won by Aetna and UnitedHealth. And so it was a competitive bid process. DHHS selected on set criteria. And again, we are stewards of the state's money. And our goal is to give high-quality care. And again, I spent a lot of my time, in

fact most of my time, dealing with quality issues and making sure that our members get quality care. [LB333]

SENATOR KOLTERMAN: So in the metropolitan areas, I assume you're talking Lincoln and Omaha? [LB333]

STEPHEN LAZORITZ: Yes, and the surrounding counties from Lincoln and Omaha. [LB333]

SENATOR KOLTERMAN: You're using UnitedHealthcare? [LB333]

STEPHEN LAZORITZ: UnitedHealth or Aetna. [LB333]

SENATOR KOLTERMAN: Okay. [LB333]

STEPHEN LAZORITZ: And the members have a choice. When they join Medicaid, they're given a choice of the two plans in each area so they can choose Aetna or United in the urban counties or Arbor or Aetna in the rural counties. [LB333]

SENATOR KOLTERMAN: Okay. And then out of all those, is...UnitedHealthcare has not participated in any of this? [LB333]

STEPHEN LAZORITZ: Well, United did sign the agreement. [LB333]

SENATOR KOLTERMAN: Okay. [LB333]

STEPHEN LAZORITZ: And United had participated. So in that room a year ago that Senator Gloor understated his role, we all signed the agreement. [LB333]

SENATOR KOLTERMAN: Okay, so you're all...most of the players that operate in the state in some capacity in the private sector are also involved in this now or at least have the ability to be? [LB333]

STEPHEN LAZORITZ: Yes, and how we support--and you'll hear from Dr. Schaefer from Blue Cross--how we support our medical homes is another story. And Arbor's approach is, we take a very hands on, we help the practices grow, we provide them the means for doing it, and we support them towards getting certified. And so we don't just give them money. We give them the support and the education. And so that's the approach Arbor took. [LB333]

SENATOR KOLTERMAN: Okay. Okay, thank you. [LB333]

SENATOR HOWARD: Any other questions for Dr. Lazoritz? Seeing none, thank you for your testimony today. [LB333]

STEPHEN LAZORITZ: Thank you. [LB333]

SENATOR HOWARD: Our next proponent? Good afternoon. [LB333]

ROWEN ZETTERMAN: (Exhibit 31) Good afternoon, Senator. My name is Rowen Zetterman, R-o-w-e-n Z-e-t-t-e-r-m-a-n, and I'm testifying in favor of LB333, the Health Care Services Transformation Act, on behalf of the Nebraska Medical Association which is...as you know is the unifying physicians organization for the state that advocates both for patients and for the physicians and the health of all Nebraskans. I want to remind you that in 2007 the Nebraska Medical Association introduced a proposal for universal healthcare coverage for Nebraska, stating that healthcare in Nebraska must be of high quality, efficient, affordable, and equitably accessible to all by requiring insurers to offer plans that reward selection of a medical home and by educating the public to choose providers based on quality and value. And over the last eight years, as you've heard, the patient-centered medical home importance as a model of healthcare has become evident: less duplication of medical tests for those in the medical home; fewer hospital readmissions for the same condition; better, more informed patient self-care for many of the things that you've heard today; and there are more. But there are still many healthcare needs and shortages throughout Nebraska: 14 percent of nonelderly adults in Nebraska lack healthcare coverage options. More patient-centered medical homes are needed to provide care. And there's no state-authorized, multidisciplinary group in Nebraska that provides leadership to transform the healthcare system of Nebraska, that provides a forum for assessment of statewide healthcare, that identifies state needs for improvement, that assists Nebraskans in obtaining high-quality care and assists providers in developing patient-centered medical homes, and perhaps most importantly, creates collaborative opportunities for healthcare across both public and private entities. If we're going to solve the healthcare problems in Nebraska, it's evident that our state government must provide leadership to transform the health system to provide high-quality, patient-centered, and patient safe care. And I believe that this advisory commission has the opportunity to initiate that process. LB333 will ensure higher quality, patient safe care for Nebraska and establish a process of state healthcare planning not only through the patient-centered medical homes but by establishing the Health Services Transformation Advisory Commission to provide a process for statewide health planning coupled with collaboration between state agencies, establishment of state goals for healthcare quality by working with population health issues and by reducing healthcare disparities and, perhaps most importantly, by addressing needed changes of our healthcare laws and regulations. As was noted by the Medical

Association in 2007, good health and access to needed healthcare are social goods that contribute to the well-being of the state and all of its residents. And the future of Nebraska's economic and fiscal success requires a healthy population and availability of high-quality healthcare for all Nebraskans. To ensure that future, the state must provide ongoing planning for a changing healthcare enterprise. And I think LB333 is poised just to do that. So thank you for giving me the opportunity to speak. [LB333]

SENATOR HOWARD: Thank you, Dr. Zetterman. Are there questions for the testifier? All right. Seeing none, thank you for your testimony today. [LB333]

ROWEN ZETTERMAN: Thank you. [LB333]

SENATOR HOWARD: Our next proponent. [LB333]

JOANN SCHAEFER: (Exhibit 32) Good afternoon. My name is Joann Schaefer, J-o-a-n-n S-c-h-a-e-f-e-r, M.D. I am the chief medical officer and senior vice president at Blue Cross Blue Shield. I'm very happy to be here today in support of LB333. Blue Cross Blue Shield of Nebraska is a domestic mutual benefit company, not-for-profit, federal income tax paying entity. We have 720,000 members here in Nebraska and they are supported by 1,100 Nebraska employees. We are supportive of the patient-centered medical home concept in many ways. We like the fact that it's been a voluntary structure since the beginning and it is not a mandate. This allows us to be very nimble in trying to transform the benefit structures that we put out and the programs that we've been launching over the last six years. I handed out some outcomes that I'm going to talk to you about in just a minute. But back when we started the program, we took a focus on some outcome measurements and those were things like Pap smears; BMI, or body mass index; colorectal screenings. And they were really good in terms of getting those measurements in and reported in our medical homes. But what we noticed is that there was minimal cost improvement over time in the very beginning of those years. And as those outcomes came in, we kind of looked at it and said, you know, are we really good at measuring those outcomes? Are we just getting better at reporting? And is it actually changing the value of the care that's delivered to the members? So we've tweaked and expanded the program and developed the program over years where you can actually see the outcomes over on the side which actually show a more comprehensive approach to the medical home where we actually decrease hospitalizations. We've had an improvement in preventable hospitalizations and readmissions. We've had better outcomes in our preventable visits and we've decreased emergency room visits. And those are the non-PCMH compared to the PCMH programs. But clearly there's still a lot of work to be done in this space. And we've noted that because we haven't put a lot of focus on the cost portion in the PCMH programs, that the outcomes have been great and we've seen a little bit of improvement on the cost side. But we've had to now go

through another iteration of our PCMH program coming up where we actually are focusing a little bit on the quality and the cost portion. But this is a huge transformation in these clinics. And just to give you a little flavor, over time, or just since...in the last three years, we've gone from 38 offices to 79 offices and from 191 physicians to 380 physicians. So we have the most of the programs that are here in the state and we are from, you know, Omaha, Lincoln, McCook, Kimball, O'Neill, so we're throughout the state and we stretch along the I-80 corridor. So it's been a lot of work. We are trying to transition our program more into even more direct access into the clinics where we're helping them transform. And we've certainly learned a lot. We participate in our...in the Blue system as a whole and our learnings have been very similar to the other Blue's plans as well. It's complicated work. It's hard work. The providers have been great to work with. But their clinics are transforming a lot. They have been able to show us that, you know, any increased reporting that they have to do is a burden on them. This committee that's worked together here under Senator Gloor's leadership has been very good in working on the quality measures and that we've agreed to a list that we're not going to ask for any more data from the clinics. That was huge. And that's been, as has been previously noted, a big win for our state because it doesn't give any more burden to the practices. It's one of the reasons why we stopped with the other quality metrics that we were going...because even though they were some that were on the list, it was burdensome for the practices to have to dig that up out of their EMRs and send them to our third-party vendor. We also noticed that that third-party vendor was adding excess cost. So it was complicated, it was burdensome to the providers, and it was adding more cost. And in the end, were we just getting better at reporting? Or were we actually seeing that driving value to the patients? Now, I would assume that it's probably driving the value, but when we were crunching all the numbers, it was really hard to see that. So they've been very good at teaching us new ways to innovate and we've been helping their practices in new ways to innovate as well. So we're very supportive of this bill. But there was some concerning language about it in Section 5(2)(e) that stated to: Develop and approve standards and measures for PCMH in Nebraska. And the only reason why we bring that up is that it's a concern on the basis if it becomes future prescriptive regulation. And having been a former regulator, I kind of almost feel like I'm the pot calling the kettle black. But, you know, eight years in that position, I do understand the point of regulation can stifle innovation. And so we're in that part in this transformation of the healthcare system with so much requirements and data, all these payment models--those payment models are difficult to tweak--and claims systems, and how we put out payment. And you will hear that resonate loudly that we think of a great idea, but the time we crank up the systems to get them out the door...those are challenging to be quick. So when you put in regulations that interrupt any part of that process, it's hard for payers--we're not alone--to respond to that. And we definitely want to be responsive to new ideas that come up. So that's the only caution that we have. We're definitely at the table. We want to be part of making this transformation happen. For me as a family physician and a former public health person, this is a very exciting opportunity to improve the health and outcomes of the citizens of the state. So thank you very much and I will yield to any questions. [LB333]

SENATOR HOWARD: Senator Riepe. [LB333]

SENATOR RIEPE: Senator Howard, thank you. Doctor, thank you for being here. Is...Primary Blue, is that one product on a menu of several different products that Blue Cross Blue Shield is selling? [LB333]

JOANN SCHAEFER: This is our patient-centered medical home. And it's not a product. So these are programs that the providers participate in. So this isn't a product. So anybody that's...has our insurance can be in these homes if their providers are in the program. [LB333]

SENATOR RIEPE: Okay. You used the word "can be," not "must be." [LB333]

JOANN SCHAEFER: Yeah, if they're...if they...if the providers have...are in the patient-centered medical home then the member, if they are a Blue Cross Blue Shield of Nebraska member, they can be in a patient-centered medical home. And so, to Dr. Rauner's point, when they're a provider and they have a full plethora of patients from other payers, it's difficult for them because a provider would like to be able to treat all of their patients the same. [LB333]

SENATOR RIEPE: I know history would show us that narrow networks, while they can provide some economic benefit, have not been well received. Do you have any...have you test marketed this to see how receptive this narrowing down that says... [LB333]

JOANN SCHAEFER: Sure. [LB333]

SENATOR RIEPE: ...you go to the primary care doc as the gatekeeper--well, not the gatekeeper, I'm sorry, Mike--as the, you know, medical home, as opposed to being able to go directly, say, to a dermatologist or something like that? [LB333]

JOANN SCHAEFER: Right. Well, although we have a narrow network product that is separate from this that...because this isn't a product, we have a narrow network product or a tiered product, you have equal access to those. But you just...so you can see a specialist. You can...you don't have to go. There's no gatekeeper model in that. What we strive for and what, I believe, a lot of members strive for in...that are in the patient-centered medical home model, is that you like your primary care physician so much, they're delivering so much value to you, is that you seek going to them first. We don't have an interest in restricting your access to a specialist. We just think that the care is so coordinated...so well coordinated and delivered at such a high value that the member wants to go there first to see what their doctor thinks before they direct access to something else. We're not restricting that access. [LB333]

SENATOR RIEPE: May I ask another question, Senator? [LB333]

SENATOR HOWARD: Sure. [LB333]

SENATOR RIEPE: Thank you. Many people end up going to retail clinics because it's a time of day when the doctor's office is not open. [LB333]

JOANN SCHAEFER: Sure. Absolutely. Right. [LB333]

SENATOR RIEPE: So do they...they can't become the medical home. They would be... [LB333]

JOANN SCHAEFER: They're not restricted from that. The goal is then the provider should do everything they can to work in different models of care delivery so that they either see those patients through extended office hours or that they're coordinating really well with those retail clinics so that the patient is taken care of one way or another and the care on the back end is coordinated so that I, as a physician, know that my diabetic has been seen three times in that urgent care clinic or that retail clinic and that we are talking so that I know that I need to get that member back to my clinic so I can make sure that nothing holistically is going wrong with their care. [LB333]

SENATOR RIEPE: Is the optimal situation then...is having electronic medical records that are fully integrated and that might be a while? [LB333]

JOANN SCHAEFER: You got it. That's some...right, and some level that...you know, the...that whole space in changing in levels that are amazing right now. And the electronic platform that shakes out over the next decade is going to be interesting. The value is the information that's exchanged. Is it a fully integrated EMR platform or is it something that's similar to your Apple iPhone where there are apps that exchange information in a much faster space that allows the patient to control that? All of those things are changing at light speed which is another reason why it's very difficult to nail stuff down in regulations because, well, some of you will remember how many times I came over here in the past to request for, okay, this law doesn't have any explanation for e-mail or fax. And so we need to change the law because we didn't account for the future technology. It's the same thing when you're trying to account for how we're going to exchange medical information and these future EMR products. There's a lot out there that's changing. But your answer to your question is, absolutely, exchanging the information between any outside provider and the patient's home physician is vital. [LB333]

SENATOR RIEPE: Thank you. Thank you very much. [LB333]

SENATOR HOWARD: Senator Kolterman. [LB333]

SENATOR KOLTERMAN: Thank you. Can you tell me...you talk about, you have these patient-centered medical homes already in existence. Are any in the rural setting or are they all metropolitan? [LB333]

JOANN SCHAEFER: Oh, no, they are all over. We have them in McCook, O'Neill, Kimball, Scottsbluff...no, not Scottsbluff yet. I have a...we have a whole list of them on a map, yeah. [LB333]

SENATOR KOLTERMAN: Okay. [LB333]

JOANN SCHAEFER: They're all throughout the state. [LB333]

SENATOR KOLTERMAN: Thank you. [LB333]

JOANN SCHAEFER: Sure. [LB333]

SENATOR HOWARD: Are there any other questions for Dr. Schaefer? Seeing none...oh. [LB333]

SENATOR CRAWFORD: It's all right. [LB333]

SENATOR HOWARD: I was excited. No, I'm kidding. [LB333]

SENATOR CRAWFORD: That's all right. I'm sorry. So thank you, Senator Howard, and thank you, Dr. Schaefer. I wondered if in a...if you would just speak for a minute, since I think one of the issues on the...you know, in the hearing has been sort of the difference between the gatekeeper model and a patient-centered medical home model... [LB333]

JOANN SCHAEFER: Sure. [LB333]

SENATOR CRAWFORD: ...which I think will be important for people as they're thinking about this, so in addition to the medical records, other ways that as you...I mean, beyond electronic health records, what are other ways that a primary care provider who has a...who is serving as a medical home, would try to make sure that they know about the specialists and other care that a

patient is getting? Like, what does that look like in terms of trying to keep that coordinated? [LB333]

JOANN SCHAEFER: Sure, well, like I said, information exchange, there's...you know, there are all sorts of triggers within information exchange: admission, discharge, and transfer data--it's referred to as ADT data--that can be passed. So when your patient is in the emergency room you get a notification that is simplistic. And it's not...doesn't require full integration of the EMR data. [LB333]

SENATOR CRAWFORD: Okay. [LB333]

JOANN SCHAEFER: So it's cheaper and more efficient and NeHII can get that done. So those are things that are really important. That allows the care coordinators that are embedded into the patient-centered medical homes to act on that kind of information. But if they don't have a care coordinator, they can't do that or they have to have dedicated staff time to be able to respond to that type of information and grab the patient, call them, and say, what's going on? So that's just an example. [LB333]

SENATOR CRAWFORD: So staff that is taking that initiative and responsibility is critical for the provider? [LB333]

JOANN SCHAEFER: Yes. Yeah. [LB333]

SENATOR CRAWFORD: That additional care-coordinating staff is important? [LB333]

JOANN SCHAEFER: Yeah, staff and team-based care within the clinic. [LB333]

SENATOR CRAWFORD: Thank you. [LB333]

SENATOR HOWARD: All right. Any other questions for Dr. Schaefer? Seeing none, it's always nice to see you. [LB333]

JOANN SCHAEFER: Great. Thank you. It's nice to see you, too. [LB333]

SENATOR HOWARD: All right. Our next proponent for LB333. Good afternoon. [LB333]

HEIDI WIETJES: (Exhibit 33) Good afternoon. My name is Heidi Wietjes, H-e-i-d-i W-i-e-t-j-e-s, and I'm a registered dietician nutritionist from Riverdale, Nebraska. I am serving as president of the Nebraska Academy of Nutrition and Dietetics, and today I'm speaking on behalf of over 640 registered dietician nutritionists who live and work in Nebraska. In Nebraska, registered dietician nutritionists are licensed as medical nutrition therapists. We are the nutrition professionals in the state and are committed to improving the health of citizens of Nebraska by helping individuals with positive lifestyle changes and to manage their chronic disease using evidence-based practice guidelines. Over 70 percent of patients seen in family medicine clinics have one or more chronic diseases. Evidence-based guidelines from the U.S. Preventive Services Task Force, the American Diabetes Association, the Academy of Nutrition and Dietetics, and many others recommend intensive self-management support to engage the patients in self-care activities. However, most family medicine clinics lack the time, staff, and resources to fully provide self-management support services. In 2014, the Centers for Disease Control and Prevention reported that only 6.8 percent of insured patients with a new diagnoses of diabetes participated in a self-management class within the first year of their diagnosis. Family medicine physicians are leading the effort to improve healthcare with the patient-centered medical home. Registered dietician nutritionists are participating in these patient-centered medical homes as healthcare providers. Medicare considers a registered dietician nutritionist as a qualified medical professional for performing the annual wellness visit, the subsequent annual wellness visit, the initial personal prevention exam, chronic care management, and intensive behavioral therapy for obesity. Providing these services in addition to medical nutrition therapy for patients has made it financially feasible for family medical practices to hire RDNs as integrated members of the healthcare team. Currently, registered dietician nutritionists are providing care in patient-centered medical homes in Nebraska clinics and Accountable Care Organizations. An RDN contributes valuable insight for the nutrition management of chronic disease and for advancing wellness and disease prevention programs. My testimony includes some specific examples of this throughout Nebraska. And one quick one: In a clinic in York, registered dietician nutritionist Charlene Dorcey has been working for over 20 years with a group of family medical physicians. Over three years ago, the clinic began a team approach for diabetes management. The team includes a physician, a nurse, and the registered dietician nutritionist. The team now functions as a family-centered medical home. The clinic is actively involved in pilot studies with insurance companies and Medicare through their Accountable Care Organization. As the RDN, Charlene has coordinated the diabetes group medical visit six times per month and was able to engage patients with uncontrolled Type 2 diabetes in monthly sessions to help them understand and become motivated in self-care. The results have been better follow up with their healthcare provider, labs done on schedule, medication changes completed without delay when needed, and patients actively participating in their care. It has led to better patient understanding of diet and its impact on blood glucose, blood pressure, lipids, etcetera. The preliminary results indicate that...patients having positive weight changes, improved A1C and lipid levels, and better self-care, working towards a goal of improved healthcare and reduced healthcare costs. The RDN

also provides medical nutrition therapy during individual sessions with patients. In addition, patients with prediabetes saw statistically significant outcomes after receiving about two or three medical nutrition therapy sessions with the registered dietician nutritionist. Outcomes observed were lower fasting glucose, greater projected weight loss at one year, and fewer medication starts, thus achieving cost savings. And you can review the other positive examples that we have in the handout. In speaking with Senator Gloor, we understand that LB333 may be combined with LB549, the "strengthening healthcare systems in Nebraska" bill. Both of these bills focus on transforming the healthcare system in Nebraska utilizing the concept of a patient-centered medical home. As commissions and committees are formed, I ask that you consider a registered dietician nutritionist as a member of the committee. The dietitian's professional skills and experience working within the patient-centered medical home will enhance the committee's work. Thank you. [LB333]

SENATOR HOWARD: Thank you. Are there questions for the testifier? Seeing none, thank you for your testimony today. [LB333]

HEIDI WIETJES: Thank you. [LB333]

SENATOR HOWARD: Our next proponent on LB333. Seeing none, is there anyone in the room wishing to testify in opposition on the bill? Seeing none, is there anyone wishing to testify in a neutral capacity? Senator Gloor, you're up. [LB333]

SENATOR GLOOR: I will just avail myself of any final questions people may have. And I'm very appreciative of the testifiers and their support. Hopefully they painted a picture for you certainly better than I can of the fact that there's a great opportunity here and this may be a way to keep that opportunity moving forward in ways that help Nebraskans and help the state of Nebraska when it comes to providing quality and cost-effective health services. [LB333]

SENATOR HOWARD: Senator Crawford. [LB333]

SENATOR CRAWFORD: Thank you, Senator Howard. And thank you, Senator Gloor. I appreciate all the work that you've been doing to really innovate. [LB333]

SENATOR GLOOR: And thanks for your interest in the patient-centered medical home. [LB333]

SENATOR CRAWFORD: Oh, you're welcome, you're welcome. So I think that the language defining a medical home in the bill may in part kind of go back to where you started when you

were first putting the pilot together which may have been, probably, before NCQA when that language was very physician specific. So I know this is a bill we're holding onto and we're going to be working together on. I just wanted to ask you, on the record, if that discussion about who providers are and what...and the different pieces that different providers play in medical homes will be a continuing part of that discussion. [LB333]

SENATOR GLOOR: Sure, absolutely, yeah, it will. [LB333]

SENATOR CRAWFORD: Thank you. [LB333]

SENATOR HOWARD: Other questions for Senator Gloor? Senator Cook. [LB333]

SENATOR COOK: Thank you, Senator Howard. And thank you, Senator Gloor. Good to see you. I...hearkening back to the origins of this bill and remembering conversations that we had about including behavioral health or mental health services, is that part of the vision when you get to the other business part of the agenda in the group? [LB333]

SENATOR GLOOR: Yes, it will be. And I think Dr. Lazoritz testified that that...in fact it already is in some of the patient-centered medical homes that they're involved in. [LB333]

SENATOR COOK: Oh, good. [LB333]

STEPHEN LAZORITZ: In the next RFP... [LB333]

SENATOR GLOOR: That's right. [LB333]

STEPHEN LAZORITZ: ...for DHHS from Medicaid, it will be required, integration of behavioral and physical health. [LB333]

SENATOR COOK: Okay. In the next RFP for behavioral health for Medicaid, it will be required... [LB333]

SENATOR GLOOR: Yeah. Yeah. [LB333]

SENATOR COOK: ...for the managed care. I'm saying that into the microphone for the transcriptionists. Thank you, Dr. Lazoritz. [LB333]

SENATOR GLOOR: Yeah, and, you know, I mean it...some of it goes back to the testifier that we just had, the dietician. I appreciate her comments. The nice thing about patient-centered medical home is it provides the platform for all clinicians to be involved in a patient-centered medical home to address the needs that may be out there. I mean, most primary care doctors would say, if childhood obesity ends up being one of the criteria they're trying to meet in their area, they are going to be busy taking care of other issues and will probably end up bringing dieticians into the...addressing that particular need, maybe even to the extent that if in their community it's a large enough issue, they may employ a dietician because it's that important for their patient-centered medical home. I would imagine in most cases it's a referral. But whether it's behavioral health, whether it's obstetrician...excuse me, dieticians, or obstetricians for that matter, you assemble a team around your patient-centered medical home to address those areas that you're trying to take care of. [LB333]

SENATOR COOK: Okay. Thank you. [LB333]

SENATOR HOWARD: Senator Crawford. [LB333]

SENATOR CRAWFORD: Thank you, Senator Howard. I just want...so one of the questions...issues that I think arises for--say dieticians and pharmacists get to play a greater role in patient-centered healthcare--is our existing reimbursement models, you know, that make it difficult for a dietician to get paid for their services... [LB333]

SENATOR GLOOR: Sure. [LB333]

SENATOR CRAWFORD: ...or that just pay a pharmacist for product instead of management. So how do you see this model as addressing that issue? [LB333]

SENATOR GLOOR: Well, I think the patient-centered medical home...let's take the clinic that we're defining as a patient-centered medical home, brings into its negotiations with the payers the fact that if we're going to make addressing obesity a major issue within the patient populations we have, that needs to be figured into some of the reimbursement we're talking about. And that may include...let's assume it's diabetics, as an example...adequately address the treatment for diabetics within a patient population maybe it requires a purchase of a certain number of home units that can be hooked up to phones that test blood sugar. And so that ends up being one of the negotiations on, we're going to need some dollars here to be able to appropriately monitor from home those patients who identified as struggling around the holidays when Christmas cookies and fudge are evident everywhere. So with Jane and Joe and Bill and Mary, we're going to call them twice a day from November through December because if we can keep them from crashing just once and going into the emergency room where they end up being

hospitalized for a couple days till their blood sugars stabilize, that's a huge savings. It's just, it's a huge savings. And that would end up being part of the discussion on looking at quality outcomes. What are we going to try and focus in on and then what's the reimbursement going to be to make sure we do an adequate job of that? You know, as Senator Riepe will tell you, the problem we've had in the past has been the death spiral of discounting. The payer wants to pay so much, the provider wants more payment, and the negotiation ends up being back and forth. It's a fee-for-service model and eventually somewhere in there, you get paid a little less and a little less and a little less. And when you're paid less, you can provide less care. And when you provide less care, you're more likely to have people with health problems. And so we struggle trying to get a handle on this. This is a reverse on looking at that traditional model that, as I said, is a death spiral. [LB333]

SENATOR CRAWFORD: Thank you. [LB333]

SENATOR HOWARD: Senator Riepe. [LB333]

SENATOR RIEPE: Thank you, Senator Howard. Senator Gloor, I think the other term means...in not only the spiraling down, we called it the limbo pricing system that, you know, how low can you go? [LB333]

SENATOR GLOOR: Yeah. [LB333]

SENATOR RIEPE: One question I would like...this...couple days ago we were talking about...with chiropractors about giving the school physicals. So I'm just curious, how would chiropractors...or would they fit into this medical home? [LB333]

SENATOR GLOOR: I think that's up to the practice again. I mean, I could see the chiropractors fitting in. You know, it's going to be up to that team model. And there are a number of communities where chiropractors get referrals regularly, in my community anyway, from primary care practices as they deem appropriate. I...whether it's physical therapist or dietician or chiropractors, once again, it's a matter of assembling a team to deal with what your outcomes are. You may not bring chiropractors into the fold as part of your patient-centered medical home approach towards addressing problems of, I don't know, pick one that you might...maybe we'll just say obesity in this case. You want to bring the dietician into that. But there may be issues of low back pain and appropriate lifting that needs to happen if you have a large number of a patient-centered medical home that addresses a manufacturing plant where there's a lot of lifting and a lot of body mechanics that go on. Well, then maybe having a chiropractor as part of that scenario makes more sense. [LB333]

SENATOR RIEPE: Is your vision of...or definition of what...primary care physicians being family medicine doctors, internists, and pediatricians? Is that... [LB333]

SENATOR GLOOR: Sure, I think it's... [LB333]

SENATOR RIEPE: Okay. [LB333]

SENATOR GLOOR: ...the same model with obstetricians being part of that when it comes to prenatal care... [LB333]

SENATOR RIEPE: Sure. [LB333]

SENATOR GLOOR: ...the OB as opposed to the GYN. But that's still pretty much the traditional model, I think, and we're not advocating that being addressed or changed. [LB333]

SENATOR RIEPE: Okay. Thank you. [LB333]

SENATOR HOWARD: Are there any other questions for Senator Gloor? Seeing none, this will close the hearing on LB333. [LB333]

SENATOR GLOOR: Great. [LB333]

SENATOR HOWARD: And we are done for the day. [LB333]