[LR181 LR185 LR231]

The Committee on Health and Human Services met at 9:00 a.m. on Thursday, November 12, 2015, in Room 1510 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public hearing on LR181, LR185, and LR231. Senators present: Kathy Campbell, Chairperson; Sara Howard, Vice Chairperson; Sue Crawford; Nicole Fox; Mark Kolterman; and Merv Riepe. Senators absent: Roy Baker.

SENATOR CAMPBELL: Good morning, everyone. Welcome to the hearings for the Health and Human Services Committee. Today we are going to hear three legislative resolutions. And I just want a couple of words before we start. This is Brennen Miller's last day with us as the clerk and so, after we finish these three hearings, I've invited another six hearings in for this afternoon (laughter). I told one of the staff people I was going to tell Brennen that I had planned the hearings to go to 4:00 this afternoon--no, not true. We're going to try to this morning, because we have three, we're going to try to hold each of the hearings to within an hour to be fair to the first and the last hearing that we have today. I'm Kathy Campbell. I serve District 25, which is east Lincoln, and we'll have...Senator, would you introduce yourself.

SENATOR FOX: Sure. Senator Nicole Fox. I serve District 7, which is downtown Omaha and south Omaha.

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

SENATOR CAMPBELL: Go ahead.

JOSELYN LUEDTKE: I'm Joselyn Luedtke. I'm the committee counsel.

SENATOR CRAWFORD: Good morning. I'm Senator Sue Crawford. I serve District 45, which is eastern Sarpy County, Bellevue, and Offutt.

SENATOR RIEPE: I got here just in time. I'm...

SENATOR CAMPBELL: Exactly. Go right...

SENATOR RIEPE: (Inaudible) it's my turn. I'm Merv Riepe, District 12, which is Millard and Ralston.

SENATOR CAMPBELL: And we only have...Ryan, you want to introduce yourself?

JOHN RYAN MacDONALD: I'm Ryan. I'm the page and an undergrad at the university of Nebraska.

SENATOR CAMPBELL: Majoring in...?

JOHN RYAN MacDONALD: History.

SENATOR CAMPBELL: Excellent. And joining us, again right on cue, Senator, you want to introduce yourself?

SENATOR HOWARD: I'm Senator Sara Howard. I represent District 9 in midtown Omaha. Thank you.

SENATOR CAMPBELL: Yes. So I'll go through a few just preliminaries to remind you that if you have a cell phone, please check it; or, anything that makes noise, try to turn it off or turn it on silent. If you are testifying today, and many of you have already taken...I can see that you have them. You need an orange sheet and complete that. As you come up to testify, we are going to have the lights today just so I can watch the time and be fair to all the senators with their hearings today. We will ask you to state your name and spell it for the record. And I think that's it. Brennen, did I forget anything? I think we're ready to go. Okay, we'll open the first hearing today, which is LR181, Senator Kolterman's hearing...or interim study to examine how to build Nebraska's work force, especially in high-need areas, and support personal responsibility and professional growth for all Nebraskans. Senator Kolterman, start us off today. [LR181]

SENATOR KOLTERMAN: Good morning, Senator Campbell. Thank you for doing this. Fellow members of Health and Human Services Committee, my name is Senator Mark Kolterman, M-a-r-k K-o-l-t-e-r-m-a-n. I represent the 24th District, comprised of York, Seward, and Polk Counties. This morning I'm introducing to you LR181. It's an interim study to examine how to build Nebraska's work force, especially in high-need areas, and support personal responsibility and personal growth for all Nebraskans. This is a familiar topic not only to this committee, but also for the Legislature as a whole. Last session the body was successful in various areas to improve the fiscal cliff, but there's still a lot that needs to be done in this arena. Today you'll hear from various individuals, ranging from advocacy groups to working Nebraskans, on how the negative effects of the fiscal cliff is affecting our state's ability to maintain a skilled work force in areas such as nursing and assisted-living facilities. While it's the job of state government to create and responsibly maintain safety nets, such as the child care subsidy program, SNAP, and CHIP, it's also the job of state government to make sure that these safety nets gradually grade out properly so we're not creating this fiscal cliff that we...that exists today. I thank the committee for allowing this hearing to go forward, as it deals with an important issue that the Legislature needs to continue to address. Due to the invited testimony--I wanted to give each of them ample time to speak--I ask that you, if you have any questions for me, that you ask them during my closing statements. So with that, any questions? [LR181]

SENATOR CAMPBELL: Any questions or any comments? We'll start out. [LR181]

SENATOR KOLTERMAN: Thank you. [LR181]

SENATOR CAMPBELL: And, Senator Kolterman, I will follow the list that you have provided. Okay? [LR181]

SENATOR KOLTERMAN: Thank you. [LR181]

SENATOR CAMPBELL: Thank you. Our first testifier today is Heath Boddy. Good morning. [LR181]

HEATH BODDY: (Exhibit 1) Good morning, Senator. How are you this morning? [LR181]

SENATOR CAMPBELL: Good. [LR181]

HEATH BODDY: Good morning, Senator Campbell and members of the Health and Human Services Committee. My name is Heath Boddy. That's H-e-a-t-h B-o-d-d-y. I'm the president and CEO of the Nebraska Health Care Association. The Nebraska Health Care Association serves as an umbrella organization for both the Nebraska Nursing Facility Association and the Nebraska Assisted Living Association. Our organization also includes the Nebraska Hospice and Palliative Care Association and the Licensed Practical Nurse Association of Nebraska, as well as an accredited postsecondary career college that's focused on caregiver education, a foundation that offers more than $20,000 in scholarships each year, and a political action committee. Together, our 430-plus skilled nursing and assisted living facility members, who are almost equally divided between nonprofit and proprietary perspectives, employ over 28,000 caregivers who provide services to more than 20,000 Nebraskans on any given day. Thanks for the opportunity to speak with you today. And I want to express sincere appreciation to Senator Kolterman and his team for helping this important issue come to the table. In addition to testimony that you're about to hear, we asked our members to send you letters with specific examples of the challenges they face in relation to the work force issues we'll be discussing. As we traveled this summer, we heard at every stop across the entire state about these challenges. Today I'd like to talk to you about the caregivers employed by our nursing and assisted living members. These individuals are truly the heart and soul of long-term care as every day they care for this state's frailest, sickest, and most vulnerable Nebraskans. They'll tell you their jobs can be rewarding and challenging. I think they'd also share with you that they chose long-term care because they wanted to help others or maybe they had an experience in their life that shone a special light on this work. In a few minutes you'll hear from some of these caregivers, individuals who have chosen a profession that allows them to serve others. They have the same goals as any professional. They want to be able to support themselves. They want to be able to support their families and advance in their chosen careers. The healthcare coverage, childcare assistance, and other supports they receive are intended to accomplish these goals. It seems imperative that public policy ensures a meaningful balance in providing enough support for enough time to allow individuals to become more self-sufficient, and that's an outcome that benefits everyone involved. With the increasing shortage of direct-care workers, our members struggle every day to find, recruit, and retain quality employees. Even staffing agencies, as we heard as we traveled the state this summer, are

struggling to find direct-care workers, and they're often importing them from other states like Texas, Louisiana, and Kentucky. And then they have to go a little further than just bringing them to the state. They have to provide housing and transportation in those scenarios. In 2014, the Nebraska median wage for a nursing assistant, a direct caregiver, was $11.41 an hour, and that amount is increasing as our members try to compete with other community businesses who pay that amount or more for work that is less demanding and way less emotional. Even with offers of higher wages, benefits, and signing bonuses, it's difficult to attract the employees needed to care for those needing the services. More members are being forced to limit their admissions because they do not have sufficient workers to care for additional individuals. This makes the retention of these employees who provide quality care of paramount importance. In this situation, an employer who would typically offer a raise in wage or other benefits, they typically would offer that...those raises. However, the raises our members are able to provide within the limitations of the Medicaid and the Medicare reimbursement system frequently cannot compensate the individual for the loss of the public assistance they were receiving. It might be interesting to note that the Paraprofessional Institute reports that 42 percent of Nebraska's direct-care workers receive some form of public assistance to help with the cost of healthcare, childcare, and food. Even though a portion of these public benefits may be federally financed, states still have the flexibility in setting eligibility criteria. Later today, you'll hear more details about the programs, programs with limitations that can serve as barriers to those individuals who wish to become more self-reliant, work more hours, and accept raises in their wages. You'll also hear examples of what other states have done. We believe these are solvable problems and hope you'll give them your full consideration. We have confidence that by working together we can find a way to support these Nebraskans who provide care every day to those in need and only want a better life for themselves and their family. Thank you again for taking up this incredibly important issue, and thanks for the opportunity to speak with you this morning. And I'd be glad to answer any questions. [LR181]

SENATOR CAMPBELL: Thank you, Mr. Boddy. Questions from the senators? Senator Riepe. [LR181]

SENATOR RIEPE: Senator Campbell, thank you. Thank you. [LR181]

HEATH BODDY: Good morning. Senator. [LR181]

SENATOR RIEPE: Thank you for being here. My question is, just what percentage of Medicaid eligibility in Nebraska in the nursing home, what percentage of the...in the home? Is it half of the patients there that are on Medicaid? [LR181]

HEATH BODDY: Of the residents that live there? [LR181]

SENATOR RIEPE: Yes. [LR181]

HEATH BODDY: It's between 55 and 60 percent. [LR181]

SENATOR RIEPE: Okay. My other question gets to be, is this issue better resolved by simply rate increases in Medicaid? [LR181]

HEATH BODDY: Well, rate increases would be an interesting discussion. The scenario that creates the difficulty really is when the benefits that somebody would be using--as an example, childcare--have sort of this, as Senator Kolterman pointed out, this cliff or this lack of a tier effect. So while the wages would be helpful, it doesn't solve the whole issue in that there still is going to be this hard stop. Example would be childcare. If we as an employer offer somebody more wages or we offer somebody the ability to work overtime, then they worry about their benefits being stopped. And so the extra that you'd gain from the wages don't always equate to being able to provide those things on your own. It seems like some sort of a tiered effect or a graduated effect would be indicated. [LR181]

SENATOR RIEPE: My concern gets to be at times is with salary compression. There's always a problem within organizations, particularly healthcare. And so unless the employer provides day care for everyone, you know, you could...we could have people that are on...at the edge of the cliff and the people that aren't and, you know, the internal...external inequity is accepted. Internal inequity is just ferocious in terms of trying to run an organization. So that's my confusing part is, how do you...some people that are on programs that would put them at the cliff, others aren't, and how do you make this as fair as you can make it... [LR181]

HEATH BODDY: Sure. [LR181]

SENATOR RIEPE: ...with all of the workers so that you don't end up with this internal strife? [LR181]

HEATH BODDY: You know, I think the thing... [LR181]

SENATOR RIEPE: We solve that one, we've got it going. [LR181]

HEATH BODDY: I think the thing that struck me this summer is you'll hear some pretty creative examples of things people are trying to do. It seems like the last thing that should stop us is these policy barriers that seem so drastic in nature. And, you know, I'm not an expert on those, so there's probably way smarter people that can tell you about how those programs work. But I tell you, as we traveled the state, it was very clear that time after time, example after example, we had opportunities to pay more, to give more hours, to pay overtime, and people wouldn't do that because they would lose benefits, whether that be food or whether that be childcare or whether that be healthcare. [LR181]

SENATOR CAMPBELL: Mr. Boddy, are you familiar with Senator Cook's bill from last year that addressed the cliff effect for child subsidy? [LR181]

HEATH BODDY: And it was for childcare--a little bit, Senator, a little bit. [LR181]

SENATOR CAMPBELL: Okay. That was meant to do exactly what you are talking about in the child subsidy area. [LR181]

SENATOR KOLTERMAN: Right. [LR181]

SENATOR CAMPBELL: And we'll be glad to get some information for you... [LR181]

HEATH BODDY: Sure. [LR181]

SENATOR CAMPBELL: ...that you might want to share with your members. Because a bill is, you know, passed, not always are people familiar with what the contents are. But it was meant...and business groups testified, a number of them, and supported the bill heavily in talking to senators for that very reason. I'm sure there's other programs that we're not aware of that your folks are going to talk about. [LR181]

HEATH BODDY: Sure. [LR181]

SENATOR CAMPBELL: But the child subsidy should begin to address that. [LR181]

SENATOR KOLTERMAN: Right. [LR181]

HEATH BODDY: It would be a great step. [LR181]

SENATOR CAMPBELL: Anybody want to add? Senator Howard. [LR181]

SENATOR HOWARD: Well, actually, I had a question about whether or not the childcare subsidy changes that Senator Cook passed, whether you had seen some improvement in some of these issues because of that bill, but it doesn't sound like you've seen any movement there yet. [LR181]

HEATH BODDY: Senator Howard, I would say, as we traveled the state this summer, we're not seeing that movement. And so I'm not sure if it's a gradual thing that will come through or if it's a training issue. I'm honestly not sure. [LR181]

SENATOR HOWARD: And then as a follow-up, are you advocating for sort of an alignment of eligibility and tiering, sort of a step down for eligibility for all of the programs, so from SNAP to LIHEAP to childcare subsidy, so that they line up together so there's some clarification among the different programs? [LR181]

HEATH BODDY: That sounds wonderful. I think what really, as we worked with Senator Kolterman, I think what we had hoped is that we could take a thoughtful look at how all those

things do line up and see if there's opportunities for adjustments or alignment so that it doesn't penalize. I use this phrase all the time, "the carrot and the stick." It seems like this is a stick issue, not an enticement with a carrot for people. And we have providers; we have people that need the care. We've got the jobs there. Some way to get that better aligned would be our goal. [LR181]

SENATOR HOWARD: Thank you. [LR181]

SENATOR CAMPBELL: We were just whispering over here. We think that the bill went into effect in August. [LR181]

HEATH BODDY: So that would make sense why... [LR181]

SENATOR CAMPBELL: So it may be a period of time... [LR181]

HEATH BODDY: Yeah. [LR181]

SENATOR CAMPBELL: ...that people are aware, but your organization could go a long way. And to Senator Riepe's point, Senator Riepe, it wouldn't...the subsidy wouldn't be handled by the facility. It's a public benefit. So they would have to have...meet a certain income and then would be eligible. But that's a public program, not a program out of a facility. Would that be... [LR181]

SENATOR RIEPE: Um-hum, thank you. [LR181]

HEATH BODDY: That's my understanding as well, Senator. [LR181]

SENATOR CAMPBELL: Yeah. Okay. And then one other question for you since Senator Howard asked about the step down for all programs if we made them all the same. Is there any question that people talk to you about asset limitations? Do you know what that means? It means if you have a certain amount of assets, then you aren't eligible either. [LR181]

HEATH BODDY: It was not one of the discussions that we had this summer. I'm more familiar with that issue on the residents side... [LR181]

SENATOR CAMPBELL: Yes. [LR181]

HEATH BODDY: ...as they apply for Medicaid benefits. I'm not as familiar with it on the employment side, so I'm probably not the best one to speak to that. [LR181]

SENATOR CAMPBELL: Okay, because that... [LR181]

HEATH BODDY: But we did...I did not hear that issue this summer. [LR181]

SENATOR CAMPBELL: Senator Crawford had a bill. Two years ago, was it? And it...which would have taken away some of the requirements on asset limitations. [LR181]

SENATOR CRAWFORD: Right, (inaudible). [LR181]

SENATOR CAMPBELL: And we didn't go forward, that bill. I think we had another one. [LR181]

SENATOR CRAWFORD: (Inaudible)...yeah. [LR181]

SENATOR CAMPBELL: But we could relook at that issue. Okay, thank you, Mr. Boddy. [LR181]

HEATH BODDY: Thanks so much. [LR181]

SENATOR CAMPBELL: Okay. Our next testifier is Jay Colburn. We meet again (laugh). [LR181]

JAY COLBURN: Good morning again. [LR181]

SENATOR CAMPBELL: Good morning. Go ahead. [LR181]

JAY COLBURN: My name is Jay Colburn, C-o-l-b-u-r-n, and I'm the administrator at York General Hearthstone. I've served the elderly in Nebraska as a long-term care administrator for just under 15 years. The York General organization includes a critical-access hospital, skilled nursing facility, assisted living facility, dialysis unit, home health, and low-income senior housing. York is fortunate to be located at the axis of Interstate 80 and Highway 81. The organization has achieved top-decile staff satisfaction and engagement scores for five years running. This fall, York General was recognized by Modern Healthcare as one of the top ten places to work in healthcare in the United States. Even with these advantages and a couple accolades, York General has struggled mightily to find quality staff to care for our residents and patients. We've even...we're kind of a poster child for what Heath was speaking to earlier about needing to deny some potential admissions with our struggles as well. Some efforts that I wanted to quickly highlight that we have taken to address our work-force issues include on-the-job training for dietary and environmental services aides as an entry point into our work force; hosting a paid certified nurse's aide class and medication aide class, so there's zero tuition cost and then we pay you while you sit in the class and pay you while you train on the floor. And then, to kind of complete our career ladder, we provide tuition support and income replacement for LPN and RN students who are interested in furthering their degree. I think nursing is a unique field that is attractive to many single mothers or other individuals trying to enter the work force. The reason is there's a clear-cut career ladder or stair step that they can follow of the CNA, medication aide, LPN, and RN. Wages increase significantly from CNA and med aide to LPN and then again LPN to RN. Our facility's example would be six of our eight current nurses in administrative roles started as nurse's aides, and several of them are or were single mothers. The nursing career ladder like York General offers was effective for our administrative nurses because they were in the work force. Other efforts that we've tried and are having some success with to partner with other educational folks is Project SEARCH. York General partnered with area high schools to provide a yearlong work experience program to students who may have different learning abilities than the typical student. We're currently in our third or fourth year and we employ three of those individuals. From all of the classes--I just heard from Nichole Wetjen, who operates the program in our organization, from the school district, and I believe one of the students was not gainfully employed. So it's been successful and a great partnership. The second

area where we've been working with educational partners to try and address the issue would be Southeast Community College. We worked with the York County Development Corporation and area York businesses to attract a satellite site. We're doing our best as an organization to engage on the advisory board and ensure that we can pool our resources with Southeast Community College and offer classes that would benefit all the area healthcare facilities, as everyone is struggling if you just crack any newspaper or look at any of the billboards. Again, my point to stating all the different educational offerings is that--and our strategic partnerships--is that they haven't been enough to meet the work force demands of our elderly population. From my perspective, there are four good reasons to get excited about the opportunity that LR181 presents. Frail, elderly Nebraskans deserve to be cared for. I could go on and on there and share some tearjerker stories about the great folks that we care for, but I hope that you get what I'm talking about. Number two, those who are capable and wish to join the work force should. We need the help and they need a career path. Policy barriers should be the last hurdle that they need to clear, instead of the first. Three: Simply put, I think, money. I think it makes sense from an economic development standpoint. And in time we should see some relief in demand for state benefits as individuals have the opportunity to work through the nursing career ladder. Fourth and final is the most obvious. The reason we're talking about it is because the problem has been identified. The grain of Nebraska is only going to intensify the work-force challenges, especially in long-term care. We all need to be working on the problem now. So thank you, Senator Kolterman, for proposing LR181. And again, work force issues have been the primary challenge for my facility for the past several years. Any questions? [LR181]

SENATOR CAMPBELL: Questions? Do all of your employees take advantage...I assume you offer healthcare. [LR181]

JAY COLBURN: We do. [LR181]

SENATOR CAMPBELL: And so do all the employees take advantage of that? [LR181]

JAY COLBURN: They do not. [LR181]

SENATOR CAMPBELL: And... [LR181]

JAY COLBURN: We have a mix that may take their spouse's insurance. Many do take advantage of our insurance, as it is pretty decent for the area and very competitive. And others decide to stay on Medicaid. [LR181]

SENATOR CAMPBELL: Okay. And so they are already eligible for Medicaid? [LR181]

JAY COLBURN: Some of our staff, as I understand, yes. [LR181]

SENATOR CAMPBELL: Parents of children below 54 percent of the poverty level or who are pregnant? [LR181]

JAY COLBURN: That sounds right to me. [LR181]

SENATOR CAMPBELL: Okay. Okay. How many employees do you think do not fit that category at all and yet do not take insurance because they can't afford it? [LR181]

JAY COLBURN: That are selecting not to have insurance, period? [LR181]

SENATOR CAMPBELL: Because they can't afford it. [LR181]

JAY COLBURN: You know, in the direct-care staff ranks, which is what we're talking about, I think it's, looking at our enrollments last go-around, it's 25-30 percent easy... [LR181]

SENATOR CAMPBELL: Okay. [LR181]

JAY COLBURN: ...that don't have insurance and simply can't afford it. [LR181]

SENATOR CAMPBELL: Okay. [LR181]

JAY COLBURN: If you look at the LPNs and RNs, our administrative desk jockeys, most of them have elected to have insurance or have coverage somewhere. [LR181]

SENATOR CAMPBELL: Okay. Thank you, Mr. Colburn. Anyone else? Okay, thank you. [LR181]

JAY COLBURN: Thanks. Appreciate it. [LR181]

SENATOR CAMPBELL: Our next two testifiers wanted to come up together and that's fine. But we just need, for the transcribers who listen, to make sure that one talks and then the other and it's very clear who it is. Okay? So we have Meredith Martin and Janet Martin and Ryan is on it. We'll get you another chair. Okay. [LR181]

MEREDITH MARTIN: Oh, this is fine. [LR181]

SENATOR CAMPBELL: Okay. [LR181]

JANET MARTIN: That's fine. We're all right. [LR181]

SENATOR CAMPBELL: Okay. Are you sure? [LR181]

JANET MARTIN: Um-hum. [LR181]

SENATOR CAMPBELL: All right. Good morning. [LR181]

MEREDITH MARTIN: Hi. My name is Meredith Martin, M-e-r-e-d-i-t-h M-a-r-t-i-n. [LR181]

SENATOR CAMPBELL: You go right ahead. [LR181]

MEREDITH MARTIN: Good morning. I am so excited to be here and have the opportunity to share with you some of my dreams and goals. My name is Meredith Martin, a self-advocate from Neligh. When I was 18 and just graduated from high school, I moved from my parents' home into my own apartment. A volunteer job at a hospital had developed into a paid position. You see, once I was no longer volunteering, they realized that I had valuable abilities and they needed me, although I had long dreamed of becoming a nurse. Working in a hospital was pretty close to

satisfying that dream. I was soon able to find and have a part-time job at the local grocery store. When I hand out samples on Friday and interact with the customers, I am showing them that people with disabilities are willing and capable of competitive employment. Not too long after that, I was hired as a kitchen aide at an assisted living facility in our community. I am a people person and working with and serving the residents there is such a joy. Not much later I was asked to spend a couple hours at the medical clinic helping with some office duties there. Well, I had four part-time jobs. So apartmentwise, how was I going to get to all these job sites? Public transportation in small towns is pretty limited and my parents were working at their full-time jobs. So I hired a driving instructor and achieved another dream. I secured a driver's license. That pretty much takes us up to today. Now I would like to ask each of you to consider this: How many of you feel self-satisfaction and a boost to your self-esteem in your positions here in our Legislature? I would assume that you, like me, feel that our jobs give our life meaning, purpose, and value. The U.S. Department of Labor and the Office of Disability Employment Policy reported in September of 2015 that only 19.1 percent of people with disabilities participate in our labor force. Now math may not be my strength, but that means that more than 80 percent of people with disabilities are not employed or even seeking employment. How sad is that? We have abilities and skills and with the right support we can be valued employees. Research also shows that the longer people are idle, they are more likely to lose some of their job skills and they may...that they may have developed in high school or adulthood. The bottom line is, I want to work. I am healthy and I believe that I am maintaining that good mental and physical health because I am making a difference in my community. I understand that my Medicaid health insurance is in jeopardy because I am working. I understand that I could lose Medicaid coverage because of that desire to work. I have been told I could quit a job so that I could keep my Medicaid. I do not want to quit any of my jobs. I love working. I honestly believe that others in our great state desire employment and would find life even better if they were employed but fear of losing health insurance coverage...although this is not just about Down Syndrome, I strongly believe in the (inaudible) campaign slogan adopted by the National Down Syndrome Congress, "We are more alike than different." We all desire a sense of purpose and well-being. Employment without fear of loss of health coverage can offer this. Thank you for listening to my concerns. [LR181]

SENATOR CAMPBELL: Ms. Martin, you did a great job. And I would guess the residents really love to have you around, so. [LR181]

MEREDITH MARTIN: Thank you. [LR181]

SENATOR CAMPBELL: With that smile, I'm sure that brightens everybody's day. [LR181]

MEREDITH MARTIN: I always do. [LR181]

SENATOR CAMPBELL: I like to see you smile. Any questions from the senators? [LR181]

SENATOR KOLTERMAN: I just have one. [LR181]

SENATOR CAMPBELL: Senator Kolterman. [LR181]

SENATOR KOLTERMAN: Well, first of all, thank you for coming all the way from Neligh. Thank you for your testimony and speaking. It takes a lot of courage and we appreciate that. [LR181]

MEREDITH MARTIN: You're welcome. [LR181]

SENATOR CAMPBELL: Thanks, and have a great day. [LR181]

MEREDITH MARTIN: Thank you. [LR181]

SENATOR CAMPBELL: Uh-huh. Our next testifier is Janet Martin. Good morning again. [LR181]

JANET MARTIN: Good morning. [LR181]

SENATOR CAMPBELL: Well, we are saying that because we met this morning as I was coming in and we had a chance to talk a little bit. So go ahead and identify yourself and... [LR181]

JANET MARTIN: I'm Janet Martin, J-a-n-e-t M-a-r-t-i-n. I, too, wish you a good morning. And although Meredith is my daughter, I regret that she did not get her "keep calm when speaking before a group" gene from me (laughter). That just happens to be one of her many gifts. However, I have been assured that most or all of you are parents and will be understanding of my passion for advocating for my child. I trust that all of you had dreams and expectations for your children when they entered your life. You looked forward to their youth and eventually becoming independent adults with a meaningful career. Many Nebraska parents had to readjust those dreams when we received a different road map at the birth or along the journey of raising our children. After years of individual education plans and IEPs and evaluations in the educational system, all of a sudden we were faced with adult living opportunities. We worked with educators along the way to prepare our children for the work force. We navigated the system, setting up job opportunities and living options, including healthcare. When they finally reached a point where they were gainfully employed, that they had reached a major milestone, we are now advised that our daughter needs to quit a job in order to keep her healthcare or her Medicaid because she is a few dollars over the allotted income. Really? We have worked all these years to develop employability skills. What good has her education provided? Although there has been an increase in minimum wage, it certainly does not offset the cost of private coverage of healthcare insurance premiums, yet it pushes many over the allowable income for continuing Medicaid coverage. Full-time employment with benefits is extremely rare for individuals with physical and mental challenges. The allowable income has not changed to fit the slight increase in wages. It is also my observation that people who are employed and fulfilling many of their basic needs through employment are much healthier, both mentally and physically. It seems only logical then that medical costs would be much less for those receiving entitlements if they were a part of the work force. Shouldn't people with mental and physical challenges be rewarded for their tenacity and willingness to work rather than being penalized? I also believe that for most individuals the key to happiness and contentment in life is engagement with other people. Many individuals with disabilities are willing to step into difficult-to-fill positions, work split shifts, fill in for others. They are dependable and loyal. Employers are searching to find folks willing to carry out those

roles. It is my opinion that being an active citizen in the community, pursuing dreams, and having a purpose for getting up in the morning and off the couch is vital for the future of our state and the work force in Nebraska. Thank you. [LR181]

SENATOR CAMPBELL: Questions for Ms. Martin? Ms. Martin, I have a question. I'm trying to recall the special program that exists for people with disabilities who work and are under the Medicaid program. I mean there is a special program. Do you remember at all the title of that program that your daughter probably is eligible for? [LR181]

JANET MARTIN: At one point, she was eligible for SSI. [LR181]

SENATOR CAMPBELL: Okay. [LR181]

JANET MARTIN: And I think that there are more programs under that. But once she became more employable and employed more, then they switched to Social Security. And so I am not aware that she is eligible for that. It was the PASS program, I believe. And that allowed her to...or allowed individuals to, say, for a certain project, you know, say it was for a CNA tuition for LPN tuition or something, but it had to have a certain end, a beginning and an end, the way I understood it at the time. [LR181]

SENATOR CAMPBELL: Senator Gloor had an interim study a few years ago in which we looked at the limit of the...the wage limit of...and the...I know there was some federal regulations that we'd look at, but we could relook at that program and what that limit is because you do want someone who can work a full-time job, like your daughter, and enjoys it, should not have to sacrifice her healthcare. [LR181]

JANET MARTIN: Thank you. I appreciate it. [LR181]

SENATOR CAMPBELL: So we'll...I'll try to find the program I'm thinking of. [LR181]

JANET MARTIN: Okay. [LR181]

SENATOR CAMPBELL: So thank you very much. [LR181]

JANET MARTIN: Thank you very much. [LR181]

SENATOR HOWARD: Is it Medicaid insurance for individuals with disabilities,... [LR181]

SENATOR CAMPBELL: Yeah, but... [LR181]

SENATOR HOWARD: ...it's up to 250 percent of the federal poverty level and they pay a premium? [LR181]

SENATOR CAMPBELL: But there's a different program that Senator Gloor looked at, so... [LR181]

SENATOR HOWARD: Yeah. [LR181]

SENATOR CAMPBELL: But that's probably what the limit is. Thank you very much. [LR181]

JANET MARTIN: Thank you. [LR181]

SENATOR CAMPBELL: Thanks, Senator Howard. Okay, our next testifier is Ashley Flemmings. Good morning. [LR181]

ASHLEY FLEMMINGS: Good morning. Thanks for letting me come speak to you guys today. [LR181]

SENATOR CAMPBELL: Do you want to spell your name for us? [LR181]

ASHLEY FLEMMINGS: Yes, ma'am. My name is Ashley Flemmings. It's A-s-h-l-e-y, Flemmings, F-l-e-m-m-i-n-g-s. [LR181]

SENATOR CAMPBELL: Go right ahead. [LR181]

ASHLEY FLEMMINGS: Okay. The reason I am coming to speak to you guys today is I'm currently receiving assistance. I work PRN at Immanuel Fontenelle Home. The reason I work PRN is I'm a full-time nursing student at College of Saint Mary here in Omaha, Nebraska. The assistance I receive helps provide the necessities for living for myself and son. Even with assistance it is not enough to survive. I often pick up hours at my job to pay for things my family needs, such as soap, clothes, and shoes for my growing son, and bus tickets which help me get from point A to B. During semester break, I worked extra hours because I was not in school, which caused me to exceed the amount a two-person family could make, resulting in loss of medical coverage for myself, increased rent, and increased day-care expenses. I had to wait three full months before I could reapply for assistance. During that time, I had to take my son with me to the library because I could not afford day care while I studied. I have doctor's bills that I still can't pay because I had no insurance. I had my lights and water turned off. I had to go to the food pantry to provide meals for my family. I attend a nursing school trying to provide a better life for my family. I have not sat for my nursing boards yet. I am not an RN yet. However, I am at risk for losing benefits permanently just for working 30 hours a week. I am hoping my story will encourage you to help single mothers like myself find a better path to becoming self-sufficient. Thank you for allowing me to speak to you guys today. [LR181]

SENATOR CAMPBELL: Ms. Flemmings, were you on ADC at one point? Is that what... [LR181]

ASHLEY FLEMMINGS: Yes, ma'am. [LR181]

SENATOR CAMPBELL: And then you lost that because you made too much money? [LR181]

ASHLEY FLEMMINGS: Yes, ma'am. [LR181]

SENATOR CAMPBELL: Okay. And so you had to wait a period of time before you could go back. [LR181]

ASHLEY FLEMMINGS: Yes. [LR181]

SENATOR CAMPBELL: We did have a bill last year. We did raise the amount, the maximum. It still may not be enough to help you with all that you have, but we really appreciate you coming and telling your story. Have you had any assistance in going to school? [LR181]

ASHLEY FLEMMINGS: Yeah, I get...yeah, I get a Pell grant. [LR181]

SENATOR CAMPBELL: Oh, good, excellent. [LR181]

ASHLEY FLEMMINGS: But I still got student loans that I'm going to have to pay because, College of Saint Mary, my Pell grant didn't cover the full tuition. [LR181]

SENATOR CAMPBELL: Okay. So how much months or years do you have left before you finish your studies? [LR181]

ASHLEY FLEMMINGS: Well, I have completed nursing school. July 28 was my last day, and I had to work so I could pay to take the NCLEX. So I'm supposed to take my NCLEX December 23. [LR181]

SENATOR CAMPBELL: Oh, okay. [LR181]

ASHLEY FLEMMINGS: So hopefully I have a nice Christmas present by passing (laughter). [LR181]

SENATOR CAMPBELL: Any questions from the senators? Ms. Flemmings, thank you very much. We very much appreciate people who come forward with their own stories, because it isn't easy. And good luck on that test. [LR181]

ASHLEY FLEMMINGS: Thank you. I need it. [LR181]

SENATOR CAMPBELL: I tell you what, you pass the test, you send us a message, okay,... [LR181]

ASHLEY FLEMMINGS: Okay, I will. [LR181]

SENATOR CAMPBELL: ...an e-mail and let me know how you did. [LR181]

ASHLEY FLEMMINGS: I will. Yes, ma'am. Thank you. [LR181]

SENATOR CAMPBELL: All right. Thank you. Our next testifier is Aleisha Perkins. Did I say the name correctly? [LR181]

ALEISHA PERKINS: Yes. [LR181]

SENATOR CAMPBELL: Good morning. How are you? [LR181]

ALEISHA PERKINS: I'm all right. How are you? [LR181]

SENATOR CAMPBELL: Very good. [LR181]

ALEISHA PERKINS: (Exhibit 2) Good. Good morning. My name is Aleisha Perkins, A-l-e-i-s-h-a P-e-r-k-i-n-s. I am a 25-year-old single mother of one. I was working at Louisville Care Center as a CNA/med aide. While working full time, my take-home pay was roughly $1,200 per month at $12.10 an hour. Out of my biweekly paycheck I was responsible for the following bills. Full-time childcare for Cruz was $130 per week, or $520 a month. In addition to childcare, I pay $300 for rent, approximately $100 for utilities--electric, gas, and water--$300 for a car payment, $120 for car insurance, and $45 for a phone. The total for these bills is $1,385 a month. This puts me $185 over budget for just my basic bills. These expenses do not take into account gas to get to work, food to feed my son and I, money to save for emergencies, such as the inevitable vehicle repairs, clothing expenses for a growing toddler boy, or anything else life should throw my way. Because of my budget deficit I really struggle to make ends meet. I could barely afford enough food for my son and I, so typically I just wouldn't eat. I was almost evicted. I constantly had shut-off notices for my utilities. And in fact, my gas and water were shut off at one point. I had my phone shut off multiple times as well. Finding myself financially overwhelmed, I decided that it would be best for Cruz and I if I applied for help through the Department of Health and

Human Services' economic assistance programs. If I could have received help with day care alone, I could scrape by and make ends meet. However, after submitting my application, I was denied. I was told my income exceeded guidelines. Shocked, I found myself budgeting and rebudgeting, hoping that if only I tweaked my finances this way or that way, I could figure out a way to make ends meet. It didn't matter how I arranged my money. The fact of the matter was I simply did not make enough to cover my bills, not even the bare minimum. After realizing I couldn't make ends meet on my own, nor did I qualify for assistance, I decided to cut my hours to part time and reapply. My director of nursing had mentioned that a previous employee had to do the same thing. I had to give it a shot too. I was desperate. This time I qualified for childcare, the SNAP program, and emergency assistance to help with my shut-off notice from OPPD. Unfortunately, I was now making less money to cover the bills that the state did not assist with, such as rent, my car payment and insurance, my phone bill, etcetera. I tried consoling myself by telling myself that at least I could work and put food on the table. However, the reality of the situation is that I shouldn't have to cut my hours to be on welfare. If I don't...I don't want to work less so that I can be assisted by the state. That type of design will only make it infinitely more difficult for me to get back on my feet without welfare. That type of design creates a dependence for government benefits. If I am willing to put in the work to get myself off welfare, why should I be held back from that? I don't want to be in fear of working too many hours, losing my benefits, and ending up in the same boat I was before. I want to use the help while I need it to get myself financially stable and hopefully never need state assistance again. Thank you for taking the time to hear my story today. I hope my experience can be used to help many others going through similar struggles. [LR181]

SENATOR CAMPBELL: Thank you very much for your testimony. Through your part-time employment, do you have healthcare? [LR181]

ALEISHA PERKINS: My son did. [LR181]

SENATOR CAMPBELL: Through the Nebraska CHIP program, the Medicaid program for kids? [LR181]

ALEISHA PERKINS: Medicaid? Yeah, um-hum. [LR181]

SENATOR CAMPBELL: Okay. And he is still on that program, is he not? [LR181]

ALEISHA PERKINS: Yes. [LR181]

SENATOR CAMPBELL: Other questions from the senators? Thank you very much. [LR181]

ALEISHA PERKINS: Thank you. [LR181]

SENATOR CAMPBELL: James Goddard. Good morning. [LR181]

JAMES GODDARD: (Exhibit 3) Good morning. Senator Campbell, committee members, my name is James Goddard. That's J-a-m-e-s G-o-d-d-a-r-d. And I'm the director of the economic justice and healthcare access programs at Nebraska Appleseed. Appleseed is a nonprofit law and policy center whose mission is to fight for justice and opportunity for all Nebraskans. Happy today to be here to testify regarding LR181. As we've already heard from many folks this morning, despite hard work, many Nebraskans are still struggling to make ends meet. In Nebraska, we know about 32 percent of working families--that's almost 70,000 people--are low income, earning less than 200 percent of the federal poverty level. That's where our work support programs, like childcare and SNAP, become critical to help these families be more healthy and to move ahead. But as we've also heard, some programs are structured in a way that can create barriers to taking a pay raise or getting a better job. This is what is referred to often as the cliff effect. I think we've already heard from several testifiers about what that...the cliff effect is. It's essentially when a family gets a modest increase, a raise, gets a new job, and that pushes them over eligibility limit in a certain program. So while a family's income may have increased slightly, the loss of the benefit ultimately doesn't equal things out for the family and they end up taking one step forward and two steps back. Now some of our programs are structured in a better, more positive way. We've seen some improvements both in the Aid to Dependent Children program and the childcare subsidy program in recent years. Still, improvements can be made to ensure more people are rewarded for working hard. What I'd like to do with the rest of my testimony--I included an attachment--to walk through very quickly with you three different programs where these aren't all the programs where we have flexibility, but these are some of I think what we've heard this morning about where we could consider some improvements. The

first is the childcare subsidy program. Just as a refresher, this is a program that subsidizes the cost of childcare for individuals with low incomes who are either working, looking for work, or are in school. You have to be doing one of those things to be eligible for the program. The subsidy doesn't go to the individual. It actually goes directly to the childcare provider. It's a mixture of funding. The big pieces of federal funding are the childcare and development block grant and the Temporary Assistance to Needy Families, or TANF, program, and we put...in turn, the state puts in some of its own dollars to draw down some of those funds. Looking to what we're talking about, program eligibility, the initial eligibility is now set at 130 percent of the poverty level. To put that in context, that's about $26,000 a year for a family of three. So that's initially, walking through the door, to be eligible for the program. Once you are on the program, you are then eligible for transitional childcare, which was Senator Cook's bill that was passed last year, up to 185 percent of the poverty level. That is now about $37,000 a year for a family of three. States are permitted go to beyond those limits. Those are the limits that the state has set at this point, but you can go higher. Some states have gone up to as high as 200 percent or 300 of the federal poverty level. To one of the questions that came up earlier about the change in Senator Cook's bill, it is clearly a significant and positive step in the right direction to dealing with the cliff effect. And I would also say, as we see it, the ideal would be to go to 185 at the front-end level, which is where we actually were in 2002 before it was changed down to 120. So, you know, over ten years ago, we were actually at a higher initial level than we are now, and you could, you know, potentially tier down from there. Moving quickly to the Supplemental Nutrition Assistance, or SNAP, Program, SNAP helps pay for the cost of nutritious food for low-income families. Eligible families get an electronic benefit transfer card that they can use a lot like a credit card at certain vendors, like grocery stores. Important note here: Federal funding pays 100 percent of the cost of the benefit, 100 percent of the cost. The state has to pick up 50 percent of the cost of administrative...the administrative costs for administrating the program. I don't think we need to get into the details, because I see I'm running out of time. There are essentially two income thresholds or two doors you have to walk through to be eligible for SNAP. One is looking at just your gross income, how much do you earn. That limit is 130 percent of poverty. Then there are certain deductions that are taken out after that for things like childcare, for things like rent. And then you have to earn less than the poverty line or 100 percent of poverty. States are able to take that...the gross income level higher if they choose to do that and many states have done so. Very quickly, the Children's Health Insurance Program, CHIP, or

Kids Connection in Nebraska, this is health insurance coverage for children whose families earn too much for traditional Medicaid but too little to pay for private insurance. It's a mixture of federal and state funding, like just Medicaid, but the match rate is much higher at present for the CHIP program. We currently have our eligibility limit at 200 percent of poverty, which is about $40,000 for a family of three. It's actually about 212 with some of the changes in the Affordable Care Act. But states are also able to take that eligibility limit up higher if they choose to do that. So, in conclusion, all of these programs allow for flexibility in their design and we should seriously consider additional improvements to reward work and help more Nebraskans move ahead. Thank you. [LR181]

SENATOR CAMPBELL: Questions, Senators? [LR181]

SENATOR KOLTERMAN: I have a question. [LR181]

SENATOR CAMPBELL: Senator Kolterman. [LR181]

SENATOR KOLTERMAN: Yeah. Thank you for coming to testify. Question about the CHIP program: Has it helped with the Affordable Care Act going all the way to 400 percent, and has that given some relief to what you're talking about here? [LR181]

JAMES GODDARD: I think it has, but there...it also...it really depends on the family's situation in part because of what...the way it's determined whether a family can access subsidies in the marketplace or not is dependent on whether an employer offers coverage to the individual that is affordable. That means 9 percent... [LR181]

SENATOR KOLTERMAN: 9.5. [LR181]

JAMES GODDARD: ...or 9.5 percent or less. But when that assessment is made, all you're looking at is the individual employee. You're not looking at whether it's affordable for the spouse or the kids. And often, though, the dependent coverage and spousal coverage is much more expensive. So you have situations where some folks, because of that, are not able to really go

into the marketplace and get subsidies. So that, you know, it's part of the reason why CHIP remains a critical program, in addition to all of the excellent services that it provides. [LR181]

SENATOR KOLTERMAN: And you're saying in essence that once they hit 212 percent, they're thrown out of Medicaid. Is that what I hear you saying? [LR181]

JAMES GODDARD: That's right. [LR181]

SENATOR KOLTERMAN: Okay. Thank you. [LR181]

JAMES GODDARD: Thank you. [LR181]

SENATOR CAMPBELL: Senator Crawford. [LR181]

SENATOR CRAWFORD: Thank you, Senator Campbell. And thank you, Mr. Goddard, for being here today. Do you happen to know if the transitional childcare benefits, the ability to stay on as your income rises, if that is in effect or if we are waiting for rules or regs to actually implement that? [LR181]

JAMES GODDARD: I believe it should be in effect. I can't remember if there was an emergency clause on that. So it should have gone into effect in the summertime. I mean there's a certain amount of time it takes to implement, I am sure, but, yes, that should be in effect at this point. [LR181]

SENATOR CRAWFORD: So now, as individual income increases, up to 185 they would be able to stay in the childcare program. [LR181]

JAMES GODDARD: For 24 consecutive months. [LR181]

SENATOR CRAWFORD: Okay. [LR181]

JAMES GODDARD: So after that period... [LR181]

SENATOR CRAWFORD: After that. [LR181]

JAMES GODDARD: ...of time they would again lose childcare, even if they were less than 185. [LR181]

SENATOR CRAWFORD: All right. Thank you. [LR181]

JAMES GODDARD: And it is, you know, notable that that again is only once you've walked through the door at 130. [LR181]

SENATOR CRAWFORD: Right. Right, exactly. [LR181]

JAMES GODDARD: And we heard from a prior testifier that she attempted to apply and was not able to do that because of that limit. [LR181]

SENATOR CRAWFORD: Right. Thank you. [LR181]

SENATOR CAMPBELL: Is it 24 months lifetime? [LR181]

JAMES GODDARD: No, it's just consecutive. [LR181]

SENATOR CAMPBELL: Okay. Do any of these programs--I can't remember--do they have asset limitations? [LR181]

JAMES GODDARD: The childcare subsidy program does. And I think Ms. Mancuso could tell you for sure. I think it's about $6,000 is the asset limit. And that, I think we're only one of the states that has an asset limit in that program. SNAP has an asset limit. It was put into place a few years ago. I think it's $25,000 liquid assets. And CHIP does not because of changes through the modified adjusted gross income. There is no asset test in that as I understand it. [LR181]

SENATOR CAMPBELL: One of the important things that best practices and research will tell us is that however critical the CHIP program is, and it is, we took it to 200 percent where the

senators from a history perspective...was Senator Avery's bill when we had the safe haven. We took it to 200 percent at that point. One of the things that best practice tells us, and research, is that more children would come onto the CHIP program if their parents had insurance because, if parents have health insurance, they tend to pay much closer attention. And not all the children in the state of Nebraska who are eligible for CHIP have it and that's what's sad. [LR181]

SENATOR KOLTERMAN: Yeah, I have a comment about that. What we've found is that when the parents apply for the exchange and they're getting a subsidy, probably they're automatically thrown into the Medicaid program through the CHIP program for children. That's been very positive and yet there's a delay in getting things to them. [LR181]

SENATOR CAMPBELL: Yeah. [LR181]

SENATOR KOLTERMAN: But that's why you're absolutely correct. When the parents get it, they automatically throw them into Medicaid. [LR181]

JAMES GODDARD: And states have done some interesting things to try to ensure that CHIP-eligible kids are actually getting enrolled through things like Express Lane, which is essentially data matching from different sources, which is certainly an effective idea. [LR181]

SENATOR CAMPBELL: But some of the states have taken their CHIP eligibility up to 400 percent or higher. [LR181]

JAMES GODDARD: That's right. [LR181]

SENATOR CAMPBELL: I mean they've put such emphasis there to make sure that that's available. We'll look into the asset limitations. Thanks. [LR181]

JAMES GODDARD: Thank you. [LR181]

SENATOR CAMPBELL: Anything else? Thank you, Mr. Goddard. [LR181]

JAMES GODDARD: Thank you. [LR181]

SENATOR CAMPBELL: Our next testifier is Aubrey Mancuso. Good morning. [LR181]

AUBREY MANCUSO: (Exhibit 4) Good morning. Good morning, Senator Campbell. 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. Thank you to Senator Kolterman for continuing to look at this important issue. We believe all children should have their basic needs met, and public programs play an important role in providing a safety net for kids who may otherwise go without essentials like food and healthcare during critical developmental years. And we need to ensure that these programs are structured in ways that support families as they work to improve their financial security. The majority of those participating in our public programs in Nebraska continue to be children. In 2013, 64 percent of Medicaid and CHIP participants were kids and half of SNAP participants were kids. And so we've long been interested in the cliff effect because it does create a disincentive for these families to improve their financial circumstances. Although we lack statewide data on the scope of this problem, in 2014 we conducted surveys and focus groups with lower-income women on barriers to economic opportunity. We found that of those participating in our public programs, 46 percent reported having experienced the cliff effect. Families in this situation often resort to coping strategies to ensure that they can meet their monthly expenses while continuing to work. And so 52 percent of those who experienced the cliff effect had used some sort of coping strategy, and the most common one was cutting back on hours at work. Participants also reported not getting married to a partner, turning down a raise, or not taking a better paying job in order to maintain their benefit eligibility. One participant, Crystal, described how this had impacted her: I was only getting $170 a month through SNAP for my daughter, but because I got a raise, a 50 cent per hour raise, I only get $88 a month now to feed my daughter--a raise that only increased her income by $20 a month but it left her with a total of $60 per month less in her food budget. In these cases, families are behaving very logically based on the way our programs are structured. They're making the choices that allow them to meet their needs temporarily but are contrary to improving their situation in the long run. In addition to where we set our eligibility levels--and, Senator Campbell and Crawford, you've mentioned this--asset limits in some of our programs, currently in childcare, ADC, can leave families one financial crisis, like a car repair, away from significant

challenges. Finally, attached to your testimony is a fact sheet that can illustrate how the cliff effect might impact a hypothetical family in the county or counties that you represent. It's based on data from our Family Bottom Line report that looks at what Nebraska families need to make ends meet without assistance based on their county, family size, and age of children. And the data also shows you what food and childcare would cost a family in those counties. And in most cases, a gap exists between the wage a family would need to meet all their expenses and where we set our eligibility levels for public programs. And this is particularly problematic for single parents. For example, you know, if we look at Lancaster County, a single parent with two young children working full time would need to earn over $22 an hour to meet all their expenses. They would transition off of food stamps at around $12, childcare under the transitional assistance at $17 an hour, and medical assistance for their kids at about $19 an hour. So we appreciate the progress that this committee helped to support last year with the passage of LB81 and we hope to continue to work to address this issue and ensure that our public programs are working for children and families. Thank you. [LR181]

SENATOR CAMPBELL: Questions from the senators? Ms. Mancuso, could you...if you don't have it today, I'm sure Voices (for Children) could research it, in terms of the number of states that have no asset limitation. I mean we must be one...or that, you know,... [LR181]

AUBREY MANCUSO: It depends on the program. But in childcare, Rhode Island was the only other one and I believe they got rid of it last year. [LR181]

SENATOR CAMPBELL: Okay. [LR181]

AUBREY MANCUSO: And then I think in SNAP it's over half of states that don't have an asset limit at all. [LR181]

SENATOR CAMPBELL: An asset limitation. [LR181]

AUBREY MANCUSO: But I would have to check. And then in ADC, only a handful of states don't have one at all. [LR181]

SENATOR CAMPBELL: Okay. Senator Crawford. [LR181]

SENATOR CRAWFORD: Thank you, Senator Campbell. If I remember correctly, the childcare asset limit could be changed with regulation. Is that correct? [LR181]

AUBREY MANCUSO: Yes, that's my understanding is that the Department of Health and Human Services is looking at that in their new set of regulations. [LR181]

SENATOR CAMPBELL: Good. I'm sure Senator Kolterman's staff can follow up with the department to find out where they are on that because, if we're the only state left, that would be an easy one to take care of for people. [LR181]

AUBREY MANCUSO: Right, absolutely. [LR181]

SENATOR CAMPBELL: Any other questions? Thanks, as always. [LR181]

AUBREY MANCUSO: Thank you. [LR181]

SENATOR CAMPBELL: Our next testifier is Andrea Wilson, and Andrea brought the cutest guest today (laughter). Not that you all aren't attractive, handsome people, but we're pretty partial to kids here. Good morning. [LR181]

ANDREA WILSON: Morning. You would think that, as a cheerleader in high school, I would not be nervous in front of you guys, but I hate talking in front of people. Good morning, Chairman Campbell and members of the Health and Human Services Committee. My name is Andrea Wilson, A-n-d-r-e-a W-i-l-s-o-n, and I am here to testify on the LR181. So again, please excuse me as for this is my first testimony and I'm a tad nervous. But I do want to thank you for hearing my story. I am a single mother, I'm 23, and also a full-time college student at the University of Nebraska-Lincoln. I do have a one-year-old. His name is Jameson (phonetic) and he's a handful. I do work full time as QA. And with my job, I am full time. They hired me full time, so I have to work 40 hours a week. I can't reduce my hours because, if I reduce my hours, then I lose my job. I do get paid $12 an hour working 40 hours a week. So that gives me a gross

income of roughly around $1,920. I do pay all my bills. I do not receive child support, even though his father is supposed to be paying. All my financial assets are on me. I pay for childcare. I pay rent which is $550 a month, water which is $12. I no longer am able to get SNAP, so that is between $350 and $400 a month. Diapers is $100. Clothes is between $50 and $70 a month. I have a credit card bill which is about $200 a month. I have gas for my car which is about $100, electric which is usually between $30 and $70 a month, a car note which is $162.12, a phone bill which is $136, car insurance which is $145, and day care which I pay for $302 because we are now on transitional. As somebody mentioned before, transitional was 24 months served consecutive, but what I was told was it was 24 months in a lifetime. So that's a little different than what I was told. As far as all those bills that I told you before, that is an income of $2,247.12 a month. Without benefits, that all would cost me $3,015.12 a month. So it is critical. I know for Medicaid they count childcare and if you do pay for loans as income. For SNAP they only count as rent and utilities. I don't think that's fair because obviously that's not the only bills we have in a month to support a family. So with being a senior at UNL, I had to decide whether...if I was going to take the semester off or work a full-time job. I obviously needed to work a full-time job, so I had to take the semester off, which then, in turn, me losing money for grants and scholarships as a refund. I do have a full ride with the Buffett scholarship, so I'd like to thank my brains for that at least. But with that being said, my Medicaid was...is in transitional to be turned off. My son is in transitional to turn into CHIP. My SNAP was taken away and my childcare was cut at least by 75 percent. So if you could think about not paying childcare at all and then all of a sudden having to pay $300 a month because you went up $3 for pay is just not fair. The struggle that I do have is I can't pay for food with my child. My bills are now late, which has affected my credit score drastically. My credit score used to be in the 700s, so it was pretty good. Now it's at 530, which is pretty bad. Let's see, for medical a mother can't make over $600-something a month for Medicaid. But for private insurance, you have to make at least $27,000-29,000 a month to even qualify. Through my job it would cost me $209 a month just to cover me and my son, and we all know that medical benefits through a job aren't that great because you would still be paying at least 50 percent of it. My son does have a peanut and tree nut allergy--so he does have a EpiPen--which requires our food to be a lot more expensive than an average family who can go buy regular food. Our groceries a month are more expensive, but they are also more natural and organic because of the allergy. We also just found out that he has a low growth hormone, so with that he hasn't been hitting a lot of his milestones and we are now in

a waiting period to see, to go back and do more testing. And if it does come out that his low growth hormone has gotten worse, he has to go on a series of expensive treatments. So then I have to worry about working. I have to worry about losing my job. I have to worry about if all of our stuff is going to be cut off. A thing that does kind of irritate me is...and I'm not here to, you know, talk bad about his father. But he does have other children that he does have and he has multiple children, so it seems that it's a lot easier for somebody to get benefits with multiple children than somebody with just one child. So my question is, is...can you tell a mom trying to feed her son that she's out of luck because she's overqualified by just $120 a month? My son is, again, is a child with an EpiPen and multiple food intolerances. One thing that...with my...the way that I calculate is I get $1,920 a month. The way you guys calculate it is that I get roughly around $2,080 a month because there's two months out of the year where you get paid three times in a month. That two months, yes, it's helpful, but again that's almost $300 that you don't see the other ten months out of the year, which is very frustrating. So with budgeting everything, it's very hard to get everything paid and not have to worry about stuff being shut off, not being able to pay your food, not even being able to, you know, get to work back and forth every day. Childcare, food, and medical is a necessity, as you can see. You can't go to work if you don't have childcare. My son can't get the medical needs that he needs if I can't work. But then again, we also need childcare. So my thing is, is the way that it is calculated and it's based and what is qualified as bills for somebody in a month is very contradicting because, no, we don't only pay rent and utilities in a month. We also have car notes and credit cards and food that we pay outside of what you guys qualify. So it would really be helpful if something can be done or some type of income can be raised because $1,700 a month on a two-income family is...it's not okay because out of that $1,920 a month that you make, at least $400 of that is taxes. [LR181]

SENATOR CAMPBELL: Well, with all the challenges that you have, I really think we all appreciate that you have pursued an education, knowing that that's important. And I hope that this works out for you to go back. [LR181]

ANDREA WILSON: I hope. [LR181]

SENATOR CAMPBELL: What are you studying? [LR181]

ANDREA WILSON: Child education. [LR181]

SENATOR CAMPBELL: Excellent. We need about 200 percent more of you. That's very critical. Any questions from the senators? Senator Riepe. [LR181]

SENATOR RIEPE: Senator Campbell, thank you. Thank you for having the courage to tell your story and to appear in front of us. I know that's not an easy task. The question I guess that I have is, as you talked about a couple of times about the father, and my question would be is, is he under court order to pay? [LR181]

ANDREA WILSON: He is. [LR181]

SENATOR RIEPE: And is he delinquent? [LR181]

ANDREA WILSON: Yes. [LR181]

SENATOR RIEPE: Okay. [LR181]

ANDREA WILSON: He was court ordered in April and we are now in November and he was court ordered to pay at least $100 a month. So as of right now, he's at least $900 behind. [LR181]

SENATOR RIEPE: So the $100 a month doesn't take all of your burdens away. [LR181]

ANDREA WILSON: Uh-uh, it doesn't. [LR181]

SENATOR RIEPE: Okay, that's where I was going. I wondered, if he owned up... [LR181]

ANDREA WILSON: Right. [LR181]

SENATOR RIEPE: ...and was responsible, if that would make your entire situation turn around. [LR181]

ANDREA WILSON: Oh, no, no. I guess my point to that was people with multiple children have more access and it's easier for them to get benefits, rather than somebody with just one child. And I don't depend on his income or the child support because I know it's not going to come. But the thing...that just...that's frustrating is that he can stay at home and live off of Section 8 and food stamps and childcare and not...and make more than I do and still get benefits. But I have one child and I make $12 an hour and I can't get benefits as to where he can go do side jobs, be paid under the table making $16-18 an hour, and get all of his benefits. [LR181]

SENATOR RIEPE: Okay. Thank you. [LR181]

SENATOR CAMPBELL: Any other questions? Thank you for coming, very much. [LR181]

ANDREA WILSON: Thank you. [LR181]

SENATOR CAMPBELL: We appreciate it. Senator Kolterman, you want to close? [LR181]

SENATOR KOLTERMAN: Senator Campbell and committee, first of all, thanks for allowing us to go forward with this hearing today. My goal really...we made some really important moves a year ago and I was completely behind those. I still am but I think we need to, as you've heard today, we need to continue to coordinate our programs, all of our different programs, and align them so that we don't have this problem. For me, it's completely inappropriate that people that you've heard from today that are working hard, young people that are trying to get out of poverty, trying to work their way into the work force, have that opportunity. There's no reason they should have to quit their job, turn down a raise, or anything like that when they really want to work. So my goal is to figure out ways not to throw up roadblocks to these people and yet there's got to be things that we can do. And so that was really the gist behind my work with these committees and I look forward to working with you in the future and moving forward and hopefully those that want to work have that opportunity. As you know, we have an Intergenerational Poverty Task Force that's working. We need to continue our work there because, along those same lines, we can hopefully create jobs, get people back to work that need to work. And those that do want to work, we just can't throw up roadblocks to them. So thank you very much. I would entertain any questions. [LR181]

SENATOR CAMPBELL: Senator Kolterman...oh, Senator Riepe. [LR181]

SENATOR RIEPE: Thank you, Senator. [LR181]

SENATOR CAMPBELL: Yeah, I got... [LR181]

SENATOR RIEPE: Senator Kolterman, thank you for being here. [LR181]

SENATOR KOLTERMAN: Yeah. [LR181]

SENATOR RIEPE: You are a member of the committee, but thank you anyway. My question is, how big an issue is this? I mean how...are we talking hundreds, thousands? Where are we at, do you know? [LR181]

SENATOR KOLTERMAN: I don't know and we're going to have to continue to research that. We're really just getting started in this arena, but it's pretty obvious. If we...I mean you heard from two or three this morning that really want to work and I think we need to be that safety net and for those that truly want to work. I don't have an answer for you on that. [LR181]

SENATOR RIEPE: Yeah. Okay. [LR181]

SENATOR KOLTERMAN: But we will continue to research that. [LR181]

SENATOR RIEPE: Do you have a sense of what the new ceiling would be, or is that sort of a relation...it's kind of open-ended, is that what your vision for this is? [LR181]

SENATOR KOLTERMAN: Well, there's some...yeah, it's open-ended and yet we have the programs in place, and so we need to make those workable for those that want to work through the system. That's really the goal here. Now for those that don't, we need to get them, we need to motivate them someway. I don't know how we do that. But obviously we have three people here today that have testified that they want to work, they like to work, and they want to promote themselves, whether they're disabled or whether they're just hardworking people. You know, I've

been there. When I was young, I had three different jobs when I first got married and I worked my way out. I've been blessed. I've been successful. But since I've been here, I've learned a lot about people that don't have the same opportunities that I had. I think they would, given the proper education and proper support. So I hope that answers your question. [LR181]

SENATOR RIEPE: Yes. Yes, it does. Thank you. [LR181]

SENATOR CAMPBELL: Two things: Senator Kolterman and I serve on the Intergenerational Poverty Task Force, and we're going to get copies for you of the first meeting we had. It was all on the profile of poverty in Nebraska and it is statistics. And quite honestly, Senator Riepe, the figures that you're asking for are in that report. [LR181]

SENATOR RIEPE: Are they? Okay. [LR181]

SENATOR CAMPBELL: One of the things I think was most startling to us on the committee was the number of people not 0 to 100 percent of the poverty level, but the people 100 to 200 percent. What the report talked about is those who are near poverty. And part of what we are seeing here I think is that you've got people that are just above that line, but that doesn't mean that they are doing okay. So we will get you a copy. In fact, we're going to have copies brought down Monday. We have the second meeting of this. And what is interesting is...Senator Kolterman, save all those questions because Monday is all on public assistance. [LR181]

SENATOR KOLTERMAN: Right. [LR181]

SENATOR CAMPBELL: So we'll be talking about ADC, SNAP, ACCESSNebraska, you know, all of that. The department will start off. We're also bringing someone from NCSL to talk about what's happening in other states and how they're looking at this issue of poverty. And then we're having the counties come because they do provide assistance when someone doesn't qualify for categorical. So you'll have a chance, Senator Kolterman, to ask them all the questions. And I think it will be interesting to follow up on the asset limitation question. [LR181]

SENATOR KOLTERMAN: Right. [LR181]

SENATOR CAMPBELL: But Mr. Weinberg will be there with some other staff from the department, so it should be an interesting day for us. [LR181]

SENATOR KOLTERMAN: Thank you. [LR181]

SENATOR CAMPBELL: You're right, spot on target... [LR181]

SENATOR KOLTERMAN: Thank you, Senator Campbell. [LR181]

SENATOR CAMPBELL: ...with your LR. All right, we will proceed--thank you, Senator Kolterman--with our next... [LR181]

SENATOR KOLTERMAN: Thank you. [LR181]

JOSELYN LUEDTKE: Oh, items for the record. [LR181]

SENATOR CAMPBELL: Oh, sorry, items for the record--I had it written down three places. [LR181]

BRENNEN MILLER: (Exhibits 5-15) Thank you, Senator. I have letters from the following: Ridgewood Rehabilitation and Care Center; Holland Children's Movement; York General Health Care Services: Tiffany Square Care Center; Heritage of Red Cloud; Ambassador Health; Sumner Place Skilled Nursing and Rehabilitation; Jessica Layton; Nebraska Hospital Association; Golden Living Center of Clarkson; Cherry Hill Estates. Thank you. [LR181]

SENATOR CAMPBELL: Okay. Senators, let's take a five-minute break and then we'll come back for Senator Crawford's LR. [LR181]

BREAK

SENATOR CAMPBELL: All right, we will resume the hearings for today, and our next hearing is LR185, Senator Crawford's interim study to examine issues faced by Nebraska's licensed

mental health practitioners, doctorate-level graduate students, nurses, and psychiatrists--long list. Senator Crawford, start us off here. [LR185]

SENATOR CRAWFORD: (Exhibit 1) Good morning, Chairwoman Campbell and fellow members of the Health and Human Services Committee. My name is Sue Crawford, C-r-a-w-f-o-r-d, and I represent the 45th Legislative District of Bellevue, Offutt, and eastern Sarpy County. I am happy to be here today to open on LR185, an interim study examining challenges currently facing Nebraska's behavioral health work force. Throughout the interim we met with providers and students from a variety of disciplines, as well as Magellan, to try to learn the scope of the issues facing this behavioral health work force. We received numerous e-mails from providers who found out we were having this interim study and wanted to share their experiences with us. I was often stopped after a meeting or event by someone telling me how important this issue was and talked about some of the challenges they faced in terms of credentialing or reimbursement and other issues. In fact, even last night at the veterans' dinner in La Vista I was stopped after that dinner by one of our counselors who works with military families, talking about the challenges that they faced with work force and with peer support issues. We asked a few providers and students from several disciplines to share their challenges with you today. We appreciate the work of the Nebraska Association of Marriage and Family Therapists (sic--Therapy), Nebraska Counseling Association, and the Nebraska chapter of the National Association of Social Workers, who collected input from their members. Dr. Cody Hollist is here to present the findings from the marriage and family therapists today. I believe representatives from the other disciplines either plan to testify or submitted letters for the record. We also asked former senator and friend of this committee, Annette Dubas, to provide some historical perspective on the provisional licensure issue for licensed mental health practitioners, or LMHPs, as well as to provide any feedback or recommendations she has as executive director of the Nebraska Association of Behavioral Health Organizations. I would like to thank Amy Holmes and others at BHECN who worked over the interim to conduct interviews and compile a report of their findings. Kaitlin is now distributing a copy of this report for your review and records. We will not have a testifier reporting on these findings, so I will briefly highlight a couple of points from the report in my opening. The report summarizes key points from their discussions with many providers and students and also provides letters from behavioral health professionals across the state describing in more detail what these challenges look like in their

own experiences. These discussions focus on key questions for recruiting and maintaining a strong behavioral health work force, as well as ensuring access to quality care for Nebraskans, such as access to education, licensure, certification for Medicaid reimbursement, and reimbursement rules. On a positive note, you will find many positive comments from students about their educational experiences and their desire to practice in Nebraska. You will also see how some of BHECN programs have helped foster more opportunities for in-state experiences for our students. Overall key challenges from both rural and urban providers include issues such as lack of telehealth services, distances people have to travel to see a provider, and length of wait times to see a provider and how those affected them. The shortage of staff was felt to be a strong issue in all locations. The most common answers to the open-ended question, what are the most challenging obstacles in your early career, are: not enough jobs available in Nebraska, especially in rural areas; restrictions on what the provisionally licensed are able to do; some insurance companies won't accept their services; they can't use telehealth services and they can't do initial diagnosis for Medicaid; there are also limits on what provisionals can do in urban settings, which you will hear about from Annette Dubas shortly; lack of funding available to pay for training opportunities; long amounts of time spent on clients' paperwork, such as payment for services or treatment progress update. From a list of commonly cited barriers, concerns to mental health counseling, a few other concerns raised include: the lack of insurance coverage for mental and behavioral health services or higher premiums or copayments compared to physical illnesses; lack of scholarships or grants for training; lack of trained staff members, providers, or clinicians and lack of financial incentives for professionals to work in rural areas; complicated and cumbersome funding arrangements; managed care organizations that place restrictions on providers; difficulties faced by rural providers when competing for funding; and the lack of telehealth services. I encourage you to take time to read the letters and the report and again I thank BHECN for their work in compiling this research. At this point, I would invite you to hear from those who have come to discuss their challenges and their ideas for improving our behavioral health work force, and I thank you for your attention today. [LR185]

SENATOR CAMPBELL: Questions from the senators? Senator Crawford, just a couple of points. Senator Sullivan and I had LR304, I think, and we brought together a group of people from education,... [LR185]

SENATOR CRAWFORD: Okay. [LR185]

SENATOR CAMPBELL: ...a lot of that, to talk about it. And one of the interesting things was Dr. Joe Evans was a part of that group from BHECN. And we talked about whether there needed to be some change in the statutes. Have you pulled together the statutes on credentials and licensing of mental health practitioners across the board? I've got that on the list, Joselyn. But if you've already done it, we won't do that or have Legislative Research... [LR185]

SENATOR CRAWFORD: Right. [LR185]

SENATOR CAMPBELL: Okay. [LR185]

SENATOR CRAWFORD: I don't think that we've pulled them together. [LR185]

SENATOR CAMPBELL: We'll have Legislative Research... [LR185]

SENATOR CRAWFORD: Okay. Excellent. [LR185]

SENATOR CAMPBELL: ...because what I'd like to do is have you also sit on...sit in because the other issue that is bubbling up, I attended the special committee on corrections and several senators are looking at specialized courts: mental health court and veterans. Senator McCollister was in the World-Herald the other day. And so I talked...or I sent a message to both of them that maybe we all sort of sit together and talk about this because, if we're going to do the specialized courts, we are going to need to move our students... [LR185]

SENATOR CRAWFORD: Correct. [LR185]

SENATOR CAMPBELL: ...into being able to serve, rather than these long periods of time, because we're losing students, according to Dr. Evans, to other states. [LR185]

SENATOR CRAWFORD: Yes, that's what we heard as well,... [LR185]

SENATOR CAMPBELL: Yeah. [LR185]

SENATOR CRAWFORD: ...in terms of opportunities early in their career. [LR185]

SENATOR CAMPBELL: Well, and the credentialing just takes such a long time, so. [LR185]

SENATOR CRAWFORD: Um-hum, right. Right. So that's a great idea. This impacts corrections and education and health, impacts in many different areas,... [LR185]

SENATOR CAMPBELL: Oh, absolutely. Yeah. [LR185]

SENATOR CRAWFORD: ...so appreciate that. [LR185]

SENATOR CAMPBELL: Thank you so much. This is great. To start out today...thank you, Senator Crawford. To start out today will be Annette Dubas, Senator Dubas, friend of all things HHS (laugh). Welcome, always good to have you. [LR185]

ANNETTE DUBAS: (Exhibit 2) It's always good to see all of you as well. It's a pleasure to be here. Good morning, Senators. My name is Annette Dubas, A-n-n-e-t-t-e D-u-b-a-s, and I am the executive director for the Nebraska Association of Behavioral Health Organizations, also known as NABHO. We really would like to thank Senator Crawford for introducing this study and inviting NABHO to share our thoughts and concerns regarding behavioral health work force. This really is a very serious issue and one that my members speak to on a very regular basis. We're not only facing a shortage right now in the current setting. The problem is going to continue to get worse and worse as we look at over half of the behavioral health work force right now is over the age of 52. And burnout certainly plays a key role in maintaining that work force as well. We frequently hear the statistic that 88 of our 93 counties are federally designated behavioral health shortage areas, but please do not think that those remaining five counties are well supplied. My urban members will quickly tell you how difficult it is to attract, retain, and fill positions in their organizations. Immediate and more obvious ideas to help build our behavioral health professional field involve internships and loan forgivenesses. Those certainly do work, but we know that that help only goes so far. Another area that needs thorough

examination, as was mentioned by Senator Crawford and Senator Campbell, is in the area of licensure and credentialing, as well as the use of provisional mental health professionals. I do understand that there's a credential regulation that has been lying on the desk of the Chief Medical Officer for a very, very long time--I would say years--that is waiting for a signature that would really be beneficial in helping us with the topic that we're talking about this morning. So looking at credentialing and licensure would go a long way in helping address some of the issues we're dealing with this morning. In fact, NABHO is going to be convening a small committee of our members trying to compile what are...what seem to be those overarching problems in credentialing and licensure that we can begin to work on some solutions for and be proactive as well. During my time in the Legislature, the decision by DHHS and Magellan to deny Medicaid payments for services provided by provisionally licensed mental health professionals came to my attention. They cited a review of the number of licensed providers across the state, as well as their concerns for quality of care provided by provisional licenses, as the reasons to justify their decision to deny these payments. So after many meetings with DHHS leadership, an amendment that I introduced on the floor of the Legislature that I in the end withdrew, we were able to get some changes made in policy that allowed provisional licenses to be reimbursed for their services. Unfortunately, at the time it was limited to counties with a population base of less than 60,000 people. Those who practiced in the more urban population centers were not allowed to be reimbursed. The department continued to state that there was not a shortage of practitioners in these particular counties, but please keep in mind that the number of licenses does not always equate to the number of providers who are actually providing services and seeing clients, especially Medicaid clients. So it is well past time for us to reexamine this exclusion. Historically, reimbursement rates for Medicaid patients are lower than that of other payer sources and we know that these low rates, the amount of paperwork that is involved, and other cumbersome administrative regulations, more and more providers are limiting the number of Medicaid patients that they will serve. Medicaid reimbursement rates alone will not cover the cost of hiring a fully licensed professional. In talking about this issue with some of my members, one of them made this observation: Using provisionally licensed professionals has the benefit of providers being able to function within a climate of lower rates, but also ensures that individuals who are provisionally licensed are able to get into agencies that can offer quality experiences and supervision. The amount of time that an employer has to invest in supervising provisional employees makes it time and cost prohibitive if we cannot be compensated for their services.

And I don't see why it should be any different in Lincoln and Omaha than it is anywhere else in the state. We also know that our students are leaving college with a large student loan debt and making it difficult for them to find employment. And I see that my time is running out, so I'll jump around here quickly. I guess one of the things that I really want to make sure I leave you with is that these provisional licenses and others in this role are really filling the pipeline not only for now but for the future. They can pick up that slack. They can be those providers who will take the Medicaid clients. They are closely supervised. We're talking 3,000 hours of supervised experience of which 1,500 are direct client services. They need work. They want work. They want to be in the field. And, you know, I just want to make sure you know that that supervision does not compromise quality of care. These people have graduated. They've fulfilled all of their educational requirements and training. You could kind of equate it to a residency for a physical health doctor. You know, they've fulfilled all of their educational requirements. Now they're just going through that extra training and supervision. The people that they would see in Medicaid, they've already qualified for Medicaid, so it wouldn't be an additional financial burden for the state. It would just be that we would pay these providers to provide these services. And I guess it appears to me that it was a rather arbitrary decision at the time. How can we as a state or a managed care organization deny paying a claim for services provided by a professional who has met all of our rules and regs and requirements for operating within our state? So with that, I'd be happy to answer any questions you may have. [LR185]

SENATOR CAMPBELL: Questions, Senators? Senator Howard, do you have a question? [LR185]

SENATOR HOWARD: In regards to provisional licensing, can you think of other healthcare professions, not mental health providers, where they have a provision license, like a resident? Are residents able to bill? [LR185]

ANNETTE DUBAS: To my knowledge, they are, yes. [LR185]

SENATOR HOWARD: Yeah. So in this instance, it was just a decision by the managed care organization to not recognize provisional licensees? [LR185]

ANNETTE DUBAS: Correct. And, I mean, these same provisional licenses would be reimbursed if they were private pay, or I think quite a few insurance companies would also reimburse well. So it was just if you were seeing Medicaid clients you are not going to be reimbursed. [LR185]

SENATOR HOWARD: Thank you. [LR185]

SENATOR CAMPBELL: Other questions? Senator Crawford. [LR185]

SENATOR CRAWFORD: Thank you, Senator Campbell. And thank you, Senator Dubas, for being here and sharing your experience. Do you recall when the rule changed and the provisionals were able to be reimbursed in rural communities, the impact of that in terms of being able to serve more patients in those communities? [LR185]

ANNETTE DUBAS: I don't have any specifics other than the fact that I didn't hear from people anymore. [LR185]

SENATOR CRAWFORD: Right. [LR185]

ANNETTE DUBAS: You know, the outcry certainly was large and loud when that decision was made from providers as well as consumers, and once that regulation was changed it settled down considerably. And I do know, of my members, that they do use those provisional licenses. [LR185]

SENATOR CRAWFORD: Excellent. Thank you. [LR185]

SENATOR CAMPBELL: Senator Dubas, do you know in other states what the practice is on provisional licenses and how long, because part of the question is really the length of it also, isn't it? [LR185]

ANNETTE DUBAS: The length and, yeah, the amount of hours and...because for those who are required to do the supervision, that can become burdensome as well. I know one of my members talked about having I think six provisionals on and, you know, if you're talking about the hours

of not only direct supervision but then the paperwork and everything that goes along with this. So they certainly want to have provisionals. They certainly understand the need for that supervision. But we probably need to maybe...and I'm sorry, I don't know what other states are like as far as that. That is something we will be looking into. But that certainly is an element that needs some consideration as well. [LR185]

SENATOR CAMPBELL: I would guess Legislative Research could find out for us on that issue so that Senator Crawford has the information, as well as the other senators who are going to be looking at the specialized courts. Have you had a chance to look at specialized courts for mental health? Is that something the association has looked at? [LR185]

ANNETTE DUBAS: We haven't looked at it in depth. It certainly is something we are very interested in and see merit with. I mean we certainly know the success that the drug courts have had. [LR185]

SENATOR CAMPBELL: Yeah. [LR185]

ANNETTE DUBAS: And so stepping it up for mental health courts, veterans, we certainly see the merit in that and would like to be involved with that as well. [LR185]

SENATOR CAMPBELL: Senator Williams seems particularly interested in that and has mentioned it several times in the corrections hearings, so we'll try to bring you into that conversation when we get the senators together. [LR185]

ANNETTE DUBAS: And going back to the point you just made about what other states do in the supervision requirement, a frustration that many of the agencies have as well is they invest their time and resources into this person with a provisional license, get them fully licensed, and then they tend to move on to places that will pay them a little bit more, which you can't blame the provider, but it is frustrating for those agencies who really do invest considerable resources into that person. [LR185]

SENATOR CAMPBELL: Yeah. Any other questions? Thank you, Senator Dubas, as always. [LR185]

ANNETTE DUBAS: Thank you so much. [LR185]

SENATOR CAMPBELL: Kristen Carson. Good morning. [LR185]

KRISTEN CARSON: Good morning. My name is Kristen Carson, K-r-i-s-t-e-n C-a-r-s-o-n. I'm a psychology postdoctoral fellow at the Munroe-Meyer Institute, which is associated with the University of Nebraska Medical Center. And today I would like to talk to you about some of the personal barriers that both myself and my colleagues have faced when obtaining licensure in the state of Nebraska. So in my personal experience, the process has been quite long and arduous. I submitted my application for the PLMHP last year and the Department of Health and Human Services states that it typically takes approximately three weeks for your PLMHP process to be completed. However, it took mine approximately closer to three months, and that was after quite a lot of follow-through on my end of calling and checking in on the status of my application. It's not very clear what the process is once your application is submitted to the licensure department. It's clear that your application exchanges many hands and that there's different people that are responsible for reviewing different parts of the application. However, this process doesn't seem to be systematic. I had to call several times to check in on the status of my application and people were often not able to tell me where my application was. They weren't able to verify for me whether or not all of my materials had been received or if any additional information was needed. And then things happened where my colleagues have experienced where they were not notified that materials were missing and that additional information was needed and it was just sort of sitting somewhere on a desk. Additionally, I was told that only one person is able to actually provide the licensure, so only one person can provide that sort of stamp of approval. And there have been times where I called or my colleagues called and this person was either out of the office or on vacation. It just doesn't appear that anybody subsumes the process of processing these applications when someone is out of the office. And delays in these licensures really impact training and impact our ability to see clients. The longer it takes for us to be able to receive licensure, the longer it takes for us to be able to service the behavioral health needs that are in our communities, especially because this is compounded by larger systemic issues of once

we obtain licensure, then we have to be paneled with each individual insurance company, which is also a time-consuming process. So this can take months and months and months and months and you could be close to the end of your training experience until you actually, finally receive licensure. A second barrier that we have experienced has been that the requirements for licensure have at times been either too subjective or too rigid with regards to the requirements. With regards to subjectivity, a personal experience was that myself and a colleague both attended the exact same graduate institution, the exact same graduate program, actually completed the exact same course curriculum and upon receiving my PLMHP they told me that I had no deficits but my colleague, who had submitted the exact same course syllabi, was told that she did not meet requirements for the ethics requirement. And so it appears that while the process is exchanging many hands and there are outlines for what...how many course hours you need for different areas, that the criteria is not objectively defined and that it's very subjective across reviewers. Additionally, and more importantly, one of the rigidity issues has been that individuals at my level of training, which is the predoctoral level of training last year, are not able to...some individuals have not been able to actually receive licensure due to the fact that they do not have a terminal master's degree. In graduate psychology training, some Ph.D. programs do not offer a term...a master's degree given along the way. They just offer a terminal doctorate degree. And so a master's degree is typically 60 hours of training and some supervised experience. At the predoctoral internship training level, we have completed 120 course hours and at least 1,000 supervised clinical hours. And so these individuals were denied licensure because they didn't actually have a master's degree in hand, despite clear evidence that they are competent, qualified, and exceed the requirements of that of a master's degree, as well as the requirements that are listed on the DHHS's requirements for licensure. And these individuals have appealed the board's decision for this with letters from their graduate training directors notifying them of the qualifications, and they've still continued to be denied licensure. And I personally have experienced delays just due to kind of minor things on application materials. Like, for example, I put that I had 3,358.15 hours. My application was returned to me that it was not known what 0.15 hours meant, and this really delayed the process of having to resubmit, reobtain original signatures. And it just seems tedious and superfluous because the requirements are 3,000 hours for clinical experience for your LMHP; and so even if we rounded down to 3,358, I still met or exceeded the requirements. So just to wrap up, I think there's a substantial need for behavioral health services to be met in our communities. And unfortunately, the personal experiences of

myself and my colleagues are just prime examples of situations in which qualified, competent individuals are being denied licensure or the licensure process is being extended unnecessarily. And this just leads to a persistence in the shortage of mental health practitioners that are able to practice in our state and, unfortunately, does deter individuals from staying and continuing to pursue additional postdoctoral training experiences and careers in the state of Nebraska. Out of the 17 colleagues, 14 of the 17 left and pursued postdoctoral fellowships in other states just mainly due to lack of opportunities for postdoctoral training and career opportunities, as well as difficulties related to licensure. Thank you very much. [LR185]

SENATOR CAMPBELL: Excellent. Thanks. Senator Howard. [LR185]

SENATOR HOWARD: Thank you, Senator Campbell. Thank you for your testimony today. I have a constituent who had some similar issues with a teaching certificate, and they would send e-mails to him letting him know that something was missing or something had not been received. How did they communicate with you when there was an issue with your application? [LR185]

KRISTEN CARSON: They did not communicate. It was only until we followed up with our applications that any information was given to us that materials were missing. In the case of my LMHP, I was communicated with, it seems like, at the end of the process. I did receive an e-mail that...with an attached letter that stated that they needed it to be resubmitted. But for the PLMHP process, for many of my colleagues, they...it wasn't until they actually called, approximately three months later, checking in to see where is the application that they were notified of these missing requirements. [LR185]

SENATOR HOWARD: Thank you. [LR185]

SENATOR CAMPBELL: Senator Riepe. [LR185]

SENATOR RIEPE: Thank you, Senator Campbell. It sounds like it is clearly an administrative problem. Is there a...within your peers, is there a model state out there that you obviously go to some conferences and they say, you know, theirs is pretty functional? I'm not a believer in creating things from the ground up if you can. [LR185]

KRISTEN CARSON: Right. [LR185]

SENATOR RIEPE: Is there a model state out there or...? [LR185]

KRISTEN CARSON: Not that I am aware of. [LR185]

SENATOR RIEPE: We're all in trouble, huh? [LR185]

KRISTEN CARSON: (Laugh) But I can certainly ask around to my colleagues and see if there is any information now that they have sort of moved on to different states, if their states have had easier processes, and provide you with that information. [LR185]

SENATOR RIEPE: That would be good because I like to learn from the mistakes of others. [LR185]

KRISTEN CARSON: Yeah. [LR185]

SENATOR RIEPE: Thank you. [LR185]

KRISTEN CARSON: Um-hum. [LR185]

SENATOR CAMPBELL: Senator Crawford. [LR185]

SENATOR CRAWFORD: Thank you, Senator Campbell. And thank you for being here and testifying. The specific examples are just so helpful for us. When we ask, when people raise questions about credentialing and we ask for information from the department, what we usually get is a summary of their time lines of how long it takes I guess for the average person in the average cases, and sometimes those don't look terribly unreasonable. So it's helpful to hear what some of those individual cases look like. And I would really just ask and encourage you and your peers to send us those details so we have that kind of information, as well, when we're talking about what some of those obstacles are and making sure that we can follow up in terms of trying to find out ways to improve that process. It sounds to me like, you know, some good ideas are

making the process more transparent. We've improved in several other areas of letting people see where their application is and the steps, like you can tell where your pizza is, you know, if you order on-line, to help you know what's going on. And also I really appreciate your mentioning the master's-level challenge. I think the doctoral programs have changed and a lot of people don't get that step anymore. So it's important for us to update. Thank you. [LR185]

SENATOR CAMPBELL: Senator Riepe. [LR185]

SENATOR RIEPE: My only comment is, maybe we need to subcontract this out to the Federal Express and they can keep track of where the process is at, going. [LR185]

KRISTEN CARSON: That would be wonderful. [LR185]

SENATOR CAMPBELL: Any other comments? Thank you very much for coming. [LR185]

KRISTEN CARSON: Thank you. [LR185]

SENATOR CAMPBELL: And I would encourage you to talk to your colleagues and send us some stories. [LR185]

KRISTEN CARSON: Absolutely, absolutely. Thank you. [LR185]

SENATOR CAMPBELL: Our next testifier is Cody Hollist. Good morning. [LR185]

CODY HOLLIST: (Exhibits 3 and 4) Good morning. Thank you, Senators and Chairperson Campbell. My name is Dr. Cody Hollist, C-o-d-y H-o-l-l-i-s-t. I'm the director of the marriage and family therapy program at the University of Nebraska-Lincoln, and I represent the Nebraska Association for Marriage and Family Therapy. I'm really grateful for this opportunity to testify to you about some of the possible solutions to the challenges of increasing our behavioral health work force. Developing a strong behavioral health work force in Nebraska, it's a major roadblock at the provisional licensure level. When our graduates acquire their degree and they're ready to work in the workplace, the practice of behavioral health service while working towards full

licensure, their options are very limited. If they want to stay in Nebraska's urban centers, where most of the agencies are and where the training programs are, they cannot submit for Medicaid reimbursement. The rural provisionally licensed professionals are allowed to be reimbursed by Medicaid, but not urban professionally licensed professionals. Most training programs are located in metropolitan areas. Building a strong behavioral health work force necessitates jobs. But because of the restrictions on provisional licensure by Medicaid, these jobs are difficult to find. I would like to present to you a handout that is being given to you as we speak. They're prepared by our discipline marriage and family therapists to show how the effects of...how this affects our graduates. We lose on average 50 percent every year. We lost every doctoral graduate to another state. And I can elaborate on this if you have questions. The solution is to reinstate Medicaid reimbursement for provisionally licensed professionals in urban areas or, in other words, in all of Nebraska. Another solution is to allow loan forgiveness programs to begin at the provisional level, rather than the fully licensed level. Currently the Office of Rural Health and Rural Health Advisory Commission will start forgiving loans only after the provisional becomes fully licensed. It is precisely during the provisional licensure time that the professional needs the incentive to work in rural areas in order to build their professional credibility. If loan forgiveness doesn't start until after full licensure, then the incentive is lost to most clinicians just starting out. An incentive that starts years after they have established their name and practice does little to motivate decisions on where to practice. As you know, 48 out of the 93 counties have no mental health professional providers. Provisionally licensed professionals are safe and effective practitioners and have added benefit of experienced supervisors overseeing their practice. Our discipline requires approved supervisors to complete graduate course on supervision, provide supervision under the direction of another approved supervisor, and several other criteria to ensure quality and effectiveness of their work. We also have data from the credentialing department to demonstrate that there is no difference in the occurrence of disciplined unprofessional conduct between fully licensed and provisionally licensed professionals in the last 22 years, the inception of the mental health practice law. So since it's been around, we haven't had a difference between fully and provisionally licensed. This is evidence that demonstrates safety and efficacy of allowing professionally licensed professionals to practice. There is currently around 950 provisionally licensed mental health practitioners. The mental health practitioners are the largest behavioral mental health work force in Nebraska, and the provisionally licensed professionals will be our future to behavioral and mental health work

force if we remove barriers the currently lead to 50 percent loss of our graduates. Thank you. Any questions? [LR185]

SENATOR CAMPBELL: Thank you, Dr. Hollist. Really good information. So part of it is in statute and part of it is in regulatory. Is that, would you say, the problem? [LR185]

CODY HOLLIST: I think the biggest problem is the reimbursement of provisionally licensed professionals... [LR185]

SENATOR CAMPBELL: Okay. [LR185]

CODY HOLLIST: ...and primarily because those first years when they're provisionally licensed they're establishing their credibility in the community. If we limit them to either providing services with insurance-only clients, they're not getting trained in how to use Medicaid. And then for them to, after fully licensed, transition back to being trained in Medicaid, they're not doing that. And so one of the issues is if we want to provide services to that group of individuals, to be that safety net, we need to be training our provisionally licensed people in how to work with that population, as opposed to training them on a different population and then wanting them to step back into learning Medicaid after they're fully licensed. [LR185]

SENATOR CAMPBELL: Good conversation with Calder Lynch. Senator Riepe. [LR185]

SENATOR RIEPE: Thank you, Senator Campbell. I think the issue here is not limited to the behavioral side because I know in the pediatric or in the medical staff business we always had problems. And I'm assuming the situation is the same for you that you cannot take a provisionally licensed person and then bill for them through a fully licensed. That would be considered fraud and abuse. [LR185]

CODY HOLLIST: Correct. [LR185]

SENATOR RIEPE: And that's the same problem we had with physicians. We wrote off literally thousands of dollars of services just because of the process of...from start to fully going might be up to four or five months, six months, and it's just incredible. [LR185]

CODY HOLLIST: And because of that, it's limited getting any kind of Medicaid. Provisionally licensed individuals treating any kind of Medicaid population is limited to a few agencies where the agency is actually licensed through Medicaid, not the individuals. And those are very few and far between. And they also take a big hit in terms of how much they can reimburse because they have this range of reimbursable clinicians. And so they're really strapped financially to be able to have that, to be able to provide that service. [LR185]

SENATOR CAMPBELL: In your experience...at the hearing or the roundtable discussion for LR304 someone talked about, also, if you're in a metropolitan area, you cannot be a preceptor or a proctor--I'm not sure I'm using the right terms--for a provisional. Do you know if that's the case... [LR185]

CODY HOLLIST: I don't. I don't know if that's the case. [LR185]

SENATOR CAMPBELL: ...because somebody said that that's also a problem because of serving particularly the inner-city schools that might refer and having practitioners who work with that population then not being able to bill and not supervise. So that was one of the issues they brought up for discussion. So we'll take a look at that too. [LR185]

CODY HOLLIST: Yeah, yeah. [LR185]

SENATOR CAMPBELL: I just quickly looked at all the data you gave us. This is really helpful, because other states must be moving the process along quickly that that many students would leave for other opportunities. [LR185]

CODY HOLLIST: They are. Several states--one example, Michigan--will allow your hours that you acquired during your program to count towards your licensure because they're being supervised at the time of. And so there are other states that are doing interesting things that are

speeding up the process of becoming fully licensed. But I would echo the previous speaker that it's cumbersome here and feels very subjective to the students getting out. And then that word gets back to the current students and they would rather go somewhere where they don't have to mess with wondering if their license was going to be approved or not. We lose a lot to Iowa and Kansas. [LR185]

SENATOR CAMPBELL: It's very human nature. We don't like to work through obstacles if we can find a better course, absolutely. Senator Riepe. [LR185]

SENATOR RIEPE: Senator, thank you. I have a quick question. On someone that provides services under a provisional license, are they then able to bill those services once they become licensed? Or are they...is that just money gone? [LR185]

CODY HOLLIST: Money gone. [LR185]

SENATOR RIEPE: Money gone, okay. [LR185]

CODY HOLLIST: Yeah. [LR185]

SENATOR RIEPE: Thank you. [LR185]

CODY HOLLIST: Yeah. They're not able to bill after the fact, after they get fully licensed. They can't... [LR185]

SENATOR RIEPE: They don't get an IOU in there. [LR185]

CODY HOLLIST: No. [LR185]

SENATOR RIEPE: Okay. Okay. [LR185]

SENATOR CAMPBELL: I'd encourage, as any more information comes your way, to feel free to share it with the committee through Senator Crawford. That would be so helpful. [LR185]

CODY HOLLIST: Yes, and please let us know if we can help. [LR185]

SENATOR CAMPBELL: We will. Thank you. [LR185]

CODY HOLLIST: Thank you. [LR185]

SENATOR CAMPBELL: That concludes the testimony that Senator Crawford had wanted in the record. Is there anyone who has different information that we need to hear? Okay. Mr. Werner. [LR185]

TERRY WERNER: Might not be different to you, Senator Campbell. [LR185]

SENATOR CAMPBELL: I'm going to take Mr. Werner's testimony. And then if anybody else...we'd ask them to submit it "writtenly." But I didn't see another hand, so I think you are it. [LR185]

TERRY WERNER: (Exhibit 5) Yeah, thank you. I thought I actually was on the list. But my name is Terry Werner, T-e-r-r-y W-e-r-n-e-r, and I'm here as executive director and lobbyist for the National Association of Social Workers, Nebraska Chapter. We have over 130,000 members nationwide and about 600 in the state of Nebraska. You'll find specially trained social workers in every area of Nebraska. We are mental health therapists, case managers, community organizers. We're in assisted living centers, school social workers, hospital social workers, corrections social workers, and many other specialty areas. I commend Senator Crawford for bringing this important topic of work force shortages to the Legislature. We not only have a shortage in behavioral health, but also in child welfare, schools, and many human services needs throughout the state. Clinical social workers actually provide the majority of mental health services in Nebraska and across the United States. We have specially...special training, unlike other professions. At every level of training social workers are required to receive up to 500 hours of practical training in the field. LB603 was the mental health bill that established BHECN in 2009 with nearly $16 million in General Funds as several bills were amended into the final passage. NASW supported the bill but added in our testimony two important suggestions. First, there must be increased emphasis on the development of licensed mental health practitioners as they

do the majority of the behavioral health work. And secondly, there is a need to establish a master of social work program in western Nebraska, specifically at the University of Nebraska-Kearney campus. As a result of NASW's efforts, UNO has stepped up its MSW program in Kearney. They continue to add enhancements, such as a foundation program for nonbachelor-level social workers who choose to enroll in the program. While they do an excellent job of training MSWs, the program is on weekends and generally for nontraditional students. NASW's position continues to support a full traditional university program at UNK. I've often had students tell me that they do not want to attend schools in Lincoln and Omaha and they prefer to stay in rural Nebraska. Since 2010, the UNO program has graduated 275 master's-level social workers, 32 from the UNK campus. The UNK campus has graduated 78 bachelor-level social workers since 2013. As Susan Feyen-Reay pointed out in her letter, there is also a serious work force shortage in other areas, such as child welfare and direct service. This is an area of concern, especially in light of the emphasis on integrated care or medical homes. There is a huge role for trained bachelor's-level social workers in these models. Too often, due to the lack of trained workers, state and other agencies hire anyone with a college degree to work with our most vulnerable children and families. This leads to burnout and turnover and, most importantly, has a negative effect on our families. There are currently six schools of social work in Nebraska and they're listed in my letter. We desperately need to graduate more social workers at every level to meet the need with well-trained workers. To that end, I have the following thoughts about how we can make steps to move towards meeting the work force needs: paid internships for child welfare workers, as well as master-level clinicians, in exchange for year-for-year commitment to work for DHHS. LB199, introduced by Senator Howard--thank you very much--and passed last year is a move towards spending federal dollars to train child welfare social workers. More needs to be done and there is a need for rural clinician internships. No news to the committee, but more money needs to be allocated to loan forgiveness. The meager amount currently appropriated primarily goes to physicians. The Grace Abbott School of Social Work is currently working on a child welfare certification which should provide a larger, better trained work force. Obviously, we need higher wages. A bachelor's-level social work licensure would enhance the qualifications of the work force, provide for higher wages, and set the standards for working with vulnerable Nebraskans. And finally, I've often met with AHEC personnel and I've suggested or asked if their charge included mental health services and they always say yes. And I've asked them over and over. I say, we have social workers in every county in this state, we'd love to provide you

with some mental health training to high school students. And I've yet to hear from them or at least be asked to do that, so I think requiring them to spend more time on mental health services and the social work profession generally. So thank you very much and I'd be happy to answer any questions. [LR185]

SENATOR CAMPBELL: Any questions for Mr. Werner? Senator Riepe. [LR185]

SENATOR RIEPE: Senator Campbell, thank you. My question is this: Is it in your vision for a master's program at the University of Nebraska at Kearney? Do you see that as an extension of the fundamental Omaha programs that (inaudible) economies of scale with administration and also maybe some accreditation extension? [LR185]

TERRY WERNER: Well, I don't know about the accreditation. I believe back in 2009 I provided this report to the committee and made the argument. I think it was about $500,000 to start the program because you'd...there's a Ph.D. requirement. UNO has done an amazing job of training social workers in Kearney and I commend them for that. And Dr. Randall provided me with some additional information on some Title IV-E projects that they're doing. I'm not sure if it could be in an extension or not. You know, there are a lot of students in western Nebraska who are getting on-line degrees from Florida State University, University of North Dakota. I even know of one who drove to University of Denver from North Platte to get an MSW. I think we need to train more social workers at every single level. And, you know, as mentioned earlier, we're an aging profession and there's going to be a critical need. [LR185]

SENATOR RIEPE: Well, one of my concerns is always needless duplication or unnecessary redundancy, and I think it plays out a little bit in the model with the engineering college in Omaha is run by Lincoln, so... [LR185]

TERRY WERNER: Sure, and I understand that and... [LR185]

SENATOR RIEPE: And if one can work, another can work. [LR185]

TERRY WERNER: And I have to tell you that I think Dr. Randall, who is director at Grace Abbott School of Social Work in Omaha, would probably agree with you and...but I think sometimes though, when you do just nontraditional programs, that there is a loss. I mean young 20-year-olds probably don't want to spend their weekends taking classes. And so there's a need for both. I don't know the answer to that. And of course, Kearney isn't exactly western Nebraska either. [LR185]

SENATOR CAMPBELL: Any other questions? Thank you, Mr. Werner. Senator Crawford, do you have some closing remarks? [LR185]

SENATOR CRAWFORD: Just briefly, yes. Thank you. Well, I thank you for your time today and I appreciate the opportunity to have this hearing to get some of the findings on the record and to allow the committee to see some of these findings during the interim. There are many other items that were...that I think will be entered on the record and so...and again, the report from BHECN that provides a lot of additional information. One of the other pieces of information that you'll have in your materials is material from the psychologists. And they provided more information about the credentialing issue that Senator Dubas mentioned, that waiting for a signature that's been delayed for six years. And they also have provided some other information about what the training and credentialing issues look like from the psychologists, which we didn't have time to talk about in our hearing today. So that's very important information and I ask you to provide some time to look at that as well. So again, I thank you for your questions. I think we have really identified some areas where we can dig in and move forward. And I appreciate your interest in looking at those licensure standards overall and looking at some of the ways that we may need to tweak some of those as well. I would just also say there is an overlap between this interim hearing and Senator Kolterman's interim hearing because we often heard many concerns about the direct-line workers, the direct-care workers, and even therapists starting out who are at those lower wages where those safety-net programs are an important part of being able to continue to serve patients and be able to still take care of their family. And so there's an important overlap, as well, in terms of making sure that those who are working with our vulnerable populations and working with people who need behavioral healthcare are also able to take care of their own families. [LR185]

SENATOR CAMPBELL: Okay. Thank you, Senator Crawford. [LR185]

SENATOR CRAWFORD: Thank you. [LR185]

SENATOR CAMPBELL: We'll close the public hearing on LR185 and move to LR... [LR185]

BRENNEN MILLER: Excuse me, Senator. [LR185]

SENATOR CRAWFORD: Oh, items for the record. [LR185]

SENATOR HOWARD: Items for the record. [LR185]

SENATOR CAMPBELL: There are items for the record. [LR185]

BRENNEN MILLER: (Exhibits 6-18) Before you close it, letters from the Nebraska Psychological Association; Behavioral Health Education Center of Nebraska; Tori Foster; Richard Elsbury; Susan Feyen-Reay; Erica Hardesseh; Angela Jordan; DeAndre Bluitt; Region 1; Shanna Rosentrater; Catherine Jones-Hazledine; Julie Clausen; and Pat Waugh. Thank you, Senator. (See also Exhibit 19.) [LR185]

SENATOR CAMPBELL: Thank you. Okay, we'll move to LR231, Senator Howard's interim study to examine the effectiveness of the prescription drug monitoring program currently housed within the Nebraska Health Information Initiative. And Senator Howard has requested that this be invited testimony only. So starting off will be Senator Howard. [LR231]

SENATOR HOWARD: Thank you, Senator Campbell and members of the Health and Human Services Committee. My name is Sara Howard, H-o-w-a-r-d, and I represent District 9 in Omaha. This morning I bring you LR231, an interim study resolution, in regards to Nebraska's prescription drug monitoring program. Earlier this year I introduced LB471 that would tighten up some of the holes in the program that we currently use. That bill is currently in committee, which I plan to address at the beginning of the upcoming legislative session. The reason I found it so important to introduce LR231 and have this discussion over the interim is because there

have been a lot of developments since we adjourned in May and I wanted to make sure that you heard from all of the major stakeholders about the new opportunities and what they mean to their organizations. As you all know, this subject is very important to me and others in our state who have been affected by loss because of prescription drug abuse. I feel that all of those who have come before me in advocating for this issue, including my mother, Senator Gwen Howard, and Senator Steve Lathrop, have really brought us to this point in time. We have been talking about making changes to this system for years. This hearing is a wonderful opportunity to educate and answer questions that the committee has about prescription drug monitoring in our state. We've been fortunate this time around to have support from the Attorney General, whose chief of staff will be speaking today. We'll also be hearing from the Department of Health and Human Services, who have made great strides in securing funding for this program. I think everyone can agree that one of our major issues in the past has been funding, and we've never had enough for what needs to be accomplished. Along with funding, I plan to make the following changes within an appropriate time line, per the request of our stakeholders, to the system that we currently use. First, we'll prohibit any patients receiving prescriptions for controlled substances from opting out of the system. We know this to be one of the biggest challenges when addressing doctor shopping and emergency room visits, one after the other. It's often a red flag when someone chooses to opt out of the system and not have their prescription information shared. Second, we'd like to require all prescriptions of controlled substances to be entered into the system, including those of third-party payers, Medicaid recipients, and those of cash-pay patients. Many patients who are accessing multiple providers, multiple physicians, and pharmacies will pay cash to avoid questions of why they're doing so. And finally, we'd like to allow all providers, prescribers, or dispensers of prescription drugs to access the system at no cost to them. The newly awarded grant funds should easily provide for this for the next three to four years. Fellow committee members, these proposed changes are momentous to the system we have now. That's why it's so important to have all the stakeholders on board. Everyone must work together and agree that this is the best option for our communities. As many of the people in this room know, this has been a long time coming, especially for our state. While the problem has always been around, in recent months there has been a rise in press coverage on the issues of prescription drug abuse in our state, and it shows that there's more of a problem here than most of us realize. On a national scale, prescription drug abuse is under more scrutiny than ever. I believe that the time to act is now. We have the funding. We have the cooperation of the

stakeholders. I believe you'll hear from testifiers behind me that now is the right time. And I thank you for considering this important issue and I'm happy to answer any questions you may have. [LR231]

SENATOR CAMPBELL: Questions from the senators? Senator Howard, thank you for your dedication to this issue. You've stayed with it through thick and thin, that's for sure. [LR231]

SENATOR HOWARD: Thank you. [LR231]

SENATOR CAMPBELL: Okay. We will start with testimony from the Attorney General's Office. Good morning. [LR231]

JOSHUA SHASSERRE: Good morning. [LR231]

SENATOR CAMPBELL: Good morning. [LR231]

JOSHUA SHASSERRE: Good morning, Senator Campbell and members of the Health and Human Services Committee. My name is Joshua Shasserre, J-o-s-h-u-a S-h-a-s-s-e-r-r-e, and I am chief of staff to Attorney General Peterson. I'd first like to simply thank Senator Howard for engaging our office and inviting our testimony today. We've been very privileged to work with her and the other stakeholders that are present today over the interim. I'd also like to thank Senator Campbell for being engaged in this issue since Senator Howard's mother brought it forth four years ago. I will start out just by reiterating what Senator Howard just stated and that we believe also that the time to act is now and that this is a...with the funding that Senator Howard mentioned and I think that will be addressed by Health and Human Services, there is a great opportunity that should be taken advantage of. From anecdotal experience of both practitioners and law enforcement and the aggregate data that's available from a variety of sources, the incidence of prescription drug abuse and overdose is increasing and comparable, if not in some years exceeding, the number of traffic deaths in Nebraska to account for the most fatalities that are accidental. This increased incidence of prescription drug overdose, particularly of Schedule II and Schedule III drugs, like oxycodone and hydrocodone, respectively, is an indicator of an even more widespread problem, prescription drug diversion, which is simply those prescription

drugs getting into the hands of those who are not the holder of the prescription. And that can occur through many criminal instances, through burglary, robbery, internal prescriber theft, identity fraud and, most commonly, doctor shopping fraud. Also, there is a corollary increase then once there's an addiction to a Schedule II, III, or IV controlled substance that then there is an instant rise of use of Schedule I controlled substances, like heroin. And so because of the public health consequences and increased incidence of criminal activity associated therewith, we believe, again, that a highly functional PDMP is necessary, certainly is only one tool in combating prescription drug overdoses, but it is certainly a critical and necessary tool and one that has to be well crafted. I think Senator Howard's intention and possible amendments to LB471 will do that. And we would agree with her and many of the other stakeholders that have been involved in this over the past several months that Nebraska's PDMP has to be universal, accessible to both prescribers and dispensers of controlled substances, including those who are nonresident pharmacists, that the prescribers and dispensers be able to share data across state lines in order to create a system that tracks all prescribed and dispensed controlled substances, and that that be done in as timely a fashion as possible, so as close to real time as possible, particularly within 24 hours. And to that point, we might suggest, as with 38 other states, allowing for a prescriber to--or a dispenser--to allow for a credentialed designee to interface with the PDMP. So again, we certainly see the use of a PDMP primarily for treatment purposes, which would also have a positive impact on necessity for law enforcement. So with that, I'll take any questions. [LR231]

SENATOR CAMPBELL: Questions from the senators? Thank you for your...oh, Senator Crawford. Sorry. [LR231]

SENATOR CRAWFORD: That's okay. Thank you, Senator Campbell. And thank you for your testimony and for your work with Senator Howard. I appreciate that very much. So just in terms of helping us understand what you would see as critical information, you mentioned, in addition to the points that Senator Howard mentioned, adding that we share data across state lines and that it's timely. I mean, is there any other way in which you would see your office or law enforcement needing to use this information that you think is important for us to consider as we move forward? [LR231]

JOSHUA SHASSERRE: Thank you for your question, Senator Crawford. I would...you know, across the country there are a myriad of ways in which states have set up their respective PDMPs in terms of how law enforcement interfaces with that and their degree of ability to access that information. I think there...more recent states, it was one of those surrounding states, do require, you know, probable cause for law enforcement to either issue a search warrant or a subpoena to access that information, and that's certainly something that we feel comfortable with from the Fourth Amendment perspective. And there is, incidentally, a pending Ninth Circuit case that touches on that, although it deals with the DEA's involvement, not a state law enforcement issue. So again, we see it as a treatment tool that, if all those other factors are in place, we'll have...we'll make that query of...from law enforcement much more efficacious. [LR231]

SENATOR CRAWFORD: Thank you. [LR231]

SENATOR CAMPBELL: Okay. Thank you very much for your testimony. [LR231]

JOSHUA SHASSERRE: Thank you, Senator. [LR231]

SENATOR CAMPBELL: Our next testifier is Jenifer Roberts-Johnson. Good morning. [LR231]

JENIFER ROBERTS-JOHNSON: (Exhibit 1) Good morning. Is it still morning? Okay. [LR231]

SENATOR CAMPBELL: It is still morning, yes, it is. [LR231]

JENIFER ROBERTS-JOHNSON: It is still morning. [LR231]

SENATOR CAMPBELL: I'm watching very carefully that it is. [LR231]

JENIFER ROBERTS-JOHNSON: Yeah. (Laugh) Well, good morning, Senator Campbell and members of the Health and Human Services Committee. My name is Jenifer Roberts-Johnson, J-e-n-i-f-e-r R-o-b-e-r-t-s, hyphen, J-o-h-n-s-o-n, and I'm the deputy director of the Division of Public Health for the Department of Health and Human Services. And I would like to thank

Senator Howard for introducing this LR and for providing us the opportunity for continued conversation and planning related to the prescription drug monitoring program in Nebraska. The prescription drug monitoring program was established, as most of you likely know, under LB237 in 2011 and authorized the Nebraska Department of Health and Human Services to collaborate with the Nebraska Health Information Initiative, or NeHII, to establish a PDMP. At that time, there was a provision included that no state funding could be used to implement or operate the PDMP. LB1072 of 2014 changed the law to allow the department to use state funds and accept grants, gifts, or other funds needed to implement and operate PDMP technology. In the spring of 2015, a grant opportunity was announced by CDC for its prescription drug overdose prevention grant that would allow 16 states funding with...those states had to have existing PDMPs and it allowed only for PDMP enhancement. Shortly following that, the Department of Justice released a grant opportunity for states to enhance PDMP as well. DHHS Division of Public Health set up meetings with PDMP stakeholders, and it was determined that the state would apply for the grants and that our program managers then started working with partners to develop those grant applications. In July, DHHS Division of Public Health received notice that the state of Nebraska was one of 16 states that was funded under the CDC prescription drug overdose prevention grant. This grant was for the amount of $771,249 per year for a funding period of four years: September 1, 2015, through August 31, 2019. The overall goal of this grant is to provide states resources and expertise to prevent overdose deaths related to opioids. The Nebraska funding will support the education of providers and patients about the risk of prescription drug overdose, enhancing the PDMP, developing prescribing guidelines, and developing new surveillance systems in an effort to reduce prescription drug overdose deaths in Nebraska. The DHHS Division of Public Health has started work-group meetings related to this grant and is looking forward to continued progress in working with the stakeholder community to address these ends. A month after the CDC prescription drug overdose prevention grant was submitted, DHHS Division of Public Health Submitted a response for the Harold Rogers grant. This grant was a collaborative project with NeHII and the Nebraska Medical Association. In mid-September, we were informed that we were awarded the Harold Rogers Prescription Drug Monitoring Program funding as well. This grant is approximately $250,000 per year for a grant-funding period of two years: from October 1, 2015, to September 30, 2017. The grant was submitted for the implementation and enhancement of the PDMP system with a new and innovative approach to the PDMP system. Largely, the innovative element of Nebraska's approach is that we are

enhancing the system that is currently housed in our state Health Information Exchange. Many states have standalone PDMP systems that are not easily linked to the patient record. With the HIE approach, providers and patients have the benefit of medical records and prescription drug information being housed in a common location: in the HIE. The DHHS Division of Public Health is very excited about the opportunity that we have received to be a part of the funded enhancement of the prescription drug monitoring program, and we are looking forward to the strides that will be made in the next few years with a focus on the public's health in enhancing the system. Thank you. [LR231]

SENATOR CAMPBELL: Thank you for your testimony. Questions? Senator Riepe. [LR231]

SENATOR RIEPE: Senator Campbell, thank you. I have an interest in terms of what the relationship might be with the poison control center. They seem to be...some synergism around those two. [LR231]

JENIFER ROBERTS-JOHNSON: Um-hum, yes. We do actually within our injury prevention area at DHHS have relationship with the poison control center in regard to take-back efforts and things like that that are in the community. They're more related to education and putting out the number, you know, so people can call if they have issues or they think poison control can help, and they're more involved I think largely in the take-back efforts than they are in the prescription drug monitoring side of things. [LR231]

SENATOR RIEPE: I know they don't do the monitoring, but they're very quick to do intervention. [LR231]

JENIFER ROBERTS-JOHNSON: Yes, they are. Yes, they are, and we do work with them through our injury prevention grant. [LR231]

SENATOR RIEPE: Which would be nice on this if we had drug abuse is to have the intervention before counting the statistics at the end of the day after they... [LR231]

JENIFER ROBERTS-JOHNSON: That... [LR231]

SENATOR RIEPE: ...after the...you know, we don't have the opportunity to turn it around. [LR231]

JENIFER ROBERTS-JOHNSON: Right. [LR231]

SENATOR RIEPE: I just...again, looking for avoidance of needless duplication. [LR231]

JENIFER ROBERTS-JOHNSON: I understand that. [LR231]

SENATOR CAMPBELL: Any other questions? Thank you very much for your testimony. [LR231]

JENIFER ROBERTS-JOHNSON: All right, thank you. [LR231]

SENATOR CAMPBELL: Our next testifier is Deb Bass. Good morning. [LR231]

DEBORAH BASS: Good morning. How are you? [LR231]

SENATOR CAMPBELL: Good. [LR231]

DEBORAH BASS: (Exhibits 2 and 3) Good morning, Chairperson Campbell, members of the committee. My name is Deb Bass. For the record, that is spelled D-e-b B-a-s-s. I'm the chief executive officer of the Nebraska Health Information Initiative, better known as NeHII. To start, I'd like to give you just a brief background on NeHII. It is a nationally recognized system that allows healthcare providers to exchange healthcare records in a secure environment. NeHII is not a data warehouse. We do not collect the records. We allow them to be exchanged. The best analogy is probably to roads. NeHII is the highway, better known as the exchange. We are not the trucking companies nor the stores at the end of the highway. NeHII is a nonprofit, public-private collaborative whose participants include healthcare providers, insurers in the state of Nebraska. NeHII's goal is to improve the quality and safety of healthcare through the exchange of medical information, completely free of charge to the consumers. Sixty-two percent of the beds in the state will be connected by year end. More than 5,100 hospitals, medical clinics,

physicians, pharmacists, and various healthcare professionals currently participate in NeHII across Nebraska. NeHII is supported largely with funds from our participants. We have built a system Nebraskans can be proud of. It has been described by physicians and office staff as easily used, even for non-computer wizards. However, NeHII, as a nonprofit, public-private collaborative, must carefully balance the needs of its stakeholders with limited budgeting for added functionalities. Therefore, the state's support in allowing NeHII to secure grant funding in collaboration with the state to accomplish the enhanced functionality request was critical to provide the necessary resources to complete the added requests for PDMP functionalities. I've distributed copies of a presentation I shared with a group of interested PDMP stakeholders in early October who were assembled by Senator Howard's office and included other state senators, the Attorney General, representatives from the NMA, the Nebraska Pharmacists Association, the NHA, the Board of Pharmacy, Blue Cross/Blue Shield, and others. Because of the limited time for this testimony today, I will simply give a high-level overview of the information and refer you to pertinent slides found in this presentation. It kicks off with just a general overview of statistics from NeHII. And as I walk through this, please refer to this handout. Slide 5 addresses the history of the legislative bills which created the collaboration between DHHS and NeHII to deliver PDMP services in 2011, and then LB1072, which allowed the state and NeHII to pursue federal grant funding for the enhanced support of PDMP in 2013. Slide 7 talks about the effectiveness of PDMPs, which is dependent on four elements: the timeliness, completeness, consistency, and accessibility of prescription data. Slide 8 looks at PDMP in other states and points out the many models of PDMPs and variations from state to state with reporting laws, who can access the information, and how frequently the data is reported. The next slide describes how other states are following the Nebraska model to incorporate their PDMP system into their state HIEs. Six are active, while three others are using grant funding to accomplish this task. Slide 10 lists the strengths of the traditional standalone PDMP, which I refer to as the siloed systems. There's no need to obtain consumer consent, no direct fees to physicians, and they include self-pay data, or prescriptions that are paid for in cash. Slide 11 covers the weaknesses to those siloed systems in that there is a delay of the prescription information because of varied reporting laws of prescription data between the states which can range anywhere from within five minutes in one state to 30 days in others. They also require the physician to log into another separate or siloed system, which leads to lack of adoption and use. There is also no master patient index functionality, which means the physician must select from a "pick" list to identify

the correct patient whose information he or she is trying to access, leading to increased effort by physicians. And finally, the systems collect only controlled substances, which, again, are defined by state laws and vary from state to state. Slide 12 speaks to the strengths of the PDMP solutions available through health information exchange. Those include near real-time and complete prescription data, as well as a comprehensive medical record, the ease and efficiency of access by...to the med data in the HIE, the use of the master patient index to accurately identify the patient the user is seeking. There are weaknesses, too, and they are listed in slide 13, which include the limited self-pay data because the current PDMP captures the majority of its med data from pharmacy benefit manager or PBM systems which do not include medications that are paid for with cash. Drug seekers are probably opting out of sharing their information for obvious reasons. Physicians are charged monthly license fees so that they, too, contribute to the sustainability of the system. And law enforcement officials are not allowed access to the medical information. However, the med history is made available when a subpoena is produced, as currently is the case in Nebraska. Slide 14 is a simple table comparing the two types of PDMP systems, their strengths and weaknesses. Slide 15 outlines the common challenges to both types of systems: again, the lack of complete data; limited physician usage because of a standalone system users must log into; cost of the system; how pricing models can support them; and lastly, the ability of law enforcement to use the data combined with the ability of physicians to refer possible drug seekers to treatment. The presentation then outlines added functionalities the NMA and other interested stakeholders have identified to strengthen the existing PDMP through NeHII: first, the addition of a more comprehensive vendor solution for medication history called DrFirst, which would be available on the landing page of NeHII. With a law such as LB471, which was introduced by Senator Howard last year, mandating consumer participation in this medication history functionality, drug seekers will not be able to opt out of the system and avoid identification of their drug-seeking behaviors. This proposed law would also require the reporting of all medications to the PDMP vendor solution so that medication from the independent pharmacies in the state which do not participate in existing PBMs will be required to report their prescription information. And I see I'm running out of time, so... [LR231]

SENATOR CAMPBELL: Go ahead and finish, Deb. [LR231]

DEBORAH BASS: Okay. All right. Finally, this vendor solution will be available to all prescribers and dispensers at no cost to remove the price barriers to users. Slides 17 and 18 include the various funding grants the state of Nebraska, DHHS, and NeHII partnered in to identify funding streams for the requested added functionalities. This past summer the state was notified it was awarded both the CDC and Harold Rogers grant funds for nearly $5 million over the next five years...four years, as indicated in the table on slide 18. Slide 19 summarizes the presentation that there are many variances in state laws that address PDMP services, and there does not seem to be a common best solution. Nebraska was and is unique with our PDMP solution. But the strengths of our solution are being emulated in other states across the country. It is critical to make all the prescription data available to prescribers and dispensers for the most effective use of PDMP services. The final slide pretty well sums it all up with this information, as it comes from an emergency department physician, Dr. Faylor, who shared the following testimonial: NeHII is a wonderful tool. I use it in the ED at least ten times per day. We had a methadone overdose patient in our emergency department. Using NeHII, we were able to find out this patient had been discharged from another ED in the Omaha area just 30 minutes prior. Ultimately, however, we believe that Nebraskans benefit when their healthcare providers have a good way to share electronic health records across the state. Better data will help with better coordination of care, which leads to safer and better outcomes at lower cost for Nebraska. I'd be happy to answer your questions. Thank you. [LR231]

SENATOR CAMPBELL: Any questions, Senators? Senator Crawford. [LR231]

SENATOR CRAWFORD: Thank you, Senator Campbell. And thank you for your testimony and your work on this issue. Do pharmacists currently have access to this system? [LR231]

DEBORAH BASS: Yes, they do. [LR231]

SENATOR CRAWFORD: Okay. [LR231]

DEBORAH BASS: We have 123 pharmacists the last time I checked the count. [LR231]

SENATOR CRAWFORD: Okay, so those who have been in the system, there are some who have and... [LR231]

DEBORAH BASS: Right. [LR231]

SENATOR CRAWFORD: Right. [LR231]

DEBORAH BASS: But they pay to use the system. [LR231]

SENATOR CRAWFORD: Right. All right, thank you. [LR231]

SENATOR CAMPBELL: And they'll be our last testifier. [LR231]

SENATOR CRAWFORD: Okay, thank you. [LR231]

SENATOR CAMPBELL: Senator Riepe. [LR231]

SENATOR RIEPE: Senator Campbell, thank you. Thank you. My question gets to be as...and it's on page 15 of your presentation. It talks about standalone siloed systems from electronic health records. We've spent billions of dollars on electronic health records with none of them interconnected, if you will. And is this a freestanding system? Or how does this all play together so that we don't end up with spending billions and then aborting those billions to spend more billions on top of that at a future date? [LR231]

DEBORAH BASS: Good question. First of all, when I refer to the siloed PDMP systems, those are standalone registries that the state has established to collect the information. They're not what we call the electronic health record that the hospitals and all the others are implementing. NeHII's role is to connect all of the HIEs...or the EHRs, sorry, the electronic health records. Think of us as the Expedia model for healthcare. When a provider enters the last name and the birth date of a patient, we go out, identify all the matches, and bring those into view at the point of care for the provider. So that's what NeHII does as a health information exchange. [LR231]

SENATOR RIEPE: Okay. Thank you. [LR231]

DEBORAH BASS: Did I answer your question? [LR231]

SENATOR RIEPE: Yeah, it's very helpful. [LR231]

SENATOR CAMPBELL: Any other questions? Thank you very much. [LR231]

DEBORAH BASS: Thank you. [LR231]

SENATOR CAMPBELL: Our next testifier is the Nebraska Medical Association. [LR231]

JASON KRUGER: Good morning. [LR231]

SENATOR CAMPBELL: Good morning. [LR231]

JASON KRUGER: My name is Dr. Jason Kruger, J-a-s-o-n K-r-u-g-e-r. I serve on the board of the Nebraska Medical Association. I'm an emergency physician here in Lincoln at St. Elizabeth Hospital. First of all, thank you so much for all of your persistence and work on this important issue. I really appreciate the work this committee has done and the individual senators that have pushed this forward. Thank you. This is a critical issue. This is something we see and treat in our emergency departments every day. People with problems with addiction need help. Our biggest problem is we struggle to identify exactly who these are. When people come into the emergency department, frequently they're in pain. We want to treat that pain effectively, but we don't want to fuel people's problems with addictions. I think a prescription drug monitoring program is an extremely useful tool for us to help identify these people and get them the appropriate treatment that they need. It is not a solution to everyone's problem, but this is an important tool that emergency physicians will use every day. We really appreciate the work that Deb Bass has done with NeHII, the Nebraska Health Information Exchange. For a while, this was kind of a battle between, for a little while it seemed, between a prescription drug monitoring program or a health information exchange. They're both important and being able to put those together is potentially, you know, very innovative and very useful for us. But we do need to capture all data. We can't

allow people to opt out of this. And we really want to encourage physicians and pharmacists to be able to use this to identify patients. And the past model of a subscription service where a large number of people subscribe but also a large number of providers didn't subscribe to this was not entirely useful in creating an effective system that could appropriately identify these people and get them the help they need. Thank you again for all of your work on this, and I'd be happy to answer any questions. [LR231]

SENATOR CAMPBELL: Any questions? It's been a long road since the first time you came to see us. [LR231]

JASON KRUGER: I'm looking forward to this being completed. Thank you so much. [LR231]

SENATOR CAMPBELL: I'm sure you are. Thank you for your persistence. Our last testifier on the list is Joni Cover. [LR231]

JONI COVER: (Exhibit 4) Good morning. It's still morning, right? [LR231]

SENATOR CAMPBELL: It is, absolutely. [LR231]

JONI COVER: Well, good morning. My name is Joni Cover. It's J-o-n-i C-o-v-e-r. I'm the CEO of the Nebraska Pharmacists Association. And on behalf of the Nebraska Pharmacists Association, I just want to say I'm very supportive of a prescription drug monitoring program in the state of Nebraska, both development and implementation of such a program. And I'm coming to you today on my sheet of paper that you have that shows the goals that we would like to see with the PDMP. Since we have the data, we kind of need to have...we need to get in the weeds just a little bit about how it should work. And we have certainly shared these different goals with NeHII and with all of the folks that are involved in the discussions right now. And I think they're achievable goals. The first thing we want to do is make sure that all the drugs that are dispensed in Nebraska to patients in Nebraska, so it's not just located in Nebraska but anybody that deals with patients in our state, have to be able to report to the PDMP. And really the best reporting comes from the pharmacies, and so we are supportive of the requirement to have pharmacies provide you the data. In the past, I know that NeHII has gotten information from prescription or

pharmacy benefit managers. And they have an enormous amount of data, but they don't have all of the data. We have all of the data. So what we're saying to you is we'll give you all of our data if you have a way to talk to us. And that's one of the other requirements that we have on this list is that we need to be able to communicate with our pharmacy systems. The second piece of paper that you have...I called one of our gurus at Walgreens. Walgreens is located in every state in the United States. And I know that Deb has also spoken with this person. And I said, okay, you connect in 48 states that have prescription drug monitoring programs, what does this look like to you? And so he sent me this document. And if you ask me any really detailed questions about all of that, I'm going to have to defer. But I can certainly get you more information. The point though is that we have the data. And if we can connect it seamlessly to NeHII or to whomever they use to use as the prescription drug monitoring program, this will be an easy thing for us because we are used to sending all of our data electronically. So it should be just as easy as a flip of the switch. Now there will be some of our independents who have some out-of-date software the need to update. But that's not a problem as well. So what I'm saying is the best data is our data. It's the most current. It's the most up to date. It's the most readily available. But I would also encourage, because we do have physicians who dispense, we have the VA that dispenses, we have some ERs that dispense, so if you're going to provide mail-order companies that dispense to patients, you know, consideration of those too. I don't know how easily they can connect. But I'm hopeful that with, you know, the use of NeHII, that may already be...that information may already be there. I think that when we set up the prescription drug monitoring program and we go live, I think the pharmacy should be required to, in at least three months in advance, start reporting to the system, because that way we have a populated system. The last thing we want is our prescribers to go check something when somebody comes into the ER and there's nothing there. That will also give us time to work out the bugs, to make sure that we can actually report. We may need to report, you know, a week at a time or until we get it populated and working and then maybe go live with real time. I'm not sure how that works, but I just think that there needs to be an opportunity for us to work out the bugs and to make sure that there's populated data in the system because we want that to be a great system. We want to have the pharmacists be allowed to access the PDMP. I know that you had asked Deb about what...how many pharmacies are connected to NeHII, and I do know that there are some. I will tell you that they don't normally check the prescription side. What they normally check is the durable medical equipment side for payment of durable medical equipment. But they also do check the

prescription information. So it's just, since we don't have as many, it's not used, readily available. We need to be able to link to other states. That's key especially with our border states. I know I have pharmacies out in western Nebraska that are connected to the Wyoming system and I know they check it all the time. We have folks in Iowa that...or in...in Omaha that check with Council Bluffs, so that across-border program, and the National Association of Boards of Pharmacy has their InterConnect. And I know that Deb is...has reached out to them and we've had some information from them. So I think that's really key. It really has to be easy to use because if it's hard to use it will make people not use it. And then we have to make sure that patients can't opt out, and that was something that Deb had shared with you. So, you know, that's our wish list. And I want to thank you, Senator Howard, for your tireless effort on this, and for the committee for being willing to listen to us year after year come and ask for this system, because I really think that we're at the cusp of something really incredible in our state. You know, maybe we'll be...usually we're last, 48th, but maybe this time we'll get to be first or second. I heard Ohio just has tried to link into their electronic health records system and maybe Deb already knows that. She's probably way ahead of us on all that. But I just want to say thank you and we're happy to work with you however we can. And if you have any questions, I'm happy to answer them. [LR231]

SENATOR CAMPBELL: Questions? You can tell we looked at the second page and went, hmm, not even sure we'd know how to ask you an intelligent question. [LR231]

JONI COVER: Well, I know about enough to be dangerous and so don't ask me the question. But I can get you some super-smart people who can answer all of those questions if we needed. And one of...and I know that Deb has already spoken with the person who gave me that information, so she already knows that I'm not the techie person that he is. I did want to say one other thing though. Talking about education, you know, that's part of the grant. And we're working with the other provider groups to do some interdisciplinary education on addiction and overprescribing and dispensing and things like that, just some education. So we'll be doing some of that as the year progresses so...because we think that's important. And of course we do need a safety net when we have these folks who need help. What do we do with them? So anyway, that's a hearing for another time. [LR231]

SENATOR CAMPBELL: It all ties into Senator Crawford's, I think. [LR231]

JONI COVER: That's right. [LR231]

SENATOR CAMPBELL: Okay, any other questions, Senators, or comments? Thank you very much. [LR231]

JONI COVER: Thank you. [LR231]

SENATOR CAMPBELL: Senator Howard, do you want to close? [LR231]

SENATOR HOWARD: Sure, very briefly. [LR231]

SENATOR CAMPBELL: While Senator Howard is making her way, are there any items for the record? [LR231]

BRENNEN MILLER: There are not, Senator. [LR231]

SENATOR CAMPBELL: The one time I remember (laughter). [LR231]

SENATOR HOWARD: One thing I forgot to mention is that I've had...I've been very fortunate to have the partnership of Senator Lindstrom on these efforts over the interim. He is also a passionate advocate for reducing prescription drug abuse and overdoses in our state. And just to reiterate our plan, so we're all on the same page, we want to remove the opt-out provision for patients who are receiving prescriptions for controlled substances, so they won't be able to opt out of the NeHII system. Their records would have to go into the system. We also are asking for mandatory reporting for all controlled substance prescribing and dispensing. And then we're asking for full access to all prescribers and dispensers at no cost. So those are our three legs of our stool to make sure that we have full access and all the information that we need for providers to be successful in reducing prescription drug abuse and prescription drug overdoses. I would be happy to try to answer any questions you may have. [LR231]

SENATOR CAMPBELL: Senator Crawford. [LR231]

SENATOR CRAWFORD: Thank you, Senator Campbell. Do we have any cost estimates to know how much the...how close the grant comes to covering this? [LR231]

SENATOR HOWARD: You know, that is a good question for Deb, and I'm certain she'll be able to follow up with you. [LR231]

SENATOR CRAWFORD: Okay, excellent. [LR231]

SENATOR CAMPBELL: Right now our estimates with the grant funds, we believe we would have three to four years of free access for providers. After that, we would have to have a conversation about how to fund it from there. A lot of states add sort of small additions to their provider licensure fees, so a dollar or two, and that funds their prescription drug monitoring program. So that's something to consider in a few years. [LR231]

SENATOR CRAWFORD: Okay, excellent. Thank you. [LR231]

SENATOR HOWARD: Thank you. [LR231]

SENATOR CRAWFORD: Or perhaps it has to start building. [LR231]

SENATOR HOWARD: Right, build up a bank of money for it, yes. Thank you. [LR231]

SENATOR CRAWFORD: Okay. Thank you. [LR231]

SENATOR CAMPBELL: We're greatly helped by the grants that the department was able to get. [LR231]

SENATOR HOWARD: We are very fortunate. [LR231]

SENATOR CAMPBELL: I mean that was just key because a lot of the early years are just...you know, part of this idea came when we were cutting the budget drastically under LR542, so for your mom... [LR231]

SENATOR HOWARD: Um-hum, from Senator Heidemann. Yeah, Senator Heidemann told my mother, yeah, you can't put any...you can't have any state funds for this program. [LR231]

SENATOR CAMPBELL: Yeah, no money. We were told we had to bring ideas that cut money, not added money. So anyway,... [LR231]

SENATOR HOWARD: Right, right. Well, thank you so much for your time today. [LR231]

SENATOR CAMPBELL: Anything else, Senators? Thank you, Senator Howard. [LR231]

SENATOR HOWARD: Thank you. [LR231]

SENATOR CAMPBELL: Thank you, everyone. That concludes our record. And note, Mr. Miller, it is 11:55 (laughter). [LR231]