Appropriations Committee October 19, 2018 Room 1003

STINNER: [00:00:00] OK. It should be noted, I did try to start this meeting on time. We now have our technical deficiencies taken care of, so I want to welcome everybody to the Appropriations hearing. My name is John Stinner. I'm from Gering. And we will start today by intro-- self-introductions. Senator Clements.

CLEMENTS: [00:00:18] I'm Rob Clements from Elmwood, Nebraska. Represent District 2, Cass and Sarpy County.

HILKEMANN: [00:00:25] I'm Senator Robert Hilkemann from west Omaha. I represent District 4.

STINNER: [00:00:30] Yeah, John Stinner, District 48, all of Scotts Bluff County.

BOLZ: [00:00:34] Senator Kate Bolz. I represent District 29 in south-central Lincoln.

WISHART: [00:00:38] Senator Anna Wishart. I represent District 27 in west Lincoln.

VARGAS: [00:00:41] Senator Tony Vargas. I represent District 7 in downtown and south Omaha.

STINNER: [00:00:45] To my left, to your right, is testifier sheets. If you're planning to testify today, please fill it out and hand it to the page when you come up to testify. If you have any handouts, please keep those until you come up to testify and then hand them to the page. We will need 12 copies. If you don't have enough copies, raise your hand and the page will make additional copies for you. For today's hearing on LR430, we will begin testimony with the introducer's opening remarks, followed-- opening statement. We will hear from invited testimony, followed by

others who would like to testify. We will wish-- we will finish with a closing statement by the introducer if she so wishes to. On LR442, we will begin testimony with the introducer's opening comments. Because this resolution will have invited testimonies only, following the opening statement we will hear from our invited testifiers. And we have a fairly robust list of invited testifiers. And as I said before, we have meetings after this in the afternoon, so we're going to try to crunch everything in as best we can to get as much information out as we can to the committee members. We will ask that you begin your testimony by giving your first and last name, and please spell those for the records. We will use the five-minute light on Senator Bolz's presentation on testifiers that come up that weren't invited testifiers. So if you're an invited testifier, we'll allow you to use as much time as you want other than don't go too long on me. As a matter of committee policy, I'd like to remind everybody that the use of cell phones and other electronic devices are not allowed during public hearings. At this time, I'd ask for all of us to silence our cell phones and-- or make sure they're on vibrate. I would also like to announce that because the committee has another hearing at 2:00 p.m., our hearing will conclude at 1:30. On that, Senator Bolz, LR430.

BOLZ: [00:02:50] Thank you, Senator Stinner. And thanks for wearing your best suit for my hearing this morning. The purpose of this hearing is to both provide some updated information about child welfare financing and discuss fiscal opportunities afforded to us under new federal legislation called Families First. So as you all know, last interim we held a hearing that illustrated that we were underfunding child welfare services, that we were not keeping up with utilization demands, and that we were missing out on opportunities to draw down federal funds. As you also know, we provided over $55 million in additional funds to child welfare through the appropriations process last year. I imagine you're curious about an update on our current status and so Liz Hruska from Legislative Fiscal has graciously offered to provide that update for us. We still have some work to do to fully leverage federal funds, both by capturing Medicaid dollars and by identifying ways to pull down what is known as Title IV-E funds, which is referencing the Title IV-E of the

Social Security Act, which are federal funds that come down for vulnerable children. We need to do that by better illustrating how we serve qualifying children. Sarah Helvey from Nebraska Appleseed will discuss those issues and how we can use opportunities in the new federal law, again, called Families First, to improve our financial standing. There's a summary of financial-- of Families First in the packet handed out to you this morning. We can also bend the cost curve by leveraging opportunities to provide preventative services, which she will discuss further. Director Matt Wallen was invited to participate in this hearing to discuss his perspective but his schedule did not allow him to attend, and he has sent a written update which Austen will kindly distribute for us. The services that are necessary and-- and available will be further discussed by Nick Juliano who will represent CAFCON, which is an association of child welfare service providers. Nick will talk about the capacity that needs to be built to further comply with the new Families First legislation and about how rates affect our ability to keep up with the demand and keep up with costs. So there are a few bottom-line takeaways from this hearing that I'll preview for you. The first is that we need to continue to fund child welfare services according to projected utilization and demand to keep us on track. I think we learned last year that when we don't keep up with utilization, eventually the bills come home and we-- we end up paying them. The number of children served increased by 8.3 percent in 2017 and 9.1 percent from '17 to '18. Number two is that we should implement needed policy change to fully enact Families First and draw down all the federal funds that we possibly can to strengthen our program. Number three is that for number one and two to succeed we need to take a hard look at provider rates and adequately fund those rates as well. As a committee, we should revisit our performance-based budgeting. I've provided a copy of the performance-based budgeting report out that is included in our budget materials. I think you'll notice, just like I noticed, that-- that we could strengthen that report out. It-- it is not as robust as it could be. But if we were able to strengthen our performance-based budgeting and the criteria that we're looking at when we set our budget, we would be-- better be able to connect the dots between what we're appropriating and the outcomes that we're-- we're seeing. You'll note in the fact sheet that is on the top of your packet that

we are not in full compliance with the administration for Children and Families for any of their seven primary indicators. So we've got some outcome work to do. So the last thing I want to do in opening is to draw your attention to the fact sheet entitled "LR430: Child Welfare Funding and the New Families First Legislation." It's on the top of your packet. The sources of information we pulled from are noted in your-- in your fact sheet. The takeaways at a 100,000-foot level are that we have more children in services than the past. And at the same time, we have fewer children in out-of-home services and fewer children being removed for parental drug abuse. Fewer children being removed from their home has some benefits. I think folks would argue that-- that there is trauma associated with removal. Others would argue that there is trauma-- trauma associated with staying in a family home where drug use is occurring. So I-- I think that a lot remains to be seen here, but I want to express some caution and maybe make a couple of notes from an appropriations perspective. A note of caution: I think the focus on voluntary placements and prevention should always be secondary to safety. As such, we should have clear parameters for who qualifies for voluntary services and who doesn't qualify. And when we say qual-- involuntary services, what we mean is court-ordered services, services that have kids involved in the criminal justice system. They might have a GAL or a court-ordered special advocate. They have a judge determining services, versus voluntary services which are decided with a caseworker and a family through a home safety plan. So they-- they are two different tiers of services. And I think we need to be careful that safety plans are strong enough to protect kids and, honestly, that as an Appropriations Committee we are adequately funding a robust menu of services that are available to those voluntary cases so that we can indeed keep them safe while we keep them home. We may also want to take a look at our drug testing policy and clarify some pieces around that. I've report-- I've provided a report that discusses some of the challenges that are related to those noncourt or voluntary cases. You can see that compliance by family members is not as strong as it is in the court-involved cases, which follows some logic but has some challenges innate to it. At the end of the day, if more children are in voluntary services, this will only protect kids if we have adequate, high-quality services in place to

keep the family safe and make them more successful. These services range from mental health therapy to substance use treatment-- treatment to respite care. I think part of our responsibility as an Appropriations Committee is inter-- in-- to ensure that we have appropriate funding to keep kids safe. So I'll let Liz and Sarah and Nick tell you more, but I'd be happy to take any questions at this point.

STINNER: [00:10:01] Do we have any questions? Senator Wishart.

WISHART: [00:10:06] Well, thank you, Senator, for bringing this important LR. Are there any states that are-- that we should look to as models for-- for being able to comply with some of the requirements of the new Families First legislation?

BOLZ: [00:10:19] That would be lovely. Families First just passed in winter of this year, so we're all figuring out what Families First should look like. I think Senator-- or Sarah Helvey might be able to describe some best practices from other states.

WISHART: [00:10:33] OK.

BOLZ: [00:10:35] But, for example, one of my favorite programs in the child welfare system is St. Monica's Project Mother and Child. So you're serving a family with substance use and mental health treatment. It's inpatient treatment, but mothers get to keep their children with them. So it's a great example of a service where they're providing those fa-- that family the service they need, but the kids and the family are together. And, you know, other preventative services range from, you know, making sure that parents have access to medication if they are mentally ill, to drop-in services that makes sure that families are on the right track. So I think some of the child welfare provider experts can tell you a little bit more about what they think the best practice preventative

services are. But there isn't a road map because the legislation is new.

STINNER: [00:11:26] Additional questions? Senator Clements.

CLEMENTS: [00:11:32] Thank you, Mr. Chairman. Thank you, Senator Bolz. You went over a couple of percentages, 8.1 percent increase, 9.2 percent. I didn't quite catch what those percentages were.

BOLZ: [00:11:37] Sure. So from '16-17 the number of kids served in the system increased by 8.3 percent and from '17-18 it increased by 9.1percent. And that's from the-- from the child welfare annual report that's provided to the Legislature. The-- the hard numbers are in-- in your summary there: roughly 11,000 in '17 and roughly 12,700 in '18. And if those numbers differ a little bit from Liz's it's probably because we picked different points in time. The-- both of those reports are provided September 15th of the-- each year.

CLEMENTS: [00:12:23] And are those percentages exceeding historical percentage increases?

BOLZ: [00:12:28] I think they're increasing over time.

CLEMENTS: [00:12:35] All right. Thank you.

BOLZ: [00:12:35] Uh-huh.

STINNER: [00:12:35] Additional questions? I have one and that's-- I know this program of child welfare is highly dependent upon having services, the appropriate amount of services, the type of services. Has anybody studied across the state? I know in western Nebraska we're devoid of a lot of

the services that are needed to make this a successful program.

BOLZ: [00:12:58] Uh-huh.

STINNER: [00:12:58] Has anybody studied across the state what's happening and what's needed?

BOLZ: [00:13:03] Uh-huh. I think that study would be very helpful. Nick Juliano from CAFCON may have better insight than I do about what's available where. But in conversations with the judges, it's one of the reasons that we see higher removals in western Nebraska than we do in eastern Nebraska is because of the lack of a menu of services. And in-- in very simple terms, Families First gives us some opportunities to leverage more federal funds if we're providing more preventative services. And so I'd really like us to-- to think about how we can expand more preventative services in western Nebraska, where we already know our higher need is because we already have a higher percentage of removals.

STINNER: [00:13:48] Thank you. Senator Wishart.

WISHART: [00:13:50] We made a significant deficit appropriation to child welfare this past year. And so I'm wondering, if we're seeing a reduction in the amount of kids that are in involuntary services, where-- where do you see that money going to?

BOLZ: [00:14:17] Well, so we saw fewer children in out-of-home placement. We saw more children in voluntary placement. We still saw, because of the increased children in voluntary placement, we saw an increase, of course, in the expenditures in voluntary. It's a little harder to get your hands around whether or not there are any cost savings related to out-of-home services, partly because we're seeing fewer kids in out-of-home services but partly because we're-- this

administration is choosing from a different menu of options. And we're seeing some things-- and I-- I hate to legislate by anecdote, but I'll share something to illustrate, which is sometimes when the-- when the courts don't have what they want to order from the menu of option-- options, they'll order from what they have. And so I've been made aware of a case in Fremont, for example, where the department wasn't removing. They wanted to keep the child in place so they had 24-hour in-home services being provided. And so whether or not we'll see any cost savings is-- is I think it's premature to know what all the numbers look like because of the complexity of services and the complexity of these families. We have not yet seen a deficit request from the department. I think those are due next week. So that'll tell us a little bit. If that deficit number is lower than it used to be in the past then maybe some of this is working from a fiscal perspective as well as from a policy perspective is what the department would argue. You know, I've had people ask questions like, well, how many voluntary cases end up in the court system anyway, and I don't know the answer to that question under these new policies. So I think there's-- I don't mean to be long-winded. There's a lot to be seen yet under both the changes in the new administration and as it relates to our opportunities in Families First.

WISHART: [00:16:24] And the reason I say this is that being on the LR296 Committee, where we're looking at community mental health, what we're seeing is that when we made a significant transition to more community-based care, the funding did not follow it. And so what we're seeing in a lot of situations is pretty horrific. And so I know this isn't exactly the same but my concern is that when we go towards voluntary that's going to take a lot of resources because you're also supporting parents as well and the family. And so I-- I do think that's something we're going to have to keep an eye on.

STINNER: [00:17:02] And I do want, for the record, to note that for five straight years we've had deficit requests out a child welfare. The $55 million was supported by some information given to us

by HHS as it relates to an increase in utilization, more kids in the system, and increase in services that they were planning to either administer or have administered. So we did have some information on how that money is getting out. And how it's being spent, that's another question. So anyhow,--

BOLZ: [00:17:34] Thank you.

STINNER: [00:17:34] -- additional questions? Seeing none, thank you.

LIZ HRUSKA: [00:17:57] Good morning, Senator Stinner and members of the Appropriations Committee. My name is Liz Hruska, L-i-z H-r-u-s-k-a. Last year Senator Bolz introduced LB-- LR139 to study child welfare financing, and I presented a history of budget adjustments and caseload changes from fiscal year '14 through '18 prior to an amended deficit request that was submitted on November 4th of last year. HHS had requested additional General Funds of $24.6 million for fiscal year '18 and $31 million in General Funds for fiscal year '19, and the Legislature approved that request. Prior to that deficit request, the biennial appropriation for child welfare aid only incre-- only included an increase for the PromiseShip contract and there were also reductions for drug testing and kinship care support. When they submitted their deficit last year, through an analysis these were the reasons driving the large deficit request. Entries-- entries into the child welfare system increased while close-- closed cases remained relatively flat, as Senator Stinner stead-- said. Also the number of services provided per child increased by about 11 percent. Of those services, family support increased by the largest amount. Subsidized adoptions and guardianships were also up. Subsidies generally are the-- equal to a foster care payment but they compound over time because those continue until the child reaches the age of majority. There was also a significant disparity in payments for tribal contracts. So they standardized the rate and those resulted in higher costs. And the savings for kinship care support were less than projected when the budget was reduced. The agency's initial deficit request included $15 million. And when they amended their

request, it was removed. The Governor did recommend the additional $15 million to be appropriated in fiscal year '19 and to use cash funds from the Medicaid intergov-- Intergovernmental Trust Fund. The Appropriations Committee didn't approve the $15 million recommendation. The transfer would have been in this current year, so the decision was made to wait until the amounts were known. And the reason driving the $15 million request was the-- the department was short on carryover funding to pay prior year bills. All agencies are required to code prior period bills in the accounting system, but the N-FOCUS system, which is part of the bill paying system at the department, doesn't have the ability to mark a prior year bill so they just estimate the amount. So it was difficult to determine how much they needed. The Auditor, I did talk with the Auditor, because they mentioned that in their report, and they came up with about $8 million that the department was short from '17 going into '18. I don't know, as Senator Bolz mentioned, whether or not they will have a deficit. Those letters are-- or those requests are due next Wednesday. In the current budget request, child welfare is flat with the exception of a decrease in the Medicaid match rate. There aren't any provider increases in the request, and that's keeping with past practices. The agency leaves rate decisions to the Legislature. And there are also no adjustments for utilization increases. There may be multiple reasons why the agency kept the request flat. I haven't fully analyzed the budget, so I don't know what their reasoning behind that is at this point in time. And they did not address any-- any impact of the Family First changes. There are opportunities, as Senator Bolz has said, for preventive services that we are currently covering with General Funds but that some of the deeper end services the legislation, the federal legislation, puts more restrictions on. So it's unclear at this point, probably because the federal law was just passed in February of this year and it's just really getting rolled out at this point. Senator Bolz had asked also about data, which she has all-- already mentioned. We did see an increase from '16 to '17 and also '17 to '18 in both the number of-- total number of kids served. In '17-- '16 to '17 state-- the number of state wards were up, but we saw a drop from '17 to '18 in the number of state wards by 7.1 percent. Noncourt-involved kids were up by 37 percent. And more children being served in a

less intrusive manner generally is considered a positive. I'll just leave it like that. And there's probably some debate, but that is kind of what is generally considered. And then also following up with what was part of LR139 from last year, they did a comparison of Promise-- PromiseShip payments compared to the balance of the state and that by '17 PromiseShip served 44 percent of the children: 41 percent were state wards and 64 percent were noncourt involved. And they received 35 percent of the state child welfare funding. It's similar in fiscal year '18 where they served 47 percent of all children. Again, 41 percent were state wards, 69 percent were noncourt involved. And their percent of state funding of the child welfare budget was 41 percent. So that the funding of the PromiseShip contract appears to be in line with the number of children that they are serving. You have any questions, I'll be happy to answer.

STINNER: [00:25:45] Senator Hilkemann.

HILKEMANN: [00:25:47] Yeah, Liz, you mentioned in here that the provider rates have remained flat. For how long a period of time have those provider rates remained flat?

LIZ HRUSKA: [00:26:01] The provider rates haven't remained flat. The budget request in the current-- for the upcoming biennium is flat. The provider rates, oh, I'd have to go through and look at the history. We've given some increases. We've held some services flat and we've actually reduced some services. My point in the testimony was that they didn't include a provider rate increase in the request. They just leave that to the Governor to recommend and the Legislature to implement.

HILKEMANN: [00:26:41] So we have the same amount of dollars but--

LIZ HRUSKA: [00:26:44] They're basically silent on provider rates in their request. They're not

saying don't fund it. They're saying that's pur-- that's the purview of the Legislature to decide that.

HILKEMANN: [00:27:04] OK. So are-- so what is happening to the provider rates? Do we know?

LIZ HRUSKA: [00:27:07] Well, I'd have to go back and look at that. I didn't focus on that issue in preparing for this and it's kind of dangerous to rely on just my memory for it. So I can get back with you and we-- yeah, I would have to-- to do some research, because off the top of my head I can't-- I-- I don't think I can.

HILKEMANN: [00:27:35] And how do those-- do we know how those providers rates vary across the state and if they're taking into accommodation sometimes the expense that these providers have in providing these, say in rural areas?

LIZ HRUSKA: [00:27:51] Periodically there's been studies and-- and, well, maybe Nick can address this better. They've kind of looked at the services and the payments. Generally though, when the Legislature gives an across-the-board increase, they just provide an across-the-board increase. So I don't know the last time there's been a full evaluation of services. But usually you'll-- you're just going to see the adjustment, if the Legislature provides 1.5 to 2 percent, they'll just increase everything by that amount.

HILKEMANN: [00:28:32] It's my understanding some private providers of this are experiencing a significant drop off in the requests for their services. Is that-- do you have that information?

LIZ HRUSKA: [00:28:45] That I don't. That I don't have. I know there's-- there's changes like to drug testing. That may be one area. In the kinship support contract, that was cut. Beyond that, I don't-- I don't know of other services that are being reduced. But again, I think the providers are

probably better able to address that than I am since I didn't-- I wasn't asked that question so I didn't--

HILKEMANN: [00:29:23] OK.

LIZ HRUSKA: [00:29:23] -- research it.

HILKEMANN: [00:29:23] Thank you.

STINNER: [00:29:26] Additional questions? I-- I have one, just an observation to make. On the eastern side it cost us $8,037 per child. In 2017 we actually upped that to $9,056. And it looks like the consistency of children has stayed the same or predominantly the same, but in the balance of the state 11,731 and we went down to 11,356. Any observations about those numbers or-- ?

LIZ HRUSKA: [00:30:02] I don't have any. I-- I think that that's sort of a separate study of its own. I'm just kind of giving the broad brush.

STINNER: [00:30:13] Well, there is a considerable disparity between the eastern and the rest of the state. I mean we're talking 2,000 dollar-- 2,500 dollars differential to do the same type of programs, right? Or obviously we don't have some of the programs in out--

LIZ HRUSKA: [00:30:34] Right.

STINNER: [00:30:34] -- most of the state. But any observation on that?

LIZ HRUSKA: [00:30:41] I don't have any. And again, I think that probably would need-- need

further study or, again, maybe the providers that are here could give you a better idea of what they think is happening.

STINNER: [00:30:59] OK. Additional questions? Seeing none, thank you.

SARAH HELVEY: [00:31:18] Good morning.

STINNER: [00:31:19] Good morning.

SARAH HELVEY: [00:31:20] My name is Sarah Helvey, that's spelled S-a-r-a-h, last name H-e-l-v-e-y, and I'm a staff attorney and director of the child welfare program at Nebraska Appleseed. And I'm here today to share with the committee about an opportunity for-- for Nebraska to maximize federal funding for our child welfare system and implement good policy to improve outcomes at the same time as part of the recently passed Fam-- Family First Prevention Services Act. But first I'd like to provide a little bit of historical context for what we know about Nebraska's use of state and federal child welfare funding. Attached to my testimony today, or actually coming around shortly, are two resources: first, the Nebraska Child Welfare Financing Primer released by the Nebraska Children's Commission in 2015 and the Blueprint Report released by the commission last year. While Nebraska has made progress in recent years, including taking advantage of federal-- a federal demonstration program to provide Nebraska with more flexibility in the use of federal foster care funding, the Financing Primer noted, among other things, that Nebraska underutilizes federal funding sources to support child welfare services. Specifically, our ratio of state spending to federal spending is second highest in the nation. At the time of the report, 77 percent of our child welfare spending came from this state General Fund and only 23 percent from federal sources. That compared with an average across all states of 54 percent federal money and 46 percent state. There is also a cost shift from Medicaid to child welfare that the report, the primer, noted. Nebraska's

Medicaid spending for child welfare has declined in recent years, illustrating a shift toward more narrowly defined allowable services and increasing denials. Meanwhile, when you look at other states, they are--- use more Medicaid dollars for a range of rehabilitative as well as case management services for children and families. When Medicaid denies a service the cost is often shifted to the child welfare side where the Division of Children and Family Services, or PromiseShip, must pay for the services out of state-only funds. So better coordination between Medicaid and CFS and more effective use of federal funds will make more efficient use of our resources. And then the Blueprint Report reflects information collected from a broad range of stakeholders, including HHS, and noted some additional improvements needed to the system. I want to highlight just one key recommendation from that report and that-- that was-- has been mentioned with previous testifier-- the previous testifier and the opening that Nebraska must address that gap in behavioral health services across the state. In particular, parental substance abuse is the second biggest reason that children are removed from the home, from their families in Nebraska, and so addressing substance abuse, both before and after birth, is important to keeping children safe. Effective October 1, 2019, Nebraska has a tremendous opportunity to address some of these issues. In February of this year Congress passed and the President signed the Bipartisan Budget Act which included the Family First Prevention Services Act, which was a historical reform to federal funding of foster care. It was actually just stuck in that budget bill. It had been a previously introduced and a lot of advocates had been watching it, but in the end it passes a little bit of surprise in February. And it had-- but it's something that has been in the work-- had been in the works for a number of years. It's been hailed as the most significant [INAUDIBLE] reform in a generation. And it amends Title IV-E-- as Senator Bolz indicated, that's Title IV-E of the Social Security Act, which is the primary federal foster care funding stream-- in a way that advocates have been seeking for decades. So specifically for the first time at the state's option the Family First Act permits states to access Title IV-E funding not only when children are removed from their home and placed in foster care but also to provide prevent-- to access that federal funding for prevention

and Family Preservation Services. And this dovetails nicely with the direction that Nebraska's child welfare system has been heading in recent years. A decade ago, Nebraska had one of the highest rates of children in out-of-home care per capita of any state in the country. Then as Senator Bolz and Ms. Hruska mentioned, we're serving many more children now voluntarily. Today we have about the same number of children in those voluntary cases as we do children in court-involved cases. However, currently there is little to no statutory authorization or guidance regarding those voluntary cases or even department regulations to guide decision making in those cases that involve the safety of thousands of children who previously had the protection and oversight of the juvenile court. And over-- in other words, there's no statutory standards for what types of cases can be handled voluntarily and the level of service utilization in those voluntary cases. The new federal law can help Nebraska address this because it sets clear policy reflecting best practices and gives Nebraska an opportunity, as I mentioned, to draw down federal funding to provide prevention services. Specifically, if federal-- certain federal requirements are met, Nebraska can receive federal matching funds for mental health and substance abuse prevention treatment services and in-home, parent, skill-based services, including individual and family counseling, for up to 12 months for children determined to be at imminent risk of entering foster care-- that's the-- the language we have to look at, "for children who are at imminent risk of entering foster care"-- and their parents or caretakers, as well as pregnant or parenting-- and parenting foster youth. But in order to maximize this opportunity, the state must meet some-- some federal requirements as part of the law, including maintaining a written prevention plan and meeting certain promising or supportive practice guidelines. If we don't take steps to ensure that federal funding requirements are met, we'll miss an opportunity to reduce that ratio of state spending to federal spending from the second highest in the nation. And meeting those federal IV-E requirements is an area in which Nebraska has struggled in the past. So with this new opportunity, we can do better for taxpayers and for children and families in Nebraska. So with that, I just want to thank Senator Bolz and the committee for your commitment to the most effective use of resources within the child welfare system. I'm happy to

ask-- answer any questions that the committee may have.

STINNER: [00:38:01] Thank you. Questions? Senator Vargas.

VARGAS: [00:38:02] Thank you very much for being here. I know you're talking about some increased flexibility we have with the Family First Act. But this point about the ratio of state spending to federal spending and us being the second highest and that there's a better way that we can more effectively use federal funds, just so that we can kind of learn from why [INAUDIBLE], what are some of the reasons that you're seeing we-- we actually got to this sort of unequitable ratio between state and federal spending?

SARAH HELVEY: [00:38:34] I think there's two primary things in child welfare. The first is that Title IV-E. We're just finishing up a five-year IV-E waiver demonstration program which has allowed Nebraska to have also more flexible use of that funding. It's kind of like a block grant where we can use that for different things. But absent that waiver, before we had that waiver, IV-E had a lot-- has a lot of requirements that must be met in order for the state to draw down federal funding. One of them, as I mentioned, is that children have to be removed from the home. And then also the home from which they were removed had to meet certain income guidelines and that's-- has been linked to old ADC standards. So Nebraska has been very low in that. Essentially, you have to be very poor. The home from which you removed had to be very poor in order to get that federal funding. And then I think with IV-E Nebraska just hasn't done always a good job of dotting the I's and crossing the Ts and meeting all those requirements and keeping track of them. So our penetration rate, which is the percentage of eligible, Title IV-E eligible kids that we're getting federal funding for has been low relative to other states. And then the second one, as I mentioned in my testimony, is Medicaid. There are a lot of services that if they're-- that other states are covering under Medicaid they get that Medicaid matching funds. We're paying for some of those services

with state-only child welfare dollars or a hundred percent General Fund.

VARGAS: [00:40:09] So some part of this is sort of internal tracking standards or--

SARAH HELVEY: [00:40:13] Yeah. IV-E is pretty tricky, right. Yeah.

VARGAS: [00:40:17] OK. But other states have figured out how to better manage this process, is what you're telling me?

SARAH HELVEY: [00:40:17] Correct.

VARGAS: [00:40:20] OK. The second question I have is just about the cost shift from Medicaid. You talked about these increasing denials, which I think I've heard of. I'm just trying to get a better sense of have you seen any data on what, where, why are these denials happening? If part of this cost shift is happening because we're-- we're underutilizing Medicaid or because we are trying to and then we are making internal decisions to then say this doesn't qualify, you know, where is that coming from beyond just there's a denial happening from our state?

SARAH HELVEY: [00:40:57] Uh-huh. Yeah, I can't, I can't speak to the-- kind of the policy behind it. But in the primer you can-- see there's a graph--

VARGAS: [00:41:05] OK.

SARAH HELVEY: [00:41:05] -- where it shows that decline.

VARGAS: [00:41:06] OK.

SARAH HELVEY: [00:41:07] You know there is-- what I can say is that there are some, in terms of the denial of certain services in individual cases, that's something that-- that you hear and we see. We get people calling our intake lines with those issues. We often take a look at that if we think the child may be have federal-- federally eligible for that service. But it's really hard. If there's a court-involved case then often the judge may just order that service if they're getting a recommendation from the child's treating provider that it's needed. So that's what I think happens. That's the cost shift I'm referring to for court-involved children. But we-- so we know that happens in individual cases, but, in a broader sense, there are also types of services that other states cover under Medicaid that Nebraska doesn't. One is treatment in foster care. I know the state is working on moving toward that. That is kind of a gap in helping high-level kids that are in a more institutional placement get us some more wraparound, stepdown. That's a service that other states cover and we are working toward in Nebraska. And as I mentioned in my testimony, some states cover a certain type of targeted case management under Medicaid. So there are certain kind of buckets of Medicaid that we don't do and then denials, I would say, in individual cases.

VARGAS: [00:42:18] And this may be a follow-up of the last question, the series of questions. Do you have any information on how we compare on some of those, a range of services that might be covered through Medicaid, considering it's, you know, contributing to some of this sort of unequalized ratio of spending?

SARAH HELVEY: [00:42:35] I don't. I would love to see that.

VARGAS: [00:42:37] Yeah, I would too. I just love comparing ourselves to other states so we can improve.

SARAH HELVEY: [00:42:39] Yeah.

VARGAS: [00:42:39] Thank you very much.

SARAH HELVEY: [00:42:46] Uh-huh. Thank you.

STINNER: [00:42:47] Senator Clements.

CLEMENTS: [00:42:47] Thank you. Thank you for your testimony. A question about your sentence says parental substance use is the second biggest reason children are removed. What was the first biggest reason?

SARAH HELVEY: [00:42:57] Well, that's interesting. I'm so glad you asked. The first is neglect, and so-- but we know that some-- I think the data on that is not perfect. We know some of those neglect also involve parental substance abuse, right? So it's kind of what-- what does the caseworker identify as the reason. And so some of that neglect we know also involves parental substance abuse.

CLEMENTS: [00:43:20] And if there's substance abuse, is the chill-- child always removed or are there cases where they're allowed to stay in the home?

SARAH HELVEY: [00:43:27] There are cases where they are allowed to stay in the home, and that's what Senator Bolz was mentioning. We're seeing that happening more and more. And so I think that's something that we need to take a look at in terms of state policy and how we're making sure we're keeping those children safe.

CLEMENTS: [00:43:43] All right. Are you seeing that as a problem that shouldn't be do-- that we should not be doing that as a policy?

SARAH HELVEY: [00:43:50] I think that there are cases where children can be maintained safely in the home where the parent has a substance abuse issue. But we need to be assessing that and making sure there's appropriate supports for the protection of the child. Another important opportunity I think that Senator Bolz mentioned in the Family First Act is that a child can reside with a parent in their residential treatment facility for substance abuse and receive drawdown for that, so like St. Monica's or some other opportunities or, sorry, providers like that around the state. And so that's a really great opportunity under this federal law to provide that substance abuse treatment and some of those treatment facilities that-- where the child can remain with the-- with the parent.

CLEMENTS: [00:44:40] OK. Thank you.

SARAH HELVEY: [00:44:40] Thank you.

STINNER: [00:44:41] Senator Wishart.

WISHART: [00:44:41] So you write here that if we don't take steps to ensure that federal fund-- funding requirements are met, we will miss an opportunity to reduce our ratio of state spending. Who is responsible for those steps? Who-- who are the big key players in making sure that that happens?

SARAH HELVEY: [00:44:59] I think the Legislature has a role to play in setting some clear policy in this area, and then the Department of Health and Human Services. And then a big piece

are our providers. And I'm so glad that so many of them are here today because this really does require them to, you know, change the way that they're doing the work and also requires us to build to support them and to build that infrastructure across the state. I think as I wrote in there, an ounce of prevention is worth a pound of cure. That is really the case here. But if we don't have the service infrastructure to provide these services then we'll continue to miss the opportunity.

WISHART: [00:45:39] And it sounds like the court system as well is--

SARAH HELVEY: [00:45:42] Uh-huh. Yes.

WISHART: [00:45:43] -- is involved as well.

SARAH HELVEY: [00:45:44] That's right. Yep.

WISHART: [00:45:45] Because what I'm hearing is that, you know, the Legislature and the provider. I just want to make sure that-- that-- that everybody who is somewhat responsible is moving in the right direction.

SARAH HELVEY: [00:45:56] Uh-huh.

WISHART: [00:45:56] Because what I'm hearing is that if a judge decides something different--

SARAH HELVEY: Uh-huh.

WISHART: [00:46:01] -- then that disallows us at times from being able to-- to take advantage of those federal dollars. Do you see that continuing to happen with Family First? Say a judge says

these kids need these services and they are not ones that would be-- would qualify for federal funding so the state will be responsible for them.

SARAH HELVEY: [00:46:25] Uh-huh. So what typically what we see with that cost shift I think I-- we had a conversation with Senator Hilkemann following last year's hearing, but just to give the example again, I think what we see often is if a child is in a court-involved case and they are receiving Medicaid, most children in foster care receive Medicaid but not all in Nebraska, and they, the child's treating provider may recommend individual therapy for the child. If Medicaid denies that service and you're a juvenile court judge and you see a recommendation from the child's treating provider that they need individual therapy and your job is to, as judge, is to determine what's in the best interests of the child, you're going to order that the child receive individual therapy. And if Medicaid has denied that service then HHS is ordered to provide it, so it ends up being state-only child welfare dollars. That's what we see in the system currently. With Family First these prevention services may tend to be with, more often, with noncourt-involved cases. So this is an opportunity to provide some, as our system moves to more voluntary type cases, this is an opportunity to truly provide services that can prevent them and keep them from coming in the system and keep them, the family safe and help them address the court issue.

WISHART: [00:47:50] Do you see the judicial system embracing a movement towards prevention and keeping kids in the home, from your experience working in this space?

SARAH HELVEY: [00:48:01] I-- I can't speak to that for sure. I know that there-- I-- I know that there are some concerns with the-- with the shift to voluntary. And so I'd invite you to speak with some of those court stakeholders because I think they have really important information to share about what they see, for example, when a case has been voluntary and then a court case has been filed and what types of services have been-- have been provided.

WISHART: [00:48:24] OK.

STINNER: [00:48:29] Additional questions? Just to be a little bit more concrete in this, we spend $123, $124 million in Medicaid in this area.

SARAH HELVEY: [00:48:40] Uh-huh.

STINNER: [00:48:40] So if we were able to maintain a written prevention plan, meet certain promising and supported practices and guidelines, we actually could reduce the-- the portion that the state-- by about over $30 million--

SARAH HELVEY: [00:48:54] Uh-huh.

STINNER: [00:48:57] -- if we just hit the averages. Is that what you think or is that--

SARAH HELVEY: [00:49:02] That sounds right to me but I--

STINNER: [00:49:04] But I'm just using some overall rounding numbers.

SARAH HELVEY: [00:49:05] Yeah, I don't know that I'm-- yeah, I've seen those numbers, yeah.

STINNER: [00:49:05] It will-- it's a big number--

SARAH HELVEY: [00:49:10] Yes, it is.

STINNER: [00:49:12] -- is what you're saying.

SARAH HELVEY: [00:49:12] Correct.

STINNER: [00:49:12] And compliance with this requires us, as senators, to pass legislation and then obviously it's going to take some time for HHS to incorporate it in the process. That obviously spills down to the providers. Is that accurate?

SARAH HELVEY: [00:49:25] I believe so.

STINNER: [00:49:29] OK. How long of a period of time do we wait till this? We pass the legislation. How long of a period of time for implementation?

SARAH HELVEY: [00:49:36] The federal law for this provision goes into effect October 1 of 2019. So--

STINNER: [00:49:41] OK.

SARAH HELVEY: [00:49:42] -- we're-- it's great that we're-- I thank Senator Bolz for introducing this interim study. It's a good time to be talking about it. I have not seen the letter that HHS provided, but I can say that they have been, in my opinion, very proactive in starting to work on this. And I would also compliment them for inviting stakeholders in that process. They have a series of work groups on a number of the provisions and they have invited stakeholders to participate in those work groups. I think Appleseed signed up for every one. So they are having conversations. They are getting input and sharing some of the drafts that they-- of prevention plans and other things that they have to provide to the feds as part of the process.

STINNER: [00:50:24] But that's prospectively. How about the fact that over the past numerous years we've been losing out and having to pay more because we can't comply with this title? Is that accurate to think that, to say that?

SARAH HELVEY: [00:50:37] To say that we have not been.

STINNER: [00:50:39] That DHHS or the Legislature hasn't passed the appropriate type of legislation that would allow DHHS to broaden their request for these types of funds. Therefore, we've been 30 percent, 25 percent behind the norm over a long period of time.

STINNER: [00:50:59] Well, if I'm following this, this law just went into effect or was just passed in February and goes into effect next year.

STINNER: [00:51:03] I'm just looking at the difference that you talk about.

SARAH HELVEY: [00:51:06] Uh-huh.

STINNER: [00:51:06] Let me just clear this up. It said General Fund, 23 percent from-- that we're getting today,--

SARAH HELVEY: [00:51:12] Uh-huh.

STINNER: [00:51:12] -- where the average of state investment was 46 percent.

SARAH HELVEY: [00:51:16] Uh-huh.

STINNER: [00:51:16] So if you take the differential of that--

SARAH HELVEY: [00:51:18] Right.

STINNER: [00:51:19] -- and apply it to the actual numbers, that's where I come up with a rounded number of 30 million.

SARAH HELVEY: [00:51:24] Yeah.

STINNER: [00:51:24] Now that, I know prospectively we've got this new law in that's going to be just wonderful for us. I'm more concerned about what has happened post and why we weren't getting the money that we-- was it the Legislature along with DHHS or just what? What has been happening?

SARAH HELVEY: [00:51:47] No. I think that our-- I think with current Title IV-E our law, our state statutes are in compliance. So I think that prior to the waiver, the IV-E, not maximizing IV-E is-- was-- is the department's responsibility. I don't think we could have had better statutes.

STINNER: [02:16:38] OK.

SARAH HELVEY: [02:16:38] Those-- those federal requirements that I think you could have in state statute are in our state statutes. And Medicaid, I mean I could suggest some changes to the Medicaid-- the state Medicaid Act. And we have tried, that have not passed, and I think would have helped there. But I think that's policy from the administration as well, in my opinion, if that answered your question.

STINNER: [02:16:53] No, I-- DHHS comes with a request every year and there's requests for deficit spends every year. And is-- this should have been a solution where we send them back: You guys figure out the IV-E instead of coming here for deficit requests.

SARAH HELVEY: [02:17:03] I would agree with that.

STINNER: [02:17:03] So I failed the process, too, by not understanding and sending them back to broaden their net. Go ahead.

WISHART: [02:17:07] Just on-- along those lines, with the changes from the federal level there will-- there will still need to be some pressure from the Legislature to do what hasn't been done in the past. Correct? I mean they are still-- expanding Medicaid, for example. Is it covered under Family First prevention in terms of some of the stuff we could do to bring down additional money?

SARAH HELVEY: [02:17:14] Correct. I agree with that. I'm-- I-- I'm of the opinion that it would be very helpful to have legislation to-- that there are some areas where we need state legislation in order to reconcile the new federal law with our state statutes and then places where it would help just to make sure that we are maximizing this opportunity by making some changes to our state statutes.

WISHART: [02:17:31] So what are some of the areas in Medicaid where we could expand the services that we provide to draw down more money to go to kids?

SARAH HELVEY: [02:17:36] Treatment foster care is a good example. And as I said, I think that that's actually in the budget request and there is a group of, under the Children's Commission, that

has been looking at that. As I said that, provides some wraparound services for children that are needing to step down from an institutional level of care but aren't quite ready to go home without that kind of support. And so that's a real key area that I know that the state is looking at and Appleseed would very much like to see.

WISHART: [02:17:58] OK.

SARAH HELVEY: [02:17:58] I wanted to just mention and I think-- oh.

HILKEMANN: [02:18:00] All right. Go Ahead. Go ahead. Finish up, finish up, Sarah.

SARAH HELVEY: [02:18:00] OK. Well, I just wanted to be clear that I'm, in my testimony, I was only-- I was focusing on this prevention provision of the Family First Act. I'm glad that you have a handout that Senator Bolz provided because there are many other good provisions of this law. This one I think is most relevant to the funding piece. But I wanted to underscore a couple things about it. The first is that, I mentioned it but just to-- to underscore, it is an optional provision under federal law so not all states are going to take up this option. But Nebraska has been-- I mean I can't speak for the department but they've been clear that that's their intention so that's a very positive thing, in my opinion. And I also wanted to mention another kind of big provision that was referenced by Ms. Hruska is that it does put some restrictions on the-- on federal funding for congregate care. And I think that those provisions are good, too. It requires that children have a treatment need to be in those group care placements and that there are some ongoing assessments of that setting. And so that I think Ms. Hruska was saying we don't know how that balances out, but at the fed-- and I think that's correct. At the federal level it was a cost-neutral legislation and that reduction in congregate care, among a few other offsets, helped to balance out the increased spending for the feds to-- for the prevention services.

HILKEMANN: [02:19:06] I have just kind of a bottom-line question--

SARAH HELVEY: [02:19:06] Uh-huh.

HILKEMANN: [02:19:06] -- on-- on this whole thing with child welfare services overall, because I know this is an area that-- that you monitor very-- how are we doing statewide?

SARAH HELVEY: [02:19:06] Just in child welfare generally?

HILKEMANN: [02:19:07] Yeah.

SARAH HELVEY: [02:19:07] I think we're in a really critical point and I think we really need to look at this voluntary and court-involved split. Senator Bolz put it as well as I could. There is a lot of great things about providing voluntary services. It's traumatic for kids to be removed from the home. But I have concerns. And so that move is something that I am personally very supportive, that Appleseed is supportive of, but we need to make sure that there are concrete supports in place for kids and that safety is being protected. And I just feel like it's-- while I'm supportive, I don't think I fully understand how those cases are managed, in part because there's not clear statute or policy on that. And so there-- I think that there are some additional protections that could be in place as Nebraska moves in that direction. Nebraska's move that direction tracks where the country is going, as evidenced by this Family First Act. So I think we're heading in the right direction, but I think there are some things that we need to do and that the Legislature can take some leadership in clarifying the system as we move forward. How's that?

HILKEMANN: [02:19:55] Are we getting-- are we get-- are we getting the best bang for our buck?

SARAH HELVEY: [02:19:55] I don't think we are getting the best bang for our buck.

STINNER: [02:19:57] Additional questions? Seeing none, thank you.

SARAH HELVEY: [02:19:57] Thank you.

STINNER: [02:19:57] Good morning.

NICK JULIANO: [02:19:58] Good morning. Senator Stinner, members of the Appropriation Committee, my name is Nick Juliano. I'm here today as the president of the Children and Families Coalition of Nebraska, N-i-c-k J-u-l-i-a-n-o. And I appreciate the opportunity and our association appreciates being a part of the thinking and the conversation around Nebraska's implementation of Family First Prevention Services Act and also to discuss some of the potential financial implications for providers as the state undergoes this implementation. And just as a little background, the 13 member agencies of CAFCON do serve children and families in every legislative district in Nebraska and literally have hundreds of years of collective experience training, implementing, developing, innovating models of prevention, early intervention, and treatment services. And we have been engaged fully with the Department of Health and Human Service on the task force of work groups for Families First and are in support of the implementation. So notwithstanding my testimony, which is going to discuss some challenges that providers will face, we're absolutely committed to helping Nebraska implement Families First in the best way possible for our children, families, and communities. There are three kind of main factors, there's-- there's probably more, but I'm going to focus on three factors today that are currently and will continue to impact providers across the state as Families First is implemented over the next year. First of all, implementation of evidence-based practices: I'm going to use that as a broad term today because

there's a whole technical discussion around that. But implementation of evidence-based practices are costly. And one of the features of the Families First Prevention Services Act is a mandate to implement certain evidence-based practices with certain levels of evidence. While that is a good thing for our system and while we want models that are proven effective with the kind of children and families who are at risk for entering our system, there are additional costs for those models. Costs may include, but are not limited to, initial training, technical assistance for implementation, ongoing consultation for the monitoring of how those models are implemented, again, very good things. However, those additional costs should not and cannot be borne on the agencies that are providing the services in Nebraska. We do have a local solution that I think would be worth exploring in the realm of some of the cost for evidence-based practices, and that's examining how the Administrative Office of Probation utilized some private foundation grant funding to implement an evidence-based practice-- multisystemic therapy-- in the juvenile justice system that is also a model that will likely be utilized under Families First Prevention Services Act. So we have a path here in Nebraska around some of the cost sharing for the implementation of those EBPs which we think would be important to explore. Second, expansion of services-- and this gets to, Senator Stinner, one of your questions, and Senator Hilkemann I believe-- any expansion of services requires start-up costs that are not reimbursed in our current contract. So as we look at our state-- and I don't believe there has been a thorough, intentional study of mapping where those services are-- we know anecdotally and through talking with judges and our system partners and legislators, there's disparity. There's regional disparity. There are more services and agencies providing services around population centers; there's less in areas of our state that are less populated. However, growing existing programs into new geographic areas or bringing new programs on or expanding existing programs even in the areas they're operating come with start-up costs. Some common example of these are recruitment and training of new staff and technology costs and leases for new offices if geographic expansion is-- is-- is what is needed, and it certainly is in Nebraska. A sampling of our members, to give you an ideas of some costs, indicates that recruitment and training

costs for new direct care staff, and this would be a direct care staff who would work in a community-based program, averages more than $4,700 per staff and can be as high as $7,500. And depending on the size of the agency and the number of staff you have, you can quickly get to training costs in half million dollar-- million dollars annually to provide services just with our service array that we have here currently in our state. Turnover costs can be three or four times that. And I mention turnover costs because both our models and our missions require us to have enough of the right kinds of staff to serve families. And, of course, there are caseload ratios for some contracts. That means when a staff leaves, those families need to be served. So turnover costs become a real thing for agencies that can't simply say, well, we're just not going to provide that service right now until we have the new staff. So those turnover costs can reach 25 or 26 thousand dollars per staff in an agency. So that certainly is part of the expansion conversation in looking at how and when agencies may expand into new geographic areas and new services. Third, as has been discussed, our current rates do not provide the full cost of services. Senator Hilkemann, to-- to your question before about, you know, whether our rates are flat or not, effectively, our rates have been flat for the last seven or eight years. Some services had minor increases. We've had cuts. We've been kept flat. That's not even taking into account cost-of-living increases. But the reality of providers is that effectively our rates for the most part have been flat. To our knowledge there has not been a state-led rate study of child welfare services. I mean I've been at Boys Town 23 years and I'm 10 years in this role, and it hasn't happened since I've been in this role. And we know that in 2008 the provider associations actually commissioned Seim Johnson to do a rate study of child welfare rates and it determined in 2008 that the previous five years, and that was a time that there were some rate increases year to year on some services, even with rate increases that accumulated to about 5 percent over five years, those increases had not kept up with rising costs, which cumulatively have been about 26-27 percent. So the long answer to the question is rates have been flat. We do need-- we do need a rate study. The impact at the agency level around rates is consistent and significant, and all of you know that because we spend a lot of time during legislative session

talking about rates. Couple of examples: One CAFCON member agency has lost $265,000 over the life of one contracted services and another large CAFCON member reports multimillion dollar losses annually across child welfare services contracts. So the current rate situation is-- is important for our current environment but needs to be discussed as we look at expanding services through Families First Prevention Services Act-- Act. We are encouraged. We had a conversation with Director Wallen last week. He has indicated a plan for procuring a rate study of child welfare services in 2019, both related to Family First and provision of the new child welfare contracts. Ultimately, what we're talking about is making necessary investments into our state system so that children and families can get what they need at the right time, for the right duration, the right service, in the right location. In addition, Families First has a maintenance of effort provision. So what that essentially means is the state will have to establish our spending currently on prevention services and maintain that level, and then to leverage more federal dollars, so to bring in more IV-E money, then we will have to actually increase our state expenditures. Now that match is a great opportunity, as discussed by Sarah Helvey, is a great opportunity to leverage those dollars. But the-- the federal dollars won't just flow into Nebraska without maintaining an increase in our current investment. So I think we've learned over the years in Nebraska, I think we learned this with safe haven, I think we learned this with welfare reform, that when we put our minds to improving our system and improving our services and changing how we do things there are long-term returns on those investments that families benefit from. However, those investments do need to made-- be made and often are an increase of what we're currently doing for some of the reasons that I've just stated. So with that in mind, I again thank you for the opportunity today. And I'll take any questions that the committee has.

STINNER: [02:26:43] Thank you. Questions? Senator Hilkemann.

HILKEMANN: [02:26:43] You mentioned at the start of your testimony that we need to monitor

the regional changes or-- or-- or-- or rates for regional areas as far as for providing those services. In other words, in rural areas it's more cost-- costly than in urban areas. Is that correct?

NICK JULIANO: [02:26:48] Yeah, so there are some unique cost drivers to rural areas. One primary one starts with the recruitment of staff and the requirements particularly under Families First with some of the evidence-based models, expansion of Medicaid, if that were to occur. Some of these models will actually require a high number of master's prepared and/or licensed staff. So our work force in the state, we-- our agencies are hiring up every master's level therapist and every LMHP and LIMHP that we can get anywhere they're available to provide the kinds of services. In some parts of the state where there are less of those individuals available recruitment becomes more difficult. The other traditional challenge for rural services-- and I'm talking about community-based services, so working with kids in their home and working with families while they have their kids at home, which has been the growth of our child welfare population has been the in-home population-- there's great distances, as you know. And so even having an office or having a team in a central location, you may have to drive an hour or two to see a family and an hour or two back. That brings in some practical complications around not only windshield time, reimbursement for that; the fact that these families are not always there when our staff show up, they're not always available. It's kind of called the no show in-- in some of the discussions that we have. So you could potentially have a staff spend four hours attempting to meet with a family and provide some services and for many reasons not be able to provide that. Not all of that time is reimbursable. That's the reality in some areas of the state that is not in our population areas. Our population areas we have other issues. So those are a couple the factors that we've been talking to Director Wallen. Frankly, we've been talking to probation administration as well about the regional differences, how some of the cost drivers are different in those areas with work force and otherwise. I would also just like to take a moment. I had not put this in my testimony but I think this conversation lends itself to also looking at both the service array for probation, juvenile justice youth, and child welfare youth. The

emerging research and the crossover youth practice models now in five counties in Nebraska says that a young person in the child welfare system is much more likely to end up in the juvenile justice system than a young person who is not in the child welfare system. So when we look at solutions to our child welfare system at the front door with prevention or even primary prevention, we are actually very closely linked to what is going on in our juvenile justice system more than sometimes we know. So if we were to undertake a process to map where the services are, and I think that study would be a worthy one across state, we would recommend we look at where-- where are the service gaps across the state for both the child welfare population and the juvenile justice population. Many of our providers serve both. In fact, most of us serve both.

STINNER: [02:29:17] Additional questions?

HILKEMANN: [02:29:17] What solutions do you have for that particular problem?

NICK JULIANO: [02:29:18] Well, I- I think part of the solution is having ways to address some of the start-up costs and some of the rate issues. And again, last week at our association board meeting we had Director Wallen in and we had Jeanne Brandner in and we had very frank conversations. Both typically on their agenda is, how can your agencies help? We need services in these areas. We have capacity issues. And we had a very, I think, honest conversation about the historical financial losses providers have taken who have started a new service and there have not been enough referrals to sustain that service or started a new service that incurred great losses or going into new geographic areas to try to build service capacities and not having the referrals, not having the families to serve and how there is a-- the financial implications to this for agencies. They're on our boards' minds when we go to them and say we need to expand services and start new programs and invest in new models. The question that-- that our execs get asked is, well, ten years ago during child welfare reform we-- we opened five or six offices. Now those offices aren't there.

And the funding wasn't sustained and the referrals never came. So while we're not going to let history burden us from being part of a solution, it's a very real sort of practical piece to look at that we think, if it can be addressed, we can start to open up some of the conversations about getting new services going, getting services in areas of the state that are-- that are lacking.

HILKEMANN: [02:30:32] Now if I understand it, you felt-- you felt heard by Director Wallen this time.

NICK JULIANO: [02:30:33] Yeah.

HILKEMANN: [02:30:33] Have you-- you presented this to-- you've presented these same issues before to the department, I'm assuming.

NICK JULIANO: [02:30:37] We have.

HILKEMANN: [02:30:38] And have you ever felt heard before or-- or heard enough that action was taken?

NICK JULIANO: [02:30:41] I-- I would-- I would characterize the conversations with Director Wallen are fundamentally different than they have been in the past with other directors. One, there's a recognition of these financial complexities and at least a willingness to look at them and look at some creative ways that the financial burden could be lessened while staying within funding guidelines in federal law and those things. In the-- in the past, those conversations tended to be nonstarters. So we're-- we're hopeful, both with Director Wallen and of probation, that there might be some opportunities to-- to look at these issues. And we already cost share, so it's not about the agencies funding all of this, but our donors are already covering significant losses and significant

indirect costs which are not part of our contracts. And so creative contracting, performance-based contracts, funding start-up costs, leveraging private funds would all be potential solutions that would help Families First Prevention Services Act and also some of the other issues we have.

HILKEMANN: [02:31:27] OK.

STINNER: [02:31:27] Senator Wishart.

WISHART: [02:31:27] Yeah, I want to speak to the-- to the performance-based contracting. Do you believe that we have-- our child welfare system is set up to reward providers who have been successful in the children that are part of their system not going into the juvenile justice system, being back with their family, going on to lead, you know, a successful life? Do we have a system-- because what I-- what I'm hearing you say is kids that are not-- kids that are in our child welfare system are more likely to go into the juvenile justice system.

NICK JULIANO: [02:31:38] Yes.

WISHART: [02:31:39] From what I understand, there's a lot of trauma from--

NICK JULIANO: [02:31:39] Yeah.

WISHART: [02:31:39] -- being involved in the child welfare system, so I get that. But these are kids where the state's eyes are on these kids. These are kids where it has now become our focus to help these kids. And so what I'm hearing, that the trend is that these are the kids that are going into the juvenile justice system. We have obviously-- and we've spent, invested a lot of money in them. We are obviously not-- it's not working. So do you think we have a performance-based system

where the providers, who have sort of figured out and-- how to serve this really tough population of kids and prevent them to go into a life cycle of trauma, where we reward that?

NICK JULIANO: [02:31:54] No. There's not a-- an intentional, designed, performance-based system now, certainly not financially. In-- in today's system, providers, all of us, have similar contracts with similar outcomes. Our rate, we receive the same rate regardless of whether the families are meeting the outcomes that we want or not. And in-- in a true performance-based environment, you start to-- to have measures that say in these service categories, during and after service, if families have the positive outcomes we're looking for, there's typically some financial incentives that would follow with that in a measured, appropriate way and monitored very closely. Iowa has-- is about ten years into some performance-based contracting on some community-based services that work that way. We don't have that in Nebraska. Now in our, again, in our conversation with Director Wallen, he's expressed an interest that over time, with the new contracts, he'd like to move in that direction where the state is purchasing outcomes. They want certain outcomes for their children and families and they want to be able to work with providers to deliver those outcomes. And then over-- over the long haul, if providers do deliver those outcomes, there could be some incentives. But we don't have that today. We've never really had an intentional conversation in Nebraska about that around our contracting, so that's another potential opportunity.

STINNER: [02:32:51] Senator Vargas.

VARGAS: [02:32:52] Along the same lines, and thank you for being here very much and representing CAFCON. The performance-based, you talked about Iowa, do they do it as an incentive in addition to sort of like a baseline sort of rate or they're doing it as like their rates are actually performance based?

NICK JULIANO: [02:32:57] So, without getting too technical there, there's a-- there's a base rate that you receive while you were serving a family. And so these are-- these are children who we're preventing entry into out-of-home placements. They stay at home with their families. Safety plans are put in place similar to what we do in Nebraska with our different in-home services. So there's-- there's a base rate that you receive for providing that service. And then at certain intervals, when certain outcomes are met, there are small incremental payments which come, which together, the way they've structured it is if you're providing quality care with your base payments and you're meeting all of your outcomes for your families, you get very close to full cost reimbursement for that service. If you don't, those incremental payments that come with, as-- as an example, six months after a case closes has that child reentered the child welfare system, that's an outcome. If six months after we're done serving that child, if they are still at home and they are safe, there's a small incentive that comes with that. If that child has reentered the system, that incentive is not there, that payment is not there. So that is one way, not the only way, to address the rate issue where you have rates that never approach full cost. Say, OK, we're willing to do that, we'll approach full cost. We'll approach full cost when we see the outcomes that we need for children and families at certain intervals.

VARGAS: [02:34:00] Are there any--

NICK JULIANO: [02:34:00] It's an oversimplification, but I think--

VARGAS: [02:34:02] No, no, no.

NICK JULIANO: [02:34:02] -- that's the concept that is generally talked about performance-based contracting.

VARGAS: [02:34:04] Yeah. Are there any other-- I'm just curious if there are any states that do it differently where it's more-- less of a baseline and then an incentive on top of that? Or is-- yeah, I just didn't-- I don't know.

NICK JULIANO: [02:34:06] A number of states have different performance-based contracting regimes and we would be glad to do some of that research and gather some of that information because it really-- there has been quite a bit of performance-based contract work in the child welfare realm in the last 10 to 15 years, so.

VARGAS: [02:34:19] Yeah. No, that would be really helpful. And more, honestly, the reason why I'm asking is I don't think-- I think a lot of the conversations we had here is wanting to make sure that there's-- where indirect accountability is by setting metrics and indicators and somehow making it fair, but then also figuring out a way to increase, at least I speak for myself, increase provider rates to keep up. And what we're seeing is 4, 4, 4.9 percent five-year rate increase versus this keeping up rising costs. Twenty-six percent is, I mean, that's just a really wide gap. So obviously,--

NICK JULIANO: [02:34:28] Yeah.

VARGAS: [02:34:28] -- there's something that we're not doing to keep up with the rising costs, but, at the same time, we want to make that there's some level of, you know, not only accountability but that there's a way to, I don't even like using the word "incentivize" because we all want the same outcomes. And I know that we're all holding ourselves accountable--

NICK JULIANO: [02:34:31] Yeah. Right.

VARGAS: [02:34:31] -- to the same indicators but some level of transparency around that. And it

would be helpful, I know you put this down there, to then send out-- I don't know if somebody already asked this so I apologize-- the rate study from [INAUDIBLE].

NICK JULIANO: [02:34:35] The Seim Johnson study--

VARGAS: [02:34:36] Yeah, Seim Johnson.

NICK JULIANO: [02:34:36] -- from 2008.

VARGAS: [02:34:36] That would be helpful to have. I know that it's-- it's encouraging that Director Wallen is going to look at doing one for 2019, but it would be helpful just to see that because, obviously, it's been a while ago.

NICK JULIANO: [02:34:40] Yes.

VARGAS: [02:34:40] [INAUDIBLE]--

NICK JULIANO: [02:34:40] Quite dated.

VARGAS: [02:34:40] -- more change. And more important, I'm interested in seeing how these rising costs-- what is-- what's included in these rising costs and which ones are sort of typical or not typical to some of the rising costs in rate studies we've done also internally for other-- other different things that we have reimbursement rates for.

NICK JULIANO: [02:34:47] Good.

VARGAS: [02:34:47] Yeah. That would be great.

NICK JULIANO: [02:34:48] Glad to do it.

VARGAS: [02:34:48] Thank you very much.

STINNER: [02:34:48] I have one question to ask and you may respond to this. You say your agencies have lost $265,000, which ties in a little bit to Senator Vargas. The other is a multimillion dollar loss. So I look at Boys Town, CEDARS Home, those types of things. Obviously, you have to make it up somehow and I'll leave it up to you to tell us how you make up these losses.

NICK JULIANO: [02:35:01] Our donors.

STINNER: [02:35:02] Okay. Thank you.

NICK JULIANO: [02:35:02] Nebraska taxpayers.

STINNER: [02:35:03] Yes, they are.

NICK JULIANO: [02:35:03] Yes.

STINNER: [02:35:03] Senator Hilkemann, sorry I didn't--

HILKEMANN: [02:35:03] Are we-- are-- as the private sector, are you finding that-- that I know I think it's a year ago that the state said they were going to take a couple more of these. Are you finding that private practices or-- or-- or private contractors are seeing fewer clients than

previously?

NICK JULIANO: [02:35:08] In terms of our agencies?

HILKEMANN: [02:35:10] Right.

NICK JULIANO: [02:35:10] Yeah. I think it was mentioned before, for some services there are less referrals.

HILKEMANN: [02:35:13] Right.

NICK JULIANO: [02:35:14] Drug testing referrals are down. Kinship support is down. The-- the kinship support plan was actually part of DHS's plan last year to address some budget issues. So for some service categories we, our members are receiving less referrals.

[WOMAN]: [02:35:25] Drop-in.

NICK JULIANO: [02:35:26] Drop-in we discussed, drop-in services. Others, the referrals are steady and so-- but it's a very good point to bring up because in, as Families First rolls out and our service array changes, that will also shift the types of services our agencies are doing. And so there is an adjustment period. There are other costs involved when an agency "sundowns" a program, perhaps, if you've hired and trained staff to do a certain service and that service is going to go away or go away in that location. And we work our darnedest to cross-train our staff that will allow someone who was doing this type of service with somebody to come over here and do this type of service. We're very good that. If this service is an in-home service by a bachelor's prepared individual who is well trained and well supervised, and in this new service is service requiring an

LMHP, we can't take this person and say, well, this program is ending because our services are changing; come on over here and do this type of work. And so in that shifting, right, there will be some factors to our agencies as well. Notwithstanding that, we understand there will be shifts and want to look at all those things. But when we talk about service shifting, it's not always apples to apples. Particularly if they're a Medicaid-funded service, they're going to have certain requirements for licensure and education, and some of the EBPs are going to have more requirements for licensure and/or education. So there's a lot of moving parts to this that, you know, impact the ability to meet the capacity needs, as well as, you know, what happens with the agencies.

STINNER: [02:36:35] Senator Wishart.

WISHART: [02:36:36] And I just [INAUDIBLE].

STINNER: [02:36:36] How many other testifiers do we have for this, please? No more? Okay, go ahead.

WISHART: [02:36:39] I wanted to speak--

STINNER: [02:36:39] I'm just trying to be conscious of time.

WISHART: [02:36:40] I wanted to talk a little more about the congregate care change.

NICK JULIANO: [02:36:41] Yeah.

WISHART: [02:36:41] So I think, in theory, it's-- it makes sense that as many kids as possible are living in a home situation. But when-- when we mandate, you know, restrictions around kids that

can be in congregate care, I'm just thinking practically--

NICK JULIANO: [02:36:46] Yeah.

WISHART: [02:36:47] -- that's-- and, again, going back to the mental health issue. We had congregate care. We moved more to community-based, which costs more when you have more dispersed care of people who need-- have serious needs. Do you anticipate that that's going to actually cost more? Because you're going to have, instead of a group of kids who have similar significant needs in one space, where you have trained staff--

NICK JULIANO: [02:37:00] Yeah. Yeah.

WISHART: [02:37:00] -- watching those kids, they're more dispersed now because of-- of that mandate and now the resources are going to need to be more dispersed.

NICK JULIANO: [02:37:02] So I'll-- I'll respond to that in a couple ways. And I'm glad you brought this concern because CAFCON, from a system perspective, very much believes in a continuum of care. And while out-of-home, you know, residential care, whether it's congregate care or it's family style residential, a place like Boys Town, that is much more costly than primary prevention, parent training, working with-- with kids in their own home. But there is a need for those young people, smaller numbers, to have that service available. So I think in all this we need to keep that in mind, that we've got the right service at the right time at the-- for the right duration for what kids needs, number one. Number two, as it relates to Families First, there is a designation within Family First called a QRTP, qualified residential treatment program, if I'm not mistaken, which is a pathway if a state wants to use IV-E dollars for out-of-home placements or congregate care. Then a young person can be placed there and then that agency has to meet those QRTP

requirements. But I will highlight that there is nothing in Families First that mandates less use of any service, let alone congregate care. What it says is if you're going to use IV-E dollars--

WISHART: [02:37:53] OK.

NICK JULIANO: [02:37:53] -- to pay for congregate care, then you have to meet these requirements of QRTPs. If the state chooses not to utilize IV-E dollars, there will be no change in-- in-- related to Families First around the use of those programs. So I think that we have to want to keep that straight. That being said, I do think, you know, our agencies that have residential programs, we are all looking at what it would mean to become a QRTP. Sarah had mentioned the-- the need for, you know, therapeutic foster care as an option in the state and some other things to make sure as providers we are contributing to keeping that continuum in place so when a child needs that, that is available.

WISHART: [02:38:20] OK.

STINNER: [02:38:20] Additional questions? Seeing none, thank you.

NICK JULIANO: [02:38:22] Thank you.

STINNER: [02:38:22] Any additional testifiers? I have one more, Senator Bolz.

BOLZ: [02:38:23] We-- we did invited testimony only. I'm sorry.

MAN FROM AUDIENCE: [02:38:24] Oh. OK.

STINNER: [02:38:24] Oh. OK.

BOLZ: [02:38:24] OK. Austen, you want to distribute?

AUSTEN BAACK: [02:38:24] Sure.

BOLZ: [02:38:24] So I-- I just want-- it's a complicated system and you received a lot of information this morning. And so I just want to try to briefly summarize what I think the takeaways are for the Appropriations Committee just to help us get clear walking away from this hearing. The first is that I think, Families First or no Families First, it's our responsibility to continue to fund child welfare services according to projected utilization and keep ourselves on track. We don't want any future Appropriations Committee to be faced with another $55 million surprise. And so it's our responsibility to monitor utilization, keep up with it. As a related note, I want to flag for the committee that the Department of Health and Human Services is undergoing their new RFP process for the privatized provider, Nebraska Families Collaborative PromiseShip, as we speak. And so you'll recall that the last time the contract was renegotiated it was a $12 million increase. I-- I cannot give you any predictions at all about what that will mean for us. I just wanted to flag that as something kind of in the queue for-- for the future. The second kind of takeaway is that I think it's important that we implement needed policy change to enact Families First to its fullest and to draw down federal funds. I think you would hear as many different perspectives about the continuum between voluntary services, drug testing, and out-of-home placements and how this should all come together as there are people in this room. My perspective is that we always need to keep an eye on safety first and that may mean the services that we fund need to go along with safety first. But bottom line, as an Appropriations Committee, I think this is one area where we need to work closely with the Health and Services Committee so that we understand how that policy change relates to the rebalancing of the funding streams that I think we hope to achieve together. The third takeaway is

that for items one and two to succeed, I think we need to adequately fund provider rates. And as Mr. Juliano articulated well, it's not just keeping up with the provider rate trends and demands. It's also turning an eye towards the requirements in Families First that we build capacity for services and use an evidence-based practice, which can have some costs that come along with it. And then the last thing that I want to say is that, just-- just briefly if you would, in the fact sheet, LR430, on the second page there's a table of the outcomes and our state performance. And-- and I guess what I want to say is, while there may be a number of different strategies that the department can utilize for performance-based contracting, I view that as an administrative decision and an administrative approach. As an Appropriations Committee, I think we could strengthen our performance-based budgeting. And what I mean by that is if these were the things that we asked the department to report out on in their performance budgeting document, rather than the document that I shared with you, and we monitored the performance over time, we could tie back better to whether or not the investments that we're making are making a difference in protecting children from abuse and neglect or making sure that children receive adequate services to meet their physical and mental health needs. And as a committee we could identify one or two of those where we'd like to see the dial moved and strategically make investments on those pieces. So I guess I just wanted to-- to-- to take a 100,000-foot view of how we, as a committee, might engage in that performance-based outcomes. So I did that as quickly as I possibly could. I think I'm done. If there's any questions, I'd be happy to answer.

STINNER: [02:41:14] Questions? Seeing none, thank you. That concludes the testimony and hearing for LR430. We'll open with LR442 and allow some in the room to change over. Thank you all for coming.

[02:41:16] [BREAK]

BOLZ: [02:41:16] Are you ready?

STINNER: [02:41:16] Yes, I am. Thank you.

BOLZ: [02:41:17] Welcome, Senator Stinner.

STINNER: [02:41:17] Now good morning, committee and Senator Bolz. For the record, my name is John, J-o-h-n, Stinner, S-t-i-n-n-e-r. I represent District 48. And since we've ran over, I'm not going to go through this whole report. I think you all heard my concerns about nursing facilities, especially in rural Nebraska. We've seen some bankruptcies pop up. We've seen some real stress in the industry. I've seen a lot of the nursing homes being taken over by villages and town simply because they weren't economically viable. We're in a situation now where we've got an aging population that's really kind of coming upon us. I think we call it, what did Heath Mello call it, a--

BOLZ: [02:41:45] Silver tsunami.

STINNER: [02:41:45] -- silver tsunami on our hands. So I think it's important when we look at nursing homes, about half of those nursing homes now are 50 percent Medicaid-funded or over. Our reimbursement rate has been questioned. We're going to have to take a look at the methodology, the status of nursing homes within the state Nebraska. I think that's the takeaways I'd like to have. I want to do a deep dive into how they get reimbursed and just exactly how this is all put together and then maybe some recommendations, especially on rebasing that might-- might happen. For the record, we have, and I remember Senator Bolz and Senator Hilkemann were part of the committee when we added about $8 million of additional dollars to the nursing homes. Those dollars never got out. I had hearings or I had meetings with HHS about why it didn't. A lot of it has to do with the formula, the methodology, utilization rates, all of that stuff. So we need to understand how that all

happened. I've got some other charts and figures, but I'd really like to turn it over now to the invited testimony people. And we do have to be out of here by 1:30. So anyhow, any questions?

BOLZ: [02:42:40] Thank you, Senator Stinner. We'll invite up the first invited testifier.

STINNER: [02:42:43] Good morning.

MATTHEW VAN PATTON: [02:42:43] Good morning, Mr. Chairman and members of the Appropriations Committee. My name is Dr. Matthew Van Patton, that's M-a-t-t-h-e-w V-a-n P-a-t-t-o-n, and I serve as the director of the Division of Medicaid and Long-Term Care within the Department of Health and Human Services here in the state of Nebraska. Thank you, Mr. Chairman, for inviting me here today to provide information related to LR442, a study resolution looking at the funding for long-term care providers, specifically skilled nursing and assisted-living facilities. Before I offer comments on the current payment methodology for skilled nursing facilities, I would like to note the place skilled nursing and assisted-living facilities hold within the continuum of care. Included in our submitted documents as Exhibit A is a chart illustrating the full continuum of care. You will note the continuum runs along a bell curve which is divided into two sides, the acute and “postacute.” Along the line you will note the various care venues that define the continuum. Venues rise along the curve reflect incre-- venues rising along the curve reflect increases in acuity, or level of care. Proper coordination of care and communication between providers is essential continuity of care for patients as they transition from venue to venue along the conven-- continuum, thus ensuring safety, quality, and overall patient satisfaction. While most services are delivered to Nebraska Medicaid members through the Heritage Health program, long-term care services, including the per diem payments made to skilled nursing facilities, are paid directly by the state using rates based on actual facility cost. According to national Medicaid data, Nebraska spend per skilled nursing facility resident was above the national average of $175.41, at $180.22, and ranks 27th across all states.

Regionally, Nebraska is consistent with neighboring states' per diem resident spend, with Iowa at 16th; Wyoming at 24th; Missouri at 26th; South Dakota, 31st; Minnesota, 32nd; Kansas, 34th; and Colorado, 39th. And I also have an additional handout that gives this to you so that you can see it, and I will leave it with the clerk as we're concluding today. Nebraska's regulations require the department to set payment rates annually for facilities on a defined cost-based methodology. Because each facility's costs are different, this methodology produces a significant range in payments to Nebraska skilled nursing providers. In the current fiscal-- state fiscal year, the rates range from a facility per diem of $119.73 to $241.09. Given the methodology is based on cost, it can produce higher rates for less efficient operators. Furthermore, the methodology has no tie to the quality of services provided. As the director, I am very focused on the value of the buy Medicaid makes within the marketplace, quantified in terms of cost and consequences, meaning quality bought or outcomes achieved. The federal Centers for Medicare and Medicaid Services, or CMS, has developed a five-star rating system for evaluating the quality of the nation's skilled nursing facilities. There is an overall five-star rating for each skilled nursing facility and a separate rating for health inspections, staffing, and 16 different physical and clinical quality measures. More information on the CMS star rating system is available at CMS.gov. In May of 2018, I asked our policy and communications team to perform an analysis of the star ratings corresponding to each of Nebraska's skilled nursing facilities. I then asked that those facilities be grouped according to their star ratings and an average of the per diem rates be tablet-- tabulated for facilities within their respective star ratings group. In Exhibits B and C, you are presented with pie charts detailing our findings. These charts reflect rates and ratings for 2017 and 2018. As you can see, nearly half of Nebraska's skilled nursing facilities are performing at a four- and five-star level, while the other half are performing at a three-, two-, and one-star level. From this data we can make two conclusions: one, we have a quality chasm; and two, the delta between our top quality performers and those at a-- those at a five-star level, and our lowest quality performers, those at a one-star level, provides very little incentive for providers to maintain quality or to improve. While not a perfect system, CMS

star ratings have created a nationally recognized and industry accepted market assessment tool that is accessible to all. Now, equipped with this market knowledge, I believe the state of Nebraska has an opportunity to release the skilled nursing industry and Medicaid from the regulatory constraints of an outdated payment system that prohibits innovation and market adaptability. While providers have raised concerns regarding the cost-based methodology over the years, there has not been consensus on what changes need to be made. As a result, the methodology has been largely unchanged for decades. Highlighted in the 2018 Department of Health and Human Services business plan is the Medicaid's Division's plan to change the current cost-based methodology to a pay-for-- pay-for-performance model. We believe such a model would provide greater predictability for the state and provider community, while simultaneously rewarding top performers and incentivizing lower performers to improve. I would also like to note for the committee work done by my staff with CMS and the Nebraska Health Information Exchange [SIC--INITIATIVE], or NeHII. We are partnering with NeHII to provide skilled nursing providers in Nebraska cost-free access to NeHII data for at least three years. We are drafting the advanced planning documents now and we are prepare-- we are drafting the advanced planning documents now in preparation for submission to CMS for review. With 70 percent of all Nebraska hospitals and 100 percent of pharmacies pushing data into the exchange, expanding access to the “postacute” care skilled nursing environment represents a monumental step forward in improving quality and coordination of care across the continuum. Access to admission, discharge, and transition data, including the medication administration record, is paramount to sound continuity of care during patient transitions. Hospitals are keenly interested in ensuring high quality of care is delivered in skilled nursing facilities to which they refer and transition patients, as the Medicare readmission rule penalizes hospital providers for readmissions within 30 days of discharge. The federal policy change has pushed greater care coordination across the continuum of care, as well as heightened the importance of quality in the marketplace. Our work with NeHII will benefit the entire continuum of care in Nebraska, specifically improving the patient experience, provider experience, improving the health

of populations, and reducing the per capita cost of healthcare by helping to avoid costly readmissions and reducing medical errors. In closing, the market dynamics faced by skilled nursing providers are complex and multifaceted. Payer mix, patient mix, referral systems, population density, and adequacy of work force are just a few of the considerations faced by skilled nursing administrators across the state and nation. Another dynamic in the market rests with the rise of services utilized in the home setting rather than skilled nursing facility. Home- and community-based services are increasing in utilization and are often preferred by patients and their families. Home care allows seniors to age in place with the resources of family and other supports wrapped around daily care needs. In Nebraska we see increasing utilization of home- and community-based services, which we believe is reflected in current nursing home occupancy rates. This is shown in the chart labeled Exhibit D. Our most recent data shows a statewide nursing facility census of 72 percent, with one county having an average census of only 34 percent. This information by county has also been provided to you as Exhibit E. Lastly, I will note our State Unit on Aging is currently conducting a statewide study of our home- and community-based services infrastructure. I expect the report to be completed by the end of this year. Thank you, Mr. Chairman and members of the committee. I appreciate the opportunity to share insight and perspective related to LR442. I am happy to answer any questions.

STINNER: [02:49:51] Questions? Senator Bolz.

BOLZ: [02:49:53] Thank you, Director Van Patton. My takeaway from what you're sharing with us is that you have a quality concern related to the half of facilities that are receiving a three-, two-, or one-star rating and that you would like to change the current cost-based methodology to a pay-for-performance model. So your testimony says that you want to reward top performance and incentivize lower performers. How are you going to do that?

MATTHEW VAN PATTON: [02:50:10] Well, I think there's certainly some options on the table and I think this also goes to the fluctuation in the market that you currently see related to the way the cost-based model has this wide range. So we would create a narrower alley of payments. So you would maybe correlate the payment for five, four, three, two, and one, and narrow that range so that it's very clear as to what you're going to reimburse at every level. And so the incentive, if you're at one star, you know exactly what it's going to be if you move to two, if you move to three, if you move to four, if you move to five. I think that is of tremendous benefit to both the industry and the state because it creates greater predictability because you have narrowed that range. So that's just one option that we're currently exploring. There are other options that we can put on the table in conversation as well related to the percentage of Medicaid patients within those facilities or even doing some possible overlays with Department of Labor data showing where and how the availability of work force within certain geographic areas may play into it. So there are certain things we can put in that are distinct related to quality and correlated to the star rating. But then we can also add some other considerations that maybe would produce a better model than what we currently have today within the cost-based structure.

BOLZ: [02:51:19] I appreciate that. And I think any model would be incomplete if it didn't consider access to work force, access to the quality trained work force, if it didn't consider the Medicaid/non-Medicaid mix, if it didn't consider the mental and behavioral health challenges of some of the nursing facilities that we're facing. So I guess if-- if we were to move to a pay-for-performance model, I would hope that it's a complex and robust model that takes into consideration the reasons that some of these facilities are and at a one quality-- or one or two star now, which I, from my experiences with our nursing facilities, has nothing to do with their desire to achieve or their intent to provide good care but some of the systemic factors that limit their ability to do so.

MATTHEW VAN PATTON: [02:51:48] Senator, if I could continue to add to that, I would

simply say, too, our intent is to create a program that incentivizes folks to naturally do better, at the same time using the levers of government and the instruments that we have to provide tools that help them get there, which is also the importance of the collaboration and the efforts that we have underway with NeHII. I am totally convinced that access to the ADT data, the admissions, discharge, and transition data, as well as the medication administration record, when you transition going from care environment to care environment, medical errors occur because of lack of continuity of information going between. So if you go into-- if you're discharged from the hospital into a skilled nursing environment without a complete understanding of the medication administration record, you have no ability to continue that therapy along those lines as you transition those spaces. And that could result in some signif-- significant occurrences of adverse events or even, to a certain point, reporting of sentinel events.

STINNER: [02:52:39] Senator Wishart.

WISHART: [02:52:40] Is it-- do you think it's financially feasible for a nursing home or assisted-living facility to be able to make it work with exclusively a Medicaid population, make their budget work?

MATTHEW VAN PATTON: [02:52:45] As I said, Senator Wishart, the management of a skilled nursing facility has to take into account lots of different variables, same as a hospital, which is my background. Payer mix, patient mix, the ability to maintain referral systems, all of those things are daily points of consideration that that facility has to take into account. And the reason I took the opportunity to point out the star ratings and the 30-day readmission rule, part of that referral system now, as hospitals are looking at their readmission rates and where those patients are coming from, if they've made referrals upon discharge to a facility and they see that they have an increased number of patients coming back from that facility because the quality of care in that facility wasn't at a level

that it should be and they sent them back, they're now penalized for it. That's going to change that institution's referral patterns. Eventually they're going to say, we're not going to send any more patients do X facility because we have a 70 percent readmission rate from them, or whatever it is. So that's also a dynamic that plays out in the marketplace.

WISHART: [02:53:39] Oh, I don't know if I was clear enough. When I'm looking at this, at Exhibit E, and I'm looking at Medicaid beds, I don't see a single facility that is operating with 100 percent Medicaid beds.

MATTHEW VAN PATTON: [02:53:40] Right.

WISHART: [02:53:40] So what I'm asking is--

MATTHEW VAN PATTON: [02:53:41] No, I do not. To answer your question specifically, I do not think that it is feasible in the marketplace.

WISHART: [02:53:44] Do you think that's a problem when there are certain parts of the state where the population is exclusively Medicaid?

MATTHEW VAN PATTON: [02:53:45] It's certainly a market challenge. But I think that there again, when we are paying, looking at what this model goes to, you have to take into account some of those geographic considerations. I think you-- you really also have to look at the ability to have a population to sustain that facility. And so we also see that we have 73 percent occupancy rates across the state, which means we have a quarter open capacity, which means we're not utilizing our full capacity in the state. And I think that goes directly to the other market dynamic of an increased utilization of home- and community-based services. And so I think when you're looking at how you

manage a Medicaid population, you also have to look at that dynamic as well. Because when you look at the cost you incur in a utilization of a facility versus a utilization of home- and community-based services, you have a distinct difference in your spend, which is presented in the data that you have there as well. And I'll also say that the star ratings also cover home health services. So as you get into CMS's data wells, and I would encourage you to take the time and go there and explore, it's public information and, in my opinion, represents one of the greatest democratizations of healthcare data that the country has ever seen and really a tremendous tool for empowering the general public on understanding what they're consuming, the variations in the marketplace, and the variations in acuity of care within those spaces. And so I simply say that to note the home- and community-based services are in those CMS star-- star rating systems, as are hospitals. So it's a really robust system that I would encourage you to look at.

WISHART: [02:55:11] Do you think that one of the solutions to potentially address, especially in the rural areas where communities may not have the ability to have that private pay dynamic like you would in Lincoln, for example, or Omaha especially, do you-- do you see any benefit to increasing the reimbursement rate for Medicaid significantly so that-- so that facilities in those rural parts the state can make it work budgetarily?

MATTHEW VAN PATTON: [02:55:22] I'm not sure that we could quantify that against the quality of services delivered in that space and that's why I've-- I've really taken the time here to promote the quality element. I give you an example of an individual who performs open heart surgeries. If you attract that talent into a hospital, you have to have the population to serve that individual at a very high level, to do a number of cases that keep that individual's clinical proficiency high. What I want to make sure of is that if you have an infrastructure in the marketplace you may. It may not be in that individual's backyard. But what I'm concerned mostly with is that that individual gets into a facility that's functioning at a much higher level. And if that's

in a neighboring county or if that's in a geographic area where that quality of service is at a higher level, I'd much rather have that Medicaid patient in that facility as long as that facility is functioning at a very high level.

WISHART: [02:56:09] Do you think that quality of services is correlated, at least in part, to provider rates?

MATTHEW VAN PATTON: [02:56:11] I think that it-- it is a factor. But as I said, there are a lot of considerations that go into the administration of a facility and that is the patient mix, that's the provider, excuse me, the payer mix, that's the availability of work force. And, frankly, that goes at multiple levels of acuity in the number of RNs that you have, the number of LPNs or certified nursing assistants, how are you staffing to that. So quality is dictated by a lot-- a lot of factors simply beyond the reimbursement rates.

WISHART: [02:56:36] But wouldn't a lot of those things, staff, the patients who come to your facility, don't a lot of those things tie into the amount of money that a facility is reimbursed for? Because if I think about it, if I'm getting additional money, Medicaid money, to serve additional Medicaid population but also to serve them better, I have more money to be able to hire more quality staff who then will be able to provide services that are more quality to the-- to the people in the facility.

MATTHEW VAN PATTON: [02:56:44] I guess, Senator Wishart, where I struggle with your-- with your notion is that Medicaid is a payer within a sea of payers, and it's also within an ecosystem of multiple providers. And so I think that a healthy-run facility maintains a very healthy payer mix, that you have to be-- begin to manage to different patient types so that you can attract different rates of reimbursement. I think it is probably a very difficult thing for the state to institutionalize policy

where Medicaid props up an individual facility. I think that would present a financial challenge for the state in long-term considerations. I think you're much better redirecting institutionalization into facilities that have healthy payer mixes, where there's a focus within that healthy payer mix on solid reimbursement from multiple payer sources in the marketplace, and focus on building quality institutions versus a broad market access. I think you get into bigger facilities where quality can be delivered on a much more comprehensive basis.

WISHART: [02:57:42] And we're seeing this to some extent with the mental health population. So then one of the issues that comes about with that is that people cannot live, potentially, in the communities to which they were raised and have lived their entire life.

MATTHEW VAN PATTON: [02:57:47] It's a challenge. Which is again why I go back to where the marketplace is going and why families are taking an interest and are opting to use home- and community-based services, where those services can be wrapped around, where quality can be maintained and those infrastructure resources of both I would call church, I would call family, I would call friends can still come into that care environment. And, frankly, I think there's a notion that if you have a facility, and as the facility those jobs would leave the facility as you have home- and community-based services rising, the jobs would stay in the community because they just shift in where they're providing their services. They just shift from utilization of those jobs in a facility to utilization of those talents within the home- and community-based environment.

WISHART: [02:58:28] Thank you.

STINNER: [02:58:28] I just want to comment on something. You're telling me that unless you have the appropriate provider rates, you're not going to survive. So then I get to go home and tell Mitchell, Morrill, Bayard, Wauneta, Grant, you got more and more and more of Medicaid folks;

you're not going to survive.

MATTHEW VAN PATTON: [02:58:39] It's a tough proposition, Senator Stinner, and I appreciate your position as an elected representative with that message. Again, I go back to let's do what we can and let's look at the payment methodology where-- where it stands. If we're solely based on cost, if we can move it over to paying for the performance but also taking into consideration the availability of work force, taking into consideration the payer mix, if you will, and help compensate and offset those, those systems, but also incentivize those facilities to maybe consolidate populations or to put more resources in consolidated centers, I think the state would be much better served because I think you will get a better product delivered to the consumer. And that goes back to our internal focus on the quadruple aim, which is four points. It is: What is the patient experience of care in both quality and satisfaction; what is the provider experience of care in both quality and satisfaction; how are we improving the health of populations; and how are we reducing the per capita spend on healthcare services? And so I think that as we're looking at that as the state, I think that those individual facilities, both certainly on the hospital side as well as the skilled nursing side, are very well acquainted with the objectives of the quadruple aim.

STINNER: [02:59:46] Let me say this different. In your one-star, two-star ratings, you've got 27 percent of the entire nursing home facilities classified in that. And nobody sitting at this table or in the audience would put a loved one in a one- or two-star facility. So that means 57 to 60 nursing facilities need to go away.

MATTHEW VAN PATTON: [03:00:01] I wouldn't say that they need to go away, Senator.

STINNER: [03:00:03] I'm just trying to--

MATTHEW VAN PATTON: [03:00:04] You're trying to get there and I appreciate that. And-- and--

STINNER: [03:00:06] -- trying to find out what this is going to look like long term.

MATTHEW VAN PATTON: [03:00:08] Yes, sir. Here's-- here's-- here's the way I would position it. If we leave things as they are without any payment correlated to the quality of services delivered within those facilities then, yes, I would say Medicaid is presented with an ethical dilemma now based on the market knowledge that we have. Do we continue to buy services for Medicaid beneficiaries in facilities functioning at one or two stars? That's one way of looking at it. If we look at it from the standpoint are we putting into the marketplace incentives that help them move up in their opportunity to improve quality within those facilities and then also giving them additional access to technology that helps them make better care transitions, remain more informed as patients move between venues, then I think let's give those facilities the opportunity and give them the help that we can by using those resources to push the quality paradigm up in the state.

STINNER: [03:00:54] And I don't mean to jump ahead of everybody but I-- I am. [LAUGHTER] You might want to enlighten us. When you talk about payers and what we pay, you've got a disparity of $119 to $241 per diem per day. That's a-- that's a $122 differential.

MATTHEW VAN PATTON: [03:01:02] Right.

STINNER: [03:01:03] What drives that differential? What causes one facility to get $119 and another to get $241?

MATTHEW VAN PATTON: [03:01:06] Well, it all goes to how they quantify their cost. And let

me say that the cost report is specific to Nebraska Medicaid. So it is an expense that those facilities have to bear to quantify their cost and report that back to the state. And so from that-- and I also have a separate handout that we will provide to you which is a representation of how the methodology works. And what I would offer the committee is-- is simply this high-level overview and the opportunity to follow up with this any additional questions that you may have, because it doesn't really get into the specifics of what actually goes into the breakdown of everything that's on that cost report. But it is from that basis that we start all our work with-- with then quantifying, in addition to other factors within this methodology that end up producing that variation and that-- that extensive range that you were just talking about, Senator.

STINNER: [03:01:51] Is there a case that says we can narrow that disparity and, therefore, help some of the facilities that are-- well, I'll just give you an example. The Mitchell facility has 88 beds, all of them covered. They just got LB840 money from the city of Scottsbluff to help them survive. So they turn in their cost study and they get cut by 7 percent. A lot of that had to do with not being able to hire the appropriate people, over time. There is a whole lot of things that from the efficiency. So I've got a little bit of a problem calling up what this cost study is about. And it's obviously incredibly important, but that made no sense whatsoever to me in terms of here-- here they are with their hand out to the city of Scottsbluff, who really didn't have any reason to give them money, did give them money because of a work force, the importance of the 88 beds. And then the state turning around, said, ah, we're going to cut your reimbursement by 7 percent, makes no sense.

MATTHEW VAN PATTON: [03:02:34] Well,--

STINNER: [03:02:34] And that's where I'm trying to get to the bottom of what we're doing per diem, what drives will [INAUDIBLE], is there modifications, and does this even make sense?

MATTHEW VAN PATTON: [03:02:38] So you-- you're getting to the core of what our issues are as an agency with the cost-based reimbursement model.

STINNER: [03:02:43] OK.

MATTHEW VAN PATTON: [03:02:43] So If you follow that logic, the more efficient that the-- that the facility operates, the lower their cost will be. And so as they then fill out that cost reimbursement form and they send it back in to the state and it goes through that methodology that's outlined for you there in that flowchart, they may actually get a-- as rates are rebased from year to year, if their costs go down, if they operate more efficiently, we actually will have to lower their rate, versus someone who operates less efficiently and their costs go up, they may actually end up with a higher rate of reimbursement. And again, none of this is correlated or contextualized to quality delivered within those facilities. And that's why I continue to go back to if you remove that cost-based reimbursement model and you move it over to some sort of formulary that's driven by quality of performance in that marketplace, and you can incentivize those who are functioning at a high level that I would contend are also functioning at very efficient rates within the marketplace, I think you begin to see those rate alleys begin to tighten up very, very quickly. And I think for the industry's-- from the industry's perspective I think mitigating that range and giving more stability and predictability as to what they know their rate alley is going to look like is probably a significant advantage to them as they begin to plan their budgets from year to year. And it certainly helps us within the agency begin to be more effective in planning ours.

STINNER: [03:04:00] I want the committee to understand that by statute we have to rebase every year. But these-- but these cost studies are two years old--

MATTHEW VAN PATTON: [03:04:05] And I would--

STINNER: [03:04:05] -- by the time you get to quantifying everything. Excuse me. Bad timing on that. But anyhow, these-- these cost studies are actually two years old before you start to rebase.

MATTHEW VAN PATTON: [03:04:11] I believe that's correct. But let me-- let me clarify that with our financial team and we'll-- we'll make that as a follow-up point for you just to make sure we're giving you the exact point of methodology there.

STINNER: [03:04:19] Does the department have information on the fiscal? Do you have a watch list of agency or nursing homes that are in fiscal stress? Do you track how-- how the agency is doing or how those facilities are doing, so you have a watch list? Your-- have a early warning system on nursing homes that are in fiscal stress, I guess is the best way to put it.

MATTHEW VAN PATTON: [03:04:35] To my knowledge, we don't track fiscal distress. We do keep an eye on where the rates are and how they-- they may change for a facility from year to year, but I'm not sure again that that would be or that that would-- the state could actually quantify that simply because you do have a range in the marketplace. And as I said earlier, a facility is taking into account lots of different things in what drives their margin from year to year. Medicaid is just one payer in a sea of payers within that ecosystem, so their bottom line is being driven by other factors than just-- than just Medicaid rates.

STINNER: [03:05:03] But DHHS, when something goes into receivership, you take it over. You have a fund, and I can't remember the name of the fund, and hopefully you have enough money in that fund. The last I looked it was, what, $3 million or something along those lines.

MATTHEW VAN PATTON: [03:05:15] You're-- you're somewhere in the right range, but I

believe that has significantly changed as we've had to deal with some of the recent marketplace destabilizations and receivership. I don't know exactly what's in that fund but we can-- we can certainly respond to you with the exact amount, if that's of interest to you, so you-- you have that information.

STINNER: [03:05:29] But under the current practice, somebody gives you a call and says, I can't make payroll, so--

MATTHEW VAN PATTON: [03:05:34] They give notice, that's correct.

STINNER: [03:05:34] -- you have no-- no way of getting prepared or--

MATTHEW VAN PATTON: [03:05:36] That's right. That's right.

STINNER: [03:05:36] Just wanted this--

MATTHEW VAN PATTON: [03:05:37] And-- and to be clear, too, that goes to licensure and that's tied into Public Health. Medicaid is the payer. Public Health is the licensure for those facilities. And so receivership is actually coordinated out of the Public Health Division. So I want to make that point of distinction for the committee as well that it's Medicaid purview that we're on the payer side of that equation and so we do have an interest in-- we do walk-- work collaboratively but that receivership piece comes in to Public Health and licensure.

STINNER: [03:05:58] I did want to enter into the record, since 2012-13 through 2016-17 the Medicaid nursing facilities' actual expenditures have ranged to $324 million, $326, $326, $327, $323. And interestingly it jumped to $344, which you may be able to talk about. But our

appropriations have gone up by 2.5 percent or about $7.3 million. We're now gapped at about a $30 million gap between what the expenditures are, or at least gapped at $30 million at 2016 versus 2017. My only-- and I know that you're about utilization, you're about cost formulas, you're about all of that, but it isn't because of the fact that we haven't appropriated funds to the nursing homes. It's just because of your methodology, formulas, rebasing, those dollars never got out.

MATTHEW VAN PATTON: [03:06:32] We've actually had occurrences in past years and I can get that specific--

STINNER: [03:06:35] $344 I think was the number I got. So it jumped from $323 in kind of a flat-line situation up.

MATTHEW VAN PATTON: [03:06:37] Right. We actually have had years where-- where, as I understand it, we've had money within our reserves to pay for additional services. But the utilization wasn't there. So you're not going to pay that money out if you don't have utilization within the marketplace of those services. So I think that's-- that's been within the context of our-- our budget that we've been able to flex and adapt. Now we've also had occurrences where we've had to absorb additional utilization expenses, and we can certainly break those numbers down for you and provide that back to the committee in a more formalized report if you're of interest.

STINNER: [03:07:05] But your model doesn't accomula-- accommodate any kind of an additional-- say, if we said we're going to give you another $8 million; we expect it to go out to reimbursing. There is no way that you could shove that back out under your current situation.

MATTHEW VAN PATTON: [03:07:12] No, sir. We-- we are operating within the prescribed regulatory framework that's codified. We have to follow that cost-based reimbursement model.

STINNER: [03:07:20] And that's can't be tweaked for the $8 million. Say that there's a base rate here and we're just going to increase the base to accommodate these extra dollars.

MATTHEW VAN PATTON: [03:07:27] No, sir. As I understand it-- it is-- it is prescribed. We follow the writ of the statute and that's how-- or the writ of the regulation and that is how we proceed on an annual basis with the rebasing.

WISHART: [03:07:37] Is that federal or state in terms of that writ?

MATTHEW VAN PATTON: [03:07:38] It's state. That is state, Senator.

WISHART: [03:07:39] And it would have to be statutorily changed?

MATTHEW VAN PATTON: [03:07:39] It could be regulatory change, but that is a process different from, as you know, the statutory prescribe, which is going to be driven by the Legislature. And I think in years past, as you began to open it up, you had differences of opinion as to what you replace it with. So moving through a regulatory rewrite would probably be quite an extensive process. And I think there's an acuity of need at issue at this point and juncture to address our methodology, that I think would be more protracted in rewriting regulation through the regulatory process versus addressing it through other legislative vehicles.

STINNER: [03:08:11] We're going to find out. Go ahead.

WISHART: [03:08:13] But we've seen-- we just had child welfare in the department's-- meetings with them about significant changes very quickly to their-- the way that they address the child

welfare system. Why can't-- why can't that happen in this case?

WISHART: [03:08:15] I think you've got a much broader population of providers with variations on opinion. You certainly have some providers who, in the current model, are doing quite well with their rates. You've got others who are functioning at a very high level of quality but aren't being compensated for it. So I'm not sure that if you did-- I can't say that it wouldn't definitively, Senator, but I'm just saying I think it would be a long, a lot more protracted process with several, as I understand the regulatory process, several public hearings that would have to occur over a period of a year. But I think if you're looking now specifically at an opportunity I would say that going through the regulatory process is not going to be the path to get there quickly. I would just leave it at that.

STINNER: [03:08:49] I've got one other question for you. When I compare Medicaid rates to Medicare, to private pay, how does that compare? Do you have a study? And I-- I realize they reimburse it. If somebody is severely handicapped, for an example, it would be a different reimburse-- reimbursement rate than somebody that was just occupying a bed. But do you-- do you have that rate differential between Medicaid and Medicare and private pay?

MATTHEW VAN PATTON: [03:09:06] Well, it's different across all facilities, because they, if they're dealing with private pay, they set their own rates and we don't always have line of sight into what that is. On Medicare, Medicare only pays for a certain number of days within skilled nursing or rehab beds. So their rates are negotiated or there are some-- they're set by fees. But then they also, if they're entered into value-based contracts between a hospital and a skilled nursing facility, they may have different rates in those structures. So it's really quite difficult, Senator, to compare Medicaid rates in comparison to Medicare rates because of those variations in the market, as well as what's going on in the private pay side of things, simply because there are different rates with

different facilities. And that has to be, you know, that's where families simply call around and shop the different facilities to see what their-- their rates would be within those care environments. We recently went through this with my-- my 97-year-old grandmother. And so you will find, as you call different facilities, there will be different day rates.

STINNER: [03:09:59] See what you can do for our line of sight so we can maybe have some way of comparing.

MATTHEW VAN PATTON: [03:10:02] We'll take note and get--

STINNER: [03:10:03] Yeah.

MATTHEW VAN PATTON: [03:10:04] -- see if we can find some data for you.

STINNER: [03:10:05] Senator Vargas, you--

VARGAS: [03:10:06] Oh yeah.

STINNER: [03:10:06] -- had your hand up and I interrupted you. I apologize.

VARGAS: [03:10:07] No, you-- you asked some of the questions that I had. So I'm trying to-- this is sort of piggybacking on what Senator Stinner, Chairman Stinner mentioned. So are you telling me that if there's a population that has an incredibly high or a higher than average Medicaid population and there's a facility there that is serving that need, that under this paradigm shift that you're trying to get to, performance-based reimbursements, that we're telling them that you need to diversify your, sort of, portfolio, people that you're bringing, that you shouldn't serve a majority of

Medicaid popula-- if those are the people in your community? Is that what we're telling facilities across the state?

MATTHEW VAN PATTON: [03:10:27] No. I think that, Senator, the perspective has to be what are the-- what are the sound business principles that drive effective management of a facility. And there are. It's multifactorial in how you manage that facility. And so if you are completely dependent on a single payer source, in my opinion, you are making yourself vulnerable. And I think you have to keep in-- you have to keep a healthy payer mix to be able to accommodate fluctuations in the marketplace.

VARGAS: [03:10:52] You're making the assumption, though, that a-- a facility is making it-- making this as a-- assuming they're-- they're making this decision as a business practice then. All the population that they're bringing in, they're doing it intentionally, rather than an area that actually has a high-- I mean, my-- my area has a very high Medicaid population,--

MATTHEW VAN PATTON: [03:10:59] Sure.

VARGAS: [03:10:59] -- one of the highest in the [INAUDIBLE].

MATTHEW VAN PATTON: [03:10:59] Sure.

VARGAS: [03:10:59] So you're talking about a facility, telling them, wait, you need to diversify intentionally, even though your community, the need, has a higher Medicaid population rate.

MATTHEW VAN PATTON: [03:11:01] Well, again, I go back to what's utilization across the state.

VARGAS: [03:11:04] Uh-huh.

MATTHEW VAN PATTON: [03:11:04] And remember, we talked about the capacity. We've got 72 percent capacity, which means we've got about a quarter of unused capacity--

VARGAS: [03:11:11] Uh-huh.

MATTHEW VAN PATTON: [03:11:11] -- in a marketplace. Now when I begin to see that, again, I'm looking at that trend line of utilization of skilled nursing--

VARGAS: [03:11:17] Uh-huh.

MATTHEW VAN PATTON: [03:11:18] -- versus utilization of home- and community-based services.

VARGAS: [03:11:19] Uh-huh.

MATTHEW VAN PATTON: [03:11:19] I'm looking at those facilities and wondering how much of those facilities' infrastructure are we keeping in place when we could have opportunity for consolidation and infill of additional capacity in other markets where you could maintain a healthier payer mix that would maintain a broader ecosystem of payers within that context so that you did not become solely dependent on one payer source.

VARGAS: [03:11:42] That-- and I feel that that makes sense in a world where at least an entire-- entire state there's sort of just equitable distribution of facilities and population, but that's not the

reality we're facing. And I'm not going to speak for Senator Stinner but-- or any community in rural Nebraska. That's not, I think, realistic of what we're seeing. So instead, we're try-- I feel like-- my concern is that we're trying to fit a peg of what we want our-- our sort-- we're saying an efficient business practice for the state to a community that has a need, and saying, facility, figure it out or you won't be able to survive. This is-- this is not-- this analogy, I'm thinking of this in, like, schools. Let's-- let's say, for example, there's a school with a very high poverty population of kids. And then we're saying, we're going to potentially reimburse. If you're not performing as well, because it's a high poverty area and there are more kids in that area, that we're going to incentivize another system, another school system that maybe has, you know, a 50 percent poverty rate versus a less 50 percent of a more affluent rate. And we're sort of incentivizing a-- a-- a-- a more balanced distribution of poverty or need. Their community still has that, that amount of need. So I'm worried that we are essentially putting-- at some extent, we'd be putting out of operation facilities, that are serving the highest need populations, inadvertently by trying to increase efficiency.

MATTHEW VAN PATTON: [03:12:21] Well, if you look at it like this, too, Senator, some of those facilities that may have high utilization of Medicaid and other facilities that may have higher or less available capacity, is there an opportunity to infill if you have availability to move those other patients so that you do get a better payer mix? And again, what's going to drive that within the marketplace? It's going to be predicated, especially if they're discharges from hospitals, if I'm a hospital administrator and I'm looking to discharge a very medically complex patient who's going to need a high acuity of care, I'm going to look at that quality score of that facility. Now they may be delivering quality and they may have a fairly high utilization of-- of Medicaid beds within that facility. But if they're doing a good job and there's available capacity there, versus I have limitations on capacity within my community, I would redirect that family and work with them through case management or care management to say there's opportunity to take a bed where there's capacity here. It may not be in your county, may be two counties over, but-- but they do well. There's a five-

star rating with that facility and they have the availability to take you. That's what I'm getting to is that you need to be able to-- to-- to care manage effectively. And as I've said recently to some other legislators, one of the greatest challenges we face in the healthcare industry today is the knowledge that we have based on the data that we're presented with and how we effectively care manage across the continuum to make sure that we're directing those patients to the appropriate venue of care to achieve the outcomes that we set out for them to achieve. And we would do it in a way that creates a good experience and we reduce those costs. And so again, that-- that-- those networks and the ability to look and flex and to help, you know, to say it's not in your county but it's in-- it's in another county, but there's an opportunity there and they do a good job; can we get you there. I think it's that presentation of information at a very, what I would call, consumer-oriented level. It-- it is quite, quite important to me.

VARGAS: [03:14:01] That's hard for-- I mean it's probably hard for me to communicate to constituents that we're viewing this as you're the consumer and we're forcing you to make a choice when this is something that we are funding. Taxpayers are funding reimbursement rates and we're trying to make sure access to quality of care is existing. So that-- maybe that's just a concern that I have. It may just be me. The other concern I have is I understand what you're saying about high quality. I think we want high quality and some accountability. And I think Senator Bolz was-- was-- was getting to this, is that the devil's in the details of how we do this. Obviously, there's indicators, but I worry of whether or not the rating system for performance is more about giving an opportunity for facilities and services to then improve and giving them actual information, because ideally we want, I--at least for me, all of the services that are being provided equitably across the state are operating at or four- or five-star,--

MATTHEW VAN PATTON: [03:14:34] Sure.

VARGAS: [03:14:34] -- just like I would think about schools. I want all of them to, not there's a school here that's a one star and so we should then figure out a way where that shouldn't exist and then get another school that's a five star, no matter if it's in another county. That's the way I'm sort of thinking about it. But I don't know how this is going to look in terms of the rating system or year-to-year, and how quickly it will pivot and how that's going to detrimentally affect a-- a facility that has a population that is high in Medicaid and is not that nimble. So I really worry about that and I'd be curious to see what the sort of breakdown of what you're proposing in this performance-based model. So I wanted to express my concern with that.

MATTHEW VAN PATTON: [03:14:53] OK.

STINNER: [03:14:53] Senator Bolz, or Senator Hilkemann. Excuse me. I'm sorry.

HILKEMANN: [03:14:54] A couple questions, Chair. I think I know the answer. We have one-star facilities getting as much as $241. Is that correct?

MATTHEW VAN PATTON: [03:14:54] Uh-huh.

HILKEMANN: [03:14:54] OK.

MATTHEW VAN PATTON: [03:14:54] It should be. I can't say that definitive but we'll say in theory. I'll have to go through the list and see, but, yes, it could be.

HILKEMANN: [03:14:57] OK. Is there any-- there any common characteristics of these one, two, and three stars?

MATTHEW VAN PATTON: [03:14:58] So I guess the best way to contextualize it, Senator, is that the star ratings are compiled around those three different areas that we talked about. Their-- their annual accreditation that comes through from the states are certainly pulled through and that's where you see a reporting of sentinel events that tie into that. For those of you who do not know what a sentinel event is, that is an event that has occurred within a facility that has equal death, permanent injury, or significant injury requiring a medical intervention to preserve life. And so it could, just an example, you could have someone who's in a skilled nursing facility who has fallen and they break a hip. That will require hospitalization. Or they are in a facility, they fall, have a traumatic brain injury because they hit their head or something along those lines. Those are the kinds of events that are reported, sentinel meaning that they alert the need for an investigation in that space. So those are certainly things that are driving those safety reviews and are reportable considerations. Secondly, in that line you're looking at the staffing mix: What's your acuity of staffing within that facility index, and you're graded on that. And the third piece are 16 additional quality measures that are folded in based on some national standards. And we can certainly, again, I would encourage-- I would encourage each of you to go to CMS Web site and look at how they're rating and how they're grading these facilities: hospitals, skilled nursing providers, again, home health agencies. There is a lot of consumer-oriented data to help you understand the marketplace as it stands today, Senator. So that's-- that's the mix. And if you-- if you want those specifics of those 16 quality measures, we can certainly provide that to you after fact.

HILKEMANN: [03:16:20] And, Doctor, there's really not a geographic component to this.

MATTHEW VAN PATTON: [03:16:20] Geographic in what context, Senator?

HILKEMANN: [03:16:21] As far as-- as far as rural, urban, any, is that a factor to this?

MATTHEW VAN PATTON: [03:16:21] You mean correlating providers--

HILKEMANN: [03:16:22] Correlating.

MATTHEW VAN PATTON: [03:16:23] -- who are at five, four, three? No, they're across the board geographically.

HILKEMANN: [03:16:24] Yeah, that's what I [INAUDIBLE]. And then there's a program at Immanuel called Immanuel Pathways. Are you familiar with that?

MATTHEW VAN PATTON: [03:16:27] Yes, and I've had an overview from them. They've been in to tell me about it and I believe it's on my calendar coming up sometime in the next couple month to go out and visit their-- their campus to learn a little more about it.

HILKEMANN: [03:16:36] OK. OK. I'm just wondering if that model is saving-- overall saving our state the dollars that we would hope it would be.

MATTHEW VAN PATTON: [03:16:37] I would-- I would put a question mark in and say I can't quantify that in this venue. It would have to be looked at.

HILKEMANN: [03:16:43] OK. Thank you. That's my questions.

STINNER: [03:16:43] Senator Bolz.

BOLZ: [03:16:43] I have two questions. The first is we are already reimbursing nursing facility providers at a rate under the actual cost of care rate, and that's-- it's significantly under the cost of

care. I'm going to see if I can make eye contact with Cindy. I think it is $28 a day under the cost of care.

CINDY KADAVY: [03:16:56] Thirty-six.

BOLZ: [03:16:57] Thirty-six. Thirty-six dollars a day under the cost of care. So is your-- is your-- can you-- do you envision us being able to change our-- our quality and our-- our pay for performance and that approach in a budget neutral way? And if so, how, because it seems like we're already asking an awful lot of folks from-- awful lot from folks who are being reimbursed under the cost of care.

MATTHEW VAN PATTON: [03:17:10] I think, I think we need to get into the economic modeling. And I will-- I will, in fairness, say that Mr. Boddy and Jenifer Acierno have been in to our office to present us with the model. They'd probably tell you about it here today. We're running through the economic modeling of that right now. So I think, you know, certainly our objective would be to produce something budget neutral. But there again that would be-- legislative purview is legislative purview and our objective is to create a model that we feel like will work for the industry and help create and sustain those providers and incentivize them to move up within the quality spectrum.

BOLZ: [03:17:37] I'll be curious to hear how that goes. I think it will be awfully challenging to-- to shuffle the resources that we already have in new ways when we're already so significantly behind. The other question I have, and I guess I don't expect you to-- to give me your thesis on it. But-- but what strategies or ideas or initiatives are you thinking about from a home- and community-based services perspective? Because it seems to me that if part of our goal is cost savings and quality of care, those home- and community-based services are a real part of that solution. What are your

thoughts?

MATTHEW VAN PATTON: [03:18:00] Uh-huh. We-- we, as I've already said, Senator, and it's reflected in that data that we shared, we've-- we've seen increased utilization. And we also have a home- and community-based services division running a waiver program, and they're actively working to help families place or move out of facilities and get them into those home environments where it's-- where it's appropriate. That's certainly a point of consideration. I will say again, as I noted in my testimony, we are currently looking, through our area on aging, we are looking at a comprehensive study as to what the home- and community-based services infrastructure is across the state. And so I'll know more about what resources we have in the marketplace and how we can more effectively utilize those, hopefully, after that report is made available to us.

BOLZ: [03:18:34] Yes. I appreciate that. It seems to me that building some capacity in our home- and community-based system is going to serve us well in the long run. Thank you.

STINNER: [03:18:38] Thank you. Additional questions? Seeing none, thank you.

MATTHEW VAN PATTON: [03:18:38] You're quite welcome. It's a pleasure to be with you.

JENIFER ACIERNO: [03:18:38] Hello, Chairman Stinner and members of the Appropriations Committee. My name is Jenifer Acierno, J-e-n-i-f-e-r A-c-i-e-r-n-o, and I am the president and CEO of LeadingAge Nebraska. Thank you for the opportunity to testify here today. LeadingAge Nebraska is an association that represents nonprofit members that provide senior care in Nebraska. That includes nursing facility, assisted living, independent living, and adult day services. Our members span across the state. Some are large, some are small, and many of them operate in our rural areas. Our members serve-- serve a high volume of Medicaid and long-term care recipients,

and our members are committed to serving Nebraska seniors and do that as a partner to the state, which is required to provide coverage for long-term care as a mandatory service under the Medicaid program. The majority of our LeadingAge Nebraska nursing facility members have been significantly impacted by the reductions in Medicaid reimbursement. Following my testimony, you will hear from Cindy Kadavy and Heath Boddy from the Nebraska Health Care Association. They also represent not-for-profit and also for-profit members in the long-term care arena in Nebraska. They, like LeadingAge Nebraska, represent large and small providers, rural and urban. What I'm trying to get at is that the concern with the current Medicaid reimbursement spans across the profession and industry of long-term care regardless of corporate status, location, or governance structure. The reimbursement issues are real. They are imminent. And they pose a threat to our Nebraska seniors to receive the care that they need. First of all, I want to set the stage about the Nebraska seniors who our members serve. These seniors lived and worked in Nebraska all, if not most, of their lives; contributed heartily to the economy of this state; raised their families here; and worked hard to care for themselves and those around them. They are the backbone of Nebraska. Few, if any, Nebraskans will tell you that they look forward to moving to a nursing facility to their care-- to receive their care. If they do, they want that facility to be within their community. And there is a point where people sometimes reach the need for a nursing facility level of care. Nebraskans are independent and take pride in taking care of themselves. Many of these Nebraskans saved all of their lives. Many of them spent all of their savings receiving care. They are not unique. They rely on Medicaid for their long-term care needs and it's the state's responsibility to help meet those needs. Unfortunately, current reimbursement does not cover even allowable costs for facilities, allowable costs that are established by the state. You will see more data and hear more about these costs shortly from Ms. Kadavy. Facilities, even those that are very efficient and provide quality care, lose money every day that they provide services to a Medicaid resident. In our small towns, payer mix is limited. In Nebraska as a whole, payer mix is limited. Our members provide those-- provide care to those in and around their communities, most of them with little regard about

payment source because they believe it's the right thing to do as a part of their community. Medicaid reimbursement and access to care in rural areas is something that this legislative resolution was set to explore. Thank you. These concerns are real. They are timely. And if action is not taken, we will see more long-term care providers closing their doors and being run by the state through receiverships. Many facilities have gone into receivership because the call to address the reimbursement issues have gone largely unheard. The ability for our seniors, your constituents, to continue to receive these necessary services rests on funding. This includes an assessment of how much funding is allocated to Medicaid for long-term care; how many of those dollars are actually spent for long-term care services; the amount of money that is left as contingency in the Medicaid budget in anticipation of an increase in utilization, even though utilization has continued to stay flat; and the unavailability of those funds to providers while communities are struggling to provide services. Every time there is a reduction in rates, there is the cumulative effect to our members because we begin the next biennium with a reduced base funding, base amount of funding. These repetitive reductions result in the inability of providers to meet basic costs of paying staff and providing care for residents. Ms. Kadavy will provide you the data that supports this information and you will hear from members of both of our associations. They will illustrate to you how reimbursement impacts their operations and the ability for Nebra-- and their ability to care for Nebraska seniors. Heath Boddy, president and CEO of Nebraska Health Care Association, will then offer final thoughts. Again, thank you for the opportunity to be here to present this information and for recognizing the importance of long-term care and the reimbursement issues facing Nebraskans.

STINNER: [03:22:51] Thank you. Questions? Senator Bolz.

BOLZ: [03:22:52] Thank you. Could you elaborate more on your perspective regarding-- and forgive me if I'm not getting it correctly, technically-- but the holdback you referenced related to expected utilization?

JENIFER ACIERNO: [03:22:59] Yes.

BOLZ: [03:22:59] Can you just tell us more what-- what should it be, what is it, what could it be? Can you just--

JENIFER ACIERNO: [03:23:02] OK. And actually, you'll see more detail from Cindy and when you look at the slides that we've provided. But what I'll tell you is that there is, and I think rightly so, a contingency held in case there's a-- an increase in utilization. And generally, I think that's a good approach. However, what we're seeing is very flat utilization, yet that contingency continues to be held instead of invested back into those providers who are struggling to do the work today.

BOLZ: [03:23:26] Very helpful. Thank you.

STINNER: [03:23:26] You have-- how big is your association? How many [INAUDIBLE]?

JENIFER ACIERNO: [03:23:26] So our association has about 78 members across the state and across those various nursing facility, assisted living, independent, and adult day services.

STINNER: [03:23:35] That's a pretty good population. Do you have a sense of how many are really in fiscal stress right at the moment?

JENIFER ACIERNO: [03:23:38] I would say for our association, because we tend to present-- represent a lot of rural providers and nonprofits, I would say I haven't heard one provider from the-- even when I think of our largest providers, who has not expressed concern about reimbursement and being able to keep their services available, making sure that they're not turning people away for

those services who need their help.

STINNER: [03:23:58] And the rural people do not turn people away because--

JENIFER ACIERNO: [03:23:59] No.

STINNER: [03:23:59] -- they are usually community members.

JENIFER ACIERNO: [03:24:00] Right. It's Just like--

STINNER: [03:24:00] So they have to take everybody.

JENIFER ACIERNO: [03:24:01] Right.

STINNER: [03:24:01] You talked about unreimbursable cost.

JENIFER ACIERNO: [03:24:03] Uh-huh.

STINNER: [03:24:03] Tell me. Give us a little bit more information about that.

JENIFER ACIERNO: [03:24:05] All right. And Cindy will cover that in more detail, too.

STINNER: [03:24:07] OK.

JENIFER ACIERNO: [03:24:07] But what I can tell you is that there are costs that a nursing facility will incur to operate. And then, as a part of the cost report that they submit, there are what

are called allowable costs determined across a few domains. And so those allowable costs are what not-- are amounts that are not being met for our providers. So even though there is a methodology that recognizes these costs should be allowable, our providers are not receiving the total of the allowable costs that they could under the current methodology.

STINNER: [03:24:32] So there's a cap on how much--

JENIFER ACIERNO: [03:24:33] Correct.

STINNER: [03:24:33] -- they can get reimbursed--

JENIFER ACIERNO: [03:24:34] Correct.

STINNER: [03:24:35] -- on allowable costs.

JENIFER ACIERNO: [03:24:35] There is. And even outside of-- even within that cap they are not realizing their total allowable costs.

STINNER: [03:24:41] OK. Thank you.

JENIFER ACIERNO: [03:24:41] Uh-huh.

STINNER: [03:24:41] Additional questions? Seeing none, thank you.

JENIFER ACIERNO: [03:24:41] OK. Thank you.

STINNER: [03:24:41] Yeah, it's still morning. Good morning.

CINDY KADAVY: [03:24:42] OK. Good Morning. Good morning. I wasn't sure if it was still morning. Good morning. My name is Cindy Kadavy, C-i-n-d-y K-a-d-a-v-y. I'm the senior vice president at Nebraska Health Care Association and speaking to you today on behalf of our nearly 200 skilled nursing facility members across the state. Just a little background on myself, I've been with the association five years. Prior to that I worked at the Department of Health and Human Services as Medicaid administrator of long-term care services, and then prior to that as the state long-term care ombudsman, which is a program that advocates on behalf of individuals who reside in facilities and their families. So this was designed to be a PowerPoint. I assume and there-- I understand there were some technical difficulties so, hence, you have this handout instead. There's a lot of information on these slides and my intent is to go through those fairly quickly. All of the data and the information, you should find the source on that slide itself. But if you have any questions or need more information, my contact information is also on that last page. We're glad to provide that information. So just as an overview, Nebraska has 221 licensed nursing facilities with the capacity to serve about, almost 17,000 Nebraskans. The other handout that you have in front of you is a list of some common terms related to nursing facilities and nursing facility reimbursement. We thought it might be helpful to have that as a reference, so you should have that in front of you. Moving forward through the slides, on each page, Medicare-- Medicare and Medicaid are a couple of programs that a lot of times get confused. So just wanted to highlight some of the difference between the two programs. They sound the same so often they're confused. Medicare is a federal program and eligibility for Medicare, it depends on your age being 65 or older or on having a permanent disability. So eligibility is not related to being-- having low income or a limited amount of assets. Medicare covers nurse--skilled nursing facility care but, as was referenced early, it's a very limited amount of care. It only covers skilled nursing facility care if there is a qualifying hospital stay and if there is a need for rehab services, and then it's just a short period of time.

Medicaid is a federal and state program. So there are federal requirements but states have some flexibility to design their own Medicaid program within those requirements. Eligibility for Medicaid is based on having a low income and a limited amount of assets. There are a number of eligibility categories but the primary ones are either being elderly, 65 and older, having a permanent disability, being pregnant, or having chill-- or being a child. So another thing that we think sometimes is a misunderstanding: Medicaid payment goes to the provider to pay for the care that the individual needs. It does not go directly to the Medicaid beneficiary. So Medicaid only pays for medically necessary services. We also had some questions that we were asked to address around the difference between mandatory and optional Medicaid services. So Medicaid mandatory services are those that are federally required. Every state must provide that, provide those services. So nursing facility services is one of those mandatory services. The next slide lists the optional Medicaid services that Nebraska is choosing to provide for recipients within our state. Sometimes there's a misunderstanding that these are luxury services. They really aren't. These are services that the federal government has looked at and determined that these can be preventative, their way to avoid higher cost down the road. So that's kind of a list of those.

STINNER: [03:28:06] So is that differently? These aren't really optional. They are prescribed by the federal government?

CINDY KADAVY: [03:28:06] They-- there's a list of services that the federal government federal regs provide that states can choose to provide or choose not to provide.

STINNER: [03:28:14] OK.

CINDY KADAVY: [03:28:14] So they're optional for the state. And then Medicaid state budget, which Is something this committee looks at, is really two different line items. One is the Medicaid

aid budget, and that's where you'll find the funding that goes to providers to pay for the care that is provided to recipients. Also in the aid budget is the money that's paid to the managed care plans and a few state contractor payments. Within the operations budget for Medicaid, that's where you find the money that goes to operate the program in the state. Typically, that's staff wages and benefits, and then a number of payments that go to state contractors who help run the program within the state. Looking at there were a lot of questions earlier about nursing facility payer mix: Who pays for nursing facility care in Nebraska? So this information is based on the most recent nursing facility cost reports, so when you look at the total amount of nursing facility days provided in the state, Medicaid is the payer for 55 percent of those days statewide. And then there's a breakdown that's given on that slide. Thirty-one percent of the nursing facility days are paid for privately, and that means through private insurance or possibly out of pocket. Nebraska has kind of a higher percentage than other states. We tend, I guess, to be savers and insurance buyers, so our percentage of private pay is a little bit higher. The remaining number of days, 14 percent, are covered by other payers. Typically that's Medicare and V.A. payments. Moving ahead on to the current limitations under the current system on nursing facility costs, it seems like there may be a misconception that cost-based reimbursement means that all nursing facility costs are covered in the Medicaid rate, when actually, if you look at this slide, it breaks down based on the most recent cost report numbers. This is the state as a whole. When you look at the total nursing facility cost for the entire state it comes to about $848 million. When you then-- so those cost reports are then audited by Medicaid staff and certain costs are not allowed. Those are the unallowable costs. So then you get down to just what are the Medicaid allowable costs, which comes to about $465 million. In addition to, once you have the Medicaid allowable costs, those costs are divided up into different cost areas and there are caps, or limits, applied to each of those cost areas, which takes those costs down to about $430 million. And these-- these costs are important because those are-- those costs are what is used to calculate the rates for the current year. And then after you have Medicaid allowable costs and then you have limits on each cost area, you have what Medicaid calls an inflation factor, which

is kind of a misleading name. In this case, it actually is a percentage that is applied to each facility's rate to deflate that rate. And so when you look at the imposition of that inflation factor, it takes the cost down to about $377 million. So this is just to illustrate that all nursing facility costs are not covered within this reimbursement system. So looking at each of those limitations, the allowable cost limitation, you might wonder what are unallowable costs. Some examples of those are listed on that slide. If a facility spends money to recruit staff, that is an unallowable cost. If the facility-- the facility is actually required to do a number of background checks on each staffperson, which is commendable, but there's a cost associated with that. That's an unallowable cost. Basically, any cost that Medicaid determines is not reasonable is an unallowable cost. So once you get down to the allowable cost, the costs are divided into different areas that are listed on that slide and there are different caps or limits applied to each of those cost areas. So when you look at direct nursing costs, those costs are limited to 125 percent of the median for all facilities across the state. So that means some facilities have costs that are disallowed just by the imposition of that cap. Support services costs are limited to 115 percent of the median across the state. Fixed costs are limited to $27 a day, and administrative costs are limited to 14 percent of that facility's costs. So looking at how do those limits impact facilities, when you look at just direct nursing cost, and direct nursing costs are basically staff wages and benefits for nursing staff only. And the bulk of any nursing facilities' costs are going to be staff and the majority of those staff are going to be those nursing staff. Twenty-seven facilities, or 13 percent, had costs that were disallowed because of that cap on direct nursing costs. Moving ahead to support services, support services costs, the main cost in that area is food, the cost of providing food for residents as well as wages for other staff that work directly with residents: dietary, activities, social service staff. Fifty-eight facilities had costs that were disallowed because of the cap in that area. Moving on to fixed costs, which a lot of those costs relate to trying to upgrade a facility, doing renovation, new construction, 20 facilities were limited on their fixed costs, had those costs disallowed. When it comes to administrative costs, which are basically the administrator wages and office wages and supplies, 54 percent of our facilities had costs disallowed

in this cost area. So you have the disallowed unallowable costs, then you have caps in each of the cost areas that disallows costs, and then you have the imposition of Medicaid's inflation factor. And what-- how that is imposed on a facilities' rate is after the facilities' rate is calculated, there is an inflation factor, which in this case, for this year, is a negative 7.17 percent, that is applied to each facilities' rate to deflate their rate, making it low enough that should utilization be as Medicaid projects it, it will-- spending, overall spending will not exceed the target amount that they set. So that is kind of a complex formula, but part of it is based, as Jenifer said, on projecting that utilization may change; that tomorrow there may be suddenly people who need nursing facility care. Despite the trend that's happened for over the past decade, that trend could change tomorrow. So projecting for that, that's what leaves that gap. So you look at the following site-- slide, and this is one that I think Senator Stinner referenced, the total Medicaid spending for nursing facility care for the past few years, and this is federal and state together, so federal and state dollars together has remained flat or gone down over the past few years. And you might think, well, that's because of utilization. Well, partly, but partly it's the way the inflation factor is calculated and applied to the rates that ensures that spending will not exceed a certain amount. And that's unusual. In the Medicaid world, if suddenly utilization of home health services goes up, then more Medicaid dollars will be spent in that area and pulled away from areas that have less utilization. So nursing homes are unique in the application of that control factor.

STINNER: [03:34:54] And everything I've read says over the last ten years medical costs and services have gone up, have gone up 5 to 7 percent.

CINDY KADAVY: [03:34:58] Yes.

STINNER: [03:34:58] OK.

CINDY KADAVY: [03:34:58] That's the same amount that we see from our members. And then there's a chart. And again, it's-- some of this information is kind of small. We're glad to provide additional information. But if the full appropriation amount, the intended amount for nursing facilities had been used in that rate calculation, there would have been, conservatively, at least $7 million more dollars that went into funding nursing home rates over the past few years. The following slides illustrate over time the legislative approved increase or decrease in provider rates. And, you know, because of state budget issues, it's not-- the Legislature has not been able to improve-- approve a high-- the high provider rate increases as they approved in the past. For last year and the current year the rates were held flat based on the Legislature-- the-- what the Legislature approved. But again, you see the slide below that illustrates Medicaid's inflation factor. When that is applied then you get, actually, a deflation to the nursing facility rates. The current year is a little bit over 7 percent. And then the next slide reflects how nursing facilities' allowable costs, so not total costs but allowable costs, have increased over the past decade. Part of the rate calculation includes the nursing facility provider tax, and this was an initiative that was brought forth by the provider community a few years back with the understanding that we, as providers, need to offer solutions to helping Medicaid find a way to fund nursing facility rates. It's an initiative that a number of states use in-- in a number of different areas. The way it works is nursing facilities pay $3.50 per resident per day for all of their residents, excluding Medicare, those paid by Medicare. And all of that money is paid to the state on a quarterly basis and it goes into the state General Fund. Those dollars are then used to leverage federal Medicaid match and those dollars are-- then go-- part of it goes to pay the state to administer that fund. Then a portion goes to nursing facilities as a small add-on to their rate. The bulk of those funds go to reduce the negative impact of that inflation factor. So you can see in the current year a little bit more than $20 million was used to raise the inflation factor from a negative 12 percent to a negative 7 percent. So it-- it was helpful in decreasing the overall negative impact. But, you know, as the trends show, it's not doing enough. The following slide is information with actual dollars amount that show the provider tax revenue

and expenditures. So as you, as the committee, look at appropriating General Fund dollars, just know that about $12 or $13 million of state General Fund dollars is-- comes from tax that nursing facilities volunteered to provide. So that money goes into the General Fund. When you're appropriating it, it looks like General Fund dollars, but it's actually facilities being willing to tax themselves in order to offer a solution. This is-- the next two slides illustrate the impact the provider tax had and the impetus for creating it in the first place. So as costs increase and provider rate increases were reduced, the industry recognized there was a need to do something. And it did work. That provider tax was implemented. You can see in the slide that it took the inflation factor in 2011-12, it took the inflation factor from a negative 4 percent to a positive 3 percent. But with trends over time, even the provider tax revenue is not helping that much. The next slide looks-- compares total Medicaid payment for nursing facility services with total Medicaid allowable nursing facility costs. And again, you see the gap as a whole is increasing over time. The following slide is basically the same information, but it breaks it down per resident per day the gap between the average Medicaid payment for nursing facility care and the average cost of providing that care to that resident. To wrap up, I wanted to go quickly through some misconceptions that we really wanted to address. So just going quickly through this, there's a misunderstanding, we feel, that Nebraska spends more on Medicaid services than other states. The following slide shows information that's provided by the Center for Medicare and Medicaid Services based on expenditure reports from each state. And it shows that Nebraska ranks 46 out of the 50 states, plus District of Columbia, on Medicaid expenditures per resident in 2015 and 2016, which is the most recent data available. Another misunderstanding is that Medicaid is the biggest part of Nebraska's budget, especially when compared to the U.S. as a whole. The next slide, and this information comes from the National Association of State Budget Officers, so each state provides this information on state spending. So this is state spending only, not federal dollars. But when you look at the percentages of Nebraska's budget and where it goes, you can see that Medicaid is not the largest state expenditure in the current budget. And the following slide compares that percentage breakdown to the U.S. as a whole.

And you can see that when you look at Nebraska's expenditure for Medicaid, it's significantly lower than the U.S. as a whole. Another misunderstanding is that Nebraska spends more on nursing facility rates than other states. Our national association, the American Health Care Association, takes Medicaid cost reports from any state that's willing to report and puts that information together. This is a chart that looks at the 33 states that reported their nursing facility-- shared their nursing facility cost reports. And it shows that Nebraska's average nursing facility rate ranks 28 out of the 33 states. And when you look at the average for those 33 states, Nebraska's nursing facility rate is $36, a little bit more than $36 under the average rate. Another sometimes misunderstanding is that Nebraska spends more on what is referred to as institutional care than they-- we do on home- and community-based services. And in 2016, and again this is information from the Centers for Medicare and Medicaid Services, in 2016 Nebraska actually spent $48 million more on home- and community-based services than on what they call institutional services, which are nursing facility and intermediate care. Another, sometimes we hear that older adults should just save and pay for their own long-term care costs. This is information and it's also referenced in testimony, written testimony, from AARP. This is a recent study that they pointed to that looks at filings for bankruptcy from 1991 to 2016 by age group. And it found that for individuals aged 65 and older, the number of bankruptcy filings increased by 500 percent over that time period. For individuals 75 and older, the increase was closer to a thousand percent. And when the participants in the survey were asked what caused that financial distress, they were told it's the increasing healthcare costs that we're paying out of pocket. And what I think this may mean for the committee is that in the future more people may rely on Medicaid to pay for their long-term care. So access may be more of a concern. Another misunderstanding, we sometimes hear that when nursing facilities are struggling with work force they should just pay their staff more. So this article is one that ran in January in the World-Herald. We commend the Governor for announcing that he was raising the starting wage for nursing assistants in state-run veterans' homes by 20 percent. That's a good move. You know, those people are the ones who care for our most vulnerable individuals, so we commend him for doing

that. Nebraska state veterans' homes do not accept Medicare or Medicaid payment, so they are not impacted by that Medicaid underfunding. So they are able to raise those starting wages that 20 percent, up to over $14 an hour for a nursing assistant. Our members would love to be able to do that. But when you rely on Medicaid funding and it's-- you're underfunded for the cost of care, it makes it difficult to do that. My last one that I wanted-- that we included here is a misunderstanding that-- and I think this might have been referenced earlier-- that our occupancy is not a hundred percent at all nursing facilities so we can afford to lose a few nursing facilities. When you look at this map of Nebraska, the counties shown in black are counties that do not have any skilled nursing facility at all within their county. The counties shown in red are the counties that have one nursing facility to serve that entire county. A lot of those in the red counties are small city- or county-owned and operated facilities that are likely more at risk financially than some others. So when you look at that map and think about what that means if we lose facilities in some of those counties, how far that individual would have to move to get nursing facility care and how far their spouse or family would have to travel to visit them in their home, I think it's impactful. So that's kind a quick overview of that information. Glad to answer any questions.

STINNER: [03:43:21] Wow. Thank You. Questions? There's so much information, it's hard to come up with questions. I did ask the director about the disparity between $119 and the $241 and what drives that. Could you give me your impression of what that's about and shouldn't it be narrowed somewhat, I would think? But-- so--

CINDY KADAVY: [03:43:27] And Heath Boddy is also going to address that to some extent. But just briefly, the cost-based reimbursement, you know, it does recognize that some facilities have-- spend more money on, you know, for whatever reason: hiring more staff, upgrading their facilities. So over time, that disparity in rates has grown. That's something that we, as the association and our members, have recognized and we have actually brought forward, even prior to Dr. Van Patton,

have come forward saying we need to change this reimbursement methodology. Even those members, and we have a number of members who are on the higher rate end, are saying this is not what's best for the state. We know it would hurt us, but we need to look forward and say what is going to may-- sustain access to these necessary services into the future. So the rate alley that Dr. Van Patton talked about is a component of the system we're proposing in order to move those rates closer together, with the idea that that's more sustainable over time. Our model also includes a quality component. We believe the same thing that he talked about, that you need to tie payment to-- to an expectation of quality care. We may not be on the same page as far as the metric. Some of those quality metrics are actually based on a bell curve, so no matter how much a facility improves there's always going to be a certain number within a state that are one and two stars. That's the way the system is-- is created. So we might not be on the same page as far as the met-- the system, but we do believe in quality care.

STINNER: [03:44:50] I won't go into the bell curve. I'll wait till Mr. Boddy gives testimony. One- and two-star facilities, are they mostly rural, are they mostly private owned, or are they owned by cities, counties?

CINDY KADAVY: [03:44:54] Well, and we can get you that data. I don't have that at hand. The one thing that I can say is the five-star system that Dr. Van Patton talked about is operated by the Centers for Medicaid and Medicare Services. In July of this year, met-- Nebraska always scores higher than the national average. We always have, you know, by and large. And so in July of this year, CMS changed how they-- how they-- how facilities are expected to report their staffing numbers. So in July, Nebraska's overall quality measures was over three stars and we were going along. In July, if you look at the data, there was a sudden drop, like this, from one day to the next. That didn't mean that all of a sudden every nursing facility provided bad care from June 30th to July 1. It meant there were problems with the reporting-- reporting mechanism. There were a number of

facilities that used a certain software that failed to report, and they were not on top of that. So it was a reporting issue. It was not a quality issue. So that's an example, just using that metric, of it-- it is a-- it is a measure and there is value in that if you say this is totally objective. And I know if I go to a one star versus a five star I'm going to get a lot better care over here, it may not completely meet that criteria.

STINNER: [03:46:08] Let me ask you this. How many, in your estimation, of the facilities that are in Nebraska are one-star rated--

CINDY KADAVY: [03:46:12] So--

STINNER: [03:46:12] -- or not rated but are one star--

CINDY KADAVY: [03:46:13] Are one star.

STINNER: [03:46:13] -- or deserve a one-star rating or a two-star rating? And we talk about this curve and it's forced into this curve--

CINDY KADAVY: [03:46:15] Yeah.

STINNER: [03:46:15] -- and I get that. I'm still trying to figure out how that works. But how many facilities truly are a one star?

CINDY KADAVY: [03:46:17] You know, I'm not sure I feel qualified to-- to answer that. You know--

STINNER: [03:46:20] Is it as bad as it shows up on this page or is it maybe a little bit better?

CINDY KADAVY: [03:46:22] I would say it's probably a little bit better than what you see on there. One of the quality measures within the five-star system actually focuses more on outcomes, so on patient outcomes. The overall quality measure is influenced a lot by staffing numbers, strict numbers. And just as the ombudsman, being an advocate, I know, by going into facilities, having more numbers of staff doesn't always necessarily mean you get better care. So metrics have good and bad, I guess.

STINNER: [03:46:49] But that's just one complement out of 16 different measures.

CINDY KADAVY: [03:46:49] Well, there's actually four measures. There's two that are staffing. One is overall nursing staffing. One is RN staffing, is weighted heavily. Then the third is their survey, their annual survey that they receive and the scores. And then the fourth is the outcome measures. So there's four components to the overall quality.

STINNER: [03:47:07] Questions? Senator Wishart.

WISHART: [03:47:07] Speaking to that, when you look at the five, the four, and the three, two, one-star ratings, how much of that is tied to the funding sort of portfolio that that facility is able to have? So how many of those two- and one-star rated facilities have a significantly higher percentage of Medicaid recipients than the five star? Because I have been to a private pay, exclusively private pay facility, and it's unbelievable. I would live there in a heartbeat now, it was that amazing, to walk down to breakfast in this beautiful restaurant.

CINDY KADAVY: [03:47:15] Yeah.

WISHART: [03:47:15] So I've been to a private pay. And then I have been visiting some assisted-living facilities. It's not nursing but assisted-living facilities where their funding is exclusively not even just Medicaid. I mean it is so much even smaller than that, and they cannot make it. And there's no way that they could be anything but a one star with that kind of money. So how much of the one and two is related to the amount of-- just the fact they don't have a diverse funding stream?

CINDY KADAVY: [03:47:27] Yeah. And, you know, a diverse funding stream is awesome. It's just not always possible. I mean you all referenced that. You know, if you're in a community, you serve that community and the needs in that community. I don't know the answer to that question, but I think you make a good point in that if you're trying to improve your quality of care it's hard to do it with less money. And if you're losing $36 a resident per day on, you know, serving the Medicaid population, you can't make that up by serving more of the Medicaid population. So--

STINNER: [03:47:52] Additional questions? Senator Bolz.

BOLZ: [03:47:52] Thank you. This is very helpful. All of your-- all of the nursing facilities in Nebraska are licensed.

CINDY KADAVY: [03:47:56] Licensed? Yes.

BOLZ: [03:47:56] Are they all accredited?

CINDY KADAVY: [03:47:57] They are not all accredited. That would be a choice of the facility. There are some facilities that are Medicare and Medicaid certified and some that are not,--

BOLZ: [03:48:05] Uh-huh.

CINDY KADAVY: [03:48:05] -- a very small amount,--

BOLZ: [03:48:06] Uh-huh.

CINDY KADAVY: [03:48:06] -- and they tend to be specialized.

BOLZ: [03:48:07] What I'm-- what I'm trying to ask, and maybe at some point you can help us navigate or figure it out, is the star rating system would not be the only system or the only way to look at whether we've got high quality or medium quality or lower quality service provision. All of the facilities are meeting a basic bar that we established, as the Legislature, and implement through Public Health licensure. So they're-- they're all meeting a standard. There are other ways besides the rating system: to say that they're accredited; they might have a specialization in Alzheimer's and dementia care. We established that a couple of years ago.

CINDY KADAVY: [03:48:32] Yeah.

BOLZ: [03:48:32] So we don't have to use the star rating system to line up with our-- we could make choices is what I'm trying to say.

CINDY KADAVY: [03:48:36] Yeah. And, you know, nursing facilities are surveyed every year. I mean that's a federal requirement. So a little bit, you know, assisted living is a little bit different, but, yeah, they are. And, you know, our facilities also do consumer satisfaction surveys. One of the things that we've been pushing with the Medicaid department even before Dr. Van Patton was there is, you know, just much like hotel ratings. We feel the best measure is ask the people who are

receiving the service and their family members, would you recommend this facility, you know, to somebody else and are you getting good care here? We feel like that's a good measure. And so we have pushed in the past to have the state take that on as a independent third party and measure that as one measure of quality, so--

BOLZ: [03:49:14] Uh-huh. That's helpful. Thank you.

STINNER: [03:49:15] Additional questions? Thank you.

CINDY KADAVY: [03:49:15] Thank you.

NATHAN SCHEMA: [03:49:15] Hello, Senator Stinner and members of the committee. My name is Nate, Nathan Schema, N-a-t-h-a-n, last name is S-c-h-e-m-a. I'm the regional vice president operations for the Good Samaritan Society in Nebraska and I'm proud to serve nine-- I oversee 19 locations in Nebraska, and part of a nonprofit Christian organization based out of Sioux Falls, South Dakota. We have over 200 locations in 24 states. Just wanted to go through a quick profile here of who we serve and what we do here in Nebraska. We serve over 2,000 Nebraskans. And if you throw in our home- and community-based service, you could add another 500 on that. So we're close to 2,500 seniors that we serve currently in the state. I wanted just to break down some specifics exactly to provide some samples of how Medicaid funding really impacts us, not only in rural areas but certainly in urban areas as well. I think, Senator Stinner and Senator Wishart, you guys have touched on this in a few different ways today. Access to services: What happens up in Cherry County right now when, as-- if you saw in Cindy Kadavy's earlier map, there's a lot of black ground? So how many miles do you have to go if you-- if we don't have services to be able to provide in a community like Cherry County? We have a lot more cows in that community than we do people. The other thing that I feel uniquely qualified to share today, and I'm not very excited to

share this with you all, but over the last 18 months I had to stand in front of a group of residents, staff, and family members, and we closed three different communities in Nebraska, not too “undifferent”-- not too unlike many of the communities that we still serve in. As you look at the map there, we're in some pretty rural communities right now. And I'm here to-- I'm here today to tell you that we're-- we have a lot of communities that are still extremely fragile and what I would describe as very much at risk. I think there's no magic number. And I think Dr. Van Patton talked about, well, there's a sea of payer mixes in many of these communities. And I just appreciate so much hearing Senator Vargas and Senator Wishart. You-- you-- you really are trying to understand what that looks like. At the Good Samaritan Society, we've been serving in many of these communities for anywhere from 50 to 75 years. We've tried to-- we've taken the position that we're going to serve these communities. We're going to serve the family members that have been there from us from the ver-- with us since the very beginning. Unfortunately, a lot of those times or at this time that we're seeing a lot of folks just run out of money and run out of funds and so that they need that Medicaid assistance. After closing three facilities in the last couple years, you would expect, well, maybe that would drop my payer mix, because oftentimes, once we hit that 60-70-80 percent Medicaid mix, it just reach-- it reaches an unsustainable point where we just don't have enough funding to run these buildings. I like to describe it as a vicious cycle. Once your Medicaid gets to a certain point, you're no longer able to compete and find the best, most qualified staff. You have to staff a certain way, because I don't have the money to pay any more. I would love to be able to staff at five-star levels in every single building, but I, honestly, don't know that we can afford that or we're not going to be able to serve these communities that we currently reside in. I think the other thing that I really wanted folks to understand today is, as you look at our map and have the access issues that we have across Nebraska, are we comfortable, as a state, saying you know what, you're going to have to drive to Lincoln and Omaha for service? Are we comfortable saying that right now, because I have a number of communities that are very much at risk. And I truly believe that if we don't see some additional funds over the next couple of years, certainly I would even probably back

up and say if we see some additional funding here within the next year, I'm going to have to get in front of a lot of constituents and have some very difficult conversations with my residents, families, in places that we've served for many, many, many years. And just lastly, the other part when I talked about it's not just an urban and-- and a rural iss-- rural issue, urban's pressures are just different. Or the wages that we have to pay in Omaha, and I only have one building in Omaha but I do have a couple there in Grand Island and Kearney, which we're-- are certainly a little bit more urban. With the V.A. paying $14 an hour a start-- start, starting wages in Kearney, I don't have the ability to pass on those costs if I'm at 60-plus percent Medicaid, which in most of my buildings I am. So when that roof comes to bear in Hastings, Nebraska, I got to replace that roof at a ticket of $750,000, I don't know where that money is going to come from. Thankfully, we've-- we've seen a lot of philanthropic support over the years, but, again, those people don't have the same resources maybe that they once did. Or we're serving a different population. Again, I don't have the ability to give on top of what they're already paying for each and every day. So I, again, I would just ask for additional consideration for funding and would certainly welcome any questions from the committee.

STINNER: [03:52:45] Questions? Senator Wishart.

WISHART: [03:52:46] So I'm going to look at Cindy for this to see if this is equivalent. But when I visited an assisted-living facility-- I know it's different from nursing-- what they were saying is-- and this is one that is-- is-- has been very resourceful in being able to serve a higher level of Medicaid recipients. They can take 30-- they said about 36 percent of their facility could be Medicaid to make it work. Any more than that and it's just not going to be financially viable. Is that similar to what we would be looking for-- for a nursing facility, about that 36 percent? Thirty-- thirty percent Medicaid population; the rest are private pay, to be able to make that work.

NATHAN SCHEMA: [03:52:58] I think there would be a lot of factors that you have to consider.

WISHART: [03:53:01] OK.

NATHAN SCHEMA: [03:53:01] And certainly I would defer to Heath and Cindy on a--

WISHART: [03:53:02] OK.

NATHAN SCHEMA: [03:53:02] -- more statewide perspective,--

WISHART: [03:53:03] Yes.

NATHAN SCHEMA: [03:53:03] -- given that there are different factors, different payers, size of locations. So I think there's a few different dynamics that would have to go in there. I don't think there is a hard and fast number. You talked about different-- if you're an extremely rural provider and sometimes your rates are even-- it's harder to find staff so you have to pay even more money. So then your pressure on your Medicaid funding is even greater.

WISHART: [03:53:21] Yeah. Because when I hear 60 percent, I find it, I mean I just, I mean I commend you for making that work. I-- I find it hard to believe that that-- that that is sustainable in terms of our rate structure right now to be able to sustain yourself at 60 percent. I did want to talk to you, it seems like some of the takeaways from today's conversation is that-- is a move towards consolidation, which would mean, from what I can see, a move out of rural areas in terms of the services, a move towards consolidation if we don't change the rates. So more closure of rural nursing facilities as we move towards consolidation and then a reliance on home healthcare. Can you talk to me about the population you serve? At least from my door-to-door experience, there

were a lot of people I met at their doors who were very isolated and not thriving within their home and would have done a lot better actually being in a residential facility. So can you talk about the population you serve and, really, the practicality of somebody living in their home?

NATHAN SCHEMA: [03:53:51] Absolutely, and I think you bring up a great point. While you might see some dollar savings if you have the ability to provide some folks care at home, what I-- what our experience has been, and again, we serve in all those different services and “postacute” care, we don't have the staff to serve people at home. I think of several different communities, especially out west, that there aren't home health agencies, there aren't hospice agencies in many, many communities because they just don't have the people to serve them, not to mention the different impact, the impact on residents with isolation,--

WISHART: [03:54:16] Yes.

NATHAN SCHEMA: [03:54:16] -- and the different dynamics that occur from social, social isolation for these residents and the impact that that has on them from a psychosocial perspective. You would argue that that certainly isn't benefiting that person versus being in that institution. So, absolutely.

WISHART: [03:54:27] Yeah.

STINNER: [03:54:28] Thank you. Additional questions? Seeing none, thank you very much.

JEAN HARTNETT: [03:54:28] Morning, Senators.

STINNER: [03:54:28] Morning.

JEAN HARTNETT: [03:54:28] My name is Jean Hartnett, that's J-e-a-n H-a-r-t-n-e-t-t. I'm the chief executive officer of the Douglas County Health Center and I am delighted to be here today to present on the services that we preside-- that we provide at the Douglas County Health Center and also talk a little bit about our challenges. The Douglas County Health Center is an institution that has served, proudly served, the Omaha community for over 100 years. We continue to be a leader in healthcare in our community and we are proudly recognized by the Centers for Medicare and Medicaid Services as a five-star rated facility. We are one of the only facilities in Nebraska that has consistently maintained this rating since the program's inception in 2008. The Douglas County Health Center is licensed for 254 beds and those beds are divided into certain specialty groups. We serve individuals that have dementia. We serve individuals that have geriatric psychiatric diagnoses, as well as individuals that present with medic-- medically complex issues. About three years ago we opened up a different neighborhood that focused solely on short-term rehab. Our occupancy average is approximately 93 percent and Medicaid accounts for approximately 76 percent of our patient care days. However, Medicaid only accounts for about approximately 54 percent of our funding. So even though we have a large percentage of Medicaid individuals, what we're getting reimbursed doesn't cover all of our cost. Douglas County provides a unique service to the community. We are known as the provider of last resort, a dubious honor that we really wear as a badge of pride. We really take those individuals that other nursing facilities are unwilling or unable to care for, so individuals that have, again, a high diagnose-- a high acuity of behavioral needs as well as certain types of dementias that progress into agitated and aggressive states. We also receive a large portion of individuals that were living in an assisted living and paid privately for a number of years, but because they spent through their wealth and have matriculated to Medicaid rolls, assisted-living facilities typically will discharge those residents to us. So they've aged in place in assisted living, spent through their wealth, and now they are a higher acuity resident that is funded through Medicaid. Our memory support and our behavioral support neighborhoods are structured at the

Douglas County Health Center to continually address the needs of those who cannot find placement in other nursing facilities. We serve individuals with serious behavioral challenges, including again, as I mentioned, the physical aggression and agitation. I'm not certain how much the committee knows about dementia, but dementia is a progressive disorder. When you're diagnosed with dementia, you can pretty much guarantee that you're not going to get better from this disease. You're actually going to get worse. And what happens for the individuals that have certain types of dementia, such as Lewy body or frontal temporal lobe dementias, those are the dementias that are-- trigger at any given point, meaning anything can trigger a certain behavior. And many facilities are unable to handle a certain type of aggression because they certainly-- they specifically don't have the staff or the expertise to know how to treat them. Douglas County, on the other hand, specializes in managing the behavioral and psychological symptoms associated with dementia. Very few facilities in this state, other than Douglas County, are willing and able to manage these residents. Residents that are in other facilities typically get discharged to an acute care hospital where their behavior only worsens because their environment has changed. They'll languish in an acute care hospital until a bed opens at Douglas County for them to be placed. In addition to the-- the dementia-related behavioral issues, Douglas County serves many older Americans that-- older Nebraskans that suffer from serious psychiatric illnesses, such as schizophrenia and bipolar disorder. These conditions also make caring for them in a traditional long-term care facility difficult or impossible. But once again, Douglas County has been willing to serve these individuals because there is no else for them, no other place for them to go. Years ago they would have gone to our psychiatric hospitals in Hastings, in Omaha, in Lincoln, but those facilities are no longer accepting residents because they are at capacity as well. My journey to managing this prestigious organization began 30 years ago when I started working as a certified nursing assistant at Madonna Rehabilitation Hospital. At the time, I was 18 years old and I was studying social work at the University of Nebraska. So this part-time job paid for my books and other sundries and really started my love and caring for individuals that can't always care for themselves. When I started in

long-term care, OBRA '87 had just become law of the land. So OBRA '87 is essentially the Nursing Home Reform Act that literally changed the way that care was being delivered. I recall coming in to my 3:00 to 11:00 shift when the organization that I worked for had implemented OBRA '87, and everything that we did with our residents had changed. There was a time when we used to do-- strap down our residents because they were a fall risk, and strap them to the bed and secure them in that environment so that they wouldn't fall. We also used to use chemical restraints or high-- high doses of medication to kind of control their behavior. We also used to use heat lamps, if you can imagine, to treat pressure sores on our elders' bottoms. All of these things we were doing back in the day we thought was great care, and it wasn't. And OBRA '87 really gave us the opportunity to reflect on the way that we're delivering care to our seniors and really helped us realize that how we were doing things wasn't necessarily best practice. Fast-forward 30 years later and we're now looking at different regulatory fixes that the Center-- Centers for Medicare and Medicaid Services believe will improve the quality of care. If you're familiar with the requirements of participation, which is a phased-in system of regulatory reform that are hitting nursing homes right now, some of the things that the CMS is asking us to do over these three years is causing an extreme regulatory burden on our facilities. We're asked to do such things as assess our residents for trauma-informed care. So, for example, if an elderly woman had been sexually assaulted in her teens, we're somehow supposed to glean that and be able to provide for this person's care and understand that it's trauma informed. So maybe, for example, how it would translate on the operational level, if there was an elderly woman who had been sexually assaulted we probably wouldn't want a man taking care of her. What the CMS is requiring us to do is to be all things to all people, but at the same time they're not willing-- we're not getting the amount of reimbursement that we are-- we need to care for the individuals that come into our nursing homes. To be a long-term care leader really requires you to be a chief cook and bottle washer of the entire operation. The demands on individuals such as myself and my other colleagues that are in this profession-- and I do call it a profession, not an industry, you will notice-- is extraordinary. As I mentioned, I've been in this since I was 18 years

old and now I'm 48. And the things that I have seen changing at the front-line level, at the operational level, it's-- it's daunting. And I worry that individuals like myself, and we come to this profession because we love it, are really going to get burnt out and-- because it's so difficult to manage a business on a shoestring. The things that I need to ask this facility, or pardon me, this com-- this committee to do for us is to really recognize how different the Medicaid reimbursement models ought to be for facilities like the Douglas County Health Center. As I mentioned, we take care of a really different population, yet our reimbursement is similar to those that don't have such challenging clients. So one of my asks of the committee is to look at ways that we can incentivize organizations like the Douglas County Health Center so that we would receive a higher reimbursement. I will close and say that I again appreciate the opportunity to testify and to provide our story, not only as the Douglas County Health Center but as an individual who comes to this profession with years of experience. We know that healthcare is going to change but we hope that in achieving the triple aim, which is better outcomes, patient satisfaction, at a lower cost, doesn't become the triple whammy.

STINNER: [04:01:55] Thank you. Questions? Senator Bolz.

BOLZ: [04:01:55] Thanks for being here. And I heard this summer from a similar organization whose owners are in my district, and I think you make a compelling case for why facilities that serve individuals who have more significant needs are different.

JEAN HARTNETT: [04:02:06] Uh-huh.

BOLZ: [04:02:06] Mental health needs are different. In order to identify that difference and reimburse you appropriately, do-- does that come through a statute change through the depart-- through the HHS Committee where we give you a different designation? Does it come through our

committee where we-- we provide a pass-through rate to mental health [INAUDIBLE]? How mechanically do we identify who we're talking about and give us a vehicle for increasing that reimbursement to you?

JEAN HARTNETT: [04:02:28] Yes, great question. I think there's a number of ways that this could be structured. Currently in the Medicaid regulations there is an opportunity for providers that are really providing care to a special population can negotiate that rate. So perfect example of that is a ventilator assistant unit. Ventilators in individuals, young, old, middle-aged, are really tricky types of programs to manage and to run, yet-- and the state has recognized that in order to do that you really need a high patient-to-staff ratio because of that acuity. I don't see that this would be any different in carving out and really applying those regulations to organizations like Douglas County that are taking care of individuals that have a prevalence of behavioral needs.

BOLZ: [04:03:07] So already existing is the opportunity to identify your types of services as a special kind of services-- service and negotiate the rate. So maybe it's a follow-up conversation, but I think we need to figure out how to translate that into an ask for this committee so that we're-- we're making sure that the goal we're trying to achieve, which is supporting nursing facilities that have a high mental/behavioral health population happens.

JEAN HARTNETT: [04:03:26] Yes.

BOLZ: [04:03:26] So we'll talk more.

JEAN HARTNETT: [04:03:26] That would be great. Thank you, Senator.

STINNER: [04:03:26] Senator Hilkemann.

HILKEMANN: [04:03:26] Just a couple of questions, and I've talked with Commissioner Boyle about the-- your facility there a lot. I was a little surprised, in your testimony you said Medicaid accounts for approximately 76 percent.

JEAN HARTNETT: [04:03:27] Yes.

HILKEMANN: [04:03:28] I would have thought it would have almost been 100 percent. What-- what's the other payer? What comes in?

JEAN HARTNETT: [04:03:28] The other payer sources that we're recognizing and that we've received revenue from is a V.A. contract as well as Medicare. So that short-term rehab program I talked about that we developed about three years ago is a short stay program that is funded through Medicare. The Veterans Administration is right across the street. And so we have a contract with them. Their rates our Medicare rates, so that is how we're able to offset the 76 percent that we receive from Medicaid.

HILKEMANN: [04:03:45] OK. Thank you.

JEAN HARTNETT: [04:03:45] Uh-huh.

STINNER: [04:03:45] I understand you saying in your testimony that without the county reimbursing you or holding you up, to the tune of about $8 million, you'd cease to exist. Tell me, if I looked back over the last five years, is that number stagnant or has it been growing?

JEAN HARTNETT: [04:03:47] That number, as far as I understand, is stagnant. And you heard

Cindy testify that the Medicaid days are going down across the state. At the Douglas County Health Center, they're going up. So what that means, again, it's that whole transition of individuals that have spent their wealth in other facilities that are coming to us on Medicaid. So our Medicaid days, the amount of days that Medicaid is paying for, is going up. The $8 million that we have been subsidized, that is tending to stay the same, which is actually good news. And the reason why we see it staying the same is that we are able to diversify our revenue by bringing in Medicare and also the V.A. contract.

STINNER: [04:04:23] OK. Tell me about capping expenses. We have allowable expenses to a level, you start to cap those. Have those caps increased with inflation over a period of time or have they stayed fairly stable?

JEAN HARTNETT: [04:04:28] From my understanding, they have stayed stable, and Douglas County Health Center is always at the caps when it comes to support services and nursing costs. One of the things that I have really focused on since being at the health center is bringing about this notion of operating with our for-- with a for-profit mind-set while keeping our nonprofit hearts, and that's not always easy to do. If you've ever been to the Douglas County Health Center, you see that our physical plant is almost an entire city block. And that physical plant has been around again for a hundred years. We have asbestos in the ceiling. We have asbestos in our tiles. So anytime that we move out a resident, we've got to do some repairs. That is not just painting and plastering. It's a whole asbestos abatement process. And so there's-- there's a lot of things from a physical plant standpoint where we really struggle to stay modernized and we kind of take it room by room by room.

STINNER: [04:05:14] OK. Thank you. Additional Questions? Seeing none, thank you.

JEAN HARTNETT: [04:05:14] Yes. Thank you.

HILKEMANN: [04:05:15] Thank you.

STINNER: [04:05:15] [INAUDIBLE].

SETH STAUFFER: [04:05:15] Hello, Senators. Thank you for-- thank you for allowing me to speak to you today. My name is Seth Stauffer, S-e-t-h S-t-a-u-f-f-e-r. I am the administrator of a nursing facility in Milford. It's about 20 miles west of Lincoln. We at Sunrise are a family-owned and operated facility and we have been for three generations. This is our 65th year. So-- sorry. What we do at Sunrise is we are a unique facility, in many ways like Douglas County Health Center. We take care of a unique population that-- that often is overlooked by other facilities and we may end up in a position of being that facility of last resort. We often take care of a wide range of ages. We have a younger population than is normal. We-- we take care of a high degree of behavioral complications and a majority of our residents have a ment-- mental illness diagnosis in addition to their other needs that qualify them for nursing home care. What we-- what we have done at Sunrise is very mission driven. We-- we take care of a population of residents that, to be frank, many people do not want to care for. Many of the facilities with business models that you would point to as successful, these are not the residents that they want. But they are the residents that we care for. And we care for them. We love them. That is what we do and we have done it for a long time. We believe in what we do. Many of our staff stay with us for long term, even though it is difficult for us to be competitive with wages and benefits. They stick with us because they love our residents and they love what we do. I believe it's a need that exists. And I-- I heard today that we shouldn't exist; we're 83 percent Medicaid and we shouldn't be there. And I disagree. And I would urge you to consider that that-- that doesn't fit with reality. Our case, like many cases, may be different, but we-- we do a good job of caring for difficult people in difficult situations and we-- we do an excellent job

doing it. This year Sunrise received a national quality award, a national silver quality award from American Health Care Association. That's-- I say that to say that, despite the challenges that we have, we still strive to provide excellent care for our-- for our residents. We, if you look at the scale of all the facilities and the reimbursements, Sunrise is 16th from the bottom as far as the total Medicaid rate. We have a very low-- for the last three years on its own we-- we've had a consistent level of 90 percent occupancy. Eighty three percent of that has been Medicaid the whole time. And we've had very consistent costs. They've increased slightly, around 1 percent per year, but over the last two years our Medicaid rates have gone down by 8 percent. With an 83 percent Medicaid population, that has put us far outside of what is sustainable. We're at a point that our facility is struggling. We-- we can't do it. Our operations have exceeded our-- our reimbursement significantly. We are seeking some kind of loan to continue operations in lieu of something changing with the-- with the rate distribution model or funding, because we believe in what we do and we want to continue doing it. I would ask the committee to consider that there-- there are outliers. And I believe that quality is an important driver to what-- to what we do and it should be considered. But behavioral health is an often overlooked sector. And very frequently the residents who have those needs, the Nebraskans who need that care are unable to receive it in other facilities that are more focused on their positive payer mix or their business model. It's-- it just doesn't-- they don't-- they just don't look good sometimes. That's just-- and that's just the truth. So if we were to see-- receive a change in funding that would go to, as it has always gone to with our organization, into increased and more competitive wages and benefits. We would continue to do the projects, maintaining our facility that-- that we have to put on hold. Three years ago we were-- we were just making it. We were-- we were just OK. We had put off projects. We have an 18-year-old 10-year roof, you know, things like that. We-- we keep stepping those back, waiting till we might have the funding. But every time we have a chance to put money into wages, a project that needs to be done, that is what we do. And since over the last two years the rates have decreased, we are reaching a point of not being able to meet our payroll. If we can't, I mean, if we cannot get a loan from our

bank, if they choose not to work with us, then in the next several months we will be another facility that's in state receivership. And from my perspective, and I grant it's-- it's a limited perspective and I'm looking at this from-- from us and what we do. If we do close, the only mistakes that we will have made, our beats-- will have been that we operated efficiently and so, therefore, we ended up with a low Medicaid rate, and we took too many Medicaid residents, even though they are the residents who need the care. So thank you.

STINNER: [04:08:43] Thank you. Questions? Senator Hilkemann.

HILKEMANN: [04:08:44] [INAUDIBLE] questions. Thank you for your ministry. Are you-- I'm assuming you are a for-profit facility.

SETH STAUFFER: [04:08:45] We are.

HILKEMANN: [04:08:45] OK. And how many stars does CMS have for you?

SETH STAUFFER: [04:08:45] Currently we are a three-star facility.

HILKEMANN: [04:08:46] OK. And you said that you had an 8 percent decrease in the last--

SETH STAUFFER: [04:08:48] Two years.

HILKEMANN: [04:08:49] Two years. OK. And what's the average age of your clients?

SETH STAUFFER: [04:08:49] The statistics are [INAUDIBLE]. We're-- it's-- it's in-- it's in the 50 to 60 range.

HILKEMANN: [04:08:50] OK. Because if you've got a lot of folks with, as you said, the mental capacities, you-- you could have them ranging from 18 to--

SETH STAUFFER: [04:08:51] Do you want a range? We have-- we are caring for residents that range in ages from 11 years old to 94 right now.

HILKEMANN: [04:08:55] Eleven to ninety-four.

SETH STAUFFER: [04:08:55] And the 11-year-old is an outlier. Generally, we have people in their 30s to 90s.

HILKEMANN: [04:08:58] OK. Thank you, Seth.

STINNER: [04:08:58] We've got the Health and Human Service people here. I thought we had a behavioral health budget to help this person out. I would probably look to see what's available out there in the special needs side of things, so. But I do appreciate your work and hopefully we can come to some decisions and conclusions.

SETH STAUFFER: [04:09:05] OK. Thank you.

STINNER: [04:09:06] Thank you.

WISHART: [04:09:06] John, from my experience, the rates for reimbursement for-- for mental health especially are-- are even more [INAUDIBLE].

STINNER: [04:09:06] Yeah. Well, I thought maybe combined.

SETH STAUFFER: [04:09:06] [INAUDIBLE].

EDWARD MATNEY: [04:09:06] Thank you to Chairman Stinner and members of the committee for allowing me to speak. My name is Edward Matney, E-d-w-a-r-d M-a-t-n-e-y, and I'm here to tell you about my family's nursing facility in South Sioux City, Nebraska. Matney's Colonial Manor was founded by my grandparents, Edward and Lily Matney, in early 1970s. It...my grandparents were raised in the Great Depression. They were tremendous work ethic individuals, very cost conscious. My grandmother was a nurse. My grandfather was a builder. They focused on saving their money and founding a business to provide care for the elderly and the infirm. It was their life's mission to have it be a family focused business, provide care to our community. And they did that for many years and in the early 1970s handed the baton to my parents, Edward and Nicola [PHONETIC] Matney, who then continued on with that legacy. My mother was also a nurse. My father was a builder. Matney's Colonial Manor became his, in particular, life's work, also for my--- for my mother, who worked in the facility as a nurse and as an assistant director of nursing. My father was the administrator. When my parents took over Matney's Colonial Manor, my dad focused on making some changes to the physical plant, obviously, modernizing things, adding on a dining room, a new activities area for life enrichment activities. They set upon strengthening the community connection that my grandparents had already built a sound foundation for. I, along with my siblings, I basically grew up around the nursing home, which is an interesting-- interesting but very rewarding experience, different from anyone I ever attended school with and get a full appreciation for your elders. Part of those community activities included fairs that they would host at the nursing facility, a huge event for many years on the 4th of July that would draw people from all over South Sioux City and even over the bridge in Sioux City, Iowa. Events that would require special permitting and permissions from the city of South Sioux City because of the fireworks,

obviously, and the parking that would be all over the place. It was truly wonderful to be a part of the community and to be a family doing that, serving other families, which I think is a very unique and honorable mission. And as the prior testifier indicated, it would be a terrible thing to lose that in our state and I'm concerned that we're on the cusp of that for others. It certainly has-- a problem that's befallen my family. One other thing my-- my dad did in the-- after taking over the facility is he saw kind of the changing trend with people wanting to live in more of an assisted-living type environment so they that could perhaps downsize from their houses and move into a smaller setting. And you'd still have an apartment and a garage, but you'd be very close by in case you would need to make a transition into a skilled nursing facility, to rehabilitate there and perhaps return to your-- to your assisted-living apartment. My dad was a great business man and-- but, above all, he always impressed upon all of us, as did our grandparents, that the business was business of caring for others. I have many fond memories of when I worked in the nursing home in various capacities, whether it was buffing the floors, working in the kitchen, mowing the lawn, along with my sisters and brother who also did all sorts of jobs around the nursing home. We would see how our parents interacted with the residents. And I'll just share a story with you. We had an individual who was a long-time resident there, suffered from MS, very difficult for people to understand and just fond memories of the interactions my father would have as he walked through the halls, particularly with her, because they would just be laughing and joking, having these conversations. And I remember asking my father, how-- how do you understand, you know, what's going on in conversation? And he just said, you know, if you are there and you spend the time with people and you love the people, communication isn't an issue. I think that's one thing a family focus brings that would be terrible to lose for Nebraskans. I've come to know a lot more about nursing facility issues than I had. I did not-- after working there during high school, I pursued a different path and have had a law practice my-- for my career. I have on occasion assisted with legal matters. But as far as operations, I've had to learn a great deal about it here just in recent months. And I found it interesting the state's response, really, to an individual who, like my father who spent four decades caring for elderly and infirm

individuals, and my perception is unreasonable reimbursement including a particularly savage cut in the last fiscal year where my family's facility was cut from a rate of $129 down to $126. You can imagine whether your household costs go down, not usually something that happens. Think about what you pay for a hotel rate, for example. And then you think about what a nursing facility provides with its care, in addition to the-- the board and the medical care, the food, the other interactions, other services. Other things that struck me as I analyzed what was going on with my family's nursing facility, managed care entities with their own internal bureaucracies and credentialing requirements and denials that you have to adjust to, and all of this from the state's perspective seemingly completely divorced from quality of care, as if that is not something the state can be bothered with. My dad died approximately four months ago and my mother had died a number of years before that from breast cancer. My father's death was unexpected. Had a heart issue and didn't recover from it. We all knew the level of care that he'd put forward to our extended family-- the residents and the employees of the facility who all-- all were like family members, part of the team. But it wasn't clearly apparent to my siblings and me until after he died the extent and the financial difficulty that he was having. At the time, he was substantially using his own personal funds as loans to the business so that the care was not compromised. Once our dad died, we realized that we weren't able to sustain that. We had to make an excruciating decision. I-- I personally drove down to Lincoln with a letter to Governor Ricketts to initiate a receivership for our family business, which, of course, just shy of 50 years, very difficult thing to do. I felt it was what my grandparents and parents would have expected. They wouldn't have wanted care to be compromised for one resident, wouldn't have wanted any employee to miss a paycheck. And while it was difficult, it was the right thing to do. My dad was forced to make a choice between caring appropriately for residents who needed it very much and risking personal financial ruin. I'm here to ask you to ensure that no provider in the state of Nebraska faces that choice again. Thank you.

STINNER: [04:13:46] Thank you. Questions? Senator Hilkemann.

HILKEMANN: [04:13:46] Well, I have to say that I have a little personal connection with your Colonial Manor. My wife used to work there while she was going through high school and college, and we appre-- she appreciated her experience there. I was very disturbed when we-- we were very disturbed when we read the note or the news your-- what-- what percentage of your facility right now is Medicaid?

EDWARD MATNEY: [04:13:55] The receivership began about a month after my father died, so I can't speak at this moment. Generally, it ran 75 percent or higher Medicaid reimbursement--

HILKEMANN: [04:14:01] Yeah.

EDWARD MATNEY: [04:14:01] -- as the payer.

HILKEMANN: [04:14:02] And what was the-- what was the CMS star rating for your facility?

EDWARD MATNEY: [04:14:03] Typically around three stars, although we had enjoyed a four-star rating right about the time we got that savage rate cut.

HILKEMANN: [04:14:06] Thank you for the service that you've given to that community of South Sioux City over the years.

EDWARD MATNEY: [04:14:09] Thank you, Senator.

STINNER: [04:14:10] Thank you for being here. Senator Wishart.

WISHART: [04:14:10] Thank you so much for being here. This is why we have interim studies and public testimony. What happened to the residents? Where-- where will they go or where have they gone?

EDWARD MATNEY: [04:14:12] They remain under a receivership--

WISHART: [04:14:13] OK.

EDWARD MATNEY: [04:14:13] -- in the-- in the facility in South Sioux City.

WISHART: [04:14:14] OK.

EDWARD MATNEY: [04:14:14] The receivership is ongoing. If-- if the facility were to close, I'm not sure where they would go. They would have to leave the community, very, very likely. And, of course, with that kind of a problem you leave not only your other family members but your medical providers, the doctors you've come to know your whole-- your whole life. So it's a very concerning possibility if that were to happen. I certainly hope it does not have to close. But it wasn't something that was sustainable. It wouldn't have been sustainable for as long as it was had not my father made those personal loans to the facility to make it happen.

STINNER: [04:14:36] Any additional questions? Seeing none, thank you very much.

EDWARD MATNEY: [04:14:38] Thank you.

STINNER: [04:14:38] We can-- we can go till 1:30, buddy.

HEATH BODDY: [04:14:39] I'll-- I'll be quick, Senator.

STINNER: [04:14:40] OK.

HEATH BODDY: [04:14:40] Good afternoon, Senator Stinner. Senators, thanks for hanging with us. Members of the committee, I'm Heath Boddy, as it's been talked about a couple times, H-e-a-t-h B-o-d-d-y. I'm the president and CEO of the Nebraska Health Care Association. Thank you for taking the time to listen to the information and the communication today. I realize we've taken a good part of your morning. As a part of my testimony today, I want to introduce into the record a letter from AARP Nebraska about their stance and some of their thoughts around Medicaid funding. Quick bit of background, in case we haven't covered this together before: I grew up in this business, much like you've heard with some of these people before. I was a provider for nearly 20 years before I came to the association. My mom did this my whole childhood, so family hardware store stuff for me. Grew up mowing, much like you just heard Ed talking about with those things in the facility. And I thought I would just make a few points, maybe a little bit of clarification points to summarize some of the important information that's been shared today. I heard Director Van Patton, in one of the very first meetings I was sitting in his office, stop his team when they're talking about-- and I don't remember exactly the subject-- and say, folks, I want to be clear, we're talking about Nebraskans here, not numbers. I thought that was a really good point and I encourage you today and as you visit with your colleagues leaving here, to help them remember to be clear, these are Nebraskans at the end of these discussions. We're talking about provider rates, but the way that that manifests itself here is the care to Nebraskan. And the vast majority of the providers in this state are good, dedicated, hardworking, and solution-focused providers. You heard Ms. Kadavy offer earlier that we've been encouraging the state as a profession for well over four years to consider some sort of a quality component to this rate methodology and consider ways to incentivize providers to do that prior to Dr. Van Patton's arrival. And Cindy alluded to the idea around customer satisfaction.

Nebraska's skilled nursing providers, and I can say this from my own experience, consider themselves a partner with you, with the state of Nebraska, to provide the care to these Nebraskans. It's not an extra thing for us. It's a partnership. And as you heard these percentages that people talk about what level, what's their payer mix look like, and how many of those customers are Medicaid, there's no other way to consider that than a partnership. And I thought it was interesting some of the discussions earlier around we have to make sure even in rural areas that we-- that we diversify that payer mix because those are the right providers. What that really says to me is that-- or maybe it bears the question-- are we okay as a state in saying we're not going to at least pay our fair share for-- for the care that we're asking-- that we're partnering with a provider to do? And that for me, I'm not supposing that free but for me that's problematic. If, Senator Wishart, you asked a question earlier that said could a facility that's 100 percent Medicaid stay viable? And the answer to that question from the director was no. That's a concerning answer to me. And if there-- if we're covering the cost of the care, that equation is very, very different and then that does allow things that you've heard from the members in this state say paying better wages, allows for some of those other payer types, payer sources to help pick those things up. It's also important for me to say out loud and for us to realize that the Nebraskans that receive this care need this care. You heard Jenifer Acierno start off saying, look, these are the folks that worked hard. They paid their taxes. They're trying to create a better life for their kids. But they made a big mistake. They outlived their resources. How unfortunate is that, is that they-- they outlived their resources? Maybe we can suppose now they should have been better planners, but here they are. They never meant to rely on Medicaid to pay. They had good plans for this. But here they are. These are not people that aren't hardworking, that aren't well-intentioned, and yet here they are again. We talked a lot about earlier about payer mix and providers, and you did some redirection on rule. And so I'll just say again, and I'm saying this from my experience, I started out in Trenton, Nebraska, about a hundred years ago. That's out by McCook, if you're not familiar with where that's at. Rural providers especially don't have the same opportunity to choose a payer mix. And you-- I think you covered that. When--

Senator Stinner and I've had this conversation before. When you're in a rural community, you may have alluded to it today, you serve that community. And so pretty much when that community comes to the door and you've got the ability to care for them, that's who you care for. That's the reason that you're there. That's the poor. And that does make-- that does make a different situation. We talked about earlier, I think we heard the director and someone else refer this idea about helping providers move up their quality. Senator Vargas redirected and said wouldn't it be great if every facility could be a four and five star? The profession would absolutely agree. Here's one problem with that. You heard Ms. Kadavy allude to this idea of a bell curve. So a five-star rating system, we spent a lot of time today using pie charts saying, gosh, we have 50 percent that are four and five stars, and 50 percent that are three or less. Here's-- here's the-- here's the struggle with that. The-- the base component of the five-star system is the survey piece. So it's survey, staffing, and then the quality metrics. The survey is an artificial bell curve. The system says 20 percent of the facilities in the state must be rated a one star. And so that's where they start the bell. Their ability to get to four or five star, it's--is not there. The system is specifically designed not to allow that. So when we're trying to say heck let's help this entire state grow, let's help them train up and find a different path, the system won't allow it. Cindy also alluded to the idea that there is a component of that, the metrics component, the clinical outcomes that could be an indicator. And again, we agree with the department that there's got to be a different way. We agree that quality has got to be a component and we've got to work the vehicle out. But I just want to make sure that that was clear because it-- the system as it said and that we laid out today wouldn't allow for those things to happen. We also talked about occupancy at 72 percent across the state. And let me just be clear. If a facility had an occupancy, and I realize we're talking about the state average but let's just take a facility and pick a town in Nebraska. If their occupancy was 72 percent and there was a private payer or Medicare customer available, I promise you they would be more than joyful to have that person come and live in their facility. They would absolutely love to have that, to diversify that payer mix. There's no provider across the state that wouldn't like to diversify because of where Medicaid lays in today.

And I think the last thing that I would just add from some cleanup stuff, Senator Vargas said earlier that the devil's in the details. Well, sadly, what it means for us is without-- you heard from some of the family providers in the state and others-- if there is not additional funding as we look forward here in Nebraska, we need to expect more closures. If we're waiting for a sign, this is the sign. This year alone we've had six nursing facilities, and we're not really covering the assisted living, but we've had six nursing facilities in our state close since January 1. We have two right now that I know of that are in active discussion, as we speak, about whether they're going to continue their operation going forward-- and you heard from some other ones today-- and both of those are in rural areas. We have 22 facilities in receivership. And just if you're keeping tabs, we had 16, that that total comes to 16 that have closed, 16 nursing facilities since 2015. You've heard many of the people that have come up to the mike thank you for your time, and I join them. Thank you for your time to help us shine a little bit of light on what this situation looks like. We share the concern that Senator Stinner had when he asked for this legislative resolution to come forth, sustaining the operations with Medicaid providers, especially those that have high volume. It is a big concern of ourselves. So as I part I would ask you three things. We'd ask you to support our profession working with Medicaid to try to develop a new payment methodology that incents quality, Incentivizes quality; it rewards the efficiency; and sustains the access for those that rely on Medicaid across this entire state, especially in the rural areas. We'd ask you to support increased transparency within the Medicaid budget. All the approp-- and that's going a little further that all the appropriation goes into the Medicaid rate as was designed. And finally, we'd support-- we'd ask that you support an increase in the provider rates over the next biennium. Thank you for time. I'd be happy to answer any questions.

STINNER: [04:20:53] We heard about disparity of per diem,--

HEATH BODDY: [04:20:55] Uh-huh.

STINNER: [04:20:55] -- or at least I've asked questions about that in the $119 to $241, what really makes-- we've got to bring those numbers together a little bit. It's Just--

HEATH BODDY: [04:20:57] Absolutely.

STINNER: [04:20:58] -- mind-boggling that I can look at that big of a disparity between facilities in terms of reimbursement rates. And I'd like to hear your understanding of maybe how we could do that. Reimbursable rates with the caps that have either been increased or haven't been increased, you may want to comment on that. And of course this inflation factor that has a direct impact on reimbursement or deflation factor, whatever the case may be. I guess when it's negative it's deflation. Those are things, those are areas that I think need to be challenged and need to be looked at, because they're a part of that methodology that we're talking about in terms of reimbursement. So I know we're running out of time, but I do want you to comment on what your thoughts are, what challenges you see are there, what opportunities might be there.

HEATH BODDY: [04:21:32] The great news is generally the profession is highly aligned with-- with Medicaid, the department of Medicaid, on specifically most of those things, Senator. We agree the rate disparity has got to come closer together. The model that LeadingAge and Nebraska Health Care proposed to Medicaid about a month ago, the director alluded to it earlier, does that. It uses a rate corridor. It starts squeezing the rates so the highs come down, the lows come up and try to get more in a rate corridor. We also agree quality has got to be a part of that, but that by itself will incentivize efficiency. Right now you've heard them respond that when they drop their costs they drop the rate. This would minimize that over time. We would have the opportunity to do that. The caps, as I understand it, have been in place for a time. I would assume-- and unfortunately I'm not a scholar of why that happened when it did. I would assume those were budget control efforts in that

time. This, the methodology we-- we suggested to the department would do some cap adjustments, again, allowing the rates to come together and making sure that quality is a key component in that. The inflation factor, in fact, is nothing even close to an inflation factor. If I'm going to be a little flippant with my words, it's an arbitrary subjective factor in which we tried to back in to what we think our total spend should be rather than saying-- many times you'll hear an inflation factor in healthcare and government funding that says, okay, let's pick the-- the CPI or some-- the healthcare CPI. We'll say, okay, it's going to go up 2 percent or 2.5 percent. This-- this is actually just a way to control what the spending is. It-- I don't know that we have the ability, as the profession, to say to Medicaid you will not do that anymore. But I agree, that does not help. That does not help getting the rates closer to the cost of care. If you asked any provider in this state what would their goal be, their goal would be to get closer to the cost of providing the care for a Medicaid recipient in Nebraska.

STINNER: [04:22:59] OK. So that gets me to my-- I'm tethered to this budget. I apologize. That gets me to the-- we're at $344 million. What number does that need to be in spend?

HEATH BODDY: [04:23:03] If we-- so the last number, there's 2.13 million Medicaid days as I saw the last numbers. So if, I mean if you really want to go long ball over time, if we said we're $36 a day on average underfunded, that's going to be long of $100 million. Not likely realistic for us to get there quickly. My answer would be if we can make sure that-- Cindy gave you a chart that pointed out, Ms. Kadavy gave you a chart that pointed out there $7.3 million that was appropriated and unspent based on the way the formula is laid out. If that could be put into play and a number that gets closer to the actual cost of inflation for healthcare-- Senator Stinner, you used 5 to 7 percent, that's a very realistic number in healthcare. I would argue with work force it's probably closer to the 7 than the 5. If there's a way to try to get in sort of that range of numbers, that at least would create the right trajectory with the Medicaid reimbursement.

STINNER: [04:23:39] Give me your thoughts on how many one- and two-star rated facilities we actually have in the state of Nebraska.

HEATH BODDY: [04:23:40] So the metrics say we know we have at least 20 percent one stars. I'm going to say-- I'm completely spitballing, I have no data in front of me to prove this-- I'm going to say that's 10 percent or less if there's a way to quantify that. The struggle is the system specifically says they're quantified, pushed into these categories. We'll-- one of the things we can do, and I'll try to get that data for you, we'll work with the American Health Care Association. Jenifer Acierno, we can ask LeadingAge national to see if there's a way for us to actually analyze that without the bell curve being in play. I don't know if that's the case but we'll try to find that information out for you.

WISHART: [04:24:05] And I'd be interested in knowing the percentage of those-- the percentages of Medicaid recipients in those facilities. I'd be interested in aligning that.

HEATH BODDY: [04:24:06] OK. Absolutely, Senator. We'll work on that. I think it's fair to say this. If you said to providers, much like was asserted earlier, we want to help everyone get better, if you said to providers we're going to, you know, we're going to incentivize you to get here, in a system that actually allows everyone to get there, and by doing that you can have, you know, a more-- a rate closer to the actual cost of care, I don't know of a provider that wouldn't strive for that. Don't know of one.

STINNER: [04:24:22] How much excess capacity do we need to have in the system?

HEATH BODDY: [04:24:23] Boy, that's an interesting question. I'm not sure I'm qualified to

answer that. I don't know. We can do some asking and see if there is-- you know, my guess is licensure might have some thoughts about that, what that looks like. If you look at the baby boomer numbers that are coming, they're, of course, not all going to go into facility-based long-term care. I would say some capacity would make sense. I might be a one-man show on that, I'm not sure. But we'll write that down, see we can find some answers to that.

STINNER: [04:24:42] OK. And I would, that's what I'm reflecting on is now, between now and 2050, we're saying we got 25 or 26 percent excess capacity. How much do we really need? And how many of these want two-star facilities? If indeed they are, and they are substandard, then they probably need to be put out of production at some point in time. We've got to bring some other things on line. How that fits in long term in the strategy of the state of Nebraska is going--

HEATH BODDY: [04:24:58] It's a great point.

STINNER: [04:24:59] We're going to need all the help we can get.

HEATH BODDY: [04:24:59] Absolutely. And as the association's-- I'll speak for LeadingAge for just second and for Nebraska Health Care-- we would be committed to helping providers grow to a place that-- that we know they want to be anyway. That's education if that's [INAUDIBLE].

STINNER: [04:25:06] Now you heard the testimony. Even though we allocate another $7 million or $7.3 million, it can't go out under the current formula. So I would presume everybody's heads can get together and figure out how this needs to work.

HEATH BODDY: [04:25:14] And we'll do some checking, because I believe that might be a regulation instead of a statute where that's tied up but we'll-- we'll-- we'll do some checking and

maybe that's-- maybe that's an opportunity.

STINNER: [04:25:22] Tell us how we get it out.

HEATH BODDY: [04:25:23] Absolutely, I agree.

STINNER: [04:25:23] I know-- I hate allocating something and then it can't be used, because it sure could be used other places.

HEATH BODDY: [04:25:24] Absolutely.

STINNER: [04:25:24] Senator Wishart.

WISHART: [04:25:24] Yes. I have just one curve ball. We had an earlier interim study on affordable housing. Has there been any conversations creatively about mixed use facilities where if you have that additional 25 percent that isn't filled now, offering that up to different residents of different ages? I know in Sweden they have seen wonderful success with college students living in nursing home facilities and getting somewhat reduced rent and just the benefits of intergenerational living.

HEATH BODDY: [04:25:33] I've actually seen some-- probably some articles, maybe one similar to you that you've read. I've actually even heard that from the work force perspective where there's been communities that are trying to creatively allow some work force housing. I don't know of a specific example in our state right now, but I know there-- our national associations are both really working on this work force issue and my guess is we'll be able to learn some more about how that might work. The real issue becomes state licensure and where they're willing to cut things off and

how they look at people living there that aren't really part of the population. So it could offer a hurdle, but it doesn't mean it's not worth a look.

WISHART: [04:25:59] OK.

STINNER: [04:25:59] Thank you. Thank you for your time. Thank you for the summary. I do have letters of support from Ron Ross, Rural Health Development, Inc.; Mike Adamy, St. Joseph Villa; Eric Gurley, Immanuel; Jordan Rasmussen, Center for Rural Affairs. And I will then want to emphasize that if you were a testifier, please fill out the cream sheets so that we can give them to the clerk, because when they type this all up they've got know how to spell your name. So thank you.