STINNER: [RECORDER MALFUNCTION] John Stinner. I'm from Gering and represent the 48th Legislative District. I serve as Chair of this committee. I'd like to start off by having members do self-introduction, starting with Senator Erdman.

ERDMAN: Thank you. Steve Erdman, District 47. I represent ten counties in the Panhandle.

CLEMENTS: I'm Rob Clements from Elmwood, District 2 is Cass County and part of Sarpy and Otoe.

McDONNELL: Mike McDonnell, LD5, south Omaha.

HILKEMANN: Robert Hilkemann, District 4, west Omaha.

STINNER: John Stinner, District 48, all of Scotts Bluff County.

BOLZ: Senator Kate Bolz, District 29.

WISHART: Anna Wishart, District 27, west Lincoln.

DORN: Myron Dorn, District 30, Gage County and southeast fourth of Lancaster.

STINNER: Assisting the committee today is Brittany Bohlmeyer, our committee clerk. Our page today is Cadet Fowler. He's studying film studies at the University of Nebraska-Lincoln. We also have with us Liz Hruska, our fiscal analyst. At each entrance you'll find a green testifier sheet. If you are planning on testifying today, please fill out a sign-in sheet and hand it to the committee clerk when you come up to testify. If you will not be testifying at the microphone but want to go on the record as having a position on a bill heard today, there are white sign-in sheets at each entrance where you may leave your name and other pertinent information. These sign-in sheets will become exhibits in the permanent record at the end of today's hearings. To better facilitate today's proceedings, I ask that you abide by the following procedures. Please silence or turn off your cell phones. Move to the reserved chairs when you are ready to testify. Order of testimony: introducer, proponents, opponents, neutral, and closing. Also when you come up to testify, will you please spell your first and last name for the record before you testify. Be concise. It is my request to limit your testimony to five minutes. Written materials may be distributed to committee members as exhibits only while testimony is being offered. Hand them to the page

for distribution to the committee and the staff when you come up to testify. We need 12 copies. If you have written testimony but do not have 12 copies, please raise your hand now so the page can make copies for you. With that, we will begin today's hearing with LB181. Senator Bolz.

BOLZ: Hi, committee. I am Senator Kate Bolz, that's K-a-t-e B-o-l-z, and today I'm bringing LB181. And when Cadet finds his way, I've got a fact sheet and an amendment for you. This bill would require the Department of Health and Human Services to contract with an independent entity for the study of a needs of Nebraska's aging population for facility-based and home- based long-term care services in close proximity to community, familial, and social support systems and make recommendations on changes to the policy and funding of Medicaid long-term care services. The goal of LB181 is the development of a strategic business-oriented plan based on reliable data for ensuring statewide access to long-term care services, especially for Nebraskans reliant on Medicaid to pay for their care. This plan would be utilized to inform the decisions made regarding strengthening and restructuring our long-term care system. And I would add that this bill is inspired by the interim study hearing that this committee had on long-term supports and services this summer. Nebraska is already facing severe challenges in this area. From 2015 through 2018, 16 skilled nursing facilities and 17 assisted living facilities closed in 25 rural communities and 8 metro areas. These facility closures are a critical threat to our small communities in Nebraska. Skilled and assisted nursing facilities are crucial to the quality of life for those who require long-term care. But beyond that, they are also part of the economic vitality of small communities in general. Many of these facilities are among their community's biggest employers and would leave residents seeking care with few reasonable options for long-term care if they choose. The combination of reduced work opportunities and diminishing care options would be dire for these areas. Worse, facilities face a number of risk factors and are currently threatened by rural work force shortages, a low Medicaid reimbursement rate, and the sparse population density of rural communities. Furthermore, the need for nursing facilities will soon accelerate and the number of Nebraskans aged 85 or older is projected to double over the next two decades. Simply put, our state must be better prepared to meet these challenges, and LB181 offers a first step. A long-term care study can utilize available demographic, economic, and employment data projections. Additionally, analyzing this data and other states' strategies will allow Nebraska to identify

innovative solutions to our current and future challenges. Finally, a strategic long-term care plan will provide us with a set of fiscally responsible recommendations that will give future Legislatures the tools to ensure access and sustainability in our systems. The bill also contemplates the Department of Health and Human Services not making significant changes until such a significant study-- data-driven study can be incorporated. None of us would ever approach a future business environment without making a strategic plan. In nearly every final-- financial situation, those that have clear data, a knowledge of the best options are the ones that, that move forward. So I would ask you to implement LB181. I would also ask you to consider the amendments brought forward to you. It was just a small oversight on our part. We used language referencing a Nebraska-based entity. That's, that's not the most appropriate way to reference who we should contract with. So we-- the amendment removes language specifying that a Nebraska-based entity should complete the study. And after doing some further analysis, we were able to recommend the appropriation amount of $175.000. That funding for the study would come from the Nursing Facility Penalty Cash Fund. The use of these funds does require approval from the federal CMS administration, which is also reflected in the amendment. Currently in the fund, the cash fund book references that we have about a little over $1 million in this cash fund, though we probably should get the most current numbers from our friend Liz. The purposes of the fund are to relocate, maintain operations, or deal with closures in nursing facilities; and so we do think it's an appropriate use of these dollars. So I hope that all came through to you. I'm happy to answer any questions to clarify or help you understand. Questions? Senator Clements.

CLEMENTS: Thank you, Senator Stinner. Thank you, Senator Bolz. I was looking at the fiscal note that said-- shows $306,000,--

BOLZ: Uh-huh.

CLEMENTS: --and wondering why you're using $175,000.

BOLZ: Uh-huh. So we've been working very closely with the Nebraska Health Care Association, which is the comprehensive association of nursing facilities and assisted-living facilities and hospice care facilities. They have been working closely with some folks who might actually implement a study like this and a $175,000 is their recommendation for what something like this might cost-- cost. They

are testifying today and you might ask for further information about where they got those projections.

CLEMENTS: All right. And what is the purpose of the moratorium on any changing? Doesn't it tie the hands of HHS?

BOLZ: Uh-huh. Yeah, I think the-- the idea is that given-- given the challenges that we're facing, we should have a well-thought-out, data-driven strategic plan before we make significant changes to the way that we're currently implementing long-term care services. And so I-- I am-- I'm-- I hear what you're saying and I'm open to further discussions about the language because I do recognize that there might be some changes that are necessary to keep up with federal guidelines or to adapt to current circumstances. The underlying idea is that before making major changes in our system as a whole we should study it and have a game plan versus making changes on the fly.

CLEMENTS: Thank you.

BOLZ: Yeah. Thank you.

STINNER: Senator Erdman.

ERDMAN: Thank you, Senator Stinner. Thank you, Senator Bolz. On page 3 on the green copy, line 21, it says create a financial sustainability five-year plan for ensuing that Nebraskans-- ensuring that Nebraskans continue to have access to long-term care. And they're going to make a report on December 1 of '19, right? Oh, excuse me. I'm one line-- it's 25. December 31, '19, they're going to give-- what are they going to tell us, what they've done so far? And then the final report is due a year later?

BOLZ: Right. That's right.

ERDMAN: So it's going to be a year and a half from now before we know.

BOLZ: That's right.

ERDMAN: OK.

BOLZ: I-- I think that-- that those time frames are-- are up for discussion. But I do want the-- the economists and the experts and the financial experts to have the time that they need to give us a good solid recommendation. Does that take 12 months? Does it take 18 months? It might be a dialogue you want to have within HCA. But I do

want to make sure that we're paying, if we're spending money on these recommendations that we get a good work product.

ERDMAN: OK. Thank you.

STINNER: Additional questions? Seeing none, thank you.

BOLZ: Thank you.

STINNER: Afternoon.

VIRGINIA CLIFT: Good afternoon. My name is Virginia Clift. First name is spelled V-i-r-g-i-n-i-a, last name is C-l-i-f-t. And I am currently a resident at the Beatrice Good Samaritan Home, but until May of 2017 I was a resident of the Good Samaritan Home in Wymore, Nebraska. And Wymore is a smaller community, as you probably know, and they closed. The Good Samaritan Home in Wymore gave-- oh, wait, I'm on the wrong page. Excuse me. Until-- until May of '17, I lived in Wymore. Wymore's nursing home was closed and I was moved to Beatrice. I grew up in Wymore. I lived there from 1960 to 1973, when I graduated from high school. I came back to the nursing home in 1970-- or in 2015 when my home was destroyed by the flood. The nursing home had been part of my school years growing up. Our class would go present programs to the residents. We would take our Scout troop in there, our Sunday school troops in there, everything, to visit the old people. We made table decorations for the residents, and we went to Good Sam to trick or treat and to sing carols. While I was growing up, the nursing home was an old hotel that sat at the very end of Seventh Street, which is the business district. In 1973 they built a brand new building, all one story right across the street from that, but it was still right downtown. While I have been living in the nursing home in Wymore, most of the residents were local people. A lot of them had lived there in Wymore or the surrounding area their entire life. They had been born there, they had worked there, and they think that their plan was to stay in Wymore, live in the nursing home, and spend the last few days of their life where they had connections to their family, to their neighbors, to local businesses and the churches. Many volunteers from the community of Wymore were involved also in the nursing home. The weekly bingo game saw ladies who liked to play bingo at the American Legion come in to help the residents who were either too blind or too deaf to play bingo anymore. And a matter of fact, Thursday ran into one of those ladies and she said tell them that we really miss our ladies. The blind-- the volunteers also had a weekly hymn sing. They came in to play cards. And people whose parents had been there in the

nursing home would still come back and volunteer just because they missed the community, the workers, and everyone else. The people that lived in the nursing home, most of them had been active in the community while they were growing up. So it was just a continuation for them to go from being a volunteer to being one that was being served. The nursing home in Wymore also gave back to the community. They took turns hosting the community coffee that was held once a month by the Chamber of Commerce. Because we had a large dining area, we could hold birthday parties for people and the different local events. The kids came in to do their piano recitals, to practice before us, to do their school things. And also we thought we residents helped by doing trick or treating for the kids. We had-- we've stuffed the plastic eggs for the Easter egg hunt and we made treat bags for the day care kids. The 4-H kids came in and used us to do projects. The high school glee club came and rehearsed in front of us. Sunday school classes and other kid groups came in to do programs for and with the residents. The one-- one tradition that Wymore had, since we were down there on main street, on prom night the girls would stop by the nursing home before they went to prom to show off their dresses. The local librarian in Wymore would pull books to be sent up to the home for individual residents. She was able to choose the books because she knew the residents and what they would like to read or else we sent lists to her. The closing of the nursing home had a very negative effect on the local economy. The nursing home I believe was the second largest employer, after the school, of people in that town and many, so many of the supplies were purchased locally. We had local tradesmen, hairdressers, the yard workers came in from the town. The Good Samaritan Home had been a vital part of Wymore's social standing, and I know that many of the people that lived there had assumed that they would move into the nursing home and live out their last days in the same town where they had been born, where they had worked, and where their family was. That way they would be surrounded by relatives, friends, schoolmates, and neighbors. Its closing had a big impact on the town.

STINNER: Questions?

DORN: Just-- just--

STINNER: Senator Dorn.

DORN: Thank you. Thank you, Chairman Stinner. Thank you, Virginia, for coming. Do you know what happened to most of the employees?

VIRGINIA CLIFT: For a good part of them. Some of them did come to the Beatrice facility to work. Some of them found work in other towns there in Beatrice, but a lot of them now are driving 15 miles to go to work in bad weather where they hadn't before. I think there's a few that actually found other jobs besides working in nursing homes.

DORN: Thank you.

STINNER: Additional questions? Seeing none, thank you.

VIRGINIA CLIFT: OK. Thank you.

STINNER: Afternoon.

CINDY KADAVY: Good afternoon, Chairman Stinner and members of the Appropriations Committee. My name is Cindy Kadavy, C-i-n-d-y K-a-d-a-v-y, and I am a senior vice president at the Nebraska Health Care Association. On behalf of our nearly 400 statewide nursing facility and assisted-living members, I am here today to speak in support of LB181. First, we want to thank Senator Bolz for her sponsorship of this bill and her support for older Nebraskans. The goal of LB181 is to take a proactive approach to addressing the needs of our state's aging population and their ability to access long-term care services in the future, focusing especially on our rural communities and on Nebraskans who rely on Medicaid to pay for their care. LB181 calls for a database study that would look at current availability of long-term care services statewide, as well as population demographics. This study would identify gaps in access, make projections of needs, and offer recommendations on innovative approaches going forward. Slide one on your handout indicates the current location of Nebraska nursing facilities by county. Those counties depicted in black reflect counties without a nursing facility. Those in red have one nursing facility, and so on. This map also points out the location of Mullen, Nebraska, in Hooker County for a reason I will describe later. Slide two shows what Nebraska would look like if the counties with only one nursing facility had closures. As you can see, this would leave significant portions of the state without access to this level of care. The next three slides provide some background information on the nursing facility in Mullen, Nebraska, as an example of Nebraska stand-alone rural facilities. Should this facility close, Mullen would not only lose their major employer and residents be forced to move a significant distance from family and friends, the community would also lose services that the facility provides to help them stay in their own homes as long as

possible. The next five slides list the nursing and assisted-living facilities that have closed from 2015 through 2018, as the senator mentioned, and the closures that were announced in January of this year. Slides 11 and 12 lists the facilities that remain under state receivership, some of which are among the announced closures. In 1996 the department undertook a similar long-term care study with a focus on developing a plan for a systems change for long-term care services and for the management of Medicaid's long-term care expenditures. In partnership with the university's Bureau of Business Research, the Medicaid division completed this study in 1997 and issued a report with multiple recommendations, some of which were implemented. One of the most innovative ideas from this study resulted in Nebraska's assisted-living conversion program which provided a financial incentive for nursing facilities to convert to assisted living. This allowed communities to better respond to the needs of Nebraskans at that time and resulted in savings for the Medicaid program. The program was later replicated in several other states. I asked the individual who was Medicaid director at the time of this study and who has since done Medicaid consultant work with other states what he would estimate the cost of this study would be. He felt a study meeting the bill's requirements could be accomplished for under $200,000. I also contacted Eric Thompson, director of the university's Bureau of Business Research, who provided an estimate of $175,000 and who will speak following me. As this would be a study looking at access to services for Medicaid beneficiaries, 50 percent federal matching funds could be leveraged bringing the estimated cost to the state of approximately $87,500. The department is correct that any use of CMP funds would need the approval of the-- of CMS. CMS has provided guidance for states on appropriate use of these funds. In general, they must benefit nursing facility residents, and this bill would seem to meet that criteria. To sum up, we feel this study would provide valuable information to those making policy decisions and would allow Nebraska to take a more strategic, planned, and considerate approach to long-term care rather than continuing to allow services and access to those services by Medicaid beneficiaries to be lost based on underfunding. Thank you for the opportunity to testify. I'm happy to answer any questions.

STINNER: Questions? Senator Wishart.

WISHART: Thank you so much, Cindy, for being here today. Do we-- do we need a study? Do we need to be investing in a study? Or do you feel we already have the experts available to help us know which direction we

should be going, and the reality is that there's a concern there isn't the political will to actually invest in seniors at the level we need to, to ensure they age gracefully in the state?

CINDY KADAVY: I think, well, we believe that there is a need for a study just because what we've seen recently with closures and the state receiverships is it's somewhat haphazard. You know it's based on, you know, not being able to sustain operations. And the question is, is that the best way moving forward? And there's a lot of data out there. A study could look at that data, analyze it, and provide-- look what other states have done, provide some recommendations going forward that might be more strategic than the current process.

WISHART: OK.

STINNER: Senator Dorn, did you have a question?

DORN: No.

STINNER: Oh, OK.

DORN: Just [INAUDIBLE].

STINNER: I have just a couple questions. Do you have information on the number of people that are employed by nursing homes? Nursing homes are a business. I noticed that it is the largest business in Mullen. But do you have any information on the total people that are employed in nursing homes?

CINDY KADAVY: So the last number we had for Nebraska was 28,000 employees. But we can make sure and get you more accurate information if that's changed.

STINNER: I noticed that Mullen's rate went from, I think, $177 to $155 between '17-18 and '18 and '19. That $20 reduction per day was due to?

CINDY KADAVY: So that was due to the-- the current rate methodology and the inflation factor that reduced their rate. Mullen's a little bit unique in that they have a large number of residents paying privately that can supplement that Medicaid rate. They also, because they're owned by the hospital district, they do get some supplemental funding through that.

STINNER: So the methodology has to do with an inflation rate that actually went down.

CINDY KADAVY: Yeah. Yeah.

STINNER: Additional questions? Thank you.

CINDY KADAVY: Thank you.

STINNER: Afternoon.

ERIC THOMPSON: Good afternoon. Should I proceed? OK. My name is Eric Thompson with the University of Nebraska Bureau of Business Research. E-r-i-c T-h-o-m-p-s-o-n, And I just wanted to talk briefly about factors that might be included in any sort of a study about-- about this sector. As been-- a number of the previous testifiers have noted, obviously demographic trends are quite important. While in metropolitan Nebraska median ages are-- are declining right now, it's still true that we'll have a substantial expansion of people in the over 85 age group as well as growing population of people with relevant disabilities that would need access to long-term care. So it's an important question how much the need and cost of long-term care will be rising in the future. I think as well as just looking at the populations, it's important look at what cost factors are relevant. Throughout Nebraska there's a many issues right now and this is often the case with labor shortages and skills shortages, and that certainly can affect the healthcare industry, including the long-term healthcare sector. Some of the fastest growing occupations in terms of wages in the state are those occupations in the lower wage quintile, which is some of the workers in this setting. So there could be significant issues of wage inflation going forward. Obviously, there's other costs in healthcare: equipment, medicine, supplies. It's important to look at the trends in that as well as survival rates from some of the diseases that affect our older population. Happily, those survival rates are going up. They would obviously have some implications for the need for long-term care. There's other relevant cost issues, for example, liability insurance, regulation, that could be looked at as well. So putting together goes demographic trends and cost trends, I think you could get a picture of what the costs are likely to be going forward in supporting facilities. I think another subject that's important to look at, is while a lot of the costs of long-term care facilities are paid by the public sector by Medicaid, there is a significant portion that are paid by private sector patients. And it would be important to look at what trends are

expected for your private sector patients because that could be the-- those private sector patients can be the increment that helps some facilities, some additional facilities survive despite some of the challenges that are out there right now. There's a number of issues to look at that there in terms of work life length. Marginal increases in work life length could generate funds to help support long-term care, trends in hourly earnings, other factors that are impacting household assets, expectations for inheritances and so forth. So there's a number of issues to look at there as well. The bottom line, obviously, would be to look at access. We've talked a lot this morning, I've heard people talk a lot this afternoon about survival of or availability of nursing homes in proximity to our state's residents, but there's, of course, other key services. Home and community-based services and even support for family caregivers it's important to have access through-- to throughout the state. So I think there is a broad range of issues to be looked at. You know, I hope any study that's done would focus on a few things. And again, I think it's important to look at that potential support for the system from private patients-- private sector patients are patients that are paying privately-- because again that can help provide key revenue for facilities in terms of their growth and survival. It's important to look at trends in relevant rates, such as how long people are surviving, such as, you know, the rate of relevant disabilities for that share of the-- the relevant population. I think it would be important for a study to focus on not just the nursing homes but also the home and community-based care and opportunities to support family caregivers. Lastly, I think it be useful to look at regulations, labor market factors, and other things which influence costs.

STINNER: Question? Senator Dorn.

DORN: Thank you, Chairman Stinner. Thank you for coming today. Any idea about what percentage are Medicaid patients and what percent are private pay?

ERIC THOMPSON: There may be testifiers that know more about that than-- than I do but--

DORN: OK.

ERIC THOMPSON: --my understanding is more than half, around two-thirds, perhaps a bit more in general are from Medicaid or-- or other public sources. Whether that trend will be, you know, even

higher or stabilize or perhaps drop a little bit in the future I think is one of the subjects to look at in the study.

DORN: OK.

STINNER: Just for the senator's knowledge, page 3 of this shows 31 percent--

DORN: Oh.

STINNER: --private pay in the state of Nebraska. So additional questions? It's a-- we had a special hearing and it was arrived at, or at least as far as the hearing was concerned, reported that $36 below cost is what the average Medicaid was. So obviously, in order to make the industry viable, private pay has to make up that, that cost. How much in your estimation should private pay have to-- have to make up?

ERIC THOMPSON: Well, of course, this is a problem throughout the healthcare industry. You know, to me, that's sort of a stealthy way to support-- for the private sector to support people who need services. Rather than sort of doing it directly through the state budget, you sort of do it indirectly through private payers paying more. I don't know that you can justify any particular number. The number you're suggesting now is already-- already fairly high. I don't know that I'd want to see that rate go up. But if we could see the mix of private payers go up a little bit, so perhaps a somewhat larger share of privately paid, somewhat lower-- lower share of publicly paid, that might be the best way to--

STINNER: But the trends, but the trends are going more toward less private pay and more Medicaid.

ERIC THOMPSON: Yes.

STINNER: Certainly, certainly in rural Nebraska, that's been the trend. So--

ERIC THOMPSON: Absolutely.

STINNER: --more and more is dependent upon private pay showing up and paying more and more of the burden. At some point in time the insurance companies or long-term folks--

ERIC THOMPSON: Right.

STINNER: --just say, hey, we can't do this.

ERIC THOMPSON: And it kind of spirals in that case.

STINNER: And even to quantify further, if I took the-- $36 times the number of-- of days on Medicaid, you'd be asking private business to pick up between $80 and $85 million--

ERIC THOMPSON: Uh-huh.

STINNER: --in the state in Nebraska because Medicaid falls short.

ERIC THOMPSON: Uh-huh.

STINNER: So at some point in time in your study you need to address that and what that trend is. And at some point in time private bays are going to say--

ERIC THOMPSON: --we can't, we can't do it anymore. So it's-- it's not just a matter of--

STINNER: Or-- or it's going to say that we can't-- we're not economically viable so we go out of business and then access to care becomes a problem.

ERIC THOMPSON: Absolutely. And I agree that such a study should include those factors, I will wholeheartedly.

STINNER: Additional questions? Seeing none, thank you.

ERIC THOMPSON: Thank you.

JINA RAGLAND: Good afternoon.

STINNER: Afternoon.

JINA RAGLAND: Chair Stinner and members of the Appropriations Committee, my name is Jina Ragland. That's J-i-n-a R-a-g-l-a-n-d. I'm here today in support of LB181 testifying on behalf of AARP Nebraska. Between 2015 and 2050 the age 85-plus population in Nebraska is projected to nearly triple. By 2030, 375,000 Nebraskans will be aged 65 and older. Everyone faces a risk of needing some kind of long-term support as we age. According to a 2017 AARP report, about 52 percent of people turning 65 today will develop a severe disability that will require long-term services. About 19 percent are expected to have needs that last a year and 14 percent are expected to have needs that

extend beyond five years. The risks and costs continue to increase as we age, especially as someone reaches 85 and older. AARP supports the need for access to an adequate statewide continuum of long-term care services for all Nebraskans. The continuum is important to caregivers and consumers, leading to improvement in satisfaction and well-being, reducing costs, and improving overall health. Allowing as many people to age in place in their homes at their lowest level of care is critical. Nebraska's long-term supports and services are becoming more balanced, with a definitive shift to home and community-based services, allowing people to receive services and care in their home, aging in place, and in turn lowering costs. As we continue shifting care, it is also pertinent to ensure our most vulnerable populations have access to long-term care facilities that are high quality and available regardless of one's financial or medical needs. Ensuring that individuals residing in long-term care facilities remain in close proximity to family, friends, and other community supports is vital. Over the past three years, multiple facilities have put-- been put into receivership across the state. Many of those have now closed or will be closing due to the inability to sustain financially. When facilities close, residents become displaced and are forced to find a new place to live, putting at risk their health and stability, physically and emotionally. Many of the closures have occurred in small towns that have few or no options for relocation and often many miles from another operating home that has the capacity to take them. Nursing home closures can take a significant physical and emotional toll on residents, some who suffer what is known as transfer trauma or relocation stress syndrome. To illustrate, I would like to share with you a story of Larry, about Larry. Larry is a 76-year-old lifelong resident of Nebraska. He worked for 37 years until suddenly he was faced with a debilitating stroke that left him with severe disabilities and dementia. Unable to continue working or being cared for at home, he was placed in has resided in a long-term care facility for the last six years. Larry was living in a facility that fell victim to receivership last year and his family was notified last month that the facility was no longer able to sustain and would be closing. They had 60 days to find a new home for him. The majority of those in the facility with him rely on Medicaid to assist in their room and board in care. This northeastern community did not have any additional open beds for Medicaid residents. Larry's family took an entire day away from work to drive to surrounding towns, eventually finding an open bed 20 miles away. His family would say they were one of the lucky ones, as other residents, many of which do not have family to advocate for them, were placed in facilities hundreds of

miles from their home. At the new facility he struggled immensely and has had great difficulties with the transition, losing 15 pounds due to his refusal to eat, increased confusion and lack of understanding to his new home and why he was there, and countless sleepless nights of endless wandering, eventually resulting in increased agitation. Previously, his wife was a daily visitor to him in his old facility, but it became difficult for her to travel or find a way now to get to the new facility to see him due to her own issues that prevent her from driving. He has had a further decline in his ability to recognize his wife, one of the only family members he was still able to recognize. To further complicate, Larry and 39 other residents were succumbed to the detrimental flooding that took place in our state last week. Thankfully, they were safe from the flooding, but for four days and nights were placed in a temporary shelter, sleeping on blown up mattresses with limited resources, as most of them lost everything that they had. Larry continues to remain confused, he's lost an additional 20 pounds, and his family reports he stares blankly at them and shows little effort or interest when it is time for him to respond. There are many more like Larry in our state suffering the consequences of the lack of sustainable access to care. Nebraska has shown improvement in shifting the way we think about assisting Nebraskans to access community-based services. As our population ages, those services will remain critical and we will have to remain creative in finding ways to fill these needs and services through community resources that might already exist or are present but not currently being utilized. LB181 will provide a road map of where we are, where we need to be, and where we anticipate being. Most importantly, we'll be able to identify areas where changes can be made to assist those in need in each of our communities. Thank you. And I'd be happy to answer any questions.

STINNER: Questions? I have to ask you some, because we just put our mom into a nursing home. And transfer trauma and relocation stress syndrome came up. Are there studies on that? And that's a real phenomena, isn't it?

JINA RAGLAND: There are, Senator Stinner. And if you'd be-- if you'd like, I could get you some information further on that. There are scientific studies that do support and also do support, especially as when you've or have someone's aged in place and then has to go to a facility. That definitely is another factor that-- that does factor into that.

STINNER: Now there's an emphasis, I know, by HHS on quality. And of course, we've seen our numbers actually go down. More, more in-house care, so the numbers in the nursing homes have-- have dipped a little bit. We may be seeing that recycle back out. Is that your expectation?

JINA RAGLAND: Absolutely. And as I said, with the 85-plus population that definitely is going to definitely increase and go up, and we need those facilities to take care of people, because as we age the likelihood of needing that care is there and it's permanent.

STINNER: And it's good to have a nursing home close by so that relatives could come visit and they don't have this, this relocation stress or at least some-- some level of that.

JINA RAGLAND: Right.

STINNER: Is that-- ?

JINA RAGLAND: And not even just for the resident but for the family themselves. You know the lady-- the Larry that I talked about from northeast Nebraska, again, the wife is not able to. She was using a handy bus to get her downtown to see her husband and now 20 miles away that's very difficult for her to do in that aspect also.

STINNER: Thank you.

JENIFER ACIERNO: Good afternoon,--

STINNER: Afternoon.

JENIFER ACIERNO: --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'm the president and CEO of LeadingAge Nebraska. Thank you for the opportunity to testify in regard to LB181, and thank you to Senator Bolz for recognizing the need for this bill. LeadingAge Nebraska is an association that represents over 70 nonprofit providers of long-term care services, including nursing facility, assisted living, independent living, and adult day services, across the state of Nebraska. LeadingAge Nebraska members span the state and include a number of stand-alone rural facilities. As you are aware, a number of long-term care providers have discontinued operation across the state due in large part to low Medicaid reimbursement. Many are at risk for closing and many are planning for closure based on what happens within this next state budget and the recognition of the need to prioritize funding for our seniors. Based on the closures that have already

occurred, seniors particularly those on Medicaid, are having more difficulty accessing care in or near their rural communities. We have an opportunity to provide information to a number of you during the LR442 interim study related to long-term care in rural areas and the growing chasms in access as well as in rates. As facilities close, those facilities in nearest proximity are already choosing to admit the facility that is closing private pay residents, and leaving a few beds available to those from their own community. This is leaving Medicaid residents potentially in the position of relocating further from their home communities. This is happening in large part due to Medicaid rates not keeping pace with increased costs of providing care. Unfortunately, this is something that providers have to consider in order to sustain continued operation within their communities. Along those lines, a study to assess statewide access to long-term care would assist in planning for the future of our Nebraska seniors. Under the current fall-as-they-may approach, we are not ensuring that seniors have adequate access to long-term care in the state. Requesting use of CMP funds in order to assist in this project allows Nebraska to take a proactive step in planning for the care of Nebraska's senior citizens. For these reasons, we support this bill. Thank you. And I am happy to answer any questions.

STINNER: Questions? Now were you the organization that was working with the-- the NHCA with a study on reimbursement methodology?

JENIFER ACIERNO: Correct, Senator, we were.

STINNER: And what was the outcome of that?

JENIFER ACIERNO: Well, the outcome of that, unfortunately, has-- there hasn't really been one. I know that any NHCA and LeadingAge Nebraska members put in a fair amount of time and resources, at the request of the previous DHHS leadership, to undertake a study to look at reimbursement methodology, the current methodology, and then to take some steps to build in some things that may help in improving that methodology or that approach. That was shared I believe with DHHS in, it was either, late September or early October. The-- at this point in time, there really hasn't been any movement forward on that.

STINNER: What-- is there a time definite that needs to be done on the methodology or is that something that's just out there to be done whenever?

JENIFER ACIERNO: I don't think there was a definite time, unless keeping facilities in business is something that you want to keep in mind, and doing it as soon as possible probably is the best timing for that. But generally speaking, I do think the-- maybe the approach in regard to methodology with the new leadership has changed and perhaps the work that was done previously is not being utilized in the same way that we had anticipated.

STINNER: Just real short, what was your recommendations? How would you change the methodology?

JENIFER ACIERNO: Right. So the recommendation on the methodology, and I'll say this, on the high level was to include some incentive for-- for quality, which was something that the department had been clear that they wanted built in, and understandably so because we all want quality care and our providers want to provide quality care. And then looking at the-- moving somewhat from the cost-based reimbursement to close the gap in what is referred to as the rate alley of, you know, providers on one end of the alley and the other end, top and bottom, to try and narrow that differential.

STINNER: OK. When you talk about incentives, that means that one- and two-star rated facilities, you're going to give them more; assess what they need and give them more money so they can improve their stars? Or as it is today, there's a difference of about $20 dollars. If you're really good you get more money and you're really bad you get less money. Is that an incentive or a disincentive?

JENIFER ACIERNO: Yeah. So we hadn't actually come to any specific determination on what those quality factors would be. There were suggestions put out there that the use of the five-star, you know, method that's out there already would be helpful, but that had not been yet determined. But that is what I've heard as far as the department's plans moving forward, that there will be dependency on that five-star rating.

STINNER: OK. And then the-- the rating is based on a bell curve. Is that right?

JENIFER ACIERNO: Correct.

STINNER: So you'll always have, no matter how good you are in the state, you always have one- and two-star rated facilities.

JENIFER ACIERNO: Correct. In essence, the state providers are competing against one another. So not all of them can be five-star providers. They-- they will have a one to five bell curve for those providers, even if they're all operating at a terrific-- terrifically efficient and quality level.

STINNER: Thank you. Additional questions? Seeing none, thank you. Afternoon.

DIANA LECHER: Afternoon. Senator. Senator-- Senator Stinner and fellow members of the Appropriations Committee, I am Diana Lecher, D-i-a-n-a, Lecher, L-e-c-h-e-r. I'm a registered nurse and the director of the Chadron Community Hospital's home health and hospice and cardiopulmonary rehab for the last 19 years. I am a member of the Nebraska Home Care Association and I am testifying on behalf of membership in support of L.B181. I drove 425 miles yesterday so I could be here to support LB181. I'm here to speak for the most vulnerable Nebraskans and rural Nebraska. We are the only home health and hospice agency that serves Dawes, Sioux, and Sheridan County. We're the most northwest counties of Nebraska. The next home health agency is a hundred miles south and 140 miles east. The next hospice agency is 250 miles away. There are places, of course, in the Panhandle, too, the do not have home health and hospice. And while their hospitals in this area, they were unable to sustain a home health or hospice agency. Home health and hospice provides freedom for patients to live at home. The Nebraska Home Health agencies can give intermittent support through a mix of nurses, physical and occupational therapists, and nurse aides to support patients to live in their own home. A list of services we provide has been attached for you. And in preparing for this testimony, I want to tell you that a concerned wife asked me to tell you she would not have been able to keep her husband home without home health and she would have not been able to keep him home his last days without hospice. All of our patients would say the same. Nursing facilities offer 24-hour care, but our goal is to-- our goal always should be to allow elderly citizens to stay home as long as possible. And I can share that a nursing home will cost about $1,300. Home health can provide a weekly nurse visit and three home health visits every day for the same cost in that week. My concern is whether the services will be there when they need them. A second concern about patients is that they sometimes have to live in the facility when home health could have provided the care at a lower cost, but there are no agencies to help them. Another concern, as you've heard about all these nursing homes closing and

people moving, as you have heard, our home-- or, excuse me, our home health agency, like others in rural Nebraska, don't make a profit, flat out. We are subsidized by our hospital. We provide the services solely because it is the right thing to do. And if we close, I can tell you no other entity would open services as comprehensive and supportive of the rural elderly as us. Home health faces federal cuts January 2020, and these are changes in payment models and they are the-- the-- the-- the National Home Care states that these are the same changes the nursing homes just went through. Medicare contractors for Nebraska are now performing probe audits. Two-thirds of their audits are pulling back partial or full payment for 60 days of care, not one visit, 60 days. And the reason often is the physician didn't document well enough on a face to face and, number two, a clinician may have forgot to cross a t or dot an i or put one item on a complicated care plan. This is not a quality of care issue that they're finding. This is a tremendous amount of overhead to make sure we're doing this correctly. Now I know those are federal issues, but when you add this to the reduction in Medicaid reimbursement, rural home health agencies in the Panhandle and western Nebraska are close to extinction. There are home health-- a Medicaid patient that may live, for one example, may live 30 miles from our office requires our agency to spend $90 between visit time, travel time, and mileage, and we get $88 on that reimbursement. Now there are some patients in town, but we serve patients up to 90-plus miles away. Then factor in the administrative expenses from the increasing regulation. Home health and hospice agencies are never reimbursed for mileage. There are many home health agencies in eastern Nebraska that can provide up to 24-hour care in the home and they let people grow old at home. But there are no agencies like this in the Panhandle. There are no formal means to even hire a caregiver formally. This is mostly due to work force limitations but also because our hospital cannot expand services where reimbursement doesn't meet cost. These types of services are not protected by critical access cost reports and reimbursements. Regarding the work force problems, shrinking Panhandle census, we have limited people to hire, coupled with the fact that home care is challenging work. We travel on bad roads, sometimes smoky and unsanitary homes, and we have to engage patients to be healthy because we're not there 24 hours a day. Only clinicians with a passion for home care would do this. Currently, I have adequate nurses because I've stole them from the nursing homes, flat out. They have decided that they would rather work for me for less money than engage in the short staffing and the increasing scrutiny that these nursing homes have to put up with. The Nebraska Home Care-- and I-- and I worry that

home health is next because I think we're one step behind those trends they've been doing. The Nebraska Home Care Association supports a long-term care study in our state, and we would be glad to partner and answer any questions that you have.

STINNER: Well, first of all, thank you for coming all that way.

DIANA LECHER: Thank you for the honor.

STINNER: I have a pretty good idea how far.

DIANA LECHER: You do, don't you? I'm about two more hours above you though.

STINNER: Yeah. But I think you-- you encapsulate a lot of the challenges in rural Nebraska, certainly out in the Panhandle. And I appreciate this, the cost of compliance and what you have to do to comply, the work force and who you have to steal from if it's available.

DIANA LECHER: Uh-huh.

STINNER: And that's what I keep running into is that work force problem out there.

DIANA LECHER: Exactly. Thank you.

STINNER: So additional-- Senator Clements. I'm sorry, I--

CLEMENTS: Thank you, Chairman Stinner. Thank you for coming, again, for so long. I'd-- I was just a little bit curious. This bill is a study on long-term care and does home health care fall into that--

DIANA LECHER: Uh-huh.

CLEMENTS: --definition?

DIANA LECHER: Yeah. I guess I see-- I see us as being the first step towards that long-term care. Trying to keep them home, more cost effective. We're not in competition with nursing homes. We work with them. So if we can keep them home where it's more-- where it's lower cost, we should do that. But there is that point where they need 24-hour care and we're not-- we're not going to provide that. So we are, I think, the first step, along with assisted livings. We always

want to put the right-- the patient in the right place at the right time.

CLEMENTS: So we're wanting this study to include home health care as a-- one of the solutions--

DIANA LECHER: Yes.

CLEMENTS: involved.

DIANA LECHER: And Senator Bolz did ask us to speak, the Nebraska Home Care Association to speak today.

CLEMENTS: Thank you.

STINNER: Just for the Senator's clarification, it is part of the long-term care section of Medicaid. So, Senator Erdman.

ERDMAN: Thank you, Senator Stinner. Thank you for coming. How are things there? Have the drifts melted?

DIANA LECHER: Excuse me?

ERDMAN: Have your snowdrifts melted?

DIANA LECHER: No, but my creek is very full.

ERDMAN: So did-- did you have problems getting around during the blizzard. Has it been hampering you from doing your work?

DIANA LECHER: Yes. You know, I experienced the fires and all the challenges with that in trying to find our patients, and the same thing has happened with those patients evacuating. We have a really good plan now about making sure they're prepared. They're going to lose electricity; do they have enough oxygen. We have a whole scenario that we do with our patient, so. But it is a challenge, I mean not-- certainly not what eastern Nebraska is going through, but.

ERDMAN: Understand. Do you have any connection or understanding of what's happening in the nursing home at Whiteclay?

DIANA LECHER: In the nursing home-- ?

ERDMAN: Whiteclay.

DIANA LECHER: Yes. Well, we have just started providing hospice care up there,--

ERDMAN: OK.

DIANA LECHER: --just two patients now.

ERDMAN: Is that facility full or do you know how many people are in that facility at Whiteclay?

DIANA LECHER: I don't think it's full, I don't think. You know I--

ERDMAN: Are they having-- are they having trouble finding people to work there?

DIANA LECHER: Yes. I've gotten letters from them looking for people, so I know they are. You know they're-- we did an orientation with them as I was driving here, so I haven't been up there yet. But we're happy to provide the hospice care there. It is a lot of miles for us to travel. Most of our patients have only lived a couple days on hospice care, so. I think that the nice thing about hospice is that it's extra in that home, in the nursing home, with them. So not only do they have all of the facility staff and all the good work they do, but they also have a hospice nurse, a hospice social worker, hospice clergy, hospice volunteers serving them. We give massages to them. So we'll help support that--

ERDMAN: OK.

DIANA LECHER: --if we're here.

ERDMAN: Thank you for coming.

DIANA LECHER: Thank you.

STINNER: Additional questions? Seeing none, thank you very much.

DIANA LECHER: Thank you for the opportunity.

STINNER: Drive carefully.

DIANA LECHER: Thank you.

STINNER: Good afternoon.

JORDAN RASMUSSEN: Good afternoon, Chairman Stinner, members of the committee. My name is Jordan Rasmussen, J-o-r-d-a-n R-a-s-m-u-s-s-e-n. I'm on the policy staff at the Center for Rural Affairs. As many have talked about before, our state of aging. Even ahead of this, these full effects of this significant demographic shift, rural Nebraska counties have a higher percentage of residents over the age of 65. As of 2016, 18.7 percent of residents in rural counties were 65 years of age or older, compared to 12.5 percent in Nebraska's urban counties. Where these residents will call home as they age and need skilled care services is of significant importance to individuals, families, communities, and the state. Older Nebraskans wish to remain in their communities and the state as they age. The Nebraska Rural Poll found that 40 percent of residents polled in the 50 to 64 age demographic did not have intentions of moving. This percentage increased to 62 percent for those Nebraskans of retirement age. The decision of where-- where to retire for all groups surveyed was driven by a desire to be close to family, proximity to healthcare services and facilities, and cost-of-living factors. Despite this personal aspiration of remaining in one's home and community, many elders and their families will be forced to seek additional healthcare services in a long-term care facility. Nationally, it's estimated that of the population over the age of 65, 35 percent will reside in a nursing home at some time during their life. For today in Nebraska, that would be about 44,000 residents that would need long-term care services as they age. Last fall, we conducted an analysis and looked at the-- that, and we found that 30 long-term care facilities closed in the state of Nebraska over the last decade, while only 20-- while only 23 new facilities opened, and that there was a loss of 16 rural long-term care facilities. In metropolitan areas there were 7 facilities that closed and 16 new facilities that emerged. When evaluated on the basis of the number of beds, this flux in the number of long-term care facilities resulted in a net loss of 213 beds statewide. In rural counties there was a loss of 753 beds, compared to a net gain of 540 in metropolitan counties. What these gains and losses in the number of beds does not reflect is the geographic scattering of these facilities across the state. While many counties maintained at least one long-term care facility following a closure, residents may not be able to remain in the communities which they have aspired to live. Closer-- closures such as those that rural communities have endured over the last decade result in the limitation of choice and force residents to travel a greater distance from their home community for care. Moreover, long-term care facility closures have significant economic impacts. According to the Seniors Speak Nebraska, long-term care and

assisted-living facilities infuse nearly $2 billion in the state's economy annually. These facilities also generate more than $854 million in annual wages. For small, rural communities where a long-term care facility is often one of the top employers, a facility closure not only displaces elderly residents but results in a significant loss in jobs and can have radiating effects in the community. While the reason for nursing home closures and the loss of beds can vary significantly from the simple renovation of a facility to financial insolvency, Medicaid reimbursements play a significant role in the viability of a facility. Yet, Nebraska long-term care facilities are faced with significant shortfalls in Medicaid reimbursement rates. In 2015 the average cost of providing care in Nebraska's long-term care facilities was about $187. On average, Medicaid reimbursed $162 of those costs, leaving a Medicaid shortfall of $25 dollars. As Senator Stinner referenced before, by 2017 that gap to-- grew to $36 per patient. If you looked at 2015 numbers, the combined Medicaid shortfall of Nebraska's long-term care facilities was over $50-- $58 million dollar loss. With that, I conclude our testimony and we just-- the Center for Rural Affairs asks that the Legislature continue to study and help intervene in the closure of these much needed long-term care facilities in rural communities. Thank you for your time. And I welcome your questions.

STINNER: Questions? Seeing none, thank you.

JORDAN RASMUSSEN: Thank you.

STINNER: Any additional proponents? We do have letters of support from: Judy Nichelson, Terry Werner, Paige Peitzmeier; and Cheryl Frickel. Are there any opponents?

ROCKY THOMPSON: Good afternoon, Chairman Stinner and members of the Appropriations Committee. My name is Thomas "Rocky" Thompson, T-h-o-m-a-s R-o-c-k-y T-h-o-m-p-s-o-n, and I serve deputy director of Policy and Communications for the Division of Medicaid and Long-Term Care within the Department of Health Human Services. I'm here to testify in opposition to LB181. And just for clarity, I have not seen the amendment. LB181 would require the department to hire a contractor, according to certain criteria, to complete a study regarding long term-care access and work force needs. The department has a number of concerns regarding the hire-- hiring of contractor and the scope of the proposed study. State law would require competitive procurement in most cases, including a request for proposals, if payments to a contractor were to exceed $50,000. The procurement

process takes time. The bill is unclear about the actual timing of the study. Section 2(1) of the bill indicates the report is due by December 31, 2019, where Section 2(3) of the bill says that only a status report is due by that date, with a final report due by December 31, 2020. Therefore, it is not clear whether the competitive procurement law would apply and, if so, whether the department could select a vendor with sufficient time remaining for the vendor to do its work well and a timely report-- report results. It is also not clear whether exists eligible contractors to fill the stated scope of the work. I do understand that the amendment takes out the independent Nebraska-based entity with proven expertise, but that's in the green copy. I will point out, since references to the cost of study, that the department did complete a similar study for long-term care services in 2017, and that study cost $584,000. In addition, LB181 proposes to pay for the study with an unspecified amount of Civil Money-- Money Penalty funds, CMP funds. CMP funds are limited and they are currently the only source of funds available to pay for life-sustaining measures that are in need for residents in facilities that go into receivership. And from my understanding, CMP funds can only be used for nursing facilities, not other long-term care services. Further, pursuant to 42 C.F.R. 488.433, the federal government decides whether to approve the use of CMP funds, we cannot assume that approval will be given. If this use is not approved by CMS, do the other provisions, like the moratorium in the bill, still go into effect? That-- that is unclear. Department also has concerns about the scope and nature of this study. LB181 outlines six required areas of focus, which include the state's long-term care work force needs and financial stability of long-term care providers. The department is not the only payer of long-term care services, nor is it in a position to dictate the business decisions of private companies, including the strategic consolidation of facilities that is called for in the bill. The department's most serious concern, however, is a provision that would prevent us from making any changes to long-term care services before the study is completed, plan created, and implemented. This would have several detrimental effects on our ability to provide for care for Nebraska's most vulnerable people. For example, would we be unable to submit any state plan amendments to the federal government even when required to continue to receive federal funds? We would be prevented from renewing waivers that allow us to provide in-home services before they expire. And another example that just became clear last week are a change in the home and community-based waivers the department is preparing to submit in light of the recent flood. The department's plan is to submit changes to its

home and community-based waivers under Appendix K authority in order to assist with flood relief across the state for those receiving home and community-based services. The Appendix K authority will waive certain requirements related to exemptions for things like settings' requirements for services, limitations on services, and provider requirements in flooding affected counties. In short, this bill would impede the department's ability to provide flood relief for some of the most vulnerable people we serve. For all these reasons, the department opposes LB181. Thank you for this opportunity to testify. And I'm happy to answer any questions you might have.

STINNER: Questions? Senator Dorn.

DORN: You-- you-- you said something about you've undertaken a study in 2017 and it costs 500-and-some thousand dollars?

ROCKY THOMPSON: That is correct, Senator. There-- there was a study, Nebraska's Long-Term Care Redesign Plan, which is available on our Web site, and we've been using that to guide the development of the changes to long-term care services. Certain recommendations we've taken; some of the recommendations we've put on hold. But this is the study that we commissioned back in 2073-- 7-- 2017 through Mercer.

DORN: And those are the guidelines that you're going by now or whatever.

ROCKY THOMPSON: That-- that's correct. It's a similar study. It's not exact-- exactly the same. It goes about the changes in the aging population in Nebraska. It doesn't go into all the financial considerations because, again, is that the role of a payer, is to look at-- at the financial stability of private businesses.

DORN: But you're here, I mean you're here testifying opposed to this. And then you're basically saying, though, that if we do this study you won't implement it.

ROCKY THOMPSON: I'm not saying that, Senator, because the study-- the bill does say that it must be implemented before any changes to long-term care services are done by the state that are paid for by Medicaid. So the bill does compel us to implement whatever recommendations are made.

STINNER: So your testimony today is that you've studied it, even though you haven't looked at the rate methodology in that study, but we don't need a study.

ROCKY THOMPSON: I would disagree with not looking at the rate methodology, Senator. We have been deep in working on the rate methodology. There is another bill that Jeremy Brunssen will be testifying on today and he can talk about his work with the associations, with different providers, and looking at the rate methodology. In fact, there was a presentation before the Long-Term Care Redesign Advisory Council on March 6 where he went over the high-level-- level recommendations for that study.

STINNER: So we do have something coming out for rate methodology. Is it-- is it normal and customary that you see this many nursing homes go insolvent and, what I hear, more coming?

ROCKY THOMPSON: I don't know what would be normal and customary. I do know that we have a very low census for certain facilities across the state. There's only a 72 percent occupancy rate for all facilities across the state. Some areas of the state have even less.

STINNER: So you're saying that depending on your area and if you can fill the nursing home you can stay open, or not?

ROCKY THOMPSON: I-- I can't say, Senator.

STINNER: Well, let me-- let me go through something with you. Just a second. And this is-- this is from testimony last year and it's-- it's-- it's the testimony that was given to me and it stuck with me for a long time. And we're talking about, I think the question was but-- I can't remember the question, but a Medicaid payer and payer mix. And we talk about within the eco-- the ecosystem of multiple providers, we go through that whole glorious language. But we come down to this: I think a much better redirect-- redirecting institutionalization into facilities that have healthier payer mixes, where there's a focus within the payer mix on solid reimbursement from multiple payer sources in the marketplace, and the focus on building quality institutions-- can't disagree with it-- versus a broad market access. So we have the issue of access and should we be providing the access. And you've just heard testimony that in rural Nebraska you're a long way from everywhere. Or we're going to stuff the quality people, quality places that have the opportunities, which to me tells me the urban areas that have a private payer mix that's larger than

what we can afford in the Mitchells to Morrills, the Bayards and all the rest of it. They just go, go away, and we'll have to find some way to consolidate something in a quality institution. Is that where we're going with this whole thing?

ROCKY THOMPSON: Senator, the payment methodology that is being proposed does have a factor in for rural versus urban areas, and also it factors in the Medicaid mix for those facilities. Those facilities with a higher Medicaid population would be reimbursed more.

STINNER: Here's another for your analysis, OK: 2012-2013 the actual Medicaid nursing facility expenditure was $324 million. I come out here to 3/16-3/17, it's $323 million. That actually went down $1.5 million. We put in, "we" meaning the Appropriations, said, hey, we'll put in a 2.25. One two and a quarter percent increase should be keeping up with inflation. Think about that. These are ongoing businesses. They're businesses that have ongoing costs. After five years we actually went down. Well, you could say so did the-- so did the census. And I agree with you except for one thing. They're ongoing businesses. They have inflationary costs. They have to hire people. So would it surprise you that the difference between-- if you would have followed the Appropriations' side of things versus your side, we would have had $30 million more going out to nursing homes. Would that have helped at all?

ROCKY THOMPSON: Senator, the way--

STINNER: Thirty million dollars is a lot of money.

ROCKY THOMPSON: I agree, it is a lot of money.

STINNER: And it's appropriated; it was not sent out.

ROCKY THOMPSON: And the way the payment methodology works, we reimburse per individual.

STINNER: And you have a problem with the payment methodology.

ROCKY THOMPSON: I agree.

STINNER: And it comes back to the payment methodology all the time. You guys, I've had so many meetings with you. You hide behind that. You have this mystery way of doing it. But it isn't a mystery. When I look at you-- at the bell curve, OK, I look at the per diem, the worst institutions get the least amount of money, but we're going to incent

them to get better? How? How does that happen? I-- I think we got a crisis on our hands. Finally, I found somebody just says, by God, if we don't increase rates we're going to fail. Well, we are. Now I don't see the department in a sense of urgency. Maybe I'm wrong. Maybe I'll be delighted to see what-- what happens in the rest of this meeting. But the fact of the matter is the dollars aren't going out. The methodology has been flawed for a very long period of time. And you know, somewhere along the line we've got to do something, don't we?

ROCKY THOMPSON: And that is why it's a focus of this administration, is to remove the methodology that's currently in the regulations and replace it with something that actually works.

STINNER: I 100 percent agree with you.

ROCKY THOMPSON: Thank you, Senator.

WISHART: What is the--

STINNER: Senator Wishart.

WISHART: --what is the time line between the methodology now and-- and when you're going to replace it with something that works?

ROCKY THOMPSON: Well, we're currently receiving feedback, Senator, from the methodology meeting that we had on March 6 with different providers. And we have a meeting with the association, I think in middle of April. And then after that, at the same time, we are removing the current methodology in our regulations because nursing facilities are one of two provider types that actually have the way we pay them in our regulations in our state plan. So we're removing that at the same time we develop this methodology in consultation with the association's individual providers. So we would estimate by next July 1 is the date I was given.

WISHART: July 1 is-- so will we anticipate then you coming in with a deficit request to adjust the dollar amount to what is appropriate for this new methodology?

ROCKY THOMPSON: Senator, we intend to work with our existing appropriations.

WISHART: With the existing appropriation.

ROCKY THOMPSON: Yes, Senator.

WISHART: Do you anticipate, one of the things that I've been hearing is that there are parts of the state where, because of the population decrease, we can anticipate that the idea of filling an entire nursing home may not be something we can do. And so then we can just anticipate that there is a different business model that those businesses are going to have to work off of. Will the-- will that be recognized in your methodology?

ROCKY THOMPSON: Senator, the payment methodology is for-- just for the payment of nursing facilities. In regards to broader business issues that are going on, it does not necessarily address those.

WISHART: From your-- just from your philosophical standpoint in the position you're in, do you-- are you-- do you-- is one of the issues you're going to work on, are you concerned about consolidation and lack of access to long-term care facilities in people's-- their own communities?

ROCKY THOMPSON: Certainly, Senator. That is a concern.

WISHART: So do you anticipate that with the direction you're moving with the department that you will be fighting against a consolidation where people are no longer living in their communities?

ROCKY THOMPSON: Senator, I think that we explore institutions but at the same time explore home and community-based so we can allow individuals to stay in those communities that might not have access to a nursing facility longer.

WISHART: OK.

STINNER: Senator Clements.

CLEMENTS: Thank you, Chairman Stinner. Thank you, Mr. Thompson. I was wondering about the changing of the methodology. Does that requires CMS approval or just amending the state plan or your waiver?

ROCKY THOMPSON: Yes, Senator, it will require change to our state plan.

CLEMENTS: And it has to be approved by CMS then?

ROCKY THOMPSON: Yes, Senator.

CLEMENTS: Now when you said next July, did you mean July of 2019?

ROCKY THOMPSON: I meant July of 2020, Senator.

CLEMENTS: That's what I was afraid of.

ROCKY THOMPSON: Well, it's the methodology is currently state law. It's in our regulations. So to make any kind of change it has to go through that promulgation process.

CLEMENTS: All right. And you're in process now of making changes?

ROCKY THOMPSON: We're in process of making those changes, Senator, and also working on other necessary changes that Jeremy Brunssen, who will be coming up on another bill, can speak more clearly to.

CLEMENTS: Have any of those proposals being published or put out for comment yet?

ROCKY THOMPSON: There was a proposal, Senator, that was released for the Long-Term Care Redesign Advisory Council back on March 6. I need to check and see if that's on our Web site or not. That has been shared with the Health Care Association.

CLEMENTS: All right. I would hope that you would get them involved too.

ROCKY THOMPSON: Yes, Senator.

CLEMENTS: Thank you.

STINNER: So since it's in statutory language right now, if we make the change to the statute it doesn't have to go through that regulatory process step. That is what was conveyed to us in our hearings.

ROCKY THOMPSON: Senator, if there is a direction to ignore rate regulations from the legislative branch, yes, that would supersede anything in our regulations.

STINNER: OK. Just wanted to make that clear because we can, from here legislate, what that could, could or it could not be. Now I will say this, I apologize for me getting excited to you because you've always

been professional. You've always answered my questions and I appreciate that.

ROCKY THOMPSON: And you're always a joy to work with, Senator.

STINNER: Yeah. All right. Seeing-- any other questions? Seeing none, thank you.

ROCKY THOMPSON: Thank you, Chairman. Thank you, Senators.

STINNER: Any additional in opposition? Seeing none, anybody in the neutral capacity? Seeing none, Senator Bolz.

BOLZ: Thanks for your time and attention, Committee. And if I could ask for just a little bit more, this is a really important issue to all of us and so I want to-- I want to work through some of the issues that came up in the hearing today. But I also want to say that I don't often-- I am often very passionate about bills; I don't often make them personal. But I do want to share the comment that we lost my grandpa this spring and-- and he received care in my district and his care was excellent. But what was more impressive to me was how kindly and tenderly the staff took care of my grandma. And I bring that up mostly to articulate again that everybody sitting at this table has someone that they love who may be in a care facility or may be in a care facility before they pass on, and so this is-- this is about a system that matters to all of us. OK. Moving on to the-- to the policy pieces, Senator Clements, I appreciate the clarification about the community-based services. If you want to turn to page 3, lines 1 through 8 and 13 through 17, that's where those community-based services are-- are referenced as a part of the overall analysis.

CLEMENTS: OK.

BOLZ: So that's one piece. The second thing that I think-- piece that I think is relatively easy to-- to sort of knock out which is I think you have heard loud and clear today that this is an important bill and an important study. If the cash funds aren't an appropriate option they're an option I bring to this committee for consideration. If that's not an appropriate fit or not a fit that we can move forward with quickly enough, I think we can find $175 in General Funds for this very important work and I would ask your consideration of that.

STINNER: That's--

BOLZ: What's that?

STINNER: A hundred and seventy-five thousand.

BOLZ: Hundred and seventy-five thou-- I'm sorry.

DORN: You said $175.

BOLZ: Oh. Well, I undersold it, $175,000. The third piece I wanted to address is I'm-- I'm absolutely willing to-- to make some changes to the language related to the moratorium. And I want to say two things about that. First is I do think that the study is valuable and important, whether or not we bring forward the moratorium language. But second I would also point out to this committee that LB468 addresses some of those issues and is prioritized by the Health and Human Services Committee. We didn't necessarily know where that bill would land when we brought this bill, so it may be more appropriate to have that conversation through the HHS Committee bill. I'm more than happy to work with the Department of Administrative Services to add more precise language regarding the contractor and the timing. I don't think that that's something that should slow this committee down. The last thing I want to say, and I know we've got a long day in front of us so I'm sorry that this conversation has gone on so long, but I think with the closures that have faced us it is an important conversation to have. The last thing that I want to say is that I have read, analyzed, summarized, and written memos around the Long-Term Care Redesign Plan. I participated in stakeholder meetings. I have spent a significant amount of time with the Long-Term Care Redesign Plan. Colleagues, make no mistake, this bill is not the same as the Long-Term Care Redesign Plan. If you'd like to spend all afternoon talking about the Long-Term Care Redesign Plan, I'd be really happy to do that. Things that that plan talk about, including standardizing assessments for people entering long-term care, updating our personal assistance services, implementing our electronic visit verification services, creating a no wrong door system, creating a system of administrative support for independent workers, all things that are really very important and that I support. And make no mistake, those things complement this bill but they do not duplicate this bill. This bill puts a fine point on the specific issues in front of us which relate to and contribute to the closures of long-term care facilities in this state and in communities that we all care about. So I want to be very clear, this is not duplicative. I'm done soapboxing. I

appreciate your time and attention. I'd be happy to answer any questions.

STINNER: Questions? Seeing none, thank you.

BOLZ: Thank you.

STINNER: That concludes our hearing on LB181. We'll now open with LB24. Senator Kolterman.

BOLZ: Good afternoon, Senator Kolterman. Welcome to Appropriations. Go right ahead.

KOLTERMAN: Thank you. Is he leaving?

BOLZ: He just needed a moment to step out. He'll probably be right back.

KOLTERMAN: Maybe he won't be as hard on me.

BOLZ: We'll do our best, Senator.

KOLTERMAN: Good afternoon, members of the Appropriations Committee. I'm Senator Mark Kolterman, M-a-r-k K-o-l-t-e-r-m-a-n. I represent the 24th District in the Nebraska Legislature. I'm here today to introduce LB24 at the request of the Nebraska Pharmacists Association and the Nebraska MEDS Coalition. The purpose of LB24 is to reappropriate money to the Department of Health and Human Services to contract for service for ongoing funding for Nebraska's statewide drug disposal program. The program, that started in 2015 when the Nebraska Legislature provided $300,000 for this purpose per a bill introduced by Senator John Kuehn on behalf of the Nebraska Pharmacists Association as a fiscal intermediary and lead organization of the Nebraska MEDS Coalition. With the budget cuts over the last several years, the amount that that program had received is closer to $260,000. They'd like to see it extended back to at least $300,000 each year. This coalition has been working on the issue of drug disposal for over 11 years. The program has 325-- or 328 pharmacies across Nebraska participating, making access for patients to get rid of unwanted, unneeded medications easily available. Nebraska, like every state in the nation, has experienced increased deaths due to prescription drug overdoses. We've done great things in Nebraska in addressing the ongoing problems, and one of our successful tools is a statewide drug disposal program. Establishing a sustainable, disposable program whereby drugs are collected at pharmacies across the state in safe,

secure, and legal containers, then incinerated for destruction, is the best method of combating each of these issues I just described. This program benefits all Nebraskans and our environment. And it's great to say that every day is take-back day in Nebraska. If you ask specific questions about the program, the next testifier can answer those for you. The Appropriations Committee receives many requests for funding. I believe that LB24 is a small program that continues to be a-- have a big impact on our state in many, many ways. With that, I would like to try and answer any questions you might have. The people behind me will talk a little bit about how the current program has been working and why it's been so successful.

BOLZ: Thank you, Senator Kolterman. Questions for the senator? OK. Thank you. Do I have proponents for LB24?

MARCIA MUETING: Good afternoon, members of the Appropriation Committee. My name is Marcia Mueting, it's M-a-r-c-i-a M-u-e-t-i-n-g, and I'm a pharmacist with the Nebraska Pharmacists Association. On behalf of the NPA, I'm here in support of LB24 and want to thank Senator Kolterman for sponsoring this legislation. Thank you for your previous support of the Nebraska Medication Education for Disposal Strategies or MEDS drug disposal program. This program allows over 320 pharmacies across the state to collect unwanted medications from patients every day anytime the pharmacy is open, which is why we say every day is take-back day in Nebraska. Looking at the data that I shared, you can see that last year alone, the program collected over 32,000 pounds of unwanted medication. I thought you might like to know the number of pharmacies that are participating in each of your districts. Senators Hilkemann and McDonnell, there are 142 pharmacies keeping drugs out of the landfills in Douglas County. Senators Wishart and Bolz, there's 46 pharmacies collecting unwanted medications from patients every day in Lancaster County. Senator Erdman, there are 11 pharmacies in your district keeping medications out of the groundwater. Senator Clements, there are ten pharmacies helping your constituents get rid of opioid medications. Senator Dorn, there are five pharmacies in your district collecting unwanted medications right now. Perfect timing, Senator Stinner; there's one pharmacy in your district that is participating in our pharmacy and another collecting unwanted medications at its own expense. The NPA currently holds a five-year contract with DHHS for this work. With the funds, we have established one of the two statewide drug disposal programs in the United States. We're really proud of that, and we hope that-- that Nebraska serves as a model for other states to follow. The Nebraska

MEDS Coalition oversees this work, and we ask that you plan to continue the incredible momentum that we have built. I'd like to list our partners. They include: AARP of Nebraska, Coalition RX, the Groundwater Foundation, Lincoln-Lancaster County Health Department, the LiveWise Coalition, the Nebraska Department of Environmental Quality, the Nebraska Department of Health and Human Services, Nebraska Environmental Trust, the Nebraska Medical Association, the Nebraska Hospital Association, the Nebraska Pharmacists Association, the Nebraska Recycling Council, the Nebraska Regional Poison Center, and the Nebraska State Patrol. With support from this appropriation, anyone can call the Nebraska Regional Poison Center's toll-free number to find a participating pharmacy near them. These funds have supported our statewide marketing efforts and the Nebraska MEDS Web site with its pharmacy locator tool. The Groundwater Foundation issues press releases when a new pharmacy location is added to the program or promotions of special events such as Earth Day or the Drug Overdose Awareness Week. When this coalition formed, over ten years ago, our primary concern was to protect the environment. We sought out an alternative to flushing or trashing unwanted medication. This drug disposal program has most recently become an important facet in combating the opioid crisis, allowing patients to dispose of leftover painkillers so they don't fall into the wrong hands. As you know or may know, many people who abuse drugs get them from the medicine cabinet of a friend or relative. Unfortunately along with other government agencies, the funding that was previously appropriated by the Legislature was cut below the $300,000 that was budgeted by this committee. We ask that you restore the original requested budget for this important program. Thank you, and I'd be happy to answer any questions.

STINNER: Any questions? Senator Bolz.

BOLZ: Could you please describe for me what will be different when you receive the additional funds? What is the unmet need that you're trying to cover?

MARCIA MUETING: Right. The funds that we're receiving from this appropriation support the marketing efforts. They support education for pharmacies. We're-- we're constantly educating the pharmacies and we're trying to educate patients as well how to use this program and the availability of this program.

BOLZ: And I'm sorry, I'm not-- I'm not sure that question got across.

MARCIA MUETING: OK.

BOLZ: What will be different? What is-- what is not being done that will be done with the additional $3,000-- $340,584?

MARCIA MUETING: Oh, OK. When we originally came to the Appropriations Committee, we had asked for $600,000, and you're asking about the balance. We're-- we're-- and we were only given the $300,000. We've learned to live within those dollars. And actually we've sought out another source of funds that actually pay for the containers themselves. These-- this funds-- this $300,000 pays for the marketing. It's TV ads. It's radio. It's newspaper ads. It's materials that we use to educate the pharmacies and educate the consumers as well.

BOLZ: So the thing that will be different is more marketing?

MARCIA MUETING: Right. Well, it's heck to be successful. Our projections for how many containers we were going to need for this program, we had no idea how successful we were going to be. A lot of the money that was originally marked for fun-- for marketing has had to pay for containers because that budget item fell short. So you haven't seen ads on TV. You haven't heard anything on the radio. There's been nothing in the paper because we decided to switch those funds over into the collection containers so that we could preserve the program for the pharmacies and for the patients to-- to use every day. Does that make sense?

BOLZ: Yes. One more question.

MARCIA MUETING: That's OK.

BOLZ: Forgive me, Committee, just one more question. It sounds to me as though people are utilizing the program and it's been very successful without-- without the marketing.

MARCIA MUETING: Um-hum.

BOLZ: What-- what added value will marketing have if its already so successful using the strategies you've already got?

MARCIA MUETING: You're right. We have been successful. But our marketing analysis were-- actually have been able to pool populations in Omaha and Lincoln, Kearney and Hastings, and so far only about 48 percent of people even know that we exist. So we still have a huge unmet need in reaching out to the consumers so that they can know that

every day is take-back day and they can get rid of their unwanted medications at pharmacies.

BOLZ: Thank you.

MARCIA MUETING: Thanks for your question.

STINNER: Additional questions? Seeing none, thank you.

MARCIA MUETING: You're welcome.

STINNER: Any additional proponents? Seeing none, I do have support letters from: Britt Thedinger-- Thedinger, Nebraska Medical Association; Julie Diegel from Nebraska Recycling Council; Jean Hammack from Nebraska Regional Poisonal-- Poison Center; and, Jina Ragland from AARP of Nebraska. Are there any opponents? Seeing none, are there anybody in the neutral capacity? Seeing none, Senator? Senator waives closing, and that concludes our hearing on LB24. We will now open with LB403.

BOLZ: Good afternoon, Chairman.

STINNER: Good afternoon, Senator Bolz and fellow members of the Appropriations Committee. For the record, my name is John, J-o-h-n, Stinner, S-t-i-n-n-e-r, and I represent the 48th District comprised of all of Scotts Bluff County. LB401-- LB403 would prohibit the Department of Health and Human Service from using a certain component of the calculation when determining Medicaid nursing facility rates. Specifically DHHS would not be allowed to include the application of the inflation factor as it is defined under the rules and regulations. This would, in effect, require DHHS to use the amounts appropriated by the Legislature for computing future nursing facility rates. During the 2018 Legislative Session, I introduced LR442 as a result of several nursing facility closures: 16 from 2015 to 2018, and the 22 facilities placed under state receiverships. The majority of these were and are located in rural areas. During the interim, we heard from providers about the gap between the cost of providing care and Medicaid rate. We also heard about the-- the-- their dedication to Nebraskans and their concern about sustainability based on the current level of Medicaid reimbursements. I've seen the situation develop over the last few years as nursing facilities in my district struggled to have funds needed to care for the elderly, especially those individuals who rely on Medicaid to pay for their care. It is not a sustainable business model when a nursing facility is paid less than

its costs to provide care. There is also a decreasing number of individuals paying privately that can't afford to pay for their own care and also supplement the amount Medicaid pays for other residents. To begin to address this critical issue, we need to ensure that the dollars we appropriate for nursing facilities actually get to their intended target. They continue to provide care for the most vulnerable Nebraskans, Nebraskans who have worked hard, provided for their families, and contributed to their communities in our state. The challenge we have seen is-- as a committee is that the additional dollars we appropriate to Medicaid for nursing facilities is never actually received by nursing facilities in their rates. The nursing facility rate methodology is complicated, and I know the associations are trying to work with DHHS to change this, to narrow the rate disparity, and incentivize quality care and cost efficiencies. That is why I kept LB403 fairly simple and technical, to get additional funding to nursing facilities and to ensure the amount that we appropriated actually goes for the care provided to Nebraskans. In a lighter conversation, the department expressed a concern that the proposed language in LB403 would interfere with their ability to utilize funds collected as part of the nursing facility provider tax. The proposed amendment, AM908, is designed to address this concern. I have some testifiers behind me who are able to provide some more detail. I do want to say this, that when you look at the inflation factor, it is-- it was testified, the inflation factor is determined from spending-- spending projections using audited costs and census data following the initial desk audits. These are two-year-old cost studies, two-years-old cost studies, budget directives from the Nebraska Legislature. So we allocate dollars, appropriate those dollars, and the deflationary factor, then, fits those dollars supposedly into the methodology. Interestingly we have allocated $7.3 million 2013-2014, we've allocated-- 2014-15 we've allocated 3.7 million 48 dollars, 2015-16 allocated $7,340,000, allocated '16-17, $7,360,000. Never went out. Never went out. Now there was a decline in the population, I get that, 4.8 percent. The decline in total dollars went down accordingly. There is no-- nothing in the methodology that would say that we have an active business here. It should have gone up and it, as I indicated, 2018-- or '16-17, if they would've paid what we had actually should have spent on nursing homes, it was about a $30 million differential. This is just one way of attacking this problem. I look forward to the testimony of people behind me, and obviously the testimony of DHHS. Thank you.

BOLZ: Thank you, Mr. Chairman. Are there questions for the senator? Go ahead, Senator Clements.

CLEMENTS: Thank you. Thank you, Senator Stinner. The $30 million shortfall or underpayment is what-- over what period of time is it then?

STINNER: This is over a five-year period of time; 2012-13 we-- that-- the amount that should have been spent on nursing facilities $324 million. And it goes by 2.25 percent, which is kind of an inflation factor, to be allocated. It should have been $353,000,937. It actually was $323,000,027 or a $30 million dollar difference. During that period of time, interestingly, the amount that was allocated actually expended out of DHHS actually went down $1,557,000 or 4.8 percent which is the exact amount-- or predominantly the exact amount of the decline in the number of people in the nursing home under Medicaid. So there is a correspondent relationship there. I acknowledge that. But the fact of the matter is-- is that these are ongoing businesses that have ongoing costs, that should be compensated in order to stay in business. When you ask, why do we have failure? Why are we on the edge? Thirty million dollars will make a difference.

CLEMENTS: Thank you.

STINNER: Seven million dollars would have made the difference, frankly.

BOLZ: Go ahead, Senator Wishart.

WISHART: Thank you so much, Chairman Stinner, for bringing this bill. You're using statistics for-- for the past several years in terms of what could have come into nursing homes, but is this a trend that has been going on longer than that?

STINNER: You know, I don't go back that far. But I remember when I was on my first year in Appropriations, we put together extra appropriations with intent language that says, this needs to go out to the nursing homes. And that-- I believe it was about $8 million at that time. And-- and my-- my-- my memory is pretty sketchy about that, but this was an amount that we actually allocated within Appropriations to go out, didn't.

BOLZ: OK. Thank you, Senator Stinner.

STINNER: Thank you.

BOLZ: Do I have proponents?

HEATH BODDY: Good afternoon, Senator Bolz, members of the committee. My name is Heath Boddy, that's H-e-a-t-h B-o-d-d-y. I'm the president and CEO of the Nebraska Health Care Association and HCA is a family of associations providing statewide continuum of long-term care services for Nebraskans. And on behalf of our nearly 200 nonprofit and proprietary, skilled nursing facility members across the state, I'm here today to speak in support of LB403. LB403 would change one aspect of the Medicaid nursing facility rate calculation that applies to a percentage component ironically known as the inflation factor to adjust each facility's rate with the goal of controlling total spending. This process is unique to nursing facility rate calculation and differs from Medicaid's typical process of adjusting rates by the amount approved in the state budget and then allowing utilization to control the total spending. To calculate their inflation factor, Medicaid basically makes projections for future nursing facility expenditures based on certain assumptions, including that utilization, the number of Medicaid resident bed days, will remain the same over a two-year period of time. By assuming nursing facility utilization will remain the same, the result is that a negative inflation factor, as applied to each facility's rate, is greater than the assumption-- is greater than if the assumption had been that utilization would decrease as has been the trend for over the past decade which is shown in chart 1 of your handouts today. Forcing the rates to be lower than they would if Medicaid had assumed utilization would decrease means the total Medicaid expenditure will be at least $7.4 million less than the appropriation. For the current year, Medicaid applied a -7.17 percent reduction to each facility's rate. Last year, Medicaid nursing facility rates were reduced by two point-- -2.65 percent, the history of the inflation factors illustrated in chart 2 of your handouts. Without the revenue from the nursing facility provider tax which nursing facilities pay on a quarterly basis to the state General Fund, Medicaid's inflation factor for the current fiscal year would have been a -12.25 percent and a -8.11 percent for the prior year. Without any change this-- to this rate calculation formula, Medicaid's inflation factor will continue to increase and put nursing facilities' sustainability in further jeopardy. The goal-- goal of LB403 is to allow the dollars appropriated by the Legislature for nursing facility care to be utilized in the rate calculation process and fully realizing the rates pay for the care of Medicaid beneficiaries.

Earlier this afternoon, as part of the testimony for LB181, you heard about nursing facility closures and a number of facilities currently under state receivership. Many other nursing facilities are at risk, especially those serving a large number of Medicaid beneficiaries without an independent source of funding to help supplement-- supplement that Medicaid shortfall. In its fiscal note, you saw the department's concern that LB403, as written, would prohibit-- prohibit them from including nursing facility provider tax revenue in the rates. AM908 would address this concern by allowing the department to calculate the rates, including the inflation-- inflation factor as usual. At that point, if the inflation factor is negative, AM908 directs that a zero-inflation factor be applied to each rate. As amended by AM908, the department would need-- would not need to modify the language in the Medicaid state plan or the nursing facility regulations. The Center for-- Centers for Medicare and Medicaid Services must approve every year that Nebraska's payment to nursing facilities remains under the Medicare upper payment limit, or called the UPL, and that payment does not limit access to nursing facility services for Medicaid beneficiaries. The department's been able to demonstrate that Nebraska meets these requirements each year, and LB403, as amended, should not impair the department's continued ability to receive that approval. As you see in chart 3 of your handout, the information provided by the department indicates if the -7.17 percent inflation factor had not been applied to each nursing facility's rate during the current 2018-2019 state fiscal year, it would have resulted in 28.7 million additional dollars, that's federal and state funds combined, going towards the care of Medicaid beneficiaries. On slide 4 of your handout, based on the information available to us, subtracting the amount unused by Medicaid due to utilization projections would leave about $21.3 million. And if we base that on the 2020 FMAP rate for Nebraska, the state share would be approximately $9.6 million. This would be the approximate amount of additional state spending on nursing facility services that would result from LB403 as amended by AM908. As I wrap up, I ask you to support the goal of LB403 which is to ensure the funding that you appropriate for nursing facility care actually gets utilized in the rate calculation and realized in the Medicaid rates to pay for the care of Nebraskans. Thank you again for the opportunity to testify today. I appreciate Senator Stinner's support on this bill, and I'm happy to answer any questions.

BOLZ: Thank you, Mr. Boddy. Questions? Go ahead Senator Dorn.

DORN: Thank you, Senator Bolz. Thank you, Heath, for being here. In real dollars, about what will that amount per-- for the rate, you know, any idea what the rate-- is it per day?

HEATH BODDY: So Senator Dorn, are you asking about the nine point--

DORN: Well, no, the $21.3 million total.

HEATH BODDY: Senator, I'd be glad to get you that. My recollection is when the provider tax bill came in a few years ago, close to that amount was around $3 per resident day.

DORN: Right.

HEATH BODDY: But I'd be happy to get that information and make sure I'm firm on that number.

DORN: OK.

BOLZ: Thank you. Go ahead, Senator.

DORN: One more question here, up here on the top of this chart number, I think it's 3, that says from July '18 to June of '19, the nursing rate-- facility rates were based on the fiscal year cost reports. So is that the cost reports from Health and Human Services or DDH?

HEATH BODDY: Senator, the cost report is submitted by each nursing facility that participates and it's a-- it's costs for two years prior to that time. So they would submit to DHHS. It would be audited. And then they would be aggregated in that way.

DORN: So they talk about it. OK.

BOLZ: I have just a couple questions for you. I think I'm remembering right, Mr. Boddy, that before you took this job at an NHCA, you were the administrator at the Adams nursing facility, is that correct?

HEATH BODDY: Yes, Senator, that's correct.

BOLZ: Can you just connect the dots a little bit for what these trend lines mean for someone who's actually running a facility like the facility you ran in Adams?

HEATH BODDY: Absolutely, Senator. When you look at the idea that more Nebraskans are relying on Medicaid for the care that they're receiving in a facility in our-- in our state and the idea that, on average,

that care is under the cost, under the approved cost, at $36 a day, so you've got typically the number of Nebraskans utilizing Medicaid increasing and the amount paid for the care decreasing, it creates a pretty traumatic business plan to try to figure out how we're going to cover the difference. And unfortunately, as you may have heard earlier today, the difference right now typically is covered by people that can pay on their own. So from a-- from a business plan perspective, you find operations or nursing facilities across the state that have to say, we're only-- to stay in business, we're only able to have X amount of Nebraskans that rely on Medicaid in our care. And-- and it-- it creates a real pressure when that community-- your charge is to care for the people in that community.

BOLZ: Thank you. And related, given your past experience, can you see it-- I mean I know that you worked with Senator Stinner on this bill. I'm sure it's very well put together. Is there any reason, from a state or federal regulatory perspective, that any of this would be problematic?

HEATH BODDY: Senator, we are not aware of an issue that would make LB403 with the amendment problematic. We've tried to-- we've used state fiscal experts, and then you'll hear from-- a little bit later, you'll hear from some profession experts as it relates to the accounting side of this, and tried to take a very thoughtful approach to this to find a way, again, to get the dollars that you appropriate into the rates in the facilities. And so we're not aware of an issue.

BOLZ: OK that's-- that's helpful. So from your personal experience, from your work with NHCA, and from your research with experts both in the regulatory field and in the financial field that you can't-- you have tried to break it and you can't break it.

HEATH BODDY: Yeah. Much better said, Senator. Thank you.

BOLZ: OK. Thank you. Any further questions? Go ahead, Senator Clements.

CLEMENTS: Thank you, Ms. Chair. Thank you, Mr. Boddy. Back to the first graph, it's declining. It's a declining number of Medicaid resident days that you're talking about resident Medicaid percentage increasing in homes that you-- also showing a drop in total Medicaid bed days. How does that work?

HEATH BODDY: Well, some of that, Senator, probably has the effect of building closures. But you're right. The census in the state has declined over time. And at the same time, the number of people who rely on Medicaid, especially in the rural areas, has increased.

CLEMENTS: Well, the percentage, the number or the percentage?

HEATH BODDY: Sorry, Senator?

CLEMENTS: You said the number has decreased, but this chart's showing it-- the number has increased. You just now said the number have increased, but this chart's showing a decrease.

HEATH BODDY: Yes. So the-- to your point with the chart, the total utilization has decreased. The number of days that are paid for in a facility, the number of people in a facility that rely on Medicaid to pay for that care, has increased. So the-- so the percentage of private pay, if you will, or other services beside Medicaid has dropped which creates the problem in the business model.

CLEMENTS: Right. And I think when you said the number has increased, I think you meant the percentage increased.

HEATH BODDY: Excuse me, Senator, if I misspoke.

CLEMENTS: Thank you.

BOLZ: OK. Thank you for your testimony. Further proponents, please.

ROGER THOMPSON: Good afternoon, Chairman Stinner and the Appropriations-- members of the Appropriations Committee. My name is Roger Thompson, no relation to Rocky Thompson, but it's R-o-g-e-r T-h-o-m-p-s-o-n. I am a health care audit and reimbursement partner at the consulting and accounting firm of Seim Johnson LLP, and have spent my entire 38-year career serving the health care and senior services industry. My firm, Seim Johnson, serves about 25 percent of the state of Nebraska's nursing facilities in some capacity. I have personally been involved with the Nebraska long-term care, Medicaid reimbursement system since the 1980s and have been responsible for working with the rate data received from the Department of Health and Human Services for over 25 years. I would-- I would also like to add I'm a native Nebraskan, and currently reside in District 39. Because of my knowledge of Nebraska's long-term care Medicaid rate setting process and the impact of current Medicaid rates paid on the financial viability of Nebraska long-term care facilities, I'm here to testify

in support of LB403. I have two exhibits attached to my testimony that we'll get to in a little bit that do indeed illustrate the impact of Nebraska long-term care Medicaid rates on an example facility. But first, I want to remind this-- brought up-- the committee on how the current Nebraska Medicaid rates are set for fiscal 2019. First of all, the long-term care facility Medicaid costs per day for fiscal 2017, two years ago, are determined by the department. These cars-- these costs are typically less than the actual long-term care operating costs per day and are subject to various limitations. But once the adjusted limited long-term care facility Medicaid cost per day are determined, then an inflation factor is applied to set the fiscal 2019 Nebraska long-term care Medicaid rates. There are two important items to note here. First of all, the adjusted and limited long-term care facility Medicaid cost used to set the rates are typically less than the long-term care facility operating costs, creating a Medicaid discount before rates are even established. And there is a two-year difference from data used to set the Nebraska long-term Medicaid rates to when the rates are paid, creating a need to consider a biannual increase in the base year rates, not a decrease, to reflect the increasing costs from the base year. And given that the long-term care facility's operating costs are nearly 70 percent related to labor, that would be salaries, contract labor, and benefits, long-term care facility operating costs have indeed increased at a rate greater than consumer price indexes over the last several years. Nebraska Medicaid beneficiaries typically represent about 60 percent of all Nebraska long-term care facility residents. So what's 60 percent? Three in five in a nursing facility are-- those residents are Medicaid beneficiaries. This is very important because Medicaid reimbursement-- or adequate Medicaid reimbursement is essential to the financial viability of Nebraska long-term care facilities. When the gap widens between Nebraska long-term care Medicaid rates and the facility's operating costs, the Nebraska long-term-- long-term care facilities are forced to make up differences by increasing private-pay resident rates well above inflation or face financial instability. In Nebraska, long-term care Medicaid rates have historically been less than the facility's operating cost. Because of this, Nebraska long-term care private-pay resident rates have exceeded the Nebraska longer-- long-term care Medicaid rates to make up the Medicaid shortfall. Given the negative impact-- or negative inflation factors that have been applied the last two fiscal years, the gap between the Medicaid rates and the long-term care facility's operating costs and private-pay resident rates have grown exponentially. With this, if you wouldn't mind turning to the exhibit 1, it's toward the back, but exhibit 1

is-- I apologize, an accountant likes numbers and financial statements. But this exhibit illustrates the financial results of a typical Nebraska nursing facility that averages about 60 residents a day of which 60 percent are Nebraska Medicaid beneficiaries. Please note lines 5 and 6 of this exhibit. This is a five-year projection ending in fiscal 2019, but 5 and 6 would illustrate, you know, what you would expect a typical operating margin that you would allow for a nursing facility, about 1 percent operating margin. Line 7 identifies that Medicaid inflationary factor that has been applied to those costs from two years ago. And you can see how, in the last two years, it's been a negative number. In order to accomplish that 1 percent margin with those-- with those negative inflation factors that have been provided by Medicaid, take a look on line 13 which indicates the private-pay rate increases that would have to have been implemented by the nursing facility to make up that Medicaid loss. Particularly look at the last several years, you know, 7 percent, 8 percent, and 8 percent. Again, such increases are well above inflation, and quite frankly, are not realistic for a long-term care facility to implement. Now Exhibit 2, same nursing facility, but this illustrates what would happen if the nursing facility was only able to implement a private-pay increase that was commensurate with inflation-- inflationary cost increases with about 3.5 percent. If you look on line 5, you can see by not being able to implement a-- or not being able to pay fairly from Medicaid, you can see how that bottom line deteriorates rather quickly. Lines 11 and 12 in this exhibit then also identify, even with the 3.5 percent, what is the true difference between private-pay rates and Medicaid rates. And then finally, if you look on line 16, you can see there's been discussion about operating costs being about $40 a day greater than the Medicaid rate. This example illustrates that. Again, please keep in mind that these results would look worse if a Nebraska facility experiences greater Medicaid resident percentages, higher labor costs, physical plan limitations, or declines in overall volume. Again, as I indicated, our firm serves about 25 percent of the Nebraska long-term care facilities. We have witnessed deterioration to financial stability and results in the last several years. So we do believe LB403 is a step in helping reverse this trend. I appreciate this opportunity to be before you today, and be happy to answer any questions that you might have.

BOLZ: Questions for this testifier? I think you're in good company. There are a few accountants in this room. I was just-- just curious. You-- you reference that the cost increases in nursing facility providers is greater than consumer price index. How much greater? And

I don't have a ton of familiarity but is it comparable to the health care consumer price index? Is there a better measure we should use there? I'm just wondering as we kind of look at inflation factors across different agencies and different purposes, how do we think about this one differently?

ROGER THOMPSON: That's a good question. I'm not-- I'm not an expert but I can attest to-- you know, if you talk like to your aids, the price of aids has gone up exponentially. Again, a lot of times these aren't even available in communities, and then you're forced to hire contract labor which contract labor is about twice the cost if you were to hire somebody. So that's where that-- that inflationary cost really is taking place is in that lower care, aid-type of individual and all which pushes the price above the typical health care consumer price index.

BOLZ: OK. So my simplified understanding of what you just said is that there are things that can be measured in terms of things you have to buy that relate to the consumer price index, but the real driver here is the cost of the front-line worker.

ROGER THOMPSON: Yes, labor. Yes.

BOLZ: Further questions for this testifier? OK. Thanks for your work. Appreciate it. Further proponents?

KARI WOCKENFUSS: Good afternoon, members of the Appropriations. My name is Kari Wockenfuss, K-a-r-i W-o-c-k-e-n-f-u-s-s. I speak today in support of LB403. I have been a licensed nursing home administrator for 26 years. Fifteen of those years have been at the Louisville Care Community. The Louisville Care Community is a city-owned facility, is currently licensed for 61 beds for long-term care and 22 assisted living apartments. Since the beginning of the fiscal year, October 1 of 2018, Louisville Care Center has lost $169,000. In 2017-18, our Medicaid base rate was $182.42 per resident per day. In 2018-19, our Medicaid base rate dropped to $180.53 per resident per day reflecting an approximate $2 per person per day less. In January of this year, our nursing facility census was 47 residents. Thirty-six of those residents, or 76 percent, relied on Medicaid to pay for their care. Five residents, or 11 percent were private pay, and 7 residents, or 13 percent, were paid by Medicare. It is a challenge to make ends meet when you are serving such a high population of residents that are receiving Medicaid. In January of 2018-- or I'm sorry, this year, our cost accountant told the board that the Louisville Care Community's

2018 actual costs versus Medicaid reimburse-- reimbursement reflected a loss of $25 per resident per day, and this is included in one of the handouts. Our financials in January of 2019 indicated that-- that Medicaid's reimbursement is now reimbursing us $73 per resident per day less than a private-pay resident were to-- would pay us at this time. During our last inspection, state surveyors noted that our two community bathrooms needed attention. We agree with that. The tile floors in these community bathhouses must be replaced because they are cracking. We currently are using Whirlpool bathtubs that we are no longer to get parts for. This project for both bathhouses will cost the facility approximately $38,000 per Whirlpool room as the whirlpool tubs costs $18,000, a new floor costs $15,000, and the cupboards to put into these bathhouses will cost $5,000. To not complete these upgrades would not only be wrong, it would compromise our quality rating and possibly result in being cited for deficiencies with less financial-- for-- with financial penalties. Louisville Care Community is one of the few facilities that is willing to admit a high percentage of Medicaid beneficiaries, especially at-- that has access to Medicaid beds in the Omaha area becomes more challenging. We do believe in, at Lewisville, of serving those who need care regardless of the payer source, but we are also a business. To ensure our payer mix is able to sustain our continued operation, we are concerned where those reliant on Medicaid will receive care in the future. Thank you for your time, and I ask you to support LB403.

BOLZ: Thank you for your testimony. Questions for this testifier? Go ahead, Senator Clements.

CLEMENTS: Thank you, Senator Bolz. Thank you, Administrator Wockenfuss. Thanks for coming, and I see the 76 percent Medicaid percentage. Could you describe how your percentage of Medicaid beds has changed in the last five years?

KARI WOCKENFUSS: It's more than doubled. Fifteen years ago, when I took the job at Louisville, we were at 47 percent. So to tell you exactly five years ago--

CLEMENTS: OK. It has been steadily increasing.

KARI WOCKENFUSS: --it's-- it's-- it has increased every year.

CLEMENTS: Have you seen a special recent increase due to other nursing home closures or not admitting Medicaid patients?

KARI WOCKENFUSS: I'm sorry, I didn't--

CLEMENTS: Has your percentage increase-- is your-- is it your opinion that recent problems in other facilities have increased your Medicaid beds?

KARI WOCKENFUSS: Yes.

CLEMENTS: Is it-- do you think it's because other facilities are not accepting these people?

KARI WOCKENFUSS: Some do not. We do not require a resident to have so many months private-pay monies before we accept them. As long as they are Medicaid-pending, we will accept them if we're able to care for them.

CLEMENTS: And are you getting people from outside of your area, your community?

KARI WOCKENFUSS: Yes. We have several from Omaha, Papillion area, and then our surrounding areas as well.

CLEMENTS: All right. All right, I see. And the Capital Construction money that you need for these two baths, you say it would affect your quality rating. Is that the star rating you're talking about?

KARI WOCKENFUSS: Yes. Yep.

CLEMENTS: OK. Thank you.

BOLZ: Go ahead, Senator Dorn.

DORN: Any idea that, you know, if you're talking this-- using this formula, and I think he said approximately $3 a day, how many-- how much will that-- how many dollars does that amount to your facility in a year's time?

KARI WOCKENFUSS: We have, I believe the one-- right now, we have 19,356 days give or take, of Medicaid residents, so it will help.

DORN: So $60,000, but you should--

KARI WOCKENFUSS: But currently we're losing $25 per the last cost report.

DORN: OK.

BOLZ: OK. Thank you for your testimony.

KARI WOCKENFUSS: Thank you.

BOLZ: Do I have further proponents?

JENIFER ACIERNO: Good afternoon, Senator Bolz 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 in regard to LB403, and thank you to Senator Stinner for bringing this bill. LeadingAge Nebraska is an association that represents over 70 nonprofit providers of long-term care services, including nursing facility, assisted living, independent living, and adult day services, across the state of Nebraska. Our members span the state and include stand-alone, rural facilities and multisite, metro facilities. As you are aware, a number of long-term care providers have discontinued operation across the state due in large part to low Medicaid reimbursement. I am not going to duplicate what you've heard already from Mr. Boddy and others that have preceded me. But what I will say is that an inflation factor alludes to something that is an increase, and the inflation factor, this last year, was a -12 percent. Because of the participation of our providers in a provider tax, that was reduced to a -7 percent. As demonstrated by the provider tax, Nebraska long-term care providers are invested in generating income for the state and have been cooperative in the past in working with the department to assist in generating federal funds to assist with the cost of supporting operations. In my opinion, what is being proposed would not prevent the Quality Assurance Assessment from being distributed, it would simply remove it from the initial or base setting process. And we have also reviewed the proposed amendment and would support, with continued discussion, that approach that if the inflation factor is to be less than zero, then a negative inflation factor may not be imposed. The other issue that is raised by this bill is that all of the funds appropriated and reappropriated by the Legislature for nursing facility rates should be used for that purpose. At this time, we know that there are funds that are not being made available to fund rates while long-term care facilities are closing at what I would say is an alarming rate. For these reasons, we support this bill. And I'm happy to answer any questions.

BOLZ: Thank you. Questions for this testifier? Thank you. Further proponents? Welcome back, Mr. Calvert.

MICHAEL CALVERT: Oh, thank you. Chairman Bolz, members of the Appropriations Committee, my name is Michael Calvert, spelled M-i-c-h-a-e-l, Calvert, C-a-l-v-e--r-t. And I want to preface my comments. Originally, I was going to testify as-- as-- in a neutral capacity, but I changed my mind. And it was the inspiring words of our Chairman Stinner that reminded me, one of the reasons why I got involved here is that there have been some longstanding frustrations, not specifically-- only specifically to this specific-- this specific issue but just generally the disconnect that can occur between Appropriations Committee intent and how that intent may be bypassed, circumvented, may not occur as-- as expected. The second thing that occurred to me is it struck me as rather ludicrous to come in as a neutral when I had a hand in writing bills. So I thought, well, I probably ought to fess up. I was approached two months ago by the Nebraska Health Care Association help in drafting language to correct what they felt were inconsistencies between past Appropriations Committee funding decisions and the actual funding results via the reimbursement formula for nursing facilities. In the association's view, funding never achieved what they believed to be Appropriations Committee intent, you've heard this all before, and thus falling short of expectations of the association and its members along with committee members. One thing that became apparent to me early on was that past decisions-- and again, what Senator Stinner said reminded me that past decisions on funding tended to relate to a percentage increase over a prior year. However, the first problem that came to mind after getting back to this project was that-- how that's interpreted. Are we talking percentage increase over what? Is it prior year appropriations? Is it prior year expenditures? Is it on a facility level? Do you adjust for the changes in client-- client populations? How do you make an overall rate adjustment? So it became apparent that language that depended on any percent change methodology could become rendered meaningless by operation of the formula set forth in the law and rules and regulations that we've been talking about. LB403 attempts to cure one aspect of the funding formula as it now exists in rules and regulations that appears to be a barrier to better aligning funding decisions with actual results through the next two fiscal years. The language targets one part of the existing formula used by HHS, that being the inflation factor. The factor appears to be used to adjust for results generated by other factors in the formula to arrive at a target figure for projected expenditures.

That does not seem to have a connection to actual appropriated amounts. LB403, as written, eliminated the inclusion of the inflation factor altogether. AM908, which I understand has been offered, offers an alternative to disallow only the negative inflation factor in the formula and thus cure the problem of excluding the Quality Assurance Assessment, the QAA, from the distribution formula. It would seem use of a negative inflation factor is aimed more at managing the result for a total expenditures and less toward implementing a funding policy articulated by this committee. If the committee wishes to pursue a policy of Medicaid reimbursement closer to provider costs, and I'd remind you this is as I understand it these are allowable costs, we're not talking about fully burdened costs of operation, then some form of the language in LB403 along with AM908 should be-- should move the needle closer to that objective, narrowing that short-funding gap. The agency fiscal note acknowledges as much, that it's a consequence of LB403 that you end up moving closer to full-cost allocation funding. The question for you will be to what degree the gap can be narrowed and managed to your satisfaction. If this concept meets with the committee's approval, this language is most appropriate for placement within the budget bill as was intended from the very beginning. And on more technical points after the fact, when we're all gone and you're back in your committee room making decisions, I urge your reliance on Liz and her sage counsel. Questions?

BOLZ: Thank you, Mr. Calvert. Questions? I do have one. You've obviously reviewed the fiscal note carefully, and I by no means want to step ahead of Liz and her wise counsel, but do you have any insights as to how the amendment may or may not impact the fiscal note?

MICHAEL CALVERT: Well, my sense is that I think Mr. Boddy went through that, and I think he ended up kind of working down to about a $9 million number. I haven't really looked at that other than I would expect that the dollar amount shown in the agency fiscal note, the cost consequence would be reduced since you can start-- you can flow in the QAA. And I can't remember what that was, like $12 million?

BOLZ: Um-hum.

MICHAEL CALVERT: Something of that. So you're-- now you're down to a net number of around 20, about 14 or 15. And I don't remember exactly how it got to nine, but I would think it would be less. That would be my expectation. And if not, we'll find another iteration.

BOLZ: Very good. Any further questions for Michael Calvert? Thanks for your testimony. Further proponents? Do I have any opponents? Good afternoon.

JEREMY BRUNSSEN: Good afternoon. Vice Chair Bolz and members of the Appropriations Committee, my name is Jeremy Brunssen, J-e-r-e-m-y B-r-u-n-s-s-e-n. I'm the deputy director of finance and program integrity for Division of Medicaid anad Long-Term Care within the Department of Health and Human Services. I'm here to testify in opposition to LB403. LB403 would prevent the department from utilizing an inflation factor when calculating Medicaid nursing facility rates for fiscal year 2020 and beyond. This bill would require that nursing facility rates be set at the amounts appropriated by the Legislature. Currently the department rebases nursing facility rates annually using cost reports. The inflation factor is calculated to adjust the cost report base data up or down in order to match the total available funding from the legislative appropriations and the Quality Assurance Assessment, commonly referred to as a provider tax. Not only would the elimination of the inflation factor make annual rebasing impossible, it would also significantly impair the QAA, the Quality Assurance Assessment. By law, statute 68-1926, proceeds from the QAA must "be used to enhance rates by increasing the annual inflation factor to the extent allowed by such proceeds and any funds appropriated by the Legislature." Without the required annual inflation factor, the Quality Assurance Assessment would be eliminated, greatly reducing funding for nursing facilities. And I would note that I have not had the chance to see the amendment that's been discussed, so I can't speak to that at this point in time. The department would also like to clarify for the committee that the legislative appropriations are a major component in how the inflation factor and rates are calculated each year. In addition to the legislative budget directives, the department also uses the audit cost and census data and funding from the nursing facility Quality Assurance Assessment. By removing the inflation factor, the department would estimate that we'd need an additional $60 million per year for nursing facilities. Additionally, the elimination of the inflation factor would make rebasing difficult as there would be no mechanism-- mechanism to align the cost-based rates to available appropriations. The bill could be interpreted as mandating the department to spend a specified amount of appropriations on nursing facilities even if services to clients weren't rendered, in essence subsidizing empty beds. While the department understands and appreciates the committee's concerns regarding nursing facilities, this legislation would in-- unintentionally jeopardize future Medicaid

funding. Respectfully, this legislation is not necessary, as appropriations are already an important factor in developing rates. It would be difficult, if not impossible, to calculate rates without this component based on the current methodology. For these reasons, we oppose LB403. I appreciate the opportunity to testify. This concludes my remarks. If you'd like, I would like to maybe talk a little bit about some of the comments that have been made, and maybe talk a little about where we're going in terms of a proposed rate reform-- reformation process if that works.

BOLZ: Respectfully, I think maybe we'll see if there are any questions, and if there is interest in having that further dialogue, we'll leave that to the committee. Are there further questions for this testifier? Go ahead, Senator Hilkemann.

HILKEMANN: In your testimony, you said you're going to jeopardize future Medicaid funding with this. Haven't we jeopardized Medicaid funding enough already?

JEREMY BRUNSSEN: Thank you, Senator. So what I was referring to was, based on how our how the statute is written today, the QAA is how we deliver the dollars back. The QAA dollars that we collect and match with federal dollars and give back to providers is done through the inflation factor. So without having seen the amendment, that's what I'm talking about, just jeopardizing future funds as well as requiring us to pay for services or pay the total appropriated amount that potentially isn't tied to the actual utilization of the service by Medicaid recipient by a-- performed by a provider.

HILKEMANN: You know, I-- you were here for the testimony that we had from-- from the-- from Roger Thompson from Seim Johnson. I mean it's pretty-- it's pretty mind-boggling when you look at those numbers, what we put our care providers through. How much more-- how much longer are they supposed to continue to carry on providing care for people while we try to come up with a quote unquote formula that works?

JEREMY BRUNSSEN: Thank you, Senator. I think to take a step back, it's important to recognize that we-- I-- in studying this over the last year, I agree that the operating conditions for the nursing facilities are extremely difficult. I believe that we have good people trying to do great things, and they have limited-- they have-- they have limitations that they're working within. So I don't see this as an us-versus-them issue. This is an opportunity for us to address the

current methodology and its shortfalls and its unintended consequences that aren't benefiting the providers. I think it's important that, you know, to understand the overall process when we look at the kind of that gap or that chasm, I think I've heard it referred to, between the costs per day and what the Medicaid reimbursement daily per diem is, that cost per day is not something the Medicaid program has any control over. So that's literally costs divided by days. So if costs stay relatively the same and utilization of services, actual Medicaid days, go down, the cost per day goes up. That does get captured to some degree within our current methodology. So I think also it's important to understand that the inflation factor today is not a rate increase or decrease. So what happens is that inflation factor aligns from the allowed cost to available appropriations. For many years, it was more. And that's been a lower amount or a negative amount the last few years. I can show that over the course of the last five state fiscal years, the actual rate paid per day on a base rate across all 200 facilities has actually gone up every year. And that amount has gone up by, in state fiscal year '14, an average across the board $163.26, in '15 to $168.51, in '16 to $172.92, and so on up to the current state fiscal year of '19 to $186.31. So the utilization services, the actual use of the services, going down has a significant impact on the revenue. So if the facilities are 70 percent occupied, they just don't have the revenue base to support the costs that they have to provide care which it's a very expensive proposition for them to provide care.

HILKEMANN: So what you're saying is-- do we have too many providers?

JEREMY BRUNSSEN: I'm-- I don't-- I can't speculate as to what-- what that is. I'm saying that Medicaid is a payer of service for our Medicaid recipients. We can't-- if we-- if we tried to meet every provider's need, I don't think we could do that as a state in terms of Medicaid program. We see there's an issue. We want to help resolve the issue. We believe that there's a better way. And that's why we're proposing to remove the current methodology from the regs. I don't believe that this fixes the issue. We currently have some providers getting paid $80 a day or more, more than another provider rendering the same exact service. It-- this incentivizes providers from doing the right thing. So you can have a provider that's really runs a great operation. They're high quality. They are 95 percent occupied. And the next year the rate could go down because their costs per day is lower than another facility that's 70 percent occupied. Is that right to the

provider that's doing great work? It's just a methodology today that doesn't incentivize the right things for providers.

HILKEMANN: Have you seen models out there that you can-- that-- that will work? Other states get this right?

JEREMY BRUNSSEN: We're doing a lot of research on that right now, and that's-- I think that's a challenge is a lot of the states near us use a cost-based reimbursement, Kansas, Iowa, South Dakota. Medicare pays on a per diem. What they did, I think back in '95 or '96, I can't-- apologize, I don't remember the exact day or year, but they went away from using cost-based reimbursement, and they set a standard per diem. And then just basically apply a inflationary factor. I forget which index is used, but they do that.

HILKEMANN: Are they experiencing a lot of nursing home closings in those states?

JEREMY BRUNSSEN: I think that-- I'm not an expert on what's going on across other states, but I think that there are-- I would ask you to talk to the Health Care Association. By-- my understanding is that many states are facing similar challenges to Nebraska.

BOLZ: I'd like you to look at your right hand there. There's a copy of the amendment right there for your reference and maybe just take a minute to look at that because I think even though you haven't had a chance to look at it, it's certainly relevant to our conversation today. Are there other questions for this testifier? Do you have one? Go ahead, Senator Wishart.

WISHART: So if we were to pass this with the amendments, and what I see is-- is potentially help to stop the bleed that we're seeing right now in terms of reimbursements for nursing home providers and then pair it with the work that you're doing on-- on reforming the-- the methodology, don't you think that that would be, as a package, the right direction forward?

JEREMY BRUNSSEN: Thank you, Senator. I think that how I would answer that is I will review this and put together a estimate based on, you know, a proposed passed amendment. What I would keep in mind is I think action is important. So we-- the department is fully supportive of making change. We just believe that the change isn't tweaking the current system. What I would want to make sure that is considered is that the current methodology-- or even with these changes, we can

appropriate-- or we can take a line-item appropriation and be told how much it should be. There's still no way for us to guarantee that we will expand the full amount that's appropriated because it's based on utilization. And I think it's important also to note that in state fiscal year '19, this year, this year is a trend that we see reversing the prior trend of reduced days in Medicaid recipients in nursing facilities. Through December, we were around 2.9 percent up, year over year, so we're seeing that decrease-- or increase. So the challenge for us is that there's no way for us to guarantee that what's intended to be appropriated is actually disbursed to providers for services because it's not only based on the utilization of service, but it's also the case mix. So if someone's at a higher level of care than a lower, the rates are different. So it's hard for me to say that we can solve the problem. I think that we're open to change and I would want to look at it and assess, what does that mean in terms of the department and how would we approach it.

WISHART: And then I do think at this point action is really critical. And I don't think we have three years. I just don't think we have three years to really-- to address this problem from everything I've been hearing. Can you get us that rate methodology for a deficit request next year?

JEREMY BRUNSSEN: I'm sorry. I'm not sure I'm following exactly what you're asking.

WISHART: So we heard from the-- from a previous testifier from the department that June of 2020 was when you anticipate you will have done all the research you need to do and have a new methodology that will fix what-- what you're saying is broken right now. I'm asking can you expedite that so that we can make legislative changes to help you in your efforts the-- at the beginning of next year?

JEREMY BRUNSSEN: Thank you for the question. I think that we would want to make sure that we look at the methodology in conjunction with our partners, with the-- with providers, with the provider community, with the Health Care Association and other associations like LeadingAge. Our original modeling that we've begun is based on us working within our current budget appropriations. Part of that is because today we have a wild, just a really extreme range in terms of the payment to providers. You know, I referenced that there is a facility-- or two facilities that have a range of $80 per day difference. So our methodology, as it's being worked on today, doesn't necessarily mean that requires a deficit request. It basically brings

payment equity to the system. So if I'm in one facility, facility A, in one town and I'm paying for a resident, that resident-- that provider is being paid the same as another resident-- as another facility a mile away that's rendering the same service. So by balancing that, it brings those providers that are really hurting at the bottom of that payment rate up. And it will bring the people that are being paid higher than that-- than the average rate down. But it creates a system where we're at least paying with equity. And then what we would do is we would propose incentivizing providers and rewarding or basically compensating providers that have higher quality. And then also we would look at-- the modeling currently includes if you provide significant services for Medicaid recipients-- so if you're a provider that's helping the department and taking a lot of patients, a lot of Medicaid recipients, then we would potentially weight your payment even further. And then we also have other considerations that we're looking strongly at, like indexes on nursing staffing, you know, shortage areas, all sorts of things.

WISHART: Well, with that level-- so first of all, I applaud you for looking into all those things. And again, we-- I will light a fire under everybody who's here today that we address that this summer so that-- because I don't understand with all of those changes how you can know right now that there won't need to be a change in terms of the appropriation. Because what I hear then is that you're going to-- that you're sticking with a number, and then you're going to try to make everything else fit within that. And I think what we're-- what we're realizing today is that we really need to look at the needs, and I agree, make sure that we're efficient and we're-- we're rewarding efficiency, but that we need to look at the needs and not just be trying to back into a number.

JEREMY BRUNSSEN: Thank you, Senator. I think that's a great point, and that's part of the research of looking at this holistically. You know, we look at it from-- for-- from our-- from the department's perspective, we pay for services for Medicaid-eligible recipients. So we're looking at it from a per-diem amount for Medicaid-eligible persons. We don't look at it at a facility or provider level. And so, you know, we do look at other states. We try to look at neighboring states, you know, Iowa, Kansas, South Dakota, Colorado, Wyoming, you name it, to look at how are they paying and how do we compare. Some of that can be a little bit challenging because there are these things I would call policy adjusters where maybe we include things in the per-diem that they don't or vice versa. But when we look at that,

based on the data we find, we don't find that we're an outlier. So it's-- we would want to do that very carefully in determining what's the need of the provider versus what are we paying for as a service to a Medicaid beneficiary.

WISHART: OK. Well, I would-- I would just say, again, that it would be a real shame if we waited until June of 2020 and-- and recognized that actually there was-- there did need to be legislative changes. And then we had to wait until January of 2021 to enact changes that then won't happen until the fall of 2021. You know, so I'm-- I'm really hoping everybody, after these hearings, is going to work so that we can make action either this year in this session or next session.

JEREMY BRUNSSEN: Thank you, Senator. I agree, and that's why in our prior discussions with the Health Care Association, we've communicated our desire to remove the payment methodology from the regulations. That allows us to make the changes. It also allows us to be adaptable because the market is changing all the time. Health care industry-- the industry is changing. And so having the ability to work with those stakeholders to make changes is important, and not having that codified in regulation is an important part of that. We still would need to go through the process of getting federal approval because that methodology would still be in our state plan amendment, so we'd still have public comment periods and other things that would be included when we need to adapt or make change. But that's a much quicker process as compared to regs.

WISHART: OK.

JEREMY BRUNSSEN: So we're ready to act. We've communicated that, you know, we're-- we want to move down this path with the Health Care Association. And we're ready to-- you know, we've begun the process of that, Chapter 12 reg rewrites, internally and are working through that.

WISHART: OK.

BOLZ: Further questions? Go ahead, Senator Erdman.

ERDMAN: Thank you, Senator Bolz. Thanks for coming. So I listened to your comments, and those that you made provoked this thought. So you said some providers are getting $80 less and others are getting $80 more, some are delivering services more efficiently. Are there nursing homes providing care to Medicaid patients that are-- that are OK with

the-- with the reimbursement we're giving them? Are they making it financially?

JEREMY BRUNSSEN: I don't know that I'm-- if I can answer your question. I think if you ask anybody, they're always going to want more money than what they're currently being paid. I think it's come out in the conversation of-- you know, there are costs that aren't allowed. So they maybe would want those costs to be included. And I can't speak to whether or not, you know, there's anybody satisfied or not. But you know, there are people that are at the higher end of the payment level and others that are at the lower end. Typically the ones that are higher per day have less occupancy, so they may not have the revenue still because, you know, their cost per day is high because they have low occupancy rates. So there's not that many days going for that cost-per-day formula.

ERDMAN: One of the facilities in my district is expanding their-- their beds. They had some beds that were offices and rooms that were offices instead of taking care of patients, and they've expanded that. And they're actually looking for licenses to expand further. So they must be doing something differently because they wouldn't be expanding if they weren't making it.

JEREMY BRUNSSEN: Thank you.

ERDMAN: I just wondered if you-- if there's others besides that one that you know of.

JEREMY BRUNSSEN: I can't speak to any of it. Thank you for the information.

ERDMAN: Thank you.

BOLZ: Go ahead, Senator Dorn.

DORN: I guess my-- thank you for coming today. Thank you, Senator Bolz. My question is a little bit along Senator Wishart's line here, I guess. As we go forward in this year and you're going to set rates this year that you're coming up with numbers, how confident are you that that will be above zero.

JEREMY BRUNSSEN: The inflation factor?

DORN: But the inflation factor last year got us below zero.

JEREMY BRUNSSEN: So Senator, just to make sure I'm understanding your question, are you asking what-- what I think the inflation factor might be this year?

DORN: I'm asking how confident you are that we won't end up with a negative number again this year.

JEREMY BRUNSSEN: Senator, I would-- while we're still working through auditing the cost reports from state fiscal year '18, I would anticipate there'd still be a negative inflation factor this year--

DORN: Sure.

JEREMY BRUNSSEN: --even if we have a provider-rate increase just because, you know, when you have a-- your occupancy is-- for '18 was still trending down at that period and the costs were still what they were. The reality is-- is we would likely still have a negative inflation factor. To-- what exactly would that be? I can't say for sure.

DORN: OK.

BOLZ: I have a few questions for you, if there aren't further questions from the committee. The first is, I'm trying to reconcile a lot of what I've heard today. So what I-- what I heard from Mr. Boddy, who has direct experience, who works for the Nebraska Health Care Association, who has consulted with experts across the-- across the industry, he didn't share the same concerns that you-- you shared, so I'm having a hard time reconciling your testimony with his testimony. If there were technical tweaks that addressed the issues you raised, like the issue related to the provider assessment, would you still oppose the bill?

JEREMY BRUNSSEN: I think I would have to understand what those tweaks are, to be able to answer your question completely.

BOLZ: If we were able to take care of the issue specifically related to the provider assessment, would you still oppose the bill?

JEREMY BRUNSSEN: I think that would definitely make it a better situation in that we would be able to distribute the provider tax with the federal share back out to providers. The department's position is that we still want to fix the methodology because even by taking out the inflation factor--

BOLZ: Um-hum.

JEREMY BRUNSSEN: --the methodology still incentivizes this lack of efficiency. It actually-- I won't say it disincentivizes. It rewards, on a rate-per-day amount--

BOLZ: Um-hum.

JEREMY BRUNSSEN: --less efficient operation. So from-- from-- from my perspective, when I'm paying for a beneficiary's service, it still is an issue for us because it's an issue for me as I look at the system that you're not paying the same to different providers for the same service. We-- you know, so that's-- that's a challenge for us.

BOLZ: I appreciate your challenges, and I don't-- I don't mean to-- to overdramatize. But the way it sounds from this end of the table, it's-- it-- it's like saying that because you need a kidney transplant, we shouldn't consider dialysis. It-- I don't understand why-- why an incremental change to try to assist the nursing facility is-- should be-- should not be considered on the basis that a more wholesale change is necessary.

JEREMY BRUNSSEN: I appreciate that perspective, and we're happy to look at amendments to address that concern.

BOLZ: I also don't understand, I find it inconsistent that what your testimony is on this bill, on LB403, is that more study is necessary, that more analysis is necessary, that-- that what you're saying is that we need more time to figure it out, and yet you're not supportive of the study that's proposed in LB181. Can you help me understand your-- your position in-- in more detail?

JEREMY BRUNSSEN: Thank you, Senator. I think I-- actually I'm not-- I'm not a proponent of more study. I think we're at the point where we need to act. And that's exactly the position that I-- that, from my perspective at the department, we're working on changing Chapter 12. We're working on a payment methodology. We've done a presentation for long-term care stakeholder redesign committee. We're ready to act. To act, it does take some time. But I don't think, from my perspective, that we-- that we're wanting to hold off and do more studies.

BOLZ: Okay. One more question. Ms. Acierno testified that there are currently funds available that are not being spent out to the nursing

facilities. Can you address that? Can you tell us where those funds-- funds sit, and what the possibilities for those funds are?

JEREMY BRUNSSEN: So I think that's-- to make sure, I'm not sure I fully understand what is being meant by those not being utilized. But what I would say is that, when we create the rate, it's based on the most recent, completed, state fiscal year's costs in days. We assume flat utilization. So if utilization goes down, we wouldn't spend as much money because there'd be less actual days to pay for. So potentially that's the difference. This year is going to be different. We're on pace to spend more because we have a 2.9 percent increase in utilization year over year. So we only pay for the services we get billed. We don't not pay or discount the rate for providers when someone submits a bill for a covered service. So those funds just-- when we're appropriated dollars in the Medicaid program, you know, they're appropriated to us, and we pay for the services whether it's in-home or community-based service or whether it's a long-term care, nursing-facility service for a per diem on a 125-level of care.

BOLZ: Are you familiar with the funds that Ms. Acierno's referencing?

JEREMY BRUNSSEN: I can't say that I know specifically what she's talking about. I'm assuming it's because of reduced utilization.

BOLZ: OK. If she approached you with further discussion to clarify that-- that issue for us, would you be willing to work with her?

JEREMY BRUNSSEN: Absolutely. I met with Ms. Acierno and Mr. Boddy many times, and I'm happy to keep, you know, that conversation ongoing.

BOLZ: Further questions from the committee? Thank you for your testimony.

JEREMY BRUNSSEN: Thank you.

BOLZ: Do I have further opponents? Do I have anyone in a neutral capacity? Senator Stinner, would you like to close?

STINNER: I know it's getting late, but this is an important subject.

HILKEMANN: Absolutely.

STINNER: I've been dealing with it for five years now. Been frustrating. Heard all the same comments that I've heard over a five-year period. But I thought that the testimony given by Roger

Thompson as a retired CPA, retired banker-- I like things in columns that I can add and subtract. I need to take some time with this. I need to digest it. But I think it talks to-- specifically to the problem. Let's reflect back a little bit as a committee and understand that we just went through a heck of a budget crisis the last two years. So everybody was fighting for dollars, holding dollars steady, and the outcomes are something that we have to measure. Well, the outcomes in this case, I think you have to be tone-deaf not to understand that we've got ourselves a situation that needs to be rectified as quickly as possible. Now, the one thing, if we want to rebase at the expenditures, now think about rebasing. Right now, you don't have a base. So I'm going to take their expenditure base and I'm going to add that 7.4 that never goes out that's been appropriated. That'll be a new base. Maybe it's a little different than Liz goes through. But then I'm going to put that 2 percent provider rate which is about $3 million. You know what it adds up to when you add the reimbursement rate by the federal government? $22, $23 million. It gets you closer to the break-even if you're using 36 as a-- that gives you about-- that gives you about $10. So instead of losing $36, it gets you to $26 that you're going to lose. That gets you closer. The idea that we can't take-- I mean we use utilization rate and compute and everything else in Medicaid. Why can't we use it here? We can guess, and then, oh my gosh, we can build a little cushion then, can't we? Don't we always do that? So the idea that we can't use this formulation and divide by the utilization rate, by the number that we increase by, or the total number, and spread those dollars out, I-- I-- I-- it defies logic to me, or at least, from the short-term standpoint, to pull these facilities that are sitting on the edge through a period of time because we see more and more folks showing up with Medicaid, and guess where they're showing up? They're showing up in the places that are owned by hospitals, not too bad, but are owned by local municipalities. And those local municipalities are saying, we can't take anymore. We got to spread it back to the taxpayer. Well, we can't do that. Well, we're going to have to close. The idea that you're 75 percent. Seventy-five percent, think of that facility that's sitting out there with 100 people. Now they only got 75, but they need to fail because they don't live up to the quality standards? There has to be access in this thing somewhere along the line. There has to be a sense of importance. And if it takes another $10 to make-- pull them through, $10 times 75 say, that-- let's say it's 50 people. Let's just do 50. How much is that a day? That's $500 a day times $30 times 12. That's a lot of money, folks. Makes a heck of a difference. That's why I'm adamant about changing the formula now and forcing these dollars

out to make sure that these facilities are pulled through. And I'll work with the department. I'll bend over backwards to provide information. So-- so will everybody else that's testified. We all got vested interest in this thing. We, as senators, are responsible for the safety and well-being in the state of Nebraska. Let's live up to it. That's my sermon for today. Thank you. Questions?

BOLZ: Thank you, Senator Stinner. Are there-- there questions? Senator Clements, go ahead.

CLEMENTS: Thank you, Senator Stinner. I see the amendment does not eliminate the inflation factor as the original bill did. It just says, it can't go less than zero?

STINNER: Can't go less than zero. That was a compromise because that was the contention that if-- if I'm king for a day, I'm going to force this through on a per diem basis. At least the increase that we add should be put-- put through on a per diem basis based on some kind of utilization rate. That would be my way of-- that-- my way of bringing those costs down per-- per resident.

CLEMENTS: I wanted to point that out because I heard in this testimony that eliminating that factor really hurts the formula, but I appreciate that change.

STINNER: Senator, the formula needs to go. It needs to be rethought. It needs to go. It's not working. It's obviously not working. It needs to go.

CLEMENTS: Thank you.

BOLZ: Further questions for Senator Stinner?

HILKEMANN: Thanks for the sermon.

BOLZ: Thank you, Senator Stinner. Round two, Senator Stinner.

STINNER: The problem is you got to listen to me again. I'll try to be a kinder, gentler person. How's that? Good afternoon, Senator Bolz and fellow members of the Appropriations Committee.

BOLZ: I'm so sorry, Senator Stinner. I do have one letter of support on LB403 from Jina Ragland [SIC] of AARP Nebraska. My apologies.

STINNER: OK. Good afternoon, Senator Bolz and fellow members of the Appropriations Committee. For the record, my name is John, J-o-h-n, Stinner, S-t-i-n-n-e-r, and I represent District 48 which is comprised all of Scotts Bluff County. LB404 is a simple and straightforward bill which would divide Medicaid budget into three separate appropriations programs, Medicaid Expansion, Medicaid Long-Term Care and Other Medical Assistance. The Medicaid Long-Term Care program would include separate subprograms for nursing facility appropriations and expenditures. This bill is designed to accompany the language found in LB403 which we just discussed. By dividing the Medicaid budget into three programs, there is more clarity to the amounts appropriated for various services and an increased ability to compare these amounts with the dollars spent. It is understandable that the Division of Medicaid and Long-Term Care would like to maintain their ability to shift funding around during the year and use it where they feel they most need it. LB404 does not prevent this. If Medicaid is spending less than anticipated in one area of their budget and wants to use the excess funds in another, LB404 simply provides more transparency and accountability to the Legislature and the public for such a shift. Medicaid makes up a significant portion of the state budget, reaching nearly 17.9 percent of our General Fund dollars. Breaking-- breaking it down into smaller programs will provide us with more specific information as we make future funding decisions. In our role as Appropriations Committee, I feel it's important that the Legislature and the public be able to track and monitor how appropriated funds are spent. I have some-- the same testifiers behind me in LB403 hearing who will be able to provide you with more detailed information. And I want to make this comment because I saw the fiscal note which just makes me so happy. I'm going to show you a report. For 20-plus years, Medicaid has provided us monthly statistics precisely the way I want it broken down. Now they're saying, oh my god, we can't do that. Sorry, I don't agree with it. And maybe I need to convey to them that this is what we need to track it with. This is accountability. This is the discipline of accounting. I want to track Medicaid expansion. I think everybody here wants to track it. I want to track what's happening in long-term care which includes not only the nursing homes, but-- but in-home care. So that's all part of it. We can track that. We can track the trends. We can track if we're doing the right things in that. And we can readily identify it. We can attract them moving around funds so that we know what's happening. That's what this is all about. It's accountability and transparency. So I'll open it up for questions. I did get preachy again, didn't I?

BOLZ: Thank you, Senator Stinner. Questions for the senator? OK. Thank you, Senator Stinner. Are there proponents for LB404?

HEATH BODDY: Good afternoon again, Vice Chair Bolz, members of the committee. My name is Heath Boddy, that's H-e-a-t-h B-o-d-d-y. I'm the president and CEO of the Nebraska Health Care Association. On behalf of our skilled nursing facility members, I'm here today to speak in support of LB404. Senator Stinner did a great job at describing what LB404 would do by dividing things into three programs. And as he also noted, LB404, the goal is to provide more clarity, transparency, and accountability to the nursing facility appropriation process. We've been told repeatedly by the Medicaid representatives who calculate nursing facility rates that the amounts they use in their calculations are unconnected with the Medicaid budgetary amounts provided to the Appropriations Committee in the amount, not necessarily in the percentage. As discussed previously in connection with LB403, we know there are aspects of the rate calculation process that result in lower rates than would be the case if trend-based projections were used. When a nursing facility closes and residents are moved to other facilities, the result is a reduction in nursing facility expenditures within a fiscal year. These are savings to the Medicaid program that could be reappropriated the following year in the calculation of nursing facility rates to help incentivize high quality care and preserve access for Medicaid beneficiaries, stated goals of both the profession and of the department. As described in the legislative fiscal note, there should not be a cost to make this change from one Medicaid Aid program to three Medicaid-- to three programs and one subprogram as these expenditures are already tracked by the department and reported to the Centers for Medicare and Medicaid Services in order to claim federal matching funds. We understand there can be an up and a downside to budget clarity and transparency as the actual appropriation and expenditure amounts are going to be known to all. LB404 is based on our belief that to be good stewards of taxpayer dollars, legislative and budgetary decisions must be based on accurate and complete information. We ask you to support LB404 as a step toward improving clarity, transparency, and accountability of the Medicaid nursing facility budget. Thank you again, to Senator Stinner for his emphasis in shining a light on --on the issues in LB404, and I thank you for the opportunity to testify today. And I'd be happy-- happy to answer any questions.

BOLZ: Thank you, Mr. Boddy. Go ahead, Senator Clements.

CLEMENTS: Thank you, Vice Chair Bolz. Thank you, Mr. Boddy. Really, I forgot to ask a question on the previous bill. I was curious on the-- I think you mentioned that Medicare pays on a per diem basis. I wondered if you had a comparison between the Medicare reimbursement to a nursing home compared to our current Nebraska Medicaid.

HEATH BODDY: I do not have one with me, Senator, but we'd be happy to get that and provide it to you.

CLEMENTS: Yeah. Well, generally is it higher? Is it-- OK.

HEATH BODDY: Substantially more. Medicare is substantially more than a Medicaid payment.

CLEMENTS: Okay. Thank you. I'd be interested in the comparison.

HEATH BODDY: Absolutely. We'll get that to you, Senator. You bet.

BOLZ: Thank you, Mr. Boddy. Do I have further proponents?

JENIFER ACIERNO: Good afternoon, Vice Chair Bolz 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 this opportunity to testify in regard to LB404. LeadingAge Nebraska is an association that represents over 70 nonprofit providers of long-term care services. We represent members that span the state and include both large, multisite providers and small, stand-alone, rural facilities. It'd probably be easiest at this point is if I just said ditto to what Mr. Boddy has said and save everybody some time. And I think essentially that that is the case, that really, the transparency and the understanding of these funds is very important. And based on the conversation that's happening today, there is definitely room for more communication and availability of that information. It doesn't seem logical to me that long-term care-related funding is in a budget that is not going out for long-term care purposes when we have providers of long-term care services who are going out of business and are not being able to provide services to citizens in Nebraska who require that care. While I agree generally that DHHS could use more resources, I thought that the fiscal note seemed excessive for a full-time individual to do reporting that's already federally required, and that the legislative Fiscal Office note did make sense. Funds that are appropriated and reappropriated by the Legislature for nursing facility rates and to care for Nebraska seniors should be used for that purpose. And for

these reasons, we support this bill. And thank you, and I'm happy to answer any questions.

BOLZ: Thank you. Questions for this testifier? Thank you for your input. Do I have further proponents?

MICHAEL CALVERT: Good afternoon, Chairman Bolz, members of the Appropriations Committee. My name is Michael Calvert, M-i-c-h-a-e-l, Calvert, C-a-l-v-e-r-t. LB404 addresses a second part of a strategy to better articulate and exert legislative intent as to funding policy for Medicaid reimbursements to Nebraska nursing facilities. The bill expresses an intent for a budget recommendation by separate program appropriations for the large Medicaid program, allowing better isolation and control of nursing facility's reimbursement levels, the clear separation from other Medicaid obligations. As written, the bill suggests that subsequent appropriations for Medicaid be made in three separate sections. And there's nothing magic about the number of sections. All I would think that a minimum of three probably makes some sense. And when I say separate sections, we're talking about a program appropriation which, in effect then, becomes a control point for purposes of budgeting so a minimum three separate sections, three separate programs. Further, the bill suggests a program designation for nursing homes, giving an additional control point within a broader program appropriation. Now this could lead to more detailed itemization of funding streams within a program appropriation if the committee so desires. And again, your wishes and Liz's counsel in terms of how that might need to be detailed out. I make no particular suggestions in that regard, but the objective is to isolate on-- on nursing facilities. LB403, which is the companion to this bill, specifies that formula calculations for building a rate rely on appropriations enacted by the Legislature, thus-- and reappropriations for that matter. Thus the additional clarity as suggested in LB404 makes sense, i.e. what is your target. And I think it-- by this methodology, be pretty specific. Now parenthetically, it seems to me, the disaggregating of the Medicaid program which is one single large program-- there are a couple of pieces and I think they're all in all disabilities in I think Beatrice. The breakdown into multiple appropriation programs makes some sense in the-- just in the pending-- the nursing facilities funding issue. I presume that you're going to be dealing with some new obligations for Medicaid expansion which will begin with the forthcoming fiscal year. And Senator Bolz and Senator Stinner, I think you may recall that you've had some experience in the past tracking the ebb and flow of some expenditures across costs

centers that are buried into a much larger overall program. And I seem to recall some difficulties we had with public assistance. So this kind of strategy is more of a programmatic focus and casting some blight and focus on the appropriation either by earmark or by program for nursing facilities makes some sense. You're going to have to decide the value of the tradeoffs. You-- on one hand, you have greater control, and it was acknowledged the agency might appreciate greater-- greater flexibility, i.e. not more programs. But at minimum, you need to establish I think a more definitive target for nursing facilities, however arrived at, seems to be desirable. Questions?

BOLZ: Thank you, Mr. Calvert. Questions? Go ahead, Senator Hilkemann.

MICHAEL CALVERT: Uh-oh.

HILKEMANN: You-- you've been around this for so many years and you've been to so many different organizations. We're kind of-- we're kind of-- who's doing this whole thing of public funding of healthcare, well, statewise? You see models out there that-- that--

MICHAEL CALVERT: Each and every state is so unique. They tailor their-- and I'm not just talking about healthcare or anything specific here, but generally they tailor to their political environments, their constitution, their statutes, their demographics. There are a whole host of influence-- things that, in my experience, influence why states do what they do and how they do it. Do some do better? Apparently, yes. But can I point to any one? No. I did take some interest about some of the comments about certain states that had-- had a certain kind of cost reimbursement-type model which, just off the top of my head, that sounds like something worthy of looking into and getting a better understanding of it. But again, that's just a-- just a guess.

HILKEMANN: Thanks.

BOLZ: Thank you, Mike.

MICHAEL CALVERT: You're very welcome. Thank you.

BOLZ: Do I have further proponents? Do I have anyone in opposition?

JEREMY BRUNSSEN: Good afternoon again, Vice Chair Bolz and members of the Appropriations Committee. My name is Jeremy Brunssen, J-e-r-e-m-y B-r-u-n-s-s-e-n. I'm the deputy director-- director of finance and program integrity for Medicaid within DHHS. And I'm here to testify in

opposition to LB404. So there's already been a summary put together, kind of how the bill intends to basically appropriate dollars into separate programs, so I'll skip that diatribe in my notes and just move on to some of the department's perspective and concern around this bill. So first, our program is a highly integrated program as it is today. So this bill unintentionally creates some administrative burden in managing the separate funding streams and limits the flexibility in addressing possible utilization changes in any particular program or service. For example, prior to the current state fiscal year, the average number of Medicaid recipients in nursing facilities was-- was declining year over year. However, in the current state fiscal year, that number is up around 2.9 percent. So if this bill were already in force, that nursing facility subprogram within the long-term care program appropriation would likely run out of money. So the department would not be able to cover the deficit with another bucket as we currently do today. We would need to come in and get a deficit request or transfer. So this is an ongoing concern in terms of managing our budget, and we have similar concerns with the expansion bucket. Second, if the purpose of the bill is just to really have a close track and monitor on certain types of Medicaid expenditures, we are fine with that. We already track and report these e expenditures-- expenditures in our annual Medicaid report that's published each year on or around December 1. Nursing facilities specifically is called out in that report. If the Legislature wishes to provide the Medicaid program a particular amount of money for nursing facilities and/or the expansion group, this could be specified in the appropriations bill without creating new programs. I think last, because we can't forecast utilization levels with 100 percent service certainty by service, and because we can only pay for medically necessary services that have been provided, it's impossible to assume-- or require that any bucketed amount would be fully expended at exactly 100 percent. In conclusion, the services provided by Medicaid Nebraska are more integrated than ever before. There's a lot of data that shows that there are better outcomes and cost-effective results as a result of integration. LB404 would inhibit this progress because it creates unnecessary segregation of the funds, limiting our ability to be flexible. And any concerns that are in place where that could potentially be addressed could be done in other means that would not have the unintended consequence of limiting our ability to be flexible. For these reasons, we oppose the bill. Appreciate the opportunity to testify-- to testify, and I'll attempt to answer any questions you may have.

BOLZ: Thank you. Any questions for this testifier? I do have one question. Your fiscal note's based on a number of assumptions. I'm just curious. Did you reach out to Senator Stinner's office regarding this bill and how it was put together before you finalized your fiscal note?

JEREMY BRUNSSEN: Yes, we actually met with Senator Stinner in his-- in his chambers. It's been maybe a month ago. I'm sorry. I don't recall the date. But we did meet with Senator Stinner and also I think other members-- other interested parties such as Health Care Association.

BOLZ: So you didn't get clarification on your assumptions?

JEREMY BRUNSSEN: We did ask questions around the bills, but I think we focused more on LB403, to be frank.

BOLZ: OK. Thank you. Further questions? Go ahead, Senator Dorn.

DORN: Thank you, Senator Bolz. Thank you for coming up here again. You-- you-- several times you mentioned-- mentioned this bill would limit your ability to be flexible. Explain that a little bit.

JEREMY BRUNSSEN: So it's really about managing the budget within the total appropriation and where these services are actually being rendered to our eligible clients. So some years, we had less utilization in nursing facility stays and maybe we had more home/community-based services being rendered. So we-- if we had bucketed funds, we might have run out in one area and had excess in another. We just spent the money that we appropriated wherever it was being rendered or delivered to the client. This would require us to come in and basically require a deficit request or transfer request, however we would administratively do that, to move those dollars rather than just managing to it. It would be similar to, you know, managing a hospital budget. Sometimes you have expenses come up that you don't plan for and you have your overall income and you manage to it.

DORN: But-- thank you for the answer, but part of my thought with this bill is we want more-- accountability isn't the right word. We want more traceability. And before you could just shift it, shift it. Now this is basically you're having to tell us where that goes.

JEREMY BRUNSSEN: Which-- which-- we're fine with telling. We already publish that annually in our Medicaid annual report. We explain

expenditure by type, by vendor. We-- I think, you know, I know for a fact that we explicitly talk about long-term services, what's paid to nursing facility versus other waiver services, home health, and other areas. We publish that. We have no problem with being accountable and transparent around how we're spending the money. We're just asking for flexibility administering the program.

DORN: Thank you.

BOLZ: Go ahead, Senator Hilkemann.

HILKEMANN: Looking at the fiscal note on this, you just-- you just alluded that you've already doing this. Why do you have to have another full-time equivalent to provide this information if you say you're already providing it?

JEREMY BRUNSSEN: So I think-- Thank you, Senator. So there's a difference between reporting and how we set up within our systems to pay. So there are funds in here requested specifically for changing how we code in our MMIS to pay different payers. There are-- there are tables of fund streams in our systems that direct, based on the type of service, where the dollars get paid from. And then we also had an additional staff person for tracking reporting above me on what we do today.

DORN: And that-- and you believe that to meet the requirements of this bill that that's necessary, that you don't already have an ability to put that into your program?

JEREMY BRUNSSEN: I think there are a lot of unknowns with exactly all the different services and where they fall in all the buckets. So there's a lot of work to be done behind the scenes in terms of administratively-- administratively how we code everything. For example, we have a lot of services that are delivered through managed care, that are part of a capitation payment paid to a managed care organization. So it might only be a $1 of their monthly payment out of a $300 payment. But today, we just pay the $301-- or $300. We don't track is that $1 for this-- for a home health agency payment or a therapy service or what. So there are some challenges that we still have to work through. So there's some unknown. We anticipate there is additional work for us to be able to make sure that we're meeting the request of this, the intent of the bill.

DORN: Anticipated but not known.

JEREMY BRUNSSEN: There are some-- some complications that-- we still don't know exactly how every single service will fall into each of these buckets.

BOLZ: Go ahead, Senator Wishart.

WISHART: I wasn't planning on asking any questions, but something did come up when you were talking about the ability to-- to shift dollars after we've gone through the appropriation process. I mean is that appropriate to do that because when we sit here and we go through all the hearings and we determine what the budget should be and we very specifically budget out for different items, is it appropriate then? Is it a separation of powers issue?

JEREMY BRUNSSEN: So we-- we receive an appropriation of funds for our program, 348 Medicaid, in total. We're not shifting anything today. We're paying out of the bucket. That's-- we're appropriated.

WISHART: Yeah. But if we're specifically appropriating for-- for-- for long-term care, different-- different forms of-- of Medicaid, it is concerning to me that then that money would be shifted around after the budgeting process.

JEREMY BRUNSSEN: I'm not sure I'm following. Today, we don't shift any money around.

WISHART: OK. So you--

JEREMY BRUNSSEN: We have one program where all the dollars get put for Medicaid. We just pay for services.

WISHART: But we have different formulas for different parts of Medicaid funding.

JEREMY BRUNSSEN: We have formulas for how we reimburse providers. Yes. Or methodologies.

WISHART: Right. So if we-- methodologies. And so we, very specifically as an Appropriations Committee, determine different levels for those funding streams, those methodologies. And so what-- what I'm hearing is that after the fact, there can be some-- some shifting around between that.

JEREMY BRUNSSEN: So I think the way I would phrase it is we're not actually changing the methodology after we've received-- we're not changing the methodology midstream. There might be less utilization in one area, and it just happens to be that there is more utilization in another. It's all still being paid out of Medicaid. We're not like-- we don't have separate dollar-- you know, separate holdings behind the scene or whatever. It's all one Medicaid budget that we're just-- the money is being paid out of that budget. We're not shifting anything. It's just-- it's based on the utilization of the actual benefits.

WISHART: OK.

BOLZ: So we have-- we have different program numbers-- programs that are identified by numbers all across HHS. We've got a different number for Medicaid than we have from public health. And so I think the question is should we have multiple more different program areas just like we different-- different-- differentiate public health from Medicaid, right? So the difference is whether we have all of DHHS under one program code or we have multiple program codes under DHHS. I think that's the conversation we're having. Is that how you understand it?

JEREMY BRUNSSEN: I believe-- I believe so. I think that's the question area.

BOLZ: OK. So I guess I would kind of be inclined to-- to understand where Senator Wishart is coming from. I think it's the Appropriations Committee's decision about how we separate out those program codes.

JEREMY BRUNSSEN: Thank you.

BOLZ: Thank you. Further questions? Thank you.

JEREMY BRUNSSEN: Thank you.

BOLZ: Further opposition? Do I have anyone in a neutral capacity? Senator Stinner, would you like to close? Senator Stinner waives closing. I do have several letters of support for LB404 from: Dr. Richard Azizkhan, CEO and president of Children's Hospital and Medical Center; Nick Juliano, the Children and Family Coalition of Nebraska; Britt Thedinger, the Nebraska Medical Association; Annette Dubas, the Nebraska Association of Behavioral Health Organizations; Janel Meis, the Nebraska Occupational Therapy Association; and, Jina Ragland [SIC] of AARP Nebraska. That closes the hearing on LB404.

STINNER: OK. So now we can open the hearing for LB480, Senator Quick. There's no Senator Quick. Oh, there he is. Senator Quick

QUICK: Good afternoon, Chairman Stinner and members of the Appropriations Committee. My name is Dan Quick, D-a-n Q-u-i-c-k, and I represent District 35 in Grand Island. LB480 was brought to me by the public health districts in the state of Nebraska to provide financial support for their efforts in strategically implementing preventive-- preventative health strategies in your community and mine. Because ours-- because our system of public health does a great job in preventing an array of diseases, public health is one of our public services that is sometimes taken for granted. With the recent weather disasters, I think Nebraskans will find a greater need for the services our public health districts provide. This bill seeks an additional $50,000 in funding for each of the public health districts in the state to build upon their strategic preventive health programs in the state's workplaces. Our public health districts go to where the people are in educating and empowering workplaces to promote preventative health strategies and battle chronic diseases. I have had the opportunity to visit the Central Health-- Central District Health Department in Grand Island. They serve many in need in an area that includes Hall-- Hall, Hamilton, and Merrick Counties. I was provided a tour of the facility and found out about all of the important services they provide. Every health district located throughout our state provides the same important services, and I think that the funding I am requesting would most importantly benefit Nebraskans who don't have access to their-- to their healthcare needs. This is a smart public policy. This modest proposal advances smart community public health efforts that will save lives. Preventing a chronic disease is the most important-- is the most effect-- is the most cost-effective, fiscally responsible expenditure that we can make. Following me are several people that can talk specifically to those efforts and impress upon you that now is the time to add resources to our system of public health across the state. I look forward to working with the committee to find a way that we can help our public health districts navigate the uncertain waters ahead. And I'm happy to answer any questions you may have.

STINNER: Any questions? Seeing none, thank you.

KIM ENGEL: Hello, Senator Stinner and--

STINNER: How are you?

KIM ENGEL: I'm good. How are you?

STINNER: You drove in for this, huh?

KIM ENGEL: I did.

STINNER: Well, good.

KIM ENGEL: I wish I'd known Diana was coming. I would have driven with her. My name is Kim Engel, K-i-m E-n-g-e-l, and I'm the health director for Panhandle Public Health. The annual price tag for chronic illness in Nebraska is over $1.8 million-- billion a year. Major risk factors for chronic disease include tobacco use, physical inactivity, and poor nutrition. So what is the role that local public health plays in the prevention of chronic illness? Public health began years ago with a focus on infectious disease, hygiene, vaccine, and antibiotics. Today's challenges call for public health to serve as the chief health strategist of the future. This will require us to: adopt and adapt strategies to combat the evolving leading causes of illness, injury, and premature death; develop strategies for promoting health and well-being that work most effectively for communities of today and tomorrow; identify, analyze, and distribute information from new, big, and real-time data sources; build a more integrated, effective health system through collaboration between clinical care and public health; collaborate with a broad array of allies, including those at the neighborhood level and the nonhealth sectors, to build healthier and more vital communities; replace outdated organizational practices with state-of-the-art business, accountability, and financing systems; and, work with corresponding federal partners, ideally a federal-- federal and state chief health strategist, to effectively meet the needs of our communities. Every three years, PPHD conducts and coordinates a comprehensive community health needs assessment with our eight local hospitals. Businesses, schools, community-based organizations, local governments, economic development, and citizens are all partners at the table. Priorities are determined based on data. Evidence-based strategies are selected. And a community health improvement plan is developed. By doing the process together, we collectively implement the strategies to make a difference in health outcomes. These processes are happening all across Nebraska so that everyone has equal access to a healthy life through the efforts of local public health. PPHD has received recognition three times from the U.S. Surgeon General's office for our efforts in the prevention of chronic disease through worksite wellness, walkability, and the National Diabetes Prevention Program. Panhandle Worksite Wellness Council was

established as part of the Panhandle Public Health District in 2011. Worksite wellness is a conduit for moving health improvement strategies into worksites. Since most employees spend a minimum of eight, ten, or twelve hours a day at work, worksite wellness focuses on helping employers create a supportive culture for their employees for healthy eating, being active, limiting tobacco use, and increasing access to chronic disease prevention supports. We work with nearly 50 companies which impact roughly 12,000 employees, or 1 in every 4 people, employed in the Panhandle. The impact reach includes an estimated additional 14,400 family members of employees. Worksite wellness policies collectively reach about 30 percent of the Panhandle's population. We provide training, technical assistance, and integrate our health promotion like diabetes prevention, health coaching, tobacco-free campuses, healthy vending policies, radon kit distribution, walkable campuses, and colon cancer screening kits. Worksite wellness is a core strategy of our community health improvement plan. We do this because research-- research shows it works and it's a cost effective. Let me give you some following examples. The annual average cost to employers is nearly $4,500 per diabetic employee. Chadron Community Hospital reduced the number of employees at high risk for diabetes by 10 percent in 1 year. The hospital has offered the National Diabetes Prevention Program to employees as a support for helping lose 5 to 7 percent of their body weight which decreased their risk for diabetes by 58 percent. They adopted a smoke-free campus and provided supports and cut their tobacco rates to 9 percent which is half the Panhandle and national rates of 17 to 20 percent. At Bayard Public Schools, staff have improved consumption of fruit and vegetables by 11 percent and decreased risk for saturated fat consumption by 10 percent. In addition, there has been an 11 percent increase in those meeting recommended physical activity guidelines. They offer National Diabetes Prevention Program not just for employees, but for the community as well. They've also started a small garden. A 2016 state survey of 2,000 Nebraska businesses showed the following recommendations: businesses would benefit in multiple ways by shifting to more upstream interventions of prevention and control; community resources can be important to address worksite wellness and can often offset direct costs and responsibility of business; and, since organizations vary significantly, there is a need to have flexibility in creating a customized, effective health and wellness program. Worksite wellness is a cost-efficient model. The local public health departments have the expertise to provide technical assistance for policy level and environmental support changes. We also understand the contextual

conditions of our communities. Worksite wellness is a proven method to prevent chronic illness, and it saves money. Thank you.

STINNER: Thank you. Any questions? Seeing none, thank you.

KIM ENGEL: OK.

STINNER: And please drive safe home.

KIM ENGEL: Thank you.

JAMES MICHAEL BOWERS: Good afternoon, Senator Stinner and members of the Appropriation Committee. My name is James Michael Bowers, J-a-m-e-s M-i-c-h-a-e-l B-o-w-e-r-s. I appreciate the opportunity to testify today on behalf of myself in support of LB480. I'm a member of the Lincoln-Lancaster County Board of Health and currently serve as vice president. Public health touches absolutely everyone every single way, every single day, in many different and important ways. The Lincoln-Lancaster Health Department ensures our neighborhoods have clean water to drink, clean air to breathe, safe and sanitary childcare facilities and restaurants, access to dental and medical care, and uses data strategically to tackle challenges and threats to our public health. People need to know this, to appreciate this, and to recognize that financial support of public health is imperative. I've seen firsthand the hard work the dedicated staff accomplishes every day to keep our city and county safe and healthy. They are efficient with their resources, passionate about their causes, and effective in their results. Appropriating $50,000 to our local health department would provide a boost to our preventative health programs. In Lincoln-Lancaster County, the preventative health programs that will benefit from this funding will be selected to: increase physical activity; prevent complications from diabetes, cardiovascular disease, and other chronic diseases; improve access to medical and dental homes; increase work size-- worksite wellness initiatives; assure preventative services for children and adults; and, promote preventative health and wellness. This one-time funding would continue the gradual investment of the state in local public health, in the safety of our neighborhoods, and taking action now to mitigate and prevent further cost and harm to our community in the near future. Too often, systems wait until serious illness, disease, or public health crises occur to act. Playing a reactive role is more costly, more damaging to public health, and hampers the ability of our health departments to take a proactive role in ensuring safety. Investing in these prevention programs saves costs, protects our neighbors' health,

and allows our departments to address big issues on our terms, not us-- as-- not a disaster's. I urge you to support the passage of LB480 and would be happy to answer any questions.

STINNER: Questions? Seeing none, thank you.

JAMES MICHAEL BOWERS: Thank you.

ADI POUR: Good afternoon, Senator Stinner.

STINNER: Good afternoon.

ADI POUR: And good afternoon, members of the Appropriations Committee. My name is Adi Pour, A-d-i P-o-u-r, and I'm the health director of the Douglas County Health Department. And I'm representing today Friends of Public Health which is an advocacy group of local health directors. For the new senators, every county in the state of Nebraska has a local-- is covered by a local health department. You can think of it like a health grid across Nebraska. I'd like to thank Senator Quick for introducing LB480. During this session, it is probably correct to say that one of your overarching goals is how can we decrease property tax and income taxes, and therefore, how can we keep more money in Nebraska's pocket. I'm suggesting to you that a decrease in taxes, but a constant increase in healthcare costs, does not achieve that goal. We need to find solutions that decrease healthcare costs. And sometimes we need to invest a little up front to get to that goal. You heard before how every community conducts community health needs assessment resulting in community health improvement plans. Chronic diseases, such as diabetes and cardiovascular disease with underlying high obesity rates in adults and children, are on the top of the list. The healthcare costs of these diseases are staggering. As you have heard before, according to the Nebraska Public Health Improvement Plan, chronic diseases, such as heart disease, stroke, and diabetes, are estimated to cost Nebraskans a total of $1.875 billion per year. If we want to effect the high chronic disease healthcare costs, we need to address this from the prevention side. We know prevention works. I'd like to tell you how they make-- that may look like. Through a grant, we completed 588 surveys with just 7 questions. Thirty percent of them were positive for prediabetes, and 65 of the individuals agreed to be followed-up with a prediabetic expert and learn more about the diabetes prevention program and potentially enroll in it and/or change their dietary habits and physical activity. The monetary expenditure, but also the poor quality of life, is horrendous for buy-- for diabetics. I have said-- several diabetics in

my department, and I asked one of them the other day, if someone would have told you ten years ago that you were prediabetic, would you have made some changes in your lifestyle. He looked at me and he said, yeah, I would if anybody would have talked to me about prediabetic, but nobody did. Now I see how he's walking-- his walking is affected. He cannot run around with his grandson. His diet is made up of Ensure. I saw him carrying in about 20 cans of Ensure this morning because the cocktail of medication that he is consuming is affecting his digestive system. I saw him taking a handful of pills the other day during a meeting. I was taken back, especially as a toxicologist, wondering what other damage is caused by the interaction of these different pills knowing that the combined effect of different drugs is never tested. The other day he changed his medication again, probably another cocktail, another doctor visit, another day off from work, another day where the quality of life is miserable, and another day where money left his pocket since he has to pay $30 for every doctor visit. The most concerning finding now is his eyesight. A huge magnifying glass is on his desk to assist him in doing his work. I asked him before I came down here how many doctor visits he makes per month. And he responded, around 4 to 6 per month which is around $180 per month or $2,150 per year out of his pocket. He maxes out on his out-of-pocket expenses every year. That is $6,000. This example is from an individual that has the best health insurance through the county, and it is what- he is well-educated. He is an attorney. At least $6,000 comes out of this Nebraskan's pocket every year for the last few years, and it will continue. I hope you can see that it is not only tax relief, but also healthcare cost relief that is necessary for Nebraskans to keep more money in their pockets. We can start to address the high health care costs for the person in Omaha and the farmer in Mullen, Nebraska, by investing in good prevention programs across the state of Nebraska. Local health departments are the chief health strategists and are vital if Nebraska wants to become the healthiest state. Thank you.

STINNER: Question? Seeing none, thank you.

ADI POUR: Thank you.

TERRY STREETMAN: Hello.

STINNER: Good afternoon.

TERRY STREETMAN: Afternoon. Chair Stinner, members of the committee, my name is Terry Streetman, that's T-e-r-r-y S-t-r-e-e-t-m-a-n. I'm

the public policy manager for the Alzheimer's Association, Nebraska chapter. I'm here to testify in support of LB480 because of the importance of public health in addressing Alzheimer's disease. Alzheimer's disease is a public health crisis that needs urgent attention. It affects 5.8 million Americans and 34,000 Nebraskans over the age of 65. It's the most expensive disease in America, costing the nation $290 billion in 2019. If the disease continues on its current course, costs are projected to rise to $1.1 trillion per year by 2050. The Nebraska Medicaid costs of caring for people with Alzheimer's alone in 2018 were $361 million. Studies by the Alzheimer's Association have shown that early diagnosis of Alzheimer's disease could save $7 trillion or more in Medicaid and long-term care costs in the lifetimes of people alive in 2018. Data from the 2015 Behavioral Risk Factor Surveillance System cognitive [SIC] module showed that 1 in 11 Nebraskans over the age of 45 experienced subjective cognitive decline, an early warning sign and major risk factor for developing dementia. Of those reporting subjective cognitive decline, only 36 percent had ever spoken to a doctor about the issue. Public health and specifically local public health departments have tremendous potential for increasing early detection of Alzheimer's and other dementias through education and awareness about early warning signs of dementia. The growing scientific consensus shows us that people can take certain steps to reduce their risk of cognitive decline. Public health departments are uniquely positioned to provide education on brain health and risk reduction either through new education and awareness campaigns or simply through incorporating brain health and risk reduction messaging into existing campaigns on subjects like heart health, tobacco cessation, and others. Appropriations such as those proposed in LB480 could provide funding necessary for campaigns like these, paying major dividends down the road in the form of Medicaid and long-term care savings. For these reasons, I urge the committee and the Unicameral to support appropriations such as those in LB480 for local public health departments' work on health promotion and preventive health. Thank you for the opportunity to testify, and I'd answer any questions.

STINNER: Thank you. Questions? Seeing none, thank you.

TERRY STREETMAN: Thank you.

STINNER: Any additional proponents? Seeing none, any opponents? Seeing none, anyone in the neutral capacity? Seeing none, Senator Quick, would you like a closing?

QUICK: Yeah, thank you. Thank you, Chairman Stinner and members of the Appropriations Committee. I think you heard from the proponents of the-- of this bill that this is an important issue for Nebraska. And I know when I looked at their Web site and all the services they provide, I think they-- they provide a vital service to-- to our communities. You know, under their topics there's community health, there's environmental health, emergency preparedness, and health projects. And they work on all these different-- in these different areas. And there's many-- if you get the chance to look at their Web site, I would encourage you to look at their Web site and see all the services that they provide and how they help our communities and the residents of our state. And with that, I hope you would support this and include this-- and give them the money to help with their-- with their services. Thank you.

STINNER: Any questions? Seeing none, thank you. I do have some letters of support for LB480 from: Dennis Kment from Elkhorn Logan Valley Health-- Public Health; Aaron Lanik; David O'Doherty; Cheryl Frickel; and, Nanette Shackelford. That concludes our hearing on LB480. And concerning-- we're going to take a ten-minute break so the clerk and other folks can take a break.